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# Words from the Wise

## President’s Column

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President, Society of U.S. Air Force Flight Surgeons**



2005, Capt Sanjay “FNG” Gogate.

I have been a flight surgeon since 2005. My flightpath to become a flight surgeon was a bit non-traditional as I was a direct accession. After a family practice residency and 3 years of private practice in Hialeah, Florida, I had two residency colleagues who were both prior military, Felix “Rico” Fernandez, DO, a prior Navy F-14 pilot, and Dr. Rick “Milk” Milkvy, DO, a prior Army general medical officer. Both shared their incredible aviation and medical experiences with me. Rico’s highlights were flying Tomcat tactical formation over the pyramids heading into Desert Storm from an aircraft carrier. Rick’s were flying medevacs via Blackhawks in Bosnia. It is because of those mentors that I decided to volunteer toward an Air

Force career as a flight surgeon. After AMP came my first flight surgeon tour as the 421st Fighter Squadron “Black Widows” flight doc with F-16s at Hill AFB, Utah, and receiving a call-sign, “Swipe.” Since then I have enjoyed feeling the direct connection to an operational mission, practicing medicine, and seeing the world... sometimes at FL300.

One of the best concepts I’ve learned about and been a part of in the USAF is the “Wingman” concept. For flight surgeons this entails “mentoring” and sometimes literally looking out at your “formation” of flight surgeon brothers and sisters, making sure they are where they should be, talking, doing cross-checks, mentoring, and sharing information to improve everyone’s lives and wellbeing. I would not be where I am today without the assistance of friends, family, and mentors. Thus, I want to take the opportunity as the new SoUSAFFS president to stress mentoring and bringing our “formation” of flight surgeons across the globe closer together to recruit our “next” generation of flight surgeons. This may entail talking to medical students, residents, or other USAF physicians, showing them your job and aircraft or mission; however this will help build the “future of aerospace medicine.” A flight surgeon is the ultimate Air and Space Force occupational health expert. Airmen and Guardians being available to their commanders to “fly, fight, and win – 24/7” is AFMS job one, and the flight surgeon possesses all the talent to make that happen.

## Inside This Issue

- President’s Column .....1
- From the Editor .....2
- Flight Surgeon Consultant’s Corner .....3
- MAJCOM Perspectives
- From the Field Flight Surgeons in  
Operation ALLIES REFUGE .....4
- Clinical Insight
- In Case You Missed It.....6
- Dethroning the PDF and Double  
Documentation: Transitioning Readiness  
Workflows to MSH GENESIS .....7
- Mentoring/Leadership Development
- The Operational Career Path –  
Level Two, AFSOC .....9
- Around the Air Force
- Look Out World, Here Come the  
Double Deuces! .....11

Mentor our Team Aerospace and remember to be humble, as your mentoring may come from an aerospace medical technician or civilian, too. Similar to the “art of medicine,” the “art of aerospace medicine” is broadened by direct learning at different assignments, missions, locations, and aircraft. I encourage everyone to broaden their careers with diverse missions and deployments. I still recall AMP Daddy Col (ret) Karl Lee in AMP ’05 saying, “Be a student of the game,” meaning we are always learning. It will be the honor of my career to serve as the SoUSAFFS president this year. The SoUSAFFS team, which is made up of dedicated current and past Total Force flight surgeons, works tirelessly to further the future of the USAF flight surgeon. Thank you to the Board of Governors, the committee chairs and members, the RAMs, and the honorary mentors for all you do as I take the reins from Col Raymond “Doogie” Clydesdale ... “SWIPE...has the JET.” 🙏

Mark “Frozone” Dudley, Col, USAF, MC, SFS  
 Chief, Flight and Operational Medicine Branch  
 Department of Health Headquarters, Falls Church,

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The time has flown by! Greetings from the Defense Health Headquarters, Falls Church, Virginia. The last 4 months have been nothing short of a whirlwind, with graduation from the residency in aerospace medicine, PCS, vacation (family time), settling the family, and jumping into the seat as the Chief of the Flight and Operational Medicine Branch. The latter has been hectic, humbling, and rewarding. At my level of responsibilities, my team’s goals are establishing, setting, and refining policy for Flight and Operational Medicine across the Air Force.

As mentioned in a prior article by Col “Doogie” Clydesdale, policy and subsequent execution do not always coexist and/or align. Often the execution of said policy may not be fully understood or the “why.” Also, policy may have not been fully vetted at the grass roots level, where the work is really happening. As we cannot vet every single policy to the field, we should do a better job of listening, communicating intent, and allowing the opportunity for feedback upon release of policy or the potential release of policy. As stated in a Forbes article, when you explain the “why” you gain four benefits: increase employee confidence, cast vision and explain the best practice, increase productivity, and drive critical thinking and innovation (Pezold, 2017).

We as SoUSAFFS can work on ensuring and refining we cast a vision and explain the best practices we have, thereby drawing in membership as there are tangible benefits. If we are able to do that, then we can drive critical thinking and innovation for SoUSAFFS. All around this makes us better at a time when we need flight surgeons to be that operational mindset voice of experience with humble confidence.

