PRESIDENT’S COLUMN

Colonel John Stepp

It has often been noted that one of the characteristics that distinguishes the dyed-in-the-wool flight surgeon is an abiding appreciation for the heritage we share. The history of aviation and of aviation medicine are intimately intertwined, and most of us take great pride, as well as delight, in these dual roots. In this regard, the contributions of hundreds of flight surgeons, past and present, which have served to preserve and strengthen this heritage, deserve to be recorded and cherished. It was with this general mindset that the SOUSAFFS Board of Governors received a presentation from the Turner Publishing Company during the 14 January 97 meeting. Turner proposed the publication of a hardbound book which would contain a general history of the Society, followed by brief biographies of all current and former flight surgeons whom we can locate. For a small fee, flight surgeons can have included longer entries containing historical anecdotes, factoids, memories, editorial comments, or whatever. The Turner representative brought for our review copies of similar publications done for other groups, and the board members appeared considerably impressed by the quality. The real beauty of their proposal is that the effort will be undertaken with NO FINANCIAL RISK

(Continued on page 2)
TO THE SOCIETY. Further, if it comes to fruition, the SOUSAFFS will reap 5% of the profits. Hearing this, the BOG voted unanimously to accept Turner’s offer.

Want more information? It’s on the way. Later this Spring, all Society members will receive in the mail a package containing descriptive literature, along with a form requesting biographical submissions. Please be looking for it, and don’t toss it into the round file along with your Reader’s Digest Sweepstakes winner notification. Look it over carefully, and consider contributing your 100 words to the heritage of our profession. In addition, this will be a topic of discussion during the Society luncheon in Chicago this May, and we will have a Turner rep and examples of their previous publications available for your review. I will be surprised if you are not as impressed and enthusiastic as the BOG was. Consequently, I am looking very much forward to presenting this to you in May. In the meantime, keep ‘em flying.

NOTES FROM THE EXECUTIVE OFFICER
Lt. Col. David B. Rhodes
Clinical Sciences Division
Armstrong Lab

Just a quick note but several important issues need addressing:

Dues:
Check your address label. If your date is 1997, you are good for this year. If it says 1996, you owe one year of dues or $15.00. Anything less than 1996 and you owe a multiple of $15.00. We allow a grace period of two years during which we continue to send the newsletter despite the fact that you have not paid for it. If you are more than two years in arrears, you no longer receive the newsletter. Please update your dues accordingly.

Membership Certificates:
If you have recently joined as a new member and have not yet received a membership certificate, please contact me at the address on the back of your newsletter or e-mail me at www.asma.org/soaffs/. Often it is due to difficulties in confirming your AsMA membership. You can help with this by sending a copy of your current AsMA membership card.

Another Item of Interest:
In reviewing information in the Society database I noticed that for many of the members there is no “Date Joined” listed. If you are sending in dues or a change of address and can include this date (found on your membership certificate) I will update this info. If you would like to send this info to the above E-mail address, please feel free to do so.

ON THE WEB
Did you know that both the Aerospace Medicine Association and SOUSAFFS have web pages? These sites can help you keep in touch with these organizations, as well as help you keep up to date on current issues. The Society web page also has some helpful files that you can download.

How do you find them? Easy!

AsMA url is:
http://www.asma.org

SOUSAFFS has a page at that site as well:
http://www.asma.org/soaffs/index.htm
I’ve heard a lot of positive comments on the Operational Aeromedical Problems Course we completed in January, the first in the new School of Aerospace Medicine. Lt. Col. Kevin West did a great job as course director. For those who were unable to attend OAP or missed the first day due to the weather, I'll list some capsule updates on some active issues (so many issues, so little space):

**Preventive Health Assessment:**

This will be an annual assessment for each active duty member that includes a fitness for duty determination, the occupational physical (includes flying), a records review, and update of prevention measures in accordance with Put Prevention Into Practice.

