President’s Column

Cheryl “SKID” Lowry, Col, USAF, MC, SFS
President, Society of United States Air Force Flight Surgeons

Our editorial staff chose leadership as the focus for this issue of FlightLines. Leadership has always been in the DNA of physicians having the motivation and honor to serve as flight surgeons. Check out the “USAFSAM at 100” article for a brief glimpse into our heritage. There are also great leadership pearls from your fellow flight surgeons.

The Air Force Medical Service (AFMS) is on the precipice of significant changes to the delivery of healthcare and support of the operational mission. While we have been deploying constantly since most of you have been in the Air Force, our in-garrison focus seems to have been on the delivery of healthcare. As a Service, we need to sharpen our skills in support of our line and deployment missions. That mission is what keeps many of us in the Air Force. You can see in the “USAFSAM at 100” article how flight surgeons were instrumental in the development of life support systems and other technologies supporting our aviators...the AFMS is pivoting back to a focus on readiness and line support, so it’s a great time to be a physician leader in our Air Force. Step up.

Already in command? Not ready for command yet? Check out Mav’s article on AsMA fellowship. Many of our daily flight surgeon activities count for “credit” toward fellowship. Any of our fellows would be glad to help you understand which of those activities count and how to document them. The Fellows Group has transformed the way they nominate and select fellows – it’s not as difficult as you might think.

If you’re attending AsMA, please stop by the SoUSAFFS table and get a ticket for the SoUSAFFS social. This year we are doing a brewery takeover and serving BBQ as we celebrate 100 years of flight surgeon support to the operational mission. Don’t miss out on this opportunity!

Cheers,
Skid
From the Editor

Brad “Candyman” Brough, Lt Col, USAF, MC, FS
Centennial RAM (XVIII)

This year we celebrate 100 years of aerospace medicine! In 1918, Captain Robert J. Hunter from Tennessee was the first flight surgeon to graduate from what is now known as the USAF School of Aerospace Medicine (USAFSAM). After graduation, many in this first class were sent off to Europe and aided the aviator while serving near the front lines of World War I. Since then, flight surgeons have helped drive safety and improved performance and health of our military. And wherever we go, we are right there with our patients.

Just as these early pioneers in aerospace medicine led the charge for improved safety and performance, we as physicians are needed to lead now. Huge changes are on the horizon. With the 2017 NDAA and DHA, no one knows what the AFMS will look like in the future. One thing that will always be needed, though, is leadership. Whether that’s big AF leadership or local clinic leadership, as physicians we are leaders. Our leadership may come in the form of leading our clinical team to provide excellent care or leading a hospital, but as physicians we need to lead. Because if we don’t, others will. And as physicians, only we know what is best for our patients. So, this edition is heavy with leadership pearls. We hope you find something here you can immediately implement in your life and career to try to be a better leader.

Additionally, we have some great “So there I was” stories. Lt Col Woodard shares his recent experience on the ice of Antarctica and Col Anderson-Doze talks about hurricane humanitarian operations. Finally, Maj Jameson Voss from USAFSAM will provide historical perspective for us as we begin to celebrate 100 years of aerospace medicine!

Keep ‘em flying! 🚀
Candyman

Call for Content

What makes FlightLines great is that it connects us with the rapid changes and variety of expertise that exist in USAF flight medicine. Send us news that affects us all, teach us about your area of expertise, and share with us your “There I was…” stories from the field. (Include your pictures!)

Submission guidelines:
500-3000 words
Pictures 300 dpi or better in.tif or .jpg

Send your articles, news, suggestions, or comments to:

michael.brough.1@us.af.mil

Moving, need your FlightLines sent to another email address? For FlightLines distribution/email update, please contact the Executive Editor, michael.brough.1@us.af.mil.
As a constituent organization of AsMA, a condition of membership within this Society is to also be an AsMA member. As such, each of you should see, and be afforded, a path to AsMA Fellowship as part of your aeromedical professional development. In past years the AsMA Fellow’s Group was seen by many (and fairly so) as an insular network with vague rules and processes for application and acceptance. A concerted effort was made over a decade ago to add transparency, accountability, and fairness to the process. Having lost some ground over the years on those initial efforts, the Chair of the AsMA Fellows chartered a group to redouble efforts to improve how AsMA Fellows are nominated and approved. The changes were voted upon in the past months by the Fellow’s Group and presented and approved at AsMA Council on 15 Nov 2017. The details of the approved changes can be found on the Fellows Page after logging into the Members Section of the AsMA website at https://www.asma.org/members-only/fellows.

So what does it take to become an AsMA Fellow? In short, you must be engaged and contribute to both the profession of Aerospace Medicine and to the organization bodies of AsMA and/or its constituents. All such activities earn points, the scoring of which is detailed in the Fellows Evaluation Committee Points Calculation Sheet, which can also be found at the site hyperlinked above. One of the significant changes mentioned above is that the threshold for Fellowship is now firmly established at 130 points. Nominees must also now be AsMA members in good standing for a period of only 7 years. The Fellows Group reserves the right to not nominate and seat Fellows based upon validated issues of professional misconduct and/or ethics violations.

So what kinds of flight surgeon activities earn you points for Fellowship? Just about everything you do: each year (full or part-time) spent practicing as a flight surgeon; membership in international aerospace committees or organizations (you might be involved in such bodies as part of your military duties); publishing peer-reviewed articles and abstracts, or being a reviewer for the “blue journal” (Aerospace Medicine and Human Performance); formal teaching positions at aerospace medicine instructional courses; presentations on aeromedical topics (be careful here – if giving the same presentation at a recurring aircrew training event that only counts once/year, but if each presentation topic is different they can be counted separately); your highest (and additional) educational degrees; internship, residency, and fellowship training; additional formal aerospace medicine courses not part of internship/residency/fellowship curricula; board certification as well as service on a specialty certification board; special interest activities and certification/ratings (Aviation, SCUBA, Parachuting, Extreme Cold Environments). Keep track of all of it. AsMA is working to web-ize the tracking database to make it easier to enter and track your activities and points.

But remember, you must also demonstrate engagement and commitment to AsMA and/or its constituent organizations. These activities also earn points. The easiest method is to first Show Up. AsMA membership and attendance at annual AsMA meetings earn points, with additional points if you make a presentation during the meeting. But more than that, get involved. Sign up and participate in any of the wide variety of AsMA committees and other leadership positions that do all the work behind the scenes for our collective aeromedical profession. Talk with the leaders of this or other constituent organizations to figure out where they can use your talents. You can sign up for AsMA committees at the registration desk during an annual AsMA meeting or go to Members Login at www.asma.org, explore online, and contact the Chair of any committees that grab your interest.

