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# Words from the Wise

## President’s Column

Ray “Doogie” Clydesdale, Col, USAF, MC, CFS  
President, Society of U.S. Air Force Flight Surgeons

### Execution is Policy



Embrace the suck. When you “seize the mantle of leadership,” it means that you often get assigned to a staff job. These administrative jobs outside the military treatment facilities typically exist at MAJCOMs or in the National Capital Region. It’s no secret that most medics desire to avoid staff jobs when possible, preferring to stay clinical or operational.

My recent assignments alternated between military treatment facility and staff jobs. Along the way, you hopefully get good at writing policy. In the end, it doesn’t matter what you write into policy; it matters how it’s interpreted by the field and executed. So, if you wrote policy requiring all flight surgeons to wear red

flight suits, but the field ignored the policy and continued to wear green flight suits, well ... then execution is really policy.

Our parent organization, the Aerospace Medical Association (AsMA), has always required that a member of a constituent organization (like SoUSAFFS) must also be a member of AsMA. Over the decades, reconciliation of the membership rolls for both organizations proved impractical. SoUSAFFS always carried several members who were not dual SoUSAFFS-AsMA members.

Along came the internet. AsMA and all constituent organizations developed their own websites. The automated tracking of a member’s subscription status was a welcome improvement. Unfortunately, SoUSAFFS’s first website had a few extra membership categories not in our bylaws. Execution became policy.

AsMA initiated an effort a few years ago to better reconcile the rolls of its constituent organizations. This resulted in the requirement to obtain an AsMA membership prior to obtaining a SoUSAFFS membership. The multiple confusing steps impeded membership growth in both organizations. We have many fewer members who represent active duty than ever before. Execution became policy.

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Paid membership in both SoUSAFFS and AsMA is required by our bylaws for the privilege of voting in our elections and running for office. Unfortunately, many well-meaning flight surgeons who were only current on SoUSAFFS dues (not AsMA members) ran and were elected to the SoUSAFFS’s Board of Governors. Execution became policy.

We are wresting back control of our membership rolls and will not change our membership bylaws in the process. We’ve updated SoUSAFFS’s website to allow you to become a SoUSAFFS member first. If you do not proceed to obtain an AsMA membership, then you will be regarded as a “partial” member. You will not have the privilege of voting or running for office. Should you go on to obtain AsMA membership, then you will be considered a “full” member with all privileges associated (voting, running for office).

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# SoUSAFFS Officers and Board of Governors

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## FlightLines Editorial Staff

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### 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.

SoUSAFFS's website is also adding more automations to personal accounts and profiles to give us better visibility on members and assist in easier transactions. The terms "partial" and "full" refer only to your stage in the process of membership, not membership categories as defined in the bylaws. These will be automated, allowing us to be honest brokers with AsMA on our "true" membership and also to develop a bench of "partial" members who we can recruit to "full" membership over time.

We are aligning execution closer to policy, ensuring that we attain our goal. Thanks for the opportunity to serve. I'm looking forward to Col Sanjay "SWIPE" Gogate's success as our next president.

*Every flight surgeon, a member.—Doogie* 🇺🇸

## From the Editor

Mark "Frozone" Dudley, Lt Col, USAF, MC, SFS  
 RAM '22

Greetings, this issue of *FlightLines* hits prior to the 2022 Aerospace Medical Association conference in Reno, NV. I am looking forward to the recharge and renewed spirit that comes from such professional organizations. The conference offers the opportunity to collaborate, network, and get great information that you can ponder and act on in your respective areas. Even if you cannot make the conference this year, consider it in the future; the Society can and should help bridge the gap in various ways. Please provide us with feedback and hold us accountable to what your needs and thoughts are in your respective AORs. We will continue with the standard flow from our last issues and will keep on track to provide good content. It is the hope that our *FlightLines* will continue to evolve, and I have some ideas (e.g., case reports/studies, research, etc.), but please provide input.

To change the subject, have you had the opportunity to read *Who Moved My Cheese?* by Spencer Johnson, M.D.? If you have not, it is a quick read and coaches us on the dynamics of change, with two options: accepting and embracing it, or becoming mired and weighed down in it. Change is inevitable for all phases of life. That fact holds true to our military careers and endeavors. The PCS season is upon us; some of us will be transiting to new areas, careers, and/or responsibilities. These transitions often come with trepidation, barriers, and/or excitement. Where are you? Where is your family? You and/or your family may be in one, three, or more emotional seasons. I know I have at least those three as I prepare for our move and new duties. We will each manage our emotions on change differently. I encourage us to embrace the change for the better. Seek opportunities to grow both personally and professionally, and make whatever organization you are attached to better.