This is my last column as editor of *FlightLines*. It has been my goal to listen and get a pulse of what the field wants to gain out of this publication. This endeavor started with a survey that led the way and vision to accomplish four editions of *FlightLines*. This summer edition finishes where I started a year ago. I now turn over the reins to Lt Col Maryrose “ATLAs” aka Boom Chuidian.

I am honored and humbled to have served as your editor.

Pezold S. 4 benefits you gain when you explain the ‘why.’ Forbes. 2017 Feb 3. [Accessed 1 Sep 2022]. Available from <https://www.forbes.com/sites/paycom/2017/02/03/4-benefits-you-gain-when-you-explain-the-why/?sh=431a5c871b47>.

## FlightLines Editorial Staff

Executive Editor Col Mark Dudley  
 Technical Editor Sandy Kawano

## FlightLines: Vision and Mission

Our vision: *FlightLines* is the written forum for the Society of United States Air Force Flight Surgeons. We help facilitate top-to-bottom, bottom-to-top, and horizontal dialogue within the Flight Surgeon community.

Our mission: We provide a vehicle to pass the vector and tools to Flight Surgeons so they can do their jobs effectively and efficiently as current and future leaders within Team Aerospace.

## Need to Update Your Membership?

To update your society membership or contact information, please visit [www.sousaffs.org](http://www.sousaffs.org), login, and select “Edit Profile.” Your dues can be paid by PayPal. For any questions or concerns regarding your membership, please contact Col Stefanie “Phantom” Nance at [membership@sousaffs.org](mailto:membership@sousaffs.org).

# Flight Surgeon Consultant's Corner

## Your New Aerospace Medicine Consultant

Anthony "MAGIC" Mitchell, Col, USAF, MC, SFS  
Air Force Aerospace Medicine Consultant



Team, I want to take a few moments to introduce myself as YOUR Aerospace Medicine Consultant. I am originally from Decatur (GO DAWGS!), GA, and entered the Air Force in 1994 as a graduate with military distinction from the U.S. Air Force Academy with a major in biochemistry. I received my Doctorate of Medicine from Harvard Medical School in 1998 and completed residency training in emergency medicine at Louisiana State University-Charity Hospital in New Orleans, LA, in 2002, when I returned to active duty service. Afterwards, I deployed multiple times in support of Operations

IRAQI FREEDOM and ENDURING FREEDOM. AFMS provided me the opportunity to further develop a broad base of skills by completing a fellowship in critical care at the Washington Hospital Center, and I earned my flight surgeon wings in 2010. After my fellowship, I served as an emergency medicine and critical care medicine instructor at the U.S. Air Force Center for the Sustainment of Trauma and Readiness Skills (C-STARS) – Baltimore and an assistant professor in military and emergency medicine at the Uniformed Services University of the Health Sciences. Additionally, I had the pleasure of applying my varied experiences as an instructor with the Defense Institute of Medical Operations, working with foreign governments and militaries, providing instruction in trauma care, mass casualty care/readiness, and CBRNE disaster preparedness. In 2017, I completed the Residency in Aerospace Medicine, followed by tours as the 96th AMDS Squadron Commander at Eglin Air Force Base, Air Force Special Operations Command Chief of Aerospace Medicine, and 8th Medical Group Commander at Kunsan Air Base, Republic of Korea.

My "WHY" for serving as your consultant is straightforward. Aerospace and operational medicine have animated just about every aspect of my career. The impact on the mission and my fellow Airmen

is why I still wear the uniform today. During my most recent assignment, our medical group hosted a TCCC rodeo and watched teams battle for operational medical supremacy on a paintball course. I witnessed innovative and dedicated medics find ways to sustain the highest readiness rate in the MAJCOM for 10 months straight. I grasped the opportunity to put my EM skills to use by leading a team in the conscious sedation of the child of a pilot to remove a foreign body and topped that off when I helped take care of a fellow soldier with new-onset diabetes in DKA who presented with a pH of 6.8. I almost forgot to mention the F-16 flight with the Operations Group Commander and the C-12 training flight to Japan that took us over Mt. Fuji.

There is no other job like that of the USAF flight surgeon—where you can do what you love, do amazing things sometimes in cool and not-so-great places, and support outstanding people to secure a mission that brings safety and security to our nation and loved ones. I could go on, but hopefully, you get my point. I sincerely desire to give every willing flight surgeon the chance to have a career or experience that you will never forget with pride and fondness. To that end, I do not expect to always be popular. Still, I will strive to be transparent, consistent, and fair in my role to accelerate the Aerospace and Operational Medicine Enterprise and every one of you as we support the people and missions of the world's preeminent Air and Space Force. 🇺🇸



### SoUSAFFS Membership at its BEST!

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- ✓ Access *FlightLines*
- ✓ Network with experts and mentors in your field
- ✓ And much, much more....