Provider involvement will be with the Primary Care Manager. Lt. Col. Courtney Scott is preparing this for presentation to the Medical Leadership Conference in April at the time of implementation.

**Reengineering Aerospace Physiology:**

A proposal to focus the work of aerospace physiologists on human performance issues and uncouple aircrew human performance training from altitude chamber training. Lt. Col. Jeff Sventek has made adjustments to the proposal based on MAJCOM comments and expects to begin briefing this at the Pentagon in February.

**Aerospace Medicine Information Systems:**

We have a funding request pending for contractor support to formally identify and integrate data requirements for all of Team Aerospace. We hope to receive the funds by the end of February and will convene functional experts to identify requirements in areas not previously covered (such as flight medicine). This is a critical step in ensuring our eventual information systems actually meet our needs and integrate with other systems supporting other aspects of clinical medicine and prevention.

(Continued on page 8)
The importance of troop hygiene in maintaining a fit fighting force has been known for centuries. Prior to the Revolutionary War the English physician, Sir John Pringle wrote:

"The prevention of disease cannot consist of the use of medicine or depend upon anything a soldier may have in his power to neglect; but upon such orders as shall either appear unreasonable to him or what he must necessarily obey."

Dr. Pringle was one of the first to preach the axiom that the protection and maintenance of the health of the troops was the responsibility of command, primarily upon nonmedical line officers. For decades following his preachings, however, line officers consistently refused to acknowledge the importance of military hygiene and as a result non-battle injury rates remained high through the Revolutionary and Civil Wars.

It was not until 1906 that the line of the Army opened its doors to allow integration of medical doctrine into the training of line officers. At that time, a military hygiene department was established at the U.S. Military Academy. Also in 1906, a medical officer, Major Edward L. Munson, was assigned to the School of the Line (later to become the U.S. Army Command and General Staff College - CGSC) where he, and his successors, would teach military hygiene and preventive medicine to line officers for the next 70 years.

In the mid 1970’s, a shortage of military physicians resulted in the removal of medical officers from teaching positions in line schools. The position at the CGSC was eliminated and the curriculum modified. In 1978, the military hygiene program at West Point was eliminated.

The need to provide some form of medical doctrine into line officer education has once again been recognized. Following successful negotiations between the Air Force Surgeon General and Air University, a position has again been established at a professional military education institution. In July, 1996, the position known as the Air Force Surgeon General Chair to Air University (Medical Chair) was born.

Situated at the Air War College, the Medical Chair is responsible for educating line officers regarding the medical assets available to them, in times of peace and war. Active in teaching in the core curriculum, the Medical Chair also offers an elective, "Medical Issues for Commanders," where concepts of preventive medicine are introduced to line officers of the Army, Navy, Air Force and Marines. Some of the topics in this eight week elective include: peacetime health issues, prevention and treatment of combat stress, BW/CW, joint task force medical operations, and military operations other than war.

The AU Medical Chair responsibilities also (Continued on page 5)
include overseeing the development and execution of the Air Force Medical Group Commander Course, briefing strategic medical issues to the students within Air University, and serving as a consultant to AU faculty on the development of medically-related curriculum.

This position represents the first step necessary to fully integrate the teaching of medical doctrine into the training and education of line officers. As long as the health and fitness of the troops remains the responsibility of the line commander, it is vital that he or she deploy with all the critical information to guarantee success.