I submit to you, considering those forthcoming changes, that our career choice of being flight surgeons/docs best suits us to embrace those changes and enjoy whatever comes. There is such a level of excitement in our career field compared to others. If you are in flight and operational medicine, the job is never stagnant or at least it should not be. There is an opportunity to do something different every day if we so choose, and at times fight for it. We like being involved with the operators and the mission, and, I dare say, we like the challenges and obstacles that come with the admin creep all to make the organization we serve better and efficient. I believe the opportunity of being a part of the Aerospace Medical Association and SoUSAFFS can help us embrace those changes more, considering there are others who understand and can indeed relate. Here's the challenge—move beyond fear, enjoy the adventure, and keep your senses heightened to know when change is coming, and be willing to navigate through it. We are SoUSAFFS, and we are here to help.

If you have content to share or discuss, please feel free to email me at [mark.dudley.3@us.af.mil](mailto:mark.dudley.3@us.af.mil). 🇺🇸

# Flight Surgeon Consultant's Corner

## You Can Do It!

**John J. "Balls" Cotton, Col, USAF, MC, CFS  
Air Force Aerospace Medicine Consultant**

This will be my last *FlightLines* article as the Aerospace Medicine Consultant. I will be moving on to group command at Misawa in June. The last 2 years have been incredibly busy, but I am optimistic that I am leaving the Aerospace & Operational Medicine Enterprise with enough airspeed and altitude to sustain it until Col Anthony "MAGIC" Mitchell takes the seat.

Since taking the vacant seat 2 years ago, I have tried to address structural issues: flight surgeon manning, AF Officer Classification Directory updates to the 48X AFSCs, AFOM/AMP course and AOMED symposium attendance prioritization plans, AFOM attendance requirements for HPSP and USUHS students, SGP grade rebalancing, SME manpower analysis, BOMC reevaluation, Aerospace & Operational Medicine Corporate Board charter updates, and ensuring that career/leadership development is a cornerstone of our Aerospace & Operational Medicine Enterprise.

My most rewarding responsibility has been mentoring and coaching flight surgeons of all ranks and at all phases of their careers. This leads back to the importance of leadership development and how it creates fulfillment, which in turn reduces burnout and improves retention. I am certain that Col Mitchell will continue – and will most likely outperform me – along this line of effort.

I would like to provide one last item to ponder: You Can Do It! If you read this and heard Rob Schneider's voice from *The Waterboy*, then it's a bonus. But consider: company commanders in the Army, Navy, or Marines are an O-3 with about 3 years of experience, and they are placed in charge of 200-350 personnel. In the Air Force, this is about the size of a group, which is led by a colonel. Our sister services expect leadership at a much earlier point in their officers' careers than we do. Why is that?

I mention this only because many of our flight surgeons may not feel qualified to become a Chief of Aerospace Medicine. This may be an artifact of traditionally requiring completion of the Residency in Aerospace Medicine, but I will tell you that we have young flight surgeons doing great things in leadership positions (ahem, Capt Prestwood Jackson, the SGP at Beale). In fact, the AF CGO and FGO Physicians of the Year were both flight surgeons (ahem, Capt Clarissa Lomonaco and Maj Roslyn Fuentes).

To be clear, the Residency in Aerospace Medicine is still relevant in creating functional experts in our field, but my point to you all is that you should not underestimate your abilities. You are obviously smart enough if you were able to get into – and out of – medical school and get a license to practice. You already shoulder enormous responsibility in delivering trusted care to our warfighters. We should, therefore, be accustomed to taking on weighty roles. Additionally, since the scope of aerospace & operational medicine programs is fairly well-defined in AFI48-101 and AFMAN48-149, it is essentially an open book test in overseeing them. It's not like having to memorize the Krebs cycle.

The future of Air Force aerospace medicine absolutely demands that we rise to the occasion in which history has placed us – a volatile, uncertain, complex, and ambiguous environment. Physicians, by nature, are problem-solvers, and flight medicine ones are even more so. We have it within us to lead our Air Force Medical Service through the changes and challenges presented to our service, so I urge you to answer the call to lead in whatever capacity you can.