# MAJCOM Perspectives

## From the Field Flight Surgeons in Operation ALLIES REFUGE

**Jeremy “Dogma” Garlick, Lt Col, USAF, MC, FS**  
**Commander, 48 SGCS**  
**RAF Lakenheath, England**

**Jaime “Hector” Rojas, Lt Col, USAF, MC, FS**  
**Chief Aerospace Medicine, 86 MDG**  
**Ramstein AB, Germany**

Operation ALLIES REFUGE supported 35K Afghan travelers, with 7.3K total personnel supporting the operation. The aeromedical evacuation team treated 257 travelers, 50 U.S. personnel, and 13 combat wounded in flight; 428 patients were treated at Landstuhl Regional Medical Center (LRMC), and 1043 patients were treated in an expeditionary medical support (EMEDS) field hospital with 38 Afghan babies born. This represented the largest non-combatant evacuation airlift in U.S. history.

### The LRMC Experience

The Kabul airport bombing on 26 August 2021 killed 183 people and injured at least 150 more, including children, becoming the largest pediatric mass casualty of the Afghanistan war. These children were taken care of by the entire spectrum of medical providers, from first responders to onsite surgical teams to aero-evacuation and critical care air transport teams (CCATTs) that dropped them on our doorstep; 29 in all required surgical or critical care intervention. Two were initially identified with traumatic brain injury and were triaged to host nation hospitals with pediatric neurosurgical capabilities. The others were treated in a makeshift pediatric intensive care unit within LRMC’s adult intensive care unit, undergoing staged, washout surgeries. Aside from the battle injured, this evacuee population had unique pathology not typically encountered stateside, from errors of metabolism to unrepaired cardiac defects to anthrax and measles and, of course, severe malnutrition. One patient required such high levels of ventilatory support that CCATT was unable to provide transport. In the context of a country that would allow refugees only a finite transit time, the treating flight surgeon quickly became the go-between for host national hospitals, our patient movement requirements center, and two governments.



Shrapnel adjacent to spinal column.

### The Ramstein Experience

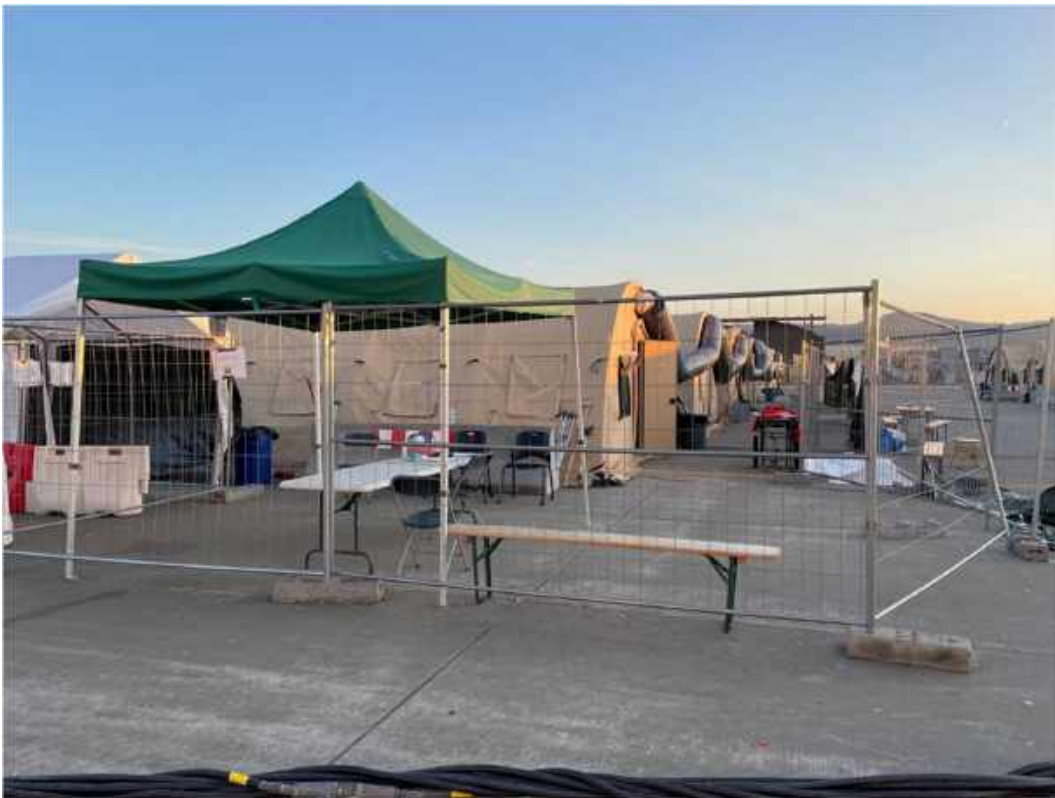
The Ramstein team was tasked to prepare for 5000 total evacuees who would immediately board an aircraft to their final destination within 24 hours. Our initial team was built off the flight medicine field response team model with two providers and four technicians. Thirty days later, we had expanded to provide 24-hour care with all the 86th’s medical manpower, 3 deployed teams, an EMEDs +10, and 11 point-of-care sites. The goal was to treat and manage 20,000 Afghan nationals on Ramstein’s flightline for more than 30 days. We prepared for expected problems—sanitation, hand hygiene, social distancing during a pandemic, and diseases not common in military medicine to name a few—but challenges in those areas arose daily if not hourly. Three big complications are noteworthy:

1. **Sanitation.** Introducing novel procedures regarding toilet usage was incredibly difficult for travelers. We placed signs and prepositioned translators to instruct members upon arrival on the proper use of temporary toilets, but the travelers would defecate/urinate on the floors and use the toilets as trash receptacles for paper and bottled water. The eventual fix was to speak to village elders and to have the Afghan travelers manage the sanitation of their living sections. Messaging from the elders held more weight and consequences if not followed, and having members responsible for their sections gave them purpose. It needs to be noted that 86th public health personnel went above and beyond as poor sanitary conditions exceeded the point of public safety. They suited up and cleaned port-a-johns, not a typical responsibility, but completed the mission until a fix was identified and implemented.
2. **Infectious Disease.** We were able to control three cases of norovirus with isolation. Isolation is difficult in the real world and vastly compounded in tight quarters within tents on a flightline. We saw cases of cutaneous leishmaniasis, anthrax, and chickenpox – rare to those who have only practiced stateside.
3. **Measles.** This virus stopped all movement leaving Ramstein for weeks. We were directed to vaccinate all members, over 8.5k, for measles, mumps, rubella, varicella, and COVID. The expectation was to accomplish this in a week, but we got it done in 2 days. We understood the medical urgency of getting the travelers out of an inhospitable environment. As much as we attempted to provide a sustainable living environment, we could not change the fact they were packed on a flightline with a German winter around the corner. This was a difficult challenge, but the mission allowed groups to shine. The call was answered by the 48th MDG team, the 31st MDG team, the 52d MDG, our Army counterparts, and many others. 🇺🇸

Continued on page 5



Tents on 86 AW flightline with hangars 1 and 2 in background.



Medical tent entry point. Fences were erected to maintain separation for travelers who required isolation.

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# Clinical Insight

## In Case You Missed It...

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### Don't Trust the Numbers

Data from 28,416 pulse oximetry and arterial blood oxygen readings in Veterans Affairs (VA) hospitals have shown that occult hypoxemia is much more likely to occur in black patients (19.6%) than white (15.7%).<sup>1</sup> Much of the same research group raised this alarm before with data from the University of Michigan.<sup>2</sup> This VA study, though, further analyzed 3016 patients who had additional testing on the same day. If the first testing showed close results between pulse oximetry and arterial blood oxygen, then the rate of occult hypoxemia for white patients in the second reading was only 2.7%. For black patients with the same initial concordance, the rate of occult hypoxemia later in the same day was 12.9%.<sup>1</sup> If you feel that this is adding uncertainty to your diagnostic prowess, don't worry. As a matter of fact, recognize and embrace it. By correlation, physicians who tolerate uncertainty are less likely to burn out than those who do not.<sup>3</sup>

### Shots, Shots, Shots, Shots

It's almost that time of year! Now add one more line to your counseling: the flu vaccine can save your heart. In a meta-analysis with 9001 patients, average age 65.5 years and 42.5% female, influenza vaccination lowered the risk of major adverse cardiovascular events by 34%.<sup>4</sup> The benefit of vaccination was by far greatest in those with recent acute coronary syndrome at a 45% reduction in risk.

### Guideline Updates

The United States Preventive Services Task Force (USPSTF) has deemed evidence insufficient to recommend screening for chronic obstructive pulmonary disease<sup>5</sup> or the use of vitamin or mineral supplements to prevent cardiovascular disease or death, with the exceptions of beta carotene and vitamin E, which are recommended against.<sup>6</sup> In a dramatic shift, based on the evidence from three significant trials, the USPSTF has changed its recommendations on aspirin for primary prevention. For patients ages 40-59 with a 10-year risk for cardiac disease of 10% or more by the American College of Cardiology/American Heart Association risk calculator, the net benefit is small, but aspirin can be considered for those at low risk of bleeding (C recommendation). For patients 60 years old and older, the USPSTF recommends against starting aspirin.<sup>7</sup>

The American Heart Association and the American Stroke Association released new joint guidance on intracerebral hemorrhage, with detailed recommendations on imaging. Also included are recommendations to use four-factor prothrombin complex concentrate in favor of fresh-frozen plasma for pertinent vitamin K antagonist patients and the recommendation to maintain systolic blood pressures around 140 mm Hg if the patient is significantly hypertensive.<sup>8</sup>