Author’s Note: As the first AU Medical Chair I have found this to be a fascinating, fast-paced and learning experience. I welcome any of your questions pertaining to PME for medical officers or about my position here. I also remain open and receptive to suggestions or ideas you might have to enhance the education of our future line leaders with respect to how they can best use their medical assets. Email address: wigermann@max1.au.af.mil

Cockpit Resource Management or Crew Resource Management (CRM) is something all flight surgeons should know a lot about. Basically, it’s utilizing all available resources to increase the safety of flight. The prime focus is on better crew communication. How does CRM affect the flight surgeon? We are usually an extra crew member not regularly there. The crew may say we are unnecessary for the mission; most often we aren’t necessary. That does not mean CRM does not apply to us. In fact, I would submit that CRM takes on extra importance when someone you don’t usually fly with is on board. Communication is often more difficult between two people who may not know each other well or when one may be intimidated by the other. I don’t mean that the pilot is always afraid of us. The flight surgeon may well be the intimidated one —often new to the aircraft, with a young pilot, and not as current as he should or would like to be.

We need to make sure that we understand what is expected of us before we step to the jet. It starts in the briefing. Don’t accept the briefing, “Okay doc, same, same.” Clarify it with something like, “Do you mean, arm the seat after the final ground checks, or on the runway?” Many pilots do procedures slightly differently and they think everyone does it like they do.

Make it clear to the pilot if there is something you expect of him. I added a new one to my briefings after I experienced an auto-roll in an F-15. Basically, the F-15 rolled on its own because of a flight control problem.

(Continued from page 4)
We were on another Eagle’s tail when it occurred. All of a sudden we did a big roll and he was on our tail. To us in back anything the plane does is done by the guy in front, so the roll didn’t seem like any big deal. The pilot made a vague comment, the bingo fuel light went on and he called a knock it off. He didn’t clarify that the airplane decided on it’s own to roll. I thought he was mad because the other pilot got on our tail. We didn’t declare an emergency and RTBed as usual. On the ground during the maintenance debrief it became clear what occurred. Now I tell the pilot in the briefing, if there is a problem I want to know it in plain English. (The USAF has lost at least one F-15 due to an auto-roll on takeoff; the pilot ejected safely).

Don’t sit in ignorance in the back. If something is going on, try to figure out what it is. Use what you know and notice if anything seems unusual to try to help out. I once sat in the back seat of an F-15 and the pilot couldn’t get the radios to work. After I sat there a while I noticed a light illuminated on the radio panel I had not noticed on before. I told the pilot and we realized the radios had been switched to the back seat on a previous flight and control not returned to the front. It was embarrassing to admit I didn’t know how the radios worked and embarrassing for him, because he didn’t think of it. We didn’t have to step to the spare jet, from a plane with good radios, because I spoke up. Not a big deal, but we worked it out together. CRM in action!

Because of that episode, I now make a point of trying to find out how all the things work that I think I may someday need to do. Then I try to get to perform them. Not drop bombs or shoot the guns, but things you may need to do in an emergency, like open the canopy, disengage the autopilot, use the brakes, work the radios...

Remember, sometimes you are the expert in the two-seat version and it’s quirks. Often there are only one or two family models in the squadron and many pilots rarely fly them. You may have to prompt the pilot for the full brief, including what you two will do if there is side-stick interference or some other emergency.

By now the flight surgeons for heavies are saying, “I hate you fighter guys. I never get anywhere near the controls.” CRM is way more than that. The multi-person crew is where CRM is really in action. The way a crew works together is easily observed by the flight surgeon and is a good debrief item for the flight surgeon, especially if the pilot seems heavy-handed on the rest of the crew and no one else speaks up. Bring up something that seemed like a confusing part of the mission. Often it’s confusing to everyone else. Now I’m thinking CRM gives me an expanded role on heavies.

I always look for traffic and frequently am the first to see it and call it out, because I don’t have quite as many tasks as the other crew members. I feel it’s a real contribution to the safety of flight. Sometimes even the crews do. I also look to see that the landing gear indicates down before landing. I’ve never said they weren’t, but I always try to look. Sometimes CRM for flight surgeons is just not distracting the crew during busy portions of the flight.