Lastly, you need a nomination from a current AsMA Fellow. Ask around; you probably know many. Keep an eye out at the AsMA meeting for the yellow Fellow ribbons. Better yet, go to the Fellows page at asma.org and look at the full list of Fellows. Find one you recognize and let him or her know you are interested in AsMA Fellowship and that you’ve met the criteria of 130 points and 7 years of AsMA membership. Hopefully, one or more of those Fellows is also reaching out to you.

If you’re already a Fellow and reading this, your charge is to search out those among us who you know meet the qualifications, offer to nominate them, and mentor them along the way. For too long we’ve had too few of our deserving Society members recognized as Fellows. Let’s do our part to change that.

If your chosen professional path is in the field of Aerospace Medicine, then you should aspire to AsMA Fellowship, as recognition of your achievements and contributions within the field. With the recent changes enacted by the Fellows Group, that path has now become even more clear and attainable for each of you.
The Aerospace Medical Association (AsMA) has a rich history dating back to Dr. Louis Bauer, who served as the founding president in 1929. How remarkable for an occupational medicine subspecialty to become its own organization so shortly after the first heavier than air flight in 1903? Just imagine if an institution dedicated to aerospace medicine was founded even before AsMA and led by founders of equal caliber to Dr. Bauer. Gather round to read the history of just such an institution.

A century ago in 1918, the Aviation Medical Research Board established a laboratory at Hazelhurst Field (in Long Island, NY) with physicians they named “flight surgeons” – a title coined for specialists dedicated to the health of aviators. Major Louis Bauer served as the first commandant of this institution. By 1922, the school for educating flight surgeons and the aeromedical research laboratory were combined into the School of Aviation Medicine. It is now known as the United States Air Force School of Aerospace Medicine (USAFSAM). Not surprisingly, 2018 is a significant year for USAFSAM as it celebrates this centennial milestone.

Our motto for the centennial celebration is “Honoring the Past, Shaping the Future.” Recognizing the legacy of USAFSAM involves a combination of historical developments and leaders who have shaped us. Throughout the year, USAFSAM will be posting press releases celebrating both. The first press release summarized the history of USAFSAM including the educational and scientific contributions that have impacted other fields [www.wpafb.af.mil/News/Article-Display/Article/1387369/usafsam-prepares-for-centennial-celebration/]. To mark the exact date of the centennial (January 19th, 1918), a formal dining out on January 19, 2018 allowed current and former leaders in the Air Force and community to celebrate these historical milestones and contributions. Throughout the remainder of the year, USAFSAM will release short biographies of exemplars who have personally shaped our history in inspirational ways.

To give a brief taste of USAFSAM’s history, consider World War II, when it became clear aviation was critical to operational success. Only 490 flight surgeons were trained from 1919 to 1940. However, by 1943, the School graduated more than 2000 flight surgeons to meet mission demands. It began training enlisted personnel who would assist flight surgeons and added a course in altitude physiology for non-physicians. The School also renewed emphasis on research, led by (then Lt Col) Harry Armstrong. Two notable innovations under Armstrong’s leadership included the development of the respirator and the first air transportable iron lung, exemplifying the school’s expertise in aeromedical evacuation. Additionally, Armstrong created the Department of Space Medicine, beginning the transition from aviation medicine into the realm of aerospace medicine.

For the next decade, the School led the nation’s space medicine research – studying cosmic radiation, advancing toxicology standards, and developing “space food.” This work created a foundation for NASA. Even after NASA was founded, the School continued to contribute to the space program. All astronauts accomplished their centrifuge and other training at USAFSAM through the end of the Shuttle program.

In 1961, the School joined a newly created Aerospace Medical Division in a complex at San Antonio. On November 21, 1963, President John F. Kennedy dedicated this new complex in what would turn out to be his last public speaking engagement. He was assassinated the next day.

During the Vietnam War, the School’s training mission changed. It grew along with the number of medical specialists in the Air Force. Research drove course development to address tropical diseases, aeromedical evacuation, and hyperbaric medicine. Researchers at the School created the first image of living tissue using nuclear magnetic resonance (what would mature into MRI). They also demonstrated a laser could reshape the cornea of the eye with almost immediate recovery (later applied in PRK).

The 1970s and 1980s witnessed USAFSAM’s focus shift yet again. The School concentrated on emerging aircraft challenges, preventive medicine, including cardiovascular risk prevention as well as chemical, biological, radiological, and nuclear research. Many of the School’s clinical studies also came to fruition, including soft contact lenses, chemical antidotes, and fatigue countermeasures.
In the 1990s, the School was marked by growth across the disciplines of consultation, education, and research. It added consultation back to its mission and reacquired the aeromedical library - the largest library in the world of its type. Around the same time, USAFSAM evolved into the training and development catalyst for Combat Medicine, eventually establishing the Expeditionary Medical Support platform and the Centers for Sustainment of Trauma and Readiness Skills. The School’s international training program expanded. By the early 2000s, after 9/11, homeland security and disaster response received increased emphasis.

As USAFSAM entered the 2000s, researchers developed enhanced biomarkers, refined operational vision assessments, and engaged in a multidisciplinary response to questions about the F-22 life support system. On the education and training side of the house, student throughput was at peak levels and the School tailored new courses to meet new Air Force demands. A renewed emphasis on the human operator focused studies to apply the behavioral and psychological aspects of flight in manned systems to “unmanned” and remotely piloted systems.

On March 25, 2008, Air Force Research Laboratory (AFRL) officials activated the 71st Human Performance Wing (HPW) at Wright-Patterson. This realignment moved most of the Texas HPW components – including USAFSAM – to Ohio over the next several years to merge into AFRL. Simultaneously, the School absorbed the Air Force Institute for Operational Health. As a result, the School received—and continues to receive—tens of thousands of respiratory samples each week from around the globe, making it one of the largest influenza and respiratory disease surveillance activities in the world. The laboratory plays an important and ongoing role in global infectious disease outbreaks (e.g., influenza and Zika virus).

While dynamic and responsive over the past 100 years, the core of USAFSAM’s original mission continues today: optimize and sustain Airmen health and performance through world-class education, expert consultation, and operationally focused research.

If you’re inspired by this history, please spread the word about this year in Aerospace Medicine and help us celebrate USAFSAM as an important institution in this field. Keep an eye out for future press releases and public events this year where you can help celebrate this milestone.