### References

1. Valbuena VS, Seelye S, Sjoding MW, Valley TS, Dickson RP, et al. Racial bias and reproducibility in pulse oximetry among medical and surgical inpatients in general care in the Veterans Health Administration 2013-19: multicenter, retrospective cohort study. *BMJ*. 2022; 378:e069775.
2. Sjoding MW, Dickson RP, Iwashyna TJ, Gay SE, Valley TS. Racial bias in pulse oximetry measurement. *N Engl J Med*. 2020; 383(25):2477-2478.
3. Begin AS, Hidrue M, Lehrhoff S, del Carmen MG, Armstrong K, Wasfy JH. Factors associated with physical tolerance of uncertainty: an observational study. *J Gen Intern Med*. 2022; 37(6):1415-1421.
4. Behrouzi B, Bhatt DL, Cannon CP, Vardeny O, Lee DS, et al. Association of influenza vaccination with cardiovascular risk: a meta-analysis. *JAMA Netw Open*. 2022; 5(4):e228873.
5. US Preventive Services Task Force, Mangione CM, Barry MJ, Nicholson WK, Cabana M, et al. Screening for chronic obstructive pulmonary disease: US Preventive Services Task Force reaffirmation recommendation statement. *JAMA*. 2022; 327(18):1806-1811.
6. US Preventive Services Task Force, Mangione CM, Barry MJ, Nicholson WK, Cabana M, et al. Vitamin, mineral, and multivitamin supplementation to prevent cardiovascular disease and cancer: US Preventive Services Task Force recommendation statement. *JAMA*. 2022; 327(23):2326-2333.
7. US Preventive Services Task Force, Davidson KW, Barry MJ, Mangione CM, Cabana M, et al. Aspirin use to prevent cardiovascular disease: US Preventive Services Task Force recommendation statement. *JAMA*. 2022; 327(16):1577-1584.
8. Greenberg SM, Ziai WC, Cordonnier C, Dowlathahi D, Francis B, et al. 2022 guideline for the management of patients with spontaneous intracerebral hemorrhage: a guideline from the American Heart Association/American Stroke Association. *Stroke*. 2022; 55(7):e282-361. 🇺🇸

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# Dethroning the PDF and Double Documentation: Transitioning Readiness Workflows to MHS GENESIS

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Most of you know me as the guy who created *Med Standards*. This mobile application mitigated two basic problems with knowledge management in the Aeromedical Enterprise through 1) notifications when applicable standards and policies are updated and 2) consolidation of pertinent guidance into a single location. On the scale of application complexity, it ranks heavily on the simpleton side. I created the initial version with zero programming experience after paying \$20 for an online tutorial on “How to Build Your First iOS App.” Logo design came through PowerPoint.

Now, this app, particularly for Apple users, is almost ubiquitous, and I’ve had many clinical groups, including one from NATO, reach out to ask for a similar app of their own. Knowledge management for clinical and administrative guidance appears to be difficult for the wider AFMS. Third-party, PDF-based applications are not the answer to this problem though. This includes *Med Standards* & similar apps, AFMS Knowledge Exchange, or any “solution” outside of the primary workflow where that guidance is needed.

From 2015, when I first published *Med Standards*, to today, this app was a success. It was a partial answer to yesterday’s war – the war in our everyday battle to establish sensible, modern clinical workflows with archaic, legacy HIT systems (when they were actually working). Unfortunately, the war was unwinnable. We could only push the broken donkey cart of AHLTA so fast. TSWF forms masqueraded as clinical decision support (CDS), when they were merely static text lined up next to input fields on a form, which created largely incomprehensible clinical notes. Beyond this static textual guidance (and some alerts around vital signs and medication interaction), advanced CDS in AHLTA was not feasible. Third-party solutions were the only answer to AHLTA’s incompetence.

Fast forward to today—2022. By around this time in 2024, AHLTA will be dead and the rollout of MHS GENESIS will be complete. We will finally have a modern, unified electronic health record (EHR) with exponentially greater CDS (and many other) capabilities than AHLTA. Admittedly, on our latest survey of MTFs on MHS GENESIS (as of 28 Jun 2022), only 23% agree or strongly agree that “the electronic health record enables me to deliver high quality care.” Unpacking this number would require multiple dedicated commentaries. I only cite it here to acknowledge MHS GENESIS cynics and state that the trajectory is only skyward. We implement 40-60 configuration changes per week and numerous additional capabilities each quarter. We will improve, but MHS GENESIS can’t do everything. It can’t make your morning coffee or scratch your back, but it can do infinitely more than what we could do before. Two of these crucial capabilities are modern CDS and the elimination of double documentation.

First, modern CDS: The era of expecting flight surgeons (or any clinician) to reference one of a dozen or more PDFs to make medical readiness or occupational dispositions must end. With MHS GENESIS, now it can. We have this capability. We can build the Medical Standards Directory, Aeromedical Waiver Guide, Approved Medication Lists, and any other reference material directly into clinical workflows to trigger exactly when the user needs to reference that material—the *right* CDS at the *right* time to the *right* person.

Within a few years, any expectation from AFMS leadership for users to reference external guidance outside of the EHR should be met with a YGBSM response. However, we need Air Force leadership to recognize and prioritize this capability. Stop spending untold dollars on useless mobile applications (e.g., the now defunct *Trusted Care* app) and start resourcing solutions that’ll alleviate the administration and cognitive burden we fight daily. Publishing PDFs and posting them on the Knowledge Exchange or Air Force ePublication portal can and should be deprecated immediately. This current state forces all the responsibility and burden of execution on the individual user.

Let’s shift the pendulum back on leadership to start intelligently leveraging existing technology. Automate the administrative minutiae that clog our clinical processes and detract from the time we spend caring for patients and special duty operators. No more pushing PDFs to the masses and expecting us to comply. With five FTEs of HIT focus at the HQ level, we’d undoubtedly save 500+ across the enterprise while simultaneously improving quality, standardization, and efficiency and reducing burnout. Until we make these steps, calls for us becoming a high-reliability organization from senior leadership will continue to fall flat on those who see patients daily.