I know the helicopter flight surgeons are working the CRM thing because they are such an integral part of so many missions. Helicopters are frequently running some sort of medically related mission that the flight surgeon is a part of. Here, the flight surgeon

(Continued on page 7)
can contribute to the situational awareness of the crew by letting them know what is going on medically. Letting the crew know the patient is doing well and we don’t need to break our butts will help calm down a crew that gets excited seeing blood and knows they’re doing the real thing. This also applies to the fixed wing air evac flight surgeons.

I find, like so many things, I’m better at the CRM thing in retrospect. But practice and awareness are what make you better. We all need to know about CRM, but we also need to practice CRM. I encourage you on your next flight to look for ways you can improve CRM, and do it. Fly safe! 

**SHOULD WE CHANGE FLIGHT SURGEON TRAINING?**

*Maj Pete Bauer*  
*RAM 98*

In addition to didactic studies in Aerospace Medicine and in the recently accredited Phase III Occupational Medicine year, RAM’s participate in a variety of hands-on training courses. RAM 98 has already survived the Combat Survival Course at Fairchild, got weathered out of the Water Survival Course at Pensacola (Ed: let’s make up *that* training during the warm and sunny springtime!), and spun with Combat Edge equipment at Holloman. This spring, we will undergo an abbreviated flight training called Medical Officer Flight Familiarization Training (MOFTT) at Randolph. Taken together, these experiences are an amalgam of fun, challenge and misery, but all are valuable training.

While at Fairchild, I was reminded that successful completion of Combat Survival School is required of all other aircrew members before they may fly operationally. Even a new one-striper wouldn’t be allowed to fly in the back of, say, an AWACS, unless he or she could complete the Fairchild gauntlet. Same for Water Survival. I began to wonder why it was that, as a rated crew member, I had flown multiple weapon systems for the previous decade without this training. After all, flight surgeons also fly combat missions, get captured by the enemy, and die during combat operations. Why are non-RAM flight surgeons, who constitute the bulk of our aerospace medicine assets, exempt from training requirements that all other aircrew mandatorily receive?

In the same vein, we have all heard the grousing about physicians who take the AMP course just to get the wings. The complaint is that flight surgeon wings will help them climb within the bureaucracy, but they never have and never will practice flight medicine. Perhaps the greater concern, though, is that new flight surgeons who are about to fly in a variety of weapons systems get only that same level of training. They do not go to Fairchild. They do not go to Pensacola. They do not go to MOFTT. They only spin at Holloman if they are assigned to fly fighters. At the outset, a new operational flight surgeon has no more depth of knowledge or experience in flight medicine than one of the “bureaucrats.”

I open the floor to discussion and debate on this issue. Let’s hear what you think. My own two cents is that flight surgeons should not hold an active flying position (“RPI-5 slot”) until they have completed Combat Survival School, formal Water Survival at Pensacola, ATLS or a deployment trauma course, and in the case of a fighter assignment, have spun in the centrifuge. 

*FlightLines page 7*
Reengineering Readiness:

New mobility teams involving flight surgeons are being registered: Preventive Aerospace Medicine Teams, Airevac Augmentation Teams, and Theater Epidemiology Teams. Each team has a MAJCOM responsible for building equipment packages, which will take place over the next two years. Overall, readiness requirements for flight surgeons and RAMs are increasing.

Rightsizing:

The Medical Service will take a 13.6% cut over the next eight years. A number of AF facilities will downsize from hospitals to superclinics and clinics. Some facilities will be Community Health Clinics providing primary care and operational support (Team Aerospace) with little or no mobility requirements. Preliminary work on rescultping the medical force to meet new requirements is underway. New requirements are based on the new readiness baseline, input from the MAJCOMs about needs for day-to-day operations, maintaining a rotation base, manning Community Health Clinics, and maintaining a training pipeline.

Graduate Medical Education:

The most recent GME Selection Board selected 17 new Air Force RAMs, an increase over the long-standing class size of 14. Increased selections were also made in General Preventive Medicine and Occupational Medicine. We expect selection numbers to grow in Aerospace Medicine and to remain at the higher levels in General Preventive Medicine and Occupational Medicine.