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**International Health Specialist Program**

**Wesley D. Palmer, Col, USAF, MC, FS**

Program Director, USAF International Health Specialist Program, AFMSA/SG3XI

One of the great aspects of being a military physician is the unique experiences that military service affords compared to civilian practice. In Air Force medicine, this is certainly true for those who have chosen Flight Medicine as a career path. I don't have to extol the virtues of Flight Medicine to this audience, but I would like to briefly discuss another military-unique opportunity that you might not know about—the International Health Specialist (IHS) Program. The AFMS awards a Special Experience Identifier (SEI) to those members with international and cross-cultural insight along with global health expertise. We have IHS teams posted with AFSOC and each of the Geographic Combatant Commands (except NORTHCOM). Each IHS team engages in various operations, activities, and actions (OAAs) with partner nations in their respective AORs. In particular for the military-to-military lines of effort related to aviation enterprise development, each team requires a flight surgeon to oversee, manage, and conduct OAAs related to his or her flight medicine expertise. To read more about various AFMS global health engagements, [http://www.airforcemedicine.af.mil/Organizations/Global-Health-Engagement/](http://www.airforcemedicine.af.mil/Organizations/Global-Health-Engagement/) or the IHS Facebook page at [https://www.facebook.com/AirForceIHS/](https://www.facebook.com/AirForceIHS/).

If you’d like to know more about the IHS program or would like to apply for the IHS SEI, please visit the IHS Kx page at [https://kx2.afms.mil/kj/kx4/InternationalHealthSpecialist/Pages/home.aspx](https://kx2.afms.mil/kj/kx4/InternationalHealthSpecialist/Pages/home.aspx).
I’m not one of those guys who had to be talked into competing for command. I knew I wanted to try for a squadron when I returned to active duty. Whether I am doing a good job of it is open for debate, but 6 months into command, I am happy with the decision…when not sitting in a meeting. True, I am in Germany at a wonderful little base with a straightforward mission, which really helps! And I followed a commander who had the squadron in super shape when I arrived, which also helped. But because relay races are often lost when passing the baton, I believed nothing was so good I couldn’t fowl it up when it was my turn. So I talked to a lot of good people before I arrived. It is remarkable how accurate people’s predictions were, how helpful the advice I received has been, and how important a very few lessons have proven. What follows is a personal reflection on my first 6 months in the seat, trying to apply what I learned.

Predictions

Many people and resources insisted the first 90 days in command would be a challenge. In fact, I heard a lot of interesting metaphors, but the consensus was that we all have to go through it, and life improves around that time. Retired Col John Knabel is a former U.S. Marine Corps F-18 and U.S. Air Force F-16 pilot, but in 2017 he commanded the 178th Wing in Springfield, OH. He told me taking command for the first time would be like taking that first hit in a football game. It shocks you. It demands your attention. But you shake off the pain and say to yourself, “Yeah, I recognize this. I can do this.” You’ll see his name again. Col Chris “BIG” Bird, now the 355th Medical Group commander at Davis-Monthan Air Force Base, AZ, told me the first 90 days felt like physical drowning when he took his first squadron command at Tyndall AFB, FL. (Sorry, Zombie, I’m sure it won’t be like that for you!) Other people expressed the same sentiment in less graphic terms, but the thought was nearly universal. Those first 3 months are tough.

While at Wright-Patterson AFB, OH, during the RAM, I lived across the street from Col Bret Burton, Air Force Materiel Command deputy surgeon general, as well as graduated squadron and group commander. We ran together once a week, except when we trained for the Air Force half marathon he talked me into, when it was three times a week. On those runs, I got an in-depth education in command. He told me a 2-year command breaks down into three blocks. The first 6 months are learning, the middle 12 are implementing, and the last 6 are transitioning. I had almost forgotten this early on. But around the 4-month point, our team crafted a strategic plan for the squadron. We began to implement it in January, which marked the 6-month point. For a number of reasons, it just didn’t make sense to start sooner. For the next year, we will work it before starting the last 6 months of transition. My colleague, 52nd Medical Operations Squadron commander Lt Col Becky Elliott, confirms having experienced this phenomenon, just as Col Burton had projected. She is in her final 6 months.

Advice

Let’s return to Col Knabel. Fighter pilots tend to tell it exactly like they see it. His first response to my question about what a wing commander wants from a squadron commander was “don’t make me do your job,” referring to commanders who refuse to discipline, but instead pass the buck. I face such times with his words in my cranium. His second was “be yourself; the Air Force chose you to command for a reason.” Don’t try to be anyone but yourself. But try very hard to make it your best possible self.

Another interesting nugget is to always say “yes.” That’s from Col Lee Harvis, now Pacific Air Forces surgeon general, and if my understanding is correct, the first RAM selected for a star in quite a few years. His advice requires some explanation. My natural tendency is to want to protect my people, and much of the popular leadership and productivity literature urges us to learn to say “no.” To achieve great results, we have to focus, right? But the rest of the answer is “and here’s what it will cost you.” So he was actually saying the same thing in another way. We all work for somebody, and that person has a mission. When I get a tasking, I owe it to my boss to let him know what the bill will be. If I don’t have the resources to do everything I was doing before as well as his new tasking, he gets to decide where I’ll focus. But I think Col Harvis was going a little deeper. We don’t want to let great opportunities for our people pass by. Retired Col Russ Turner, a graduated commander now working at the U.S. Air Force School of Aerospace Medicine, echoed that. What has surprised me is how much I now value it when people in my squadron follow this advice! Please don’t lead with “no.” Tell me if you can meet commander’s intent, and tell me the cost. We’ll sort out details later.

The next gem from Col Burton appears to flip the rest of it on its cranium. Upon taking command, first ask for help before offering it. He told me it would be better to put myself in debt to others. He believed it would demonstrate humility. He was right! It would have been fake to ride into town full of bravado. Excited about the potential, yes. Ready and willing to help the team, absolutely! But hopefully, admitting my weak spots early on told my fellow commanders, three letters, and squadron teammates that I was there to learn.

I’m also forever grateful to Col Burton for this: Communicate your expectations early. What chance does your team have of fulfilling expectations if they don’t know what those expectations are? Col Burton had delivered letters outlining his expectations for his direct reports when he was in command. So I did the same for each flight commander and flight surgeon I rate. Each of us knows going in to a feedback session what we’ll talk about, and the person I rate already has an idea of what I’ll say.

The last bit of advice I will recount is to get your core leadership team together often and don’t make big decisions without them. Those include your deputy and your squadron superintendent. These wise words came from USAFSAM commander Col Alden Hilton, and old friend from internship at Scott AFB, IL. Sharing the load has made a difference. I value their counsel and assistance. Col Hilton said it helps decrease pressure to always be at the office, and it makes it more likely I’ll actually go on leave once in a while. Right again. In fact, I’m actually on leave on one of the days I’m writing this. My deputy has the stick, and I’m not a bit concerned things are spinning out of control.