Next, double documentation. To keep myself *somewhat* attached to patient care realities in the MHS, I see patients for half a day every other week (not much, I know). I cringe every time I complete a PHA, flight physical, or any encounter involving ASIMS interaction, particularly when I copy/paste ASIMS text into AHLTA. Beyond the wasted discrete data, the furthering of digital documentation illegibility, and minimal value proposition, these redundant actions are now unnecessary and obsolete with MHS GENESIS capabilities.

We can build application programming interfaces to send/receive any discrete data to any third-party system, ASIMS or otherwise. Clinicians should never open any system or application beyond the EHR. MHS GENESIS can meet the requirements of each of these legacy workflows without the need for a separate location for data entry. If external readiness systems are still needed, their functionality can be deprecated to only ingest MHS GENESIS data and operate as mere dashboards for non-clinical users. However, MHS GENESIS reporting capabilities can potentially meet these requirements as well.

Quality, intuitive design responsive to end-user workflows and needs is hard. This transition will not be easy. As with most endeavors we undertake, it’ll be prone to many external threats including death by a thousand [stakeholders], bureaucratic arm wrestling, and questionable resource prioritization – all feeble excuses not to start.

First step? There’re two that can be initiated concurrently. Let’s start with the easy one: submit an MHS Service Help Desk ticket. Yes, I said it. This will kick off the project initiation phase in which there’re already 100+ in the queue. In other words, submit the ticket to get in line.

Now for the hard one: digitize medical standards to make them machine ingestible. No, an Excel version of the Medical Standards Directory does not count. This entails creating a platform and database

Continued on page 8



that can interface with MHS GENESIS. It entails mapping our standards and medication lists to existing medical terminologies including RxNorm, SNOMED, ICD-10-CM, and LOINC. This mapping will enable the construction of a modern *Readiness* Decision Support System, one that directly aligns with the vernacular of modern medicine. When the standards are updated, MHS GENESIS is updated instantaneously. The platform becomes the source of truth, not the PDF.

While I created *Med Standards* independently, I hope that in my current official position I can orchestrate its demise. The next steps will require strategic prioritization from the likely readers of this article. No more ctrl+F'ing through a PDF; no more double documentation.

Now, we just need concrete actions to make it happen. 🙏

## SoUSAFFS Website



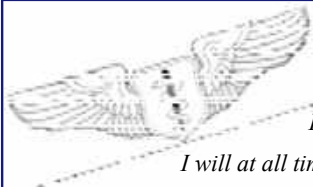
**Colby C. Uptegraft, Maj, USAF, MC, FS**  
**Solution Owner, Forms Management**  
**Defense Health Agency, Falls Church, VA**

SoUSAFFS continues to advance, with enhancements on the website as one example. Other than a shiny, modern feel and MANY backend improvements, the new platform also includes a few new features that our members will [hopefully] find useful:

- **Flight Surgeon Forum:** Accessible only to SoUSAFFS members, this page allows any member to post or reply to questions and topics from other members. Users may also follow individual posts or topic areas. We hope this forum enables connections between both junior and senior flight surgeons across the Aerospace Medicine community. Have a question? Post it to the Flight Surgeon Forum!
- **Announcements:** Any time SoUSAFFS posts an announcement, all subscribed members will immediately receive an email [make sure to add [info@sousaffs.org](mailto:info@sousaffs.org) to your "safe senders" list].
- **Sign in with Google:** No more forgotten SoUSAFFS passwords! Sign in and link your SoUSAFFS website account with Google.
- **Mobile Responsiveness:** Website content automatically adjusts to your device's screen resolution.
- **File Archive:** Find old issues of *FlightLines* and Board of Governors meeting minutes here. Again, this page is only accessible to SoUSAFFS members.
- **Order Merchandise Online:** Order SoUSAFFS patches and guides through the website. Invoices are automatically sent to our merchandise chair for fulfillment. For now, though, please email [info@sousaffs.org](mailto:info@sousaffs.org) directly if you're shipping to an APO, FPO, or DPO address.

Please visit [sousaffs.org](http://sousaffs.org) to see and explore the new website yourself. If you have any suggestions on additional content or how the website can be improved, please don't hesitate to email us at [info@sousaffs.org](mailto:info@sousaffs.org).

## Flight Surgeon Oath



*I accept the sacred charge to assist in the healing of the mind as well as of the body.*

*I will at all times remember my responsibility as a pioneer in the new and important field of aviation medicine.*

*I will bear in mind that my studies are unending; my efforts ceaseless; that in the understanding and performance of my daily tasks may lie the future usefulness of countless airmen whose training has been difficult and whose value is immeasurable.*

*My obligation as a physician is to practice the medical art with uprightness and honor; my pledge as a soldier is devoted to Duty, Honor, Country.*

*I will be ingenious. I will find cures where there are none; I will call upon all the knowledge and skill at my command. I will be resourceful; I will, in the face of the direst emergency, strive to do the impossible.*

*What I learn by my experiences may influence the world, not only of today, but the air world of tomorrow which belongs to aviation. What I learn and practice may turn the tide of battle.*

*I may send back to a peacetime world the future leaders of this country.*

*I will regard disease as the enemy; I will combat fatigue and discouragement as foes; I will keep the faith of the men entrusted in my care; I will keep the faith with the country which has singled me out, and with my God.*