Medical Service Mission Support Plan:

The 1997 plan is being released now. This document is a roadmap to meeting current and future requirements for the Medical Service. We are rolling occupational safety and health issues for aircrew into Goal 4 along with the preexisting issues of this type for ground personnel. Additionally, high-priority needs for human performance enhancement are identified and prioritized. We will be reconvening a team to review and reprioritize the deficiencies/solutions for the 1998 Mission Support Plan in March. Anyone aware of an issue that needs a solution should contact their MAJCOM SGPA.

The Consultation Service:

As many of you know, the Consult Service is losing most of its manpower positions and much of its funding for FY98. These resources previously came from "research dollars" that are taking big cuts across the Air Force. We need a Consult Service to provide the scientific base and consultation services for our aerospace medicine system. We are working hard to find a way to have a consult service that meets our future needs.

I'll have to end it here to avoid jeopardizing a rain forest. Believe me, there are more issues.

Lastly, we gave Major General George K. Anderson an aerospace medicine send-off at Hangar 9 one evening during OAP. We are grateful to Gen Anderson for his many contributions to Aerospace Medicine and the Air Force, and we look forward to more opportunities to work with him in our community.

Editor’s Note: We look forward to an annual “supper with the stars” at the OAP. We will be able to meet and greet the leaders of Aerospace Medicine in an congenial atmosphere for an evening of history-making and fellowship.
Recent events have dictated the above question be asked from the highest levels within the military services. Make no mistake about it, in these times of military cutbacks and right-sizing, the aviation/aerospace medicine community is under attack. Like other specialties within the military medical system, we will be asked this question repeatedly to justify our numbers and the legitimacy of our special skills.

Perhaps, to answer the question, we need to look at what it is that we do. We must look with precision at what we bring uniquely to the medical community in general and the military in particular. This is our “ecological niche”, as it were. We must ask ourselves what it is that I do that the standard government issue GMO, Family Practice or General Internal Medicine trained specialists couldn’t otherwise do? What special knowledge, skills, procedures or secret handshakes were imparted to me during the 9 or 13 week course in basic flight medicine that would set me apart from my peers?

The question needs to be answered and the justification made. The wolf is at the door. As we speak, a proposal has been made to train intensivists in the transport of critically ill (read life support) patients. Why not? The civilians do it all the time. Are they safe and successful? I’m sure that there is a financially and medically sound reason for flying intensivists not otherwise trained in aviation medicine.

Will the transport specialists and their teams be allowed to draw flight pay, wear the flight suit and otherwise be regarded as an integral part of the aviation picture? The answer, so far, is no. They are first and last, clinicians who just happen to perform some of their duties in the air. So what are you, doctor? Why do you draw flight incentive pay and they do not? They are going to ask the question.

What will be your answer?

I’ve already hinted at the best answer to that question and all the issues dealing with the big question: “Why a Flight Surgeon?”

Regardless of how your medical peers or superiors view your position, you are more than a clinician. You also hold a unique position, bridging the technical world of medicine and patients with the world of military operations. Notice that I did not say flight operations. Specifically, you are the liaison between the line commander and the hospital and you speak to the medical issues involved with the day to day military mission in general and military aviation in particular. **No one else does that!** Your title, position and rank may be General Medical Officer and Captain, but you are better trained and more experienced than you sometimes give yourself credit for. You are the Operational (Field) Medical Specialist. Not only are you trained in this particular area, but you are...
actually actively practicing. That, as they say in the military, makes you the subject matter expert.

As the subject matter expert, it behooves you to keep abreast of the developments within your field. Read your texts and journals, prepare yourself for your hoped for residency in ophthalmology (or whatever), but learn your art by doing it. Go to the field with the troops, go to the Volant Rodeos, William Tell’s and National Training Center. FLY.