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Lessons Learned

Show up with your priorities straight. I knew my “why,” and that was important. Col Knabel was right about that first football hit. It does shake you up. I think you can either let it set you back or remind you that what you’re doing is a real job with real people and real consequences. But you also feel like you’re drowning in a river of queep until you learn to triage the demands on your time. Your “why” determines how you triage.

Show up with a plan. General Eisenhower is said to have stated, “In preparing for battle I have always found that plans are useless, but planning is indispensable.” There are probably some good reasons that man wore five stars. When you make your plan before command, you consider your priorities (see above), estimate your early mission objectives, and determine how to accomplish them. Then when your first plan makes first contact with the enemy and goes to pieces, you fall back on your priorities and make a new plan. But it’s easier since you’ve done it before, and it’s far more applicable, because you now have eyes on.

Communication is a really, really, big deal. Bigger than I ever realized, and I thought it was a big deal before. When two people in my squadron aren’t getting along, it’s likely they haven’t communicated expectations to each other. When I am unhappy with somebody’s performance, it’s often because I didn’t communicate expectations clearly. Remember in medical school how we were taught if we find ourselves getting angry at a patient, think about personality disorders? I believe when we see emotional temperatures rise, we should first look at communication.

Prepare for false summits. Three weeks into the job, I had a really funny thought. I believed I was getting the hang of this job. Then we sat down in a readiness meeting. I rejected my premature conclusion, which had been just flat out stupid. But it happened again in December, a story I can’t tell in this forum. My guess is I’ll continue to have grandiose thoughts of competence from time to time, only to become disillusioned shortly thereafter.

Final Words

People did not come to me with these ideas. I looked for people who were doing things I thought were cool and I asked. I hope young flight docs are doing the same, whether or not they are preparing for command. I also recommend supplementing good advice from trusted mentors with solid reading. Because if you’re like me, you’re not usually willing to bug people with your questions before 0700 on a regular basis. Unless I’m bugging Col Burton, who brought it on himself when he talked a reformed offensive lineman into running a half marathon. Here’s an abbreviated list of books I found very helpful:


My new boss, Col Ed LaGrou, 52 MDG/CC, making the biggest mistake of his life handing me the guidon at the 52 AMDS change of command. See how scared he looks??? (U.S. Air Force photo by Staff Sgt. Jonathan Snyder)
My Tips on Leadership

Christopher E. Backus, Lt Col, USAF, MC, FS
Commander, 87th Aerospace Medicine Squadron

Leadership is a topic that has been written about countless times, but each book or article can contribute to understanding, which I hope this will. Two books on leadership I recently read were *American Generalship: Character is Everything* by Edgar Puryear and *Leaders Eat Last* by Simon Sinek. I mention those up front because my views on leadership are not unique, so I want to give credit to those who have influenced me. I’m certainly not perfect, and what little I know I’ve learned in the process of trying to improve. My goal is to provide some advice that you can apply now and throughout your career.

Leadership is more than “Command.” Every flight surgeon is a leader, so try to be a good one! You start by leading yourself. Every time you choose to study instead of your preferred recreation that is self-leadership. Leading yourself must become as natural and as automatic as breathing, because we have too many examples of leaders who had lapses in personal leadership that impaired their ability to lead others. Stay fit. Keep up your medical skills. Control your emotions. Then, once you’re leading yourself in the right way, lead in your clinic. Strive for better patient encounters leading to happier, better counseled patients with more informed commanders. Ask your technicians for a debrief after a day of clinic and see how you could improve. If you see something you know or understand better than one of your peers, teach it. If you do these basics, you will have a great start.

Selflessness is the core of leadership. If you’re thinking about how to make yourself look good, you’re not thinking about how to accomplish the mission, heal the patient, or help your tech. The Air Force and the AFMS have made this pretty easy for us—focus on your people and being the best at your profession, and you’ll likely get promoted to Lieutenant Colonel and probably Colonel, especially if you study how to be better in our profession (PME). So, you’ve got no reason to be self-centered! They’ve made it so that part takes care of itself for us. Why? So we can focus on what’s more important—the mission and the people. Don’t waste those opportunities we’ve been given.

One of my central tenets is to not overcomplicate things. Get back to the basics. Be fit, wear your uniform right, show up where you’re supposed to be on time (which is 5 minutes early), know your job, try to know your boss’s priorities and his boss’s priorities, meet needs before you’re told to, practice good medicine, and be good to your people—it’s really that easy. In a short paragraph, I believe I’ve captured the gist of our career. It’s not the knowledge, it’s the execution that’s hard. So, when I hit a low point and feel like I’m failing, I go back to the basics. What can I do to meet one of those tasks? Can I walk around my unit and see how others are? Should I go for a run? Don’t make it mentally complicated, because it’s not; just do the right thing and you’ll be a good leader.

Command – I’m not egotistical enough to think I’m the expert on the topic after 18 months of experience, but…if you ever think you’re the only one with imposter syndrome, don’t. We all learned “see one, do one, teach one,” right? To me, command has been all about implementing the basics I discussed above. The theme for my change of command speech was that it’s not about me. I wanted to send the message immediately to my Airmen that I realized that. Then, having said it in public, I set about proving it. Col Lee Harvis gave me a great talk at AsMA in Atlantic City the spring before I took command. One of his central themes was loyalty. I listened and I aligned myself with my commander. My commander saw that and took me under his wing, teaching and guiding me to be a better leader. My commander saw the basics I discussed above. The theme for my change of command speech was that it’s not about me. I wanted to send the message immediately to your people and being the best at your profession, and you’ll likely get promoted to Lieutenant Colonel and probably Colonel, especially if you study how to be better in our profession (PME). So, you’ve got no reason to be self-centered! They’ve made it so that part takes care of itself for us. Why? So we can focus on what’s more important—the mission and the people. Don’t waste those opportunities we’ve been given.

One challenge was dealing with a situation where one of my Airmen was being investigated for sexual assault. My commander considered canceling my temporary duty travels, but the investigation report wasn’t complete, so there was little I could do immediately. I continued to my temporary duty location, but my mind was still largely at home. Discipline is one of the most difficult roles for a military commander, because you can’t use the basic strategy of trust and empower. Leading up to this, I had provided my Airmen with the understanding that there were differences between mistakes and crimes. I didn’t jump to conclusions or take drastic measures. Instead, I worked through the situation by consulting the wing legal team at every step. I treated my Airman like one of my Airmen throughout, because whether they’re suspected of a crime or just about to receive an award, they always deserve that. Ultimately, that was the right strategy and we were able to bring this case to the appropriate conclusion to protect the alleged victim, maintain standards of good order and discipline, and protect the Airman accused of a crime. I learned from the experience and have had to apply those lessons since.