*I do solemnly swear these things by the heavens in which men fly.*



# Mentoring/Leadership Development

## The Operational Career Path—Level Two, AFSOC

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**Chief, Division of Aerospace Medicine, HQ AFSOC**  
**Hurlburt Field, FL**

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**Chief, BOMC Development Division, USAFSAM**  
**Wright-Patterson AFB, OH**

Hello flight docs! Hope you're having a great Air Force day. Maybe you're performing your “normal” day job, plus somehow remotely covering additional duties that in another world would be considered a second full-time job. However, you're enjoying the entire process because of the importance of your mission, despite the profound amount of caffeine you're consuming. Think how boring it would be to have a run-of-the mill, private practice job! Embrace the experiences and memories! And why is “normal” in quotations? That's my segue: there isn't a “normal” job as a flight surgeon. AFSOC is no exception, but that doesn't mean it isn't exceptional. We'll wrap up our tour of Level Two jobs on the pyramid with a couple of positions unique to AFSOC.

Let's return to the Operational Support Medical flight, the OSM. Recall that being a Special Operations Forces Medical Element (SOFME) flight surgeon looks somewhat like a squadron medical element flight surgeon as described in AFMAN 48-149, but with significant differences. All our SOFME flight docs belong to the line, but not a flying squadron. We group them together in the Operations Support Squadron (OSS) where they can standardize training. In fact, they train much more than MTF docs in areas like casualty evacuation (CASEVAC) and field skills. Previously, they were much more likely to deploy and spent little time in the MDG. We are now pushing a greater emphasis on work in the MDG to maintain aeromedical skills and accomplish METALS. Here's what an OSM flight commander had to say about his job.

### OSM Flight Commander

- *How long were you in this job?* I have been OSM Flt/CC since 4 Jan 2021.
- *What was your path to get this job?* Internal Medicine Residency at SAMMC; 353<sup>rd</sup> SOSS/OSM SOFME; 1<sup>st</sup> SOSS/OSM Training Element OIC; 27 SOSS/OSM Chief Medical Plans/Operations OIC.
- *What best prepared you?* Unfortunately, I do not have a succinct answer for this. I think that it has more to do with personal attributes/experiences. Interest/Passion—I was very excited to become a SOFME, so there was intrinsic motivation. Deployments to Afghanistan—This was when I first saw how SOFME could be effectively used in a kinetic environment. I valued the work that we did and respected the SOF members that we supported. Taking Responsibility—Understanding/prioritizing and honestly obsessing about exactly what type of medical care I was capable of providing downrange and how I would provide that care with limited equipment/medications/personnel. Interest in Human Capital—It has been a pleasure to mentor young/bright/passionate/motivated medics.

- *What are/were your top three priorities?* “To create and maintain clinically proficient, tactically relevant SOFMEs that can deploy in N+12 (i.e., within 12 hours).” Lead by Example—In my opinion the importance of this cannot be overstated: people will work harder/smarter/more creatively if they admire their leader. Expect Excellence—First in my own work and then by praising/giving credit to members when they go above and beyond. Once the majority of members embrace this attitude, it becomes even easier as new members try to assimilate into this culture of excellence. Delegate Leadership—I almost always delegate projects/positions and not tasks; this allows each member to think critically, take responsibility, and honestly succeed/fail at an appropriate level. This is even more effective when the member is responsible for compiling an AAR that is pushed up to squadron/group/wing and sometimes MAJCOM level. I try to always highlight to leadership that this project was designed/completed by Sergeant/Capt Snuffy so that the member knows I am not taking credit for his or her hard work.
- *What is/was your biggest challenge?* For most of my career, I was only interested in being a good physician and later a good SOFME. It has been hard to try to be interested in EPRs/OPRs/awards/unnecessary emails and meetings/bureaucracy. It has been difficult to maintain highly motivated/trained SOFMEs when we do not currently have a deployment with CASEVAC potential. At times it seems that leadership at all levels does not know how to best utilize SOFMEs as BOS (base operations support)/CASEVAC/Medical Advisor.
- *What is/was your favorite part?* Thinking about inefficiencies/deficiencies in the system, creating a solution, and seeing the solution put into action. Seeing OSM members strive for excellence. Working with people both below and above me that I respect.
- *If you have completed this job, what next jobs did it set you up to hold?* I have not completed this job yet.

Turn the page! AFSOC sometimes assigns a wing or special tactics group surgeon (SOW/SG or STG/SG) to serve as a functional area manager, often for medics within special tactics (ST). The surgeon acts as liaison between AFSOC/SG and the wing or group for medical issues unique to his/her unit. If working the group level, the surgeon will help plan medical support for ST missions and in selection of ST candidates. We're including these two levels together since it's a very narrow field, but the SOW/SG is generally an O-6 position, while the STG/SG is generally O-5. In this case then, we're creeping up a bit into level 3 of the pyramid.