The next question is: What do you do when you fly? Recent events have shown that reading novels and sleeping onboard is not the right answer. Participating in and evaluating crew AND POST-FLIGHT answer. Were you there for the Mission Brief, doctor? Did you help with the aircraft sports car to make it home in time to watch the game on TV? Didn’t you think that your watch the game, too? The attitude you display will have a lasting effect on the crew. With the flight hour programs taking big reductions, the crews won’t watch out them.

Another major area of concern within your unit safety officers are? Have you ever talked to them? Have you attended the answers to those questions are no, you are wrong. In future editions of , we will examine this issue in more detail.

called CRM (cockpit resource management).

(Continued on page 11)

HISTORICAL VIGNETTE

RAM 98

1st Lt. WILLIAM R. SCHICK, M.D.
THE FIRST U.S. FLIGHT SURGEON TO DIE IN WORLD WAR II

Just outside the main auditorium at the School of Aerospace Medicine are the bronze tablets honoring the flight surgeons who have given their lives in service of their country. There are two lists: those killed in action and those killed in aircraft accidents. On the tablet listing flight surgeons killed in action, the first plate on that tablet reads:

William R. Schick
1st Lt. M.C.R. Pearl Harbor, T.H. December 7, 1941

William Schick was born 17 August 1910 to German and Lithuanian immigrant parents in a tenement neighborhood in Chicago. His home was near the infamous stockyards and both his parents worked in the slaughterhouses there. Bill liked reading, but dropped out of high school after his sophomore year. After working in a factory for three years he returned to high school and finished third in his class at Lindblom High School in Chicago. He then went to University of Illinois at Champaign-Urbana and graduated in 1935. He went to medical school at the University of Illinois College of Medicine in Chicago and graduated on 1 July 1940. He did his internship at Evangelical Hospital in Chicago where he met his wife to be, Lois Richmann. He started a surgery residency at Leila Hospital in Battle Creek, Michigan. They were married in June 1941. Two weeks later, with war just on the horizon, Bill felt his services could best be used

(Continued from page 10)
in the military, so he joined the Army.

Dr. Schick was commissioned a 1st Lieutenant and he was assigned to the 19th Bombardment Group at Albuquerque, New Mexico. They moved to New Mexico and greatly enjoyed the area. Lois was a nurse and they both volunteered their time doing medical work with the local Pueblo tribe. On 1 October 1941 he was sent to the eleven-week long Aviation Medical Examiner Course (flight surgeon’s course) at Randolph Field, TX. He was to graduate from flight surgeons school on Dec. 20. War appeared imminent, and his unit was being deployed, so he was released from class four weeks early, with full credit. Captain Sidney Seid, another doctor from Albuquerque Army Air Field Hospital had already deployed with other support units of the 19th to the Philippines. (Dr. Seid survived the Bataan “Death March” and three years in a Japanese POW camp).

Dr. Schick made a quick visit home to Clinton, Iowa. Schick and his wife drove back to Albuquerque on Nov. 30, 1941 and he was assigned to the 38th Reconnaissance Squadron. The 38th was being transferred to Clark Field in the Philippines. On the night of the 3rd of December while eating dinner with Dr. George Mitchell and his wife, Lt. Schick received a phone call telling him to be ready to leave the next morning. The next morning his wife said a long goodbye on the porch of their home and gave him a new camera. Dr. Mitchell drove Lt. Schick to the flightline the next morning. They had a weather delay so they went to the base hospital. All the doctors, including the hospital commander, kept Bill company drinking coffee in the mess hall. Soon the weather delay was over and they all went to see him off. He must have looked the typical flight surgeon of the day ready for deployment — leather flying jacket, camera over the shoulder and climbing into a B-17 Flying Fortress.