Another situation in which I applied those lessons was when another Airman decided to drive while intoxicated. I received a letter from the Airman’s parents recommending leniency in discipline. Many commanders would not have replied, but I believe part of my role as a commander was to respond to the parents with an explanation of decisions I would make that would affect the Airman. I crafted a response and had the wing legal team evaluate it before I sent it. I openly discussed the difficult balance I needed to strike between setting a standard for my unit that made good order and discipline a clear priority, teaching this Airman judgment to protect himself and others in the future, and trying not to end his career or discourage him from reaching his potential. It is a difficult balance and even tougher to put into words for concerned parents, but I did my best, because I think that’s what commanders do.

Leadership is needed at all levels of the Air Force and the AFMS. We’re clearly called to be these leaders, whether in the exam room, the classroom, or the executive meeting room. Lead yourself first. Stay true to your roots, maintaining credibility in the exam room and in the aircraft. Grow yourself and reach your own potential, pulling your fellow Airmen up with you. No matter your duty title, then you’ll be a leader.
Attributes of a Highly Effective Leader

Christopher “BIG” Bird, Col, USAF, MC, CFS
Commander, 355th Medical Group

Being a commander in the United States Air Force, I have had many opportunities to work on developing my leadership philosophy and style. I occasionally find myself thinking back on past leaders that I have had and consider what they might have done in a given situation. By paying attention, someone can learn from good leaders as well as those who were not so good. For instance, I recall a supervisor who made some very critical remarks on an evaluation. After asking for clarification and examples, she refused to provide any additional information that could have been useful to me. From this, I have learned to be open and honest with those I evaluate and always provide specific, constructive criticisms when needed. Typically, I try to remember those good leaders and emulate what I think they might have done in the moment, and have strived to use these instances to develop a foundation for being a good leader.

One of the most important lessons that I have learned is the concept of enhancing your personal strengths, rather than attempting to improve your weaknesses. You are selected as a leader because somebody sees potential traits that set you up for success. Nobody can be the perfect, ideal leader, and focusing too much attention on minor deficiencies will only make you mediocre. By amplifying your strengths, you can constantly improve and eventually move toward being an outstanding leader.

Over my tenure as a commander, I have come to realize that there are three attributes that pay extreme dividends to being an effective leader, and having a deficit in these areas can create fatal flaws. These attributes are humility, approachability, and availability. Humility ultimately means that you have the mindset to be a continuous learner. Effective leaders listen to their people and do not always jump to a solution without consulting their advisors. Most people can describe leaders as one who is humble or not, but this can be a learned behavior. Additionally, humility can help feed into approachability. An effective leader is one whose followers feel comfortable approaching at any time for any reason, whether it is good or bad. Clearly, a leader who is unapproachable is ineffective. Approachability means nothing unless the leader is also available. Most people have probably had experience with a leader who had an “open door policy” but was never around or worse, those who hid behind actual or virtual barriers making it difficult to contact.

As I have developed as a leader, I have developed my own leadership philosophy. The framework of any philosophy naturally begins based on a pattern found in a book or discussion with a mentor and is fed by personal feelings and experiences, typically through the process of trial and error. For me, my values are communication, compliance, and professionalism. These are the focus areas that I expect my medics to apply to their jobs on a daily basis. Communication is essential in any military organization. We have heard of the term “fog of war,” which is a loss of situational awareness in a conflict, but also applies to our operations in a nonconfictual state. If we are not communicating, then various entities within an organization begin to move out of sync and eventually become unproductive. Continuous, timely, and clear communication can help achieve synchronicity and improve the performance of the unit. This communication needs to be vertical, up and down the chain of command, as well as horizontal, meaning flights and squadrons are communicating effectively.

As a military and a medical institution, we are expected to comply with vast amounts of instructions and regulations. These include Department of Defense instructions, Air Force instructions, Medical Group instructions, and requirements from civilian accrediting bodies, such as The Joint Commission. I have made it explicitly clear that we are not to ignore standards that we do not agree with or feel that do not apply to us. There are processes in place to request waivers for these circumstances. Furthermore, I have stressed to my Airmen that we need to have an explicit knowledge of the requirements so that we know where we stand at all times. Certainly, understanding picks up as a unit nears a UEI, for example, but this needs to be a continuous process and adjustments need to be made as these regulations evolve.

My third leadership value is professionalism, which encompasses several key points. Trusted Care is the process by which our Medical Group works to enhance patient safety. While certainly not the only reason for embracing this concept, one of the quickest ways for patients to lose confidence in our organization is to needlessly allow harm to come to them. We strive to prevent as much harm as possible to our patients. Attention to detail is a cornerstone of a professional organization. Sloppy work at all levels, no matter how minute, propagates an air of unprofessionalism. Another key component of a professional organization is the concept of teamwork. Nobody can do everything by themselves, and we should be watching out for our peers and those who follow us.

While the core of my leadership philosophy is composed of communication, compliance, and professionalism, there are additional concepts that I feel are required as a baseline. The Air Force core values provide a starting point that all can agree to adhere to and hold each other accountable. Dignity and respect for each other are absolutely vital in being an effective organization. Having fun without compromising professionalism helps in making tough times more bearable. Finally, remembering to find balance can help maintain resiliency when stress levels begin to reach critical mass.

Remember, while there are many who naturally possess the qualities of a good leader, being a great leader requires continuous learning and self-evaluation. Never be so afraid of making mistakes that you fail to develop these qualities. Rather, be bold and move with conviction, always pausing momentarily to assess what went right and what went wrong. Over time, you will develop a philosophy that amplifies your natural qualities and puts you on the path to become an exceptional leader.
There are thousands of books, articles, and websites devoted to leadership. We also get some principles in PME and from mentors, but it is clear that the “secret” to being a good leader is elusive, and sometimes illusive. That is to say that there is no one single effective leadership style. What follows are 12 principles that served me well in my two tours as a squadron commander.

1. **Embody the Air Force Core Values.** Every belief system needs a touchstone, a “true north,” and for us it is our Core Values. Do the right thing, aspire to excellence, and serve your people and the mission. Adhering to them is 90% of success.

2. **Be authentic.** Be the best you that you can be. Being authentic and sincere fosters trust. Don’t pretend to be something that you’re not because all facades are easily (and inevitably) seen through. When that happens, you lose credibility and respect.

3. **Develop a leadership philosophy, communicate it, and be consistent.** In my experience, Airmen respect a system where the rules and expectations are well known and uniformly applied. Tell your Airmen what you hold important, what “redlines” exist for you, and how you view life, the Air Force, and everything. When they face a dilemma, they need to be able to ask themselves (or have their superiors ask them), “What would the Squadron Commander do?” and know the answer.