Good luck in the future, do not hesitate to reach out if you have questions or are seeking advice and, above all, Keep 'Em Flying (and Orbiting)! 🚀

### SoUSAFFS Membership at its BEST!

Fast    Easy    Convenient    Reliable

- Our newly designed website allows you to:
  - ✓ View your membership status
  - ✓ Review/pay for your membership → Updated immediately
  - ✓ Create your own profile & follow/connect with others
  - ✓ Access mentorship & clinical forums
  - ✓ Create a forum highlighting your interest or topic
  - ✓ Purchase merchandise and actually get it shipped to your address
  - ✓ Access *FlightLines*
  - ✓ Network with experts and mentors in your field
  - ✓ And much, much more....



### 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).

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# MAJCOM Perspectives

## What's So Special About AFSOC?

**Eric "De-Mo" Chumbley, Col, USAF, MC, SFS  
Chief, Division of Aerospace Medicine, HQ AFSOC  
Hurlburt Field, FL**

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The term "special operations" carries a certain mystique, just as applicable to Air Force Special Operations Command (AFSOC) as well as any other Special Operations Force (SOF). Our story goes back roughly 80 years. In 1943, British Brigadier Orde Wingate's Raiders needed air support for long-range penetration operations into Burma. The RAF must have been tied up. What began as a composite group ultimately became the 1<sup>st</sup> Air Commandos of the U.S. Army Air Force. Talk about mystique! If you don't think it's cool for a guy named Orde Wingate, referred to for all time as a "Brigadier," to lead a group of "Raiders" into battle far behind enemy lines, we can't be friends. Further, if you don't appreciate the ability to form a hybrid organization with "Commandos" in the title, at the end of a very long logistical chain, determined to poke the enemy in the eye where he doesn't expect it, you probably won't admire AFSOC. But if you do, stay with me. This is only one of the origin stories of AFSOC. From the Carpetbaggers of World War II to Operation Just Cause in 1989, there's a rich special air operations history that preceded the name AFSOC. This command actually activated here at Hurlburt Field in 1990. After Operation Eagle Claw, the failed 1980 attempt to rescue American hostages from Iran, the Nunn-Cohen Amendment to the Goldwater-Nichols Defense Reorganization Act directed the activation of the U.S. Special Operations Command with component service commands. Since its inception, AFSOC has supported no less than 32 named contingency operations.

To understand what AFSOC does that is so different, it's helpful to summarize the SOF Truths. They emphasize high quality people, the time it takes to build that quality, and that SOF operations almost always require non-SOF support. We are the smallest major command in the Air Force, with a wide mission set, often working behind the scenes to project Air Power in a very special way. AFSOC is that incredibly flexible air asset in the Department of Defense's tool box, both duct tape and a multi-tool rolled together. We provide specialized air mobility, precision strike, battlefield air operations, intelligence, reconnaissance, and surveillance, aviation foreign internal defense, and command and control.

Like all major commands, we organize, train, and equip forces for combatant commanders. That often means U.S. Special Operations Command, and its very specialized support. For example, AMC can move almost anything, but if your requirement involves clandestine operations into a fairly hostile environment, AFSOC gets the call. ACC excels at destroying things, but when human eyes must be on site because friendly troops are in contact nearby, it's tough to beat AFSOC combat controllers. Our combat aviation advisors work directly with foreign aviation forces in all environments to navigate the alphabet soup of special operations – FID (foreign internal defense), SFS (security force assistance), and UW (unconventional warfare). Summing up, AFSOC does what the rest of the Air Force does, but differently.

It should come as no surprise much of AFSOC medicine is also non-standard. While we do have MTFs with flight surgeons assigned to the medical groups (actually, Special Operations Medical Groups), you'll also find a very heavy emphasis on operational medicine. Many positions require a training pipeline of a year or more, and some are invitation-only. I hope you have been reading our series about different flight surgeon jobs on the Integrated Operations face of the Medical Corps pyramid, where we have given first-hand accounts of flight surgeon-specific jobs across the spectrum. Permit us an overview of all AFSOC operational medicine.

Right out of the gate, AFSOC does not have squadron medical elements. We have SOFMEs, and the difference is not just in the name. SOFMEs are embedded SOF medical elements. Like squadron medical elements, they are composed of two IDMTs and a flight surgeon and are charged with aeromedical care of their own flying units, both in garrison and deployed. But the SOFME is also trained to provide casualty evacuation and medical services in non-permissive environments. Like other AFSOC members, they learn