(Continued on page 12)
The crew was a fairly experienced one for 1941. Captain R.T. Swenson was the pilot. He and the navigator 2nd Lt. H.R. Taylor had already flown to Hawaii in the spring. Lt. Ernest L. Reid was a new copilot. Aviation Cadet G.C. Beale was the bombardier. MSgt L.B. Pouncy was the flight engineer, Sgt Earl T. Williams the assistant engineer and gunner, Cpl M.C. Lucas the radio operator and Pvt Bert Lee the final gunner. The airplane was a C model B-17, not the latest version, but a capable bomber. The first leg of the journey was to Hamilton Field, California — just above San Francisco.

The next two days were spent there. The squadron commander, Major Truman Landon, was fighting the red tape to get guns for his squadron’s planes, before they deployed overseas to a potential combat zone. The problem was solved, new guns were packed onboard, minus ammunition, and the 38th’s twelve B-17s left Hamilton for Hickam Field, Hawaii on the night of 6 Dec 1941. They could pick up ammunition in Hawaii. The first plane off was at 2100 hours with 15 minute spacing. Lt. Schick’s B-17 was the second to take off at 2115 hours. Rather than take off and form up, they flew single ship towards Hawaii to save fuel.

The radar site on Oahu was warned to be on the lookout for a large squadron of B-17s to be showing up on the screen on the morning of the 7th. They saw multiple radar targets that morning that were unfortunately mistaken for the flight of B-17s. The targets were of course the initial strike aircraft of the Imperial Japanese Navy.

The 14 hours plus flight was uneventful until the last fifteen minutes. The crew saw land with the first recognizable feature being Diamond Head. Approaching Oahu, Lt. Schick took out his camera and took some photos. Passing Diamond Head at 0800 hours they noticed some antiaircraft fire off in the distance. They thought somebody was just practicing. Then they saw six pursuit aircraft with antiaircraft fire bursting around them and thought somebody was getting carried away on the ground. They had stumbled into the first wave of attack aircraft on Pearl Harbor, but still did not realize it.

They started a long base leg following a canal into Hickam Field. Captain Swenson ordered the landing gear lowered and the copilot complied. They noticed a great deal of black smoke rising from the Pearl Harbor area. The pilot thought at first it was sugar-cane being burned off. Then they turned got their first clear look at what was going fire.

through the fuselage. Lt. Schick was stand-
are shooting at us from the ground.” Copilot Reid said it was coming from behind. Lt. bullets they’re shooting. I am hit in the leg.” Four bullets were later found to have also hit

Japanese Zero fighters were making passes at the B-17. The copilot advanced the tles and hit the landing gear retraction switch to go around and hide in some clouds. stantly smoke began to fill the cockpit. Some bullets had hit the magnesium flares in

burning fiercely. The pilots realized they must land and put the landing gear back in the first place. A few seconds later they landed hard and bounced high due to the

(Continued from page 11)
reduced visibility from the smoke in the cockpit. The pilots recovered for a good touchdown and while still rolling out the fuselage broke in two where the aircraft was burned through.

The pilot killed the engines and the copilot set the parking brake and everyone egressed the aircraft. The crew found themselves in the middle of the field, hundreds of yards from shelter. Just as they were escaping the aircraft, another Japanese Zero fighter was making a firing pass down the runway. The crew split up. One group ran for the hanger line with burning aircraft and buildings. The other group including Dr. Schick sprinted for the Honolulu side of the field, where the crew of the first B-17 to have arrived was hugging the ground. Lt. Schick was hit again in the head with a bullet from the fighter as he ran across the runway. He was picked up by an ambulance and taken to the hospital but died later that day. Some reports say he was killed instantly. Other members of Lt. Schick’s crew suffered lesser injuries. Aviation Cadet Beale was hit in the leg, Lt. Taylor had a small shrapnel cut and Lt. Reid had some singed hair from the aircraft fire.

Lt. Schick’s B-17 had been the only one destroyed of the twelve from Hamilton Field. Photographs of it are commonly seen and can be recognized as the B-17 with a forward fuselage and wing and nothing aft of the wing’s trailing edge. Others were hit but landed safely either at Hickam or Wheeler Field. One belly-landed safely on a golf course.