4. **Develop emotional intelligence (EQ).** EQ focuses on empathy, the control of emotions, and honest self-reflection. I truly believe that it adds “meat” to the “bones” of any leadership philosophy. View situations from another person’s perspective to help you gain better insight into the issue and reduce your blind spots and the pitfalls of “optics” in decision-making. Manage your emotions so you can make better decisions and avoid regrettable consequences (e.g., don’t email angry – ever!). Be honest with yourself – the good and the bad. Acknowledge your limitations, admit your mistakes, address where you have made a bad call, and work to overcome them or do better. EQ cultivates an environment of dignity and respect, which in turn leads to better stability, teamwork, and productivity. Finally, EQ helps you to connect and communicate with your Airmen. As the adage goes, “People don’t care how much you know until they know how much you care.” Really knowing your people and taking an interest in their overall well-being will get the best out of them and make your squadron better.

5. **Know and support your commander.** Don’t forget who – and what – you are working for. It is great to have a squadron and people to lead, but you also have to nest your priorities within those of your MDG/CC and your WG/CC (remember who signs your OPR)!. If your squadron’s activities are not supporting theirs, then you need to recage your gyro and figure out how to do so.

6. **You are not an Air Force of one.** While responsibility for your squadron ultimately rests on your shoulders, you have a supporting cast to help you. Seek feedback from your MDG/CC, bounce ideas off your fellow Sq/Ccs, and phone a friend/mentor. But don’t forget your Superintendent, the First Sergeant, your Flt/CCs, and NCOICs. Sharing your decision-making process with others adds granularity to your leadership philosophy and enables better decisions upstream, downstream, and sidestream. This also means that there are things that can be delegated so that you don’t get overwhelmed.

7. **Do the “housekeeping.”** Make sure the little things reflect the qualities that you want you and your organization to stand for. Be on time, meet suspenses, do what you say you’ll do, be courteous and professional, adhere to dress and appearance, customs and courtesies, and fitness standards, proofread correspondence, keep a neat workplace. Strive for a reputation of dependability, effectiveness, and honor.

8. **Be flexible, but principled in your flexibility.** Commanders live in the gray space between black and white. You will sometimes have to make exceptions or deviate from a standard or norm. When you do, make sure that there is good reason to do so, that it is defensible and comports with your leadership philosophy, and that your rationale is effectively communicated to all involved.

9. **Be humble and give credit where credit is due.** Respect the responsibility of command. It’s not about you, it’s about the success of your organization, which is a reflection of you. Recognize hard work, good work, good deeds, and great ideas. Conversely, do not place blame. Instead, focus on how/why a problem occurred and its solution. Try to seek win-win situations inside and outside your unit. This helps you lead out of inspiration, not fear.

10. **Never stop growing or learning.** Leadership is an evolutionary process. There are lessons to be gained from every situation, and what works in one may not work in another. Always seek to improve – and at times change – how you lead. Actively seek the growth and betterment of your people and your unit, as well.

11. **Be accessible and be there for your people.** Don’t rule from an ivory tower. Get out and get to know your people. Engage with them and participate in activities with them. Take an interest in their lives, and do what you can to help them. Have an open door policy: let them know when your door might necessarily have to be shut and when it will always be open. In other words, there are times when you can’t talk with an Airman, but there are also other times when you will clear your entire schedule for them.

12. **Enjoy the privilege of being a commander.** By this, I don’t mean that you should revel in the title, the parking space, the social invites, or people standing up when you enter the room. Rather, enjoy the tour. You are shaping people’s lives, affecting the mission, and making a difference. Have fun with your people and savor every minute of it because it is arguably the best job in the Air Force.

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**Call for Patch Design**

Attention artists! SoUSAFFS is looking for a patch and coin design. If you have an idea that captures the spirit of SoUSAFFS, please send your draft design or idea to VADER (christopher.mclaughlin.11@us.af.mil) and Candyman (michael.brough.1@us.af.mil). Drafts will be evaluated by the SoUSAFFS Board of Governors. We are looking forward to your submissions.

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Leadership Pearls by Lt Gen(r) Tom Travis  
Senior Vice President, USUHS

Brad “Candyman” Brough, Lt Col, USAF, MC, FS  
Centennial RAM (XVIII)

From 2012-2015, our medical service was led by Lt Gen Tom Travis, the 21st Surgeon General of the Air Force. Since his retirement, he continues to find ways to lead, currently serving as a Senior Vice President for the Uniformed Services University of the Health Sciences. As I sat in a recent MedXcellence course and listened to him talk of leadership, I realized I needed to write these words of wisdom down before they floated away. This led me asking if I could “steal” his leadership pearls for our FlightLines winter edition. Some of these come from his own personal experiences, others from leaders he worked with and observed throughout his career. So, without further ado, leadership pearls by Lt Gen Travis…

1. Care for your Team!
   A. Never pass up a chance to say, “thank you!”
   B. The very best leaders care about people.
   C. Pros treat pros like pros.
   D. Remember Your Manners (RYM).
      (1) If you are wrong – admit it.
      (2) If you need to apologize… apologize!

2. Lead with enthusiasm.
   A. Pessimists cannot lead effectively.
   B. You are always an example for someone else – be a great example.
   C. Boost morale – lift people up.
   D. Make a conscious decision every day to be positive – not always easy!

3. Be a great communicator.
   A. A good leader ALWAYS communicates.
   B. Communicate UP, DOWN, and SIDEWAYS.
   C. Best mentorship is constant and subconscious.
      (1) People watch you every day – be a good example rather than a bad one!

4. Trust your instincts.
   A. Experience, talent, and situation awareness (SA) add up to instinct…
      (1) If something doesn’t seem right, you can’t immediately get more experience or talent, but you can get more SA! Then make a decision…
   B. Turbulence creates opportunity – and the best planners recognize opportunity.
   C. Shape and influence – don’t react.
      (1) If you don’t shape events, you become a victim of them rather than a leader!

5. Be genuine.
   A. Operate openly – no hidden agendas!
   B. Don’t praise too lavishly and be careful how you criticize.
   C. Trust your folks – they will do amazing things!

Four leadership Pass/Fail items (taken from General Wilbur L. “Bill” Creech, Commander, Tactical Air Command, May 1978 – December 1984):
1. Any personal integrity violation
2. Ruling through fear
3. Temper tantrums (public display of raw emotions)
4. Abuse of office or authority

Leading up can be tough!
1. Listen well to make sure you truly understand your boss’s perspective; otherwise, any effort to guide your boss might be seen as resistance.
2. Communicate commitment – if your boss truly knows you share his/her commitment to success, you have a powerful voice.
3. Do your homework and pick your moment… and style matters.