Continued on page 10

## Special Operations Wing or Group Surgeon

- *How long were you in this job?* 4 years (extended for 1 year).
- *What was your path to get this job?* Staff pediatrician at JBER for 3 years, staff pediatrician for 2 years at Hurlburt; Medical Services Flt/CC and deputy SGH for 2 years at Hurlburt; PCA to Flight Medicine at Hurlburt for 6 months; PCA to 1 SOSS/OSM as flight surgeon, then Flt/CC for 2 years at Hurlburt.
- *What best prepared you?* Exposure to SOF and to leadership at 1 SOSS/OSM, as well as Flt/CC and deployment experience.
- *What are/were your top three priorities?* Keep flyers flying; train for contingency response at a moment's notice; enable career progression for team.
- *What is/was your biggest challenge?* Difficulty maintaining training opportunities/program in the UK with vacant positions.
- *What is/was your favorite part?* Opportunity for unique mission set and challenges across Europe and Africa.

- *If you have completed this job, what next jobs did it set you up to hold?* Accepted selectively manned, data-masked position. Alternatives would have been TSOC/SG, HQ position, Sq/CC, MTF/SGP or SGH.

We hope you're getting a very strong sense that there is no single career path that leads to success or fulfillment. If you're disappointed with where you are, there's a good chance you'll get something vastly different if you hang in there. Because there *is* something vastly different out there. Read these articles to develop that picture, talk to people you know at other bases and in other MAJCOMs, or just call us and talk!

Next issue, you're in for a real treat as we begin to step through level three. Through the course of that level, you'll hear about the entire arc of several careers, which is interesting in and of itself. The responses are already rolling in, and they're far surpassing my expectations. You'll hear from COCOM and Theater Special Operations surgeons, HAF- and MAJCOM-level staff officers, and more than you knew existed at USAFSAM. Stick with us! 🇺🇸



Photo courtesy of Maj Michael Chiappone, 1 SOSS/OSM Flight Commander.

# Around the Air Force

## Look Out World, Here Come the Double Deuces!

**David “Dirty” Miller, Col, USAF, MC, CFS  
RAM Program Director**

Thank you, SoUSAFFS, for your continued support of the RAM! The great cake was a centerpiece for the historic graduation ceremony for the Double Deuces (RAM ‘22). This June, the USAFSAM Residency in Aerospace Medicine graduated 5 RAMs, who are heading off to key leadership positions throughout the USAF. We also have our first official “Space RAM,” who graduated from the University of Texas Medical Branch Aerospace Medicine Residency, while sneaking up to USAFSAM to round out his military and operational training.



The RAM continues to advance and grow, based heavily on the input and efforts of our high-octane residents, including the leadership of our Chief (Boom!) and class Senior Ranking Officers (NORDO and P-Dubs). There is an exciting (and a little terrifying) energy in the RAM right now; this is a great time to be here and shape the future of aerospace medicine for the world. No, I don’t always write in hyperbole. Sometimes I actually believe the stuff I write. We are actively looking for the best RAMs out there. Give me a call if you know someone who fits the bill – or you think you might. 🚀



RAM Graduate	New Assignment
Col Michael Rhode (Space RAM)	Commander, 56 <sup>th</sup> OMRS, Luke AFB
Col Mark “Frozone” Dudley	Chief, Flight & Operational Medicine, AFMRA
Col I. David “RIDLR?” Gregory	Chief, Accession Medical Waiver Division, JBSA
Col Jeff “Hedo” Harris	Chief, International Training Branch, USAFSAM
Lt Col Jeff “Woody” Kinard	Commander, 460 <sup>th</sup> OMRS, Buckley SFB
Maj Caleb “RICK” James	Chief of Aerospace Medicine, 5 MDG, Minot AFB

Continued on page 12





Second-Year RAMs	Prior Specialty	MPH
Col Steve “NORDO” Nordeen	Family Medicine	WSU
Lt Col Maryrose “ATLaS” (aka Boom) Chuidian	Family Medicine	WSU
Lt Col Matthew “Fargo” Hoyt	Family Medicine	WSU
Lt Col Bashir “Bash” El-Khoury (Space RAM)	Nephrology	UTMB
Lt Col Phillip “Sandman” Strawbridge	Family Medicine	Harvard
Maj Catherine “Gidget” Blasser	Internal Medicine	WSU
Maj Brian “Stitch” Hanshaw (Space RAM)	Family Medicine	UTMB
Maj Micah “Doppler” Rejcek	Family Medicine	WSU
Maj W. Taylor “Jedi” Timberlake	GMO	WSU
Maj Isaac “Frodo” Yourison	Family Medicine	WSU
Capt Robert “SALAD” Wright	GMO	UGA & WSU

UGA = University of Georgia; UTMB = University of Texas Medical Branch; WSU = Wright State University



Welcome New Residents!	Prior Specialty	MPH
Lt Col Noel “Tums” Colls	Family Medicine	WSU
Lt Col Shana “Whiskers” Hirschert	Family Medicine	WSU
Lt Col W. David “Flash” Smith	GMO	WSU
Lt Col Monica “P-Dubs” Pierce Wysong	Family Medicine	WSU
Maj Alexander “Evil” Haley	GMO	WSU
Maj Preston Moore	Family Medicine	Yale
Maj Dane “Kingpin” Newell	Family Medicine	WSU
Maj Clifford “Nastee” Nolt	Family Medicine	WSU