Two other military physicians died that day at Pearl Harbor. Commander Samuel E. Johnson, MD on the USS Arizona and LT. j.g. Richard R. Rall, MD on the USS Pennsylvania.

Lois Schick moved to Chicago from Albuquerque. On August 17, 1942, what would have been Bill’s 32nd birthday, Lois gave birth to their son, William Richmann Schick. The baby was baptized in a christening gown made of silk from his father’s parachute.

The death of Lt. William R. Schick was certainly not forgotten. The flight Surgeon Class of 20 Dec 1941 started the bronze plaque at the school of Aerospace Medicine. Ceremonies honoring Dr. Schick were held by Native American friends in Albuquerque. Bill’s parents donated their son’s microscope in his honor to the University of Illinois College of Medicine for use by needy students. On plaques in the Student Union at the University of Illinois, Schick’s name joins that of 838 of his fellow alumni killed in World War II. In Clinton, Iowa the Army named its new 2,500 bed hospital Schick General Hospital. Thousands of wounded soldiers were cared for there during World War II, until it was closed in 1946. Dr. Schick’s body was returned to the family 21 Jan 1949 and he was laid to rest in a country cemetery in Lowden, Iowa. Lois Schick never remarried and died of cancer in 1971. She was buried next to husband Bill. Their son is alive and is a publishing executive in Chicago.

References:
1. Memorial Plaques, Outside Main Auditorium, USAF School of Aerospace Medicine, Brooks

(Continued on page 14)
This is definitely an area we need to be involved with. Major Marchiando discusses medicine in more depth elsewhere in this

A final note, in the event of war or deployment dependent on your knowledge of the men, will look to you for information on medical threats to the operation, medical treatment thousand too numerous to list here. If you're doing the job right, you'll be a valued, integral member of his staff and your feelings of pride and accomplishment, it should. For bag”, it doesn’t get better than that! 

Have you registered for the annual Aerospace Medicine Association meeting yet? May isn’t so far away. If you don’t have a Blue Journal application handy, try contacting AsMA through the Web site!
Traditionally, two or three RAM’s in their Phase II (Aerospace Medicine) year receive the baton from the preceding class and take over the duties as the FlightLines editorial staff. Beginning with this issue, three new editors from the RAM class of 1998 face this challenge:

Maj (Lt Col-select) Pete Bauer  
Maj (Lt Col-select) Andy Marchiando  
Maj Bob Ruiz

As the guy who rarely lets his laptop — and therefore his email — stray too far out of reach, Pete Bauer will be the primary point of contact for FlightLines contributions. His email is:

bauer@usafsam.brooks.af.mil

The handoff from the preceding class to the next has, it is said, been accompanied through time immemorial by an admonition: the hardest part of the job is getting fellow flight surgeons to contribute to their own publication! Already, we are finding that ancient wisdom to be canon. You’ll notice that the editors have been prime contributors to this issue. It is neither the role nor the desire of your editorial staff to stuff FlightLines with our own thoughts; content is YOUR job. On the one hand, it may be that an article or letter to the editor was lost in the “fog of transition.” If so, let us know! We’ll apologize and get your submission published in an upcoming issue. On the other hand, it is clear that we are simply not receiving many contributions from the busy folks out in the field, the ones from whom we most need to hear!

So, we inaugurate our tenure as editors with an earnest and open invitation to ALL members: take the effort to share your experiences, wisdom and follies with your colleagues. FlightLines isn’t for someone else; it is for YOU.

Lookin’ forward to hearing from you soon!

Ed: Well, gee, we don’t have any. Got any opinions you’d like to share?

Please remember that your Society is on the Web, and you can contact the FlightLines editors via email. See the box on page 3 for details.

LETTERS TO THE EDITOR

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