Really, it comes down to this. You have three choices to make:
1. Turn down opportunities to lead.
2. Accept opportunities but fail to make a difference.
3. Accept opportunities to lead and make a difference! 🌟
What I Did on My “Summer” Vacation

Tory “SHOT” Woodard, Lt Col, USAF, MC, SFS
35 AMDS Commander, Misawa AB, Japan
RAM 2016

I appreciate the opportunity to tell you about my recent experience as the Joint Task Force-Support Forces Antarctica flight surgeon for Operation DEEP FREEZE during the 2017-2018 season. The first thing you probably want to know is “How do I get that Job?” Each year, PACAF and the Air National Guard choose teams to deploy to the National Science Foundation’s (NSF) McMurdo Station in Antarctica for three separate 2-month rotations. The rotations start in October and end in February, as this corresponds to summer in the Southern Hemisphere. Each rotation has a three-member team consisting of a flight surgeon, a flight nurse, and an aeromedical evacuation technician. The teams are chosen months in advance, after an application and interview process. Preference is given to flight surgeons with primary care, critical care, or RAM training, some operational/deployment experience, and knowledge of the aeromedical evacuation system. Active duty crews are usually chosen from PACAF, as the Joint Task Force commander is located at Hickam and the mission stages out of New Zealand.

The primary mission of the USAF is to provide logistics and support to the NSF-managed U.S. Antarctic Program. Many of you are familiar with the ski-equipped LC-130 aircraft from the 109th Airlift Wing of the New York Air National Guard. These aircrew and maintainers deploy every year to Antarctica to fly support and research missions in support of the NSF. Additionally, they are the primary MEDEVAC airframe should any patient need to be moved during the summer research window. Much of the LC-130 flying is done to move food, supplies, research equipment, and fuel to the South Pole and other large research camps accessible by the aircraft. (Smaller camps are reached by civilian-contracted Twin Otter aircraft or helicopters.)

Travel to McMurdo station is via Christchurch, New Zealand. This location is on the South Island of New Zealand and is just around the corner from Lyttelton, the launching point for many of the famous early Antarctic expeditions. It was not lost on me that I was due to rotate in for the 100th anniversary year of the launching of Earnest Shackleton’s adventure and his epic tale of survival and perseverance. You spend 1-2 days acclimating to the time zone and getting issued all your survival and extreme cold weather gear at the Antarctic Program processing center. This is one part logistics hub/warehouse, one part pax terminal, and one part administration center. All of these items must be carried with you on the plane and put on prior to landing. It’s quite a sight to see over 100 people tripping over each other in the back of a C-17 trying to put on their ski pants and parkas 20-30 minutes prior to landing! The flight down to Antarctica is approx. 5.5 hours on a C-17 and 7-8 hours on a C-130. It’s then another 3- to 4-hour flight by LC-130 to the South Pole, if that is your intended destination.

The medical footprint at McMurdo station consists of a mix of civilian and military medics. The clinic itself is currently run by the University of Texas Medical Branch (UTMB), a subcontractor to prime contractor Leidos. UTMB is an organization familiar to the RAMs through our joint ventures at NASA and frequent contests at the RAM Bowl. UTMB supplies the civilian medical personnel. They even send UTMB RAM residents and staff for short rotations each year. UTMB runs the day-to-day operations while our USAF team supplements them by assisting with patient care, seeing all the USAF flyers and maintainers, and communicating with providers at the South Pole and other remote research locations. Additionally, the USAF flight surgeon acts as the local validating flight surgeon and MEDEVAC consultant, working with TPMRC-West on both USAF and civilian patient movements. Equipment at the clinic consists of a two-bed “trauma” bay, a four-bed ward, a dental suite, digital x-ray suite, small lab, pharmacy, and even a mono-place hyperbaric chamber. This was checked weekly by a trained crew and kept constantly ready in case we had to treat a diving injury, severe altitude sickness, DCS, etc.

The weather in McMurdo during the summer can quickly range from downright dangerous to surprisingly nice at times. Early in the season (October) the temps are low and the winds are high. In the middle of the Antarctic summer, when I had the good fortune to be there, the weather was relatively warm (average temp in the 20s-30s). The entire time I was there, I never saw the sun set and it only dipped a little on the horizon in the evening. As summer wanes, the temps will again begin to drop and the weather will turn nasty again. It will often get to 20 below with elevated winds, making simple tasks such as walking 100 meters to the dining hall a challenge.

Flight operations at McMurdo are a unique experience. The views are breathtaking both on the ground and in the air. Landing on the skis feels similar to any other landing, except the pilot taxis and steers the aircraft on the ground only using differential thrust with the outboard engines. Landing at the South Pole is an experience, simply because it is over 9,000 feet altitude. You are literally landing on ice almost 2 miles thick. Because of the pressure altitude exceeding 10,500 feet, the entire crew has to don oxygen masks for takeoff and landing. Taking off in the ski-equipped LC-130 for the first time is quite different from any other experience. You line up on the skis (runway for skis), push the throttles forward, and start accelerating. At about 60 knots the pilot pulls back on the yolk and lifts the nose ski off the ground, thus reducing drag. You effectively ride a “wheelie” down the runway on the rear skis waiting to reach takeoff speed, then slowly climb into the sky.

There are some unique human performance aspects of life on the ice. For instance, how do you communicate to ATC and other aircraft where you are flying when everything is essentially north? Answer: they operate on “grid north” with McMurdo being homeplate. So we would fly “north” to the South Pole and “south” up to New Zealand. While this sounds confusing, it works well and you soon adopt this and other quirky Antarctic lingo.

So what was a typical week like? Usually I would see clinic 4-5 days a week. Sometimes it was feast or famine for patients, but there was a decent variety of primary care and minor injuries to treat. We also had a pool of civilian pilots flying helicopters and small aircraft, so I was able to see them as an FAA AME and advise on medication use to avoid potential grounding and mission impact. Like a lot of deployed locations, the potential for injury in Antarctica is ever present. With all the machines, trucks, forklifts, etc. in the harsh environment, it’s a testament to the people and the safety focus that we did not have too many injuries. We did have to monitor a few people on our small ward overnight for items like pneumonia, the evening. As summer wanes, the temps will again begin to drop and the weather will turn nasty again. It will often get to 20 below with elevated winds, making simple tasks such as walking 100 meters to the dining hall a challenge.

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new onset seizures, cellulitis, and mental health issues. We performed a variety of routine and urgent MEDEVACs while there, a few times moving people from the South Pole for further monitoring or moving them to New Zealand for further evaluation. With no CT or MRI, we often had to stabilize injuries and then transport when the flight timing (or weather) allowed. Weather can dictate a lot down in Antarctica, so we always had to be prepared to hold someone for an extra couple of days. Conversely, we would send people out on any aircraft of opportunity if we had any suspicion their condition could decompensate. On my 2-month rotation we performed eight MEDEVAC missions.

Overall, DEEP FREEZE was a very unique and rewarding experience. It’s definitely different from any other deployment I have been on, as you are essentially working on an NSF base with the USAF as a support organization. But many things seemed the same, as you continue to train and prepare for any contingency, see routine sick call, and even perform occupational shop visits. If you ever get the opportunity to apply for one of the PACAF or Air National Guard slots on this mission, I highly recommend it!

Lt Col Woodard quickly braving the elements at the South Pole for a picture. Despite the appearance, temperature on this day was -30°C at the field elevation of 9301 ft.

Lt Col Woodard at the ceremonial South Pole, with the Amundsen-Scott Research station in the background.

OPERATION DEEP FREEZE rotation team members. L to R: Maj Eric Miller (Flight Nurse), Lt Col Tory Woodard (Flight Surgeon), SMSgt Matt Monjes (Aeromedical Evacuation Technician).
Help SoUSAFFS Grow!

Flight Surgeons, have you joined SoUSAFFS yet? The Society of Air Force Flight Surgeons is a constituent organization of AsMA that more specifically supports the needs of AF Flight Docs, with a focus on education, mentoring, and networking. We are reaching out to our cadre of young physicians to make our organization one that is essential to be a part of. Not only will SoUSAFFS membership afford you invaluable networking opportunities, but it will also make you eligible for retreats/trips to other bases to experience other missions/airframes and bond with your fellow Flight Docs! There’s even better news…you no longer need to be an AsMA member to join SoUSAFFS*, and instead you pay only $20 annually. We want to grow our organization, and we can’t do that without bright ideas from excited young docs! Join us today at www.sousaffs.org.

For more information, please contact Capt Brooke Organ at brooke.organ.1@us.af.mil.

*If you are a non-AsMA member of SoUSAFFS, you are ineligible to vote in AsMA elections.
Hurricane Maria: Patient Evacuation Ops – A RAM’s Perspective

Elizabeth Anderson-Doze, Col, USAF, MC, FS
RAM #976

Within 45 minutes of getting “boots on ground” in Christiansted, St. Croix, we were literally overrun with a virtual tsunami of patients. They were dehydrated, hungry, deathly ill, all from the hospital and were dropped off at our “front door.” We set up shop in the Port Authority room of the airport because it was one of the few places in the building with air conditioning. It became our triage and staging center during the day and our living quarters at night. We soon discovered on that first night, after weathering a storm, that it had a very leaky roof. This realization came rudely to me when I awoke to find that the raft I was floating on was really a very wet patient litter, now in a very large puddle!

The patients sent to us “day 1” were not properly triaged by the hospital, and many so-called “ambulatory patients” ended up as CCAT with diagnoses like severe dehydration, malignant hypertension, diabetic ketoacidosis, and near death. Thank God on that first crazy day a CCAT team was with us and had an IO kit. It came in very handy during a code and after intubating a patient who had passed out literally in front of us. He regained his pulse and we sent him back to the hospital. Unfortunately, he later died likely from the heat and dehydration. It quickly became apparent to us that this was not going to be a simple “triage, categorize, and evacuate/transport” mission. People were literally dying around us!

We had to adjust on the fly and began to ask the patients questions like the following: Have you had your meds today? Do you have enough for a few days? Show us what you are taking (often listed MARs were incorrect or had an entirely different name). Have you eaten? Are you thirsty? Do you make urine (lots of dialysis patients)? Trusted care had to be front and center in our minds because there were just too many chances to slip up.

Many of the non-medical attendants traveling with the patients seemed just as sick as or sicker than the patients themselves, but could not be left behind because there would have been no one at home to care for them. We learned to provide urinals to male patients and to make patients with poor limbs, artificial limbs, or no limbs at all litter patients (because walkers just don’t work well in the back of a C-17 or C-130).

In addition to treating and clearing the local residents, we also had ADNavy patients from a nearby Navy ship brought to us via helicopter, which we then cleared for transport on to CONUS. One of those members got acutely ill while waiting on the C-130 to arrive and became a CCATT patient. We also did a tail-to-tail clearance from a FEMA-sponsored Lear jet to a C-130 of a patient sent from St. Thomas to PR to escape Hurricane Harvey and then from PR to St. Croix. On another occasion we lost power to include the generator, just as the last patient got loaded on the C-130!

The most amazing thing to me, though, was the compassion and caring attitude of the 375th Scott team. No one whined or complained about being rained on in their sleep, of not having phone or internet service, of having to use baby wipes to bathe for the first 3-4 days, or even of having to consume MREs. I saw nurses and techs and manpower members giving patients food from their own rations, giving away water and power bars from personal stashes, and saving parts of their personal lunches for them. Two technicians were spotted hand feeding patients who were blind and elderly (see picture on the right).
A few weeks after returning home I ran into the SG for USTRANSCOM and he laughed and said that his people told him, “Sir, we have a real doctor here!” Having gone through the ACCAE course as a RAM and having deployed as a clearing flight surgeon previously made it just slightly less difficult to handle the “rapid fire” of patients we were deluged with on those first couple of days. By day 3 things were more organized thanks to the great organizational skills of the senior nurse doing triage. I had my trusted and very worn copy of my Flight Surgeon’s Checklist to which I referred frequently for guidance. Without internet or phone access it was an invaluable resource. My experience as a previously deployed operational flight doc also prepared me for what I needed to bring. I created a “what I wish I could have in my medical bag if marooned on a desert island list.” I passed it on to the next team’s much less experienced and never deployed FS, who was gearing up for a possible stint in PR. I also packed supplies for personal use for our own team members (22 of us in all) and ran a de facto “sick call,” seeing and treating 6 of our own team as well as 2 SF guys. Don’t worry; it was all documented on paper SF 600s (yes those still exist). I later turned them in for scanning into AHLTA at the Med Records office at Scott.

I found that the medical supplies considered standard for an ERPSS team were not sufficient in my opinion and was thankful we brought along a narcotics bag (we gave more than one local patient morphine and po meds) as well as emergency meds like epi and Benadryl. We did not have a glucose monitor and could not check sugars until CCATT arrived. I am told our team was a unique version of an ERPSS and we were the first team to deploy as an RRAPS or Rapid Response Aeromedical Patient Staging.

All in all, over an 8-day period, we cleared 55 litter patients, 80 ambulatory, and 114 NMAs. We were very grateful for the opportunity to go on this mission, and as Major Wood, one of our nurses, phrased it, “We were all blessed.” Very rewarding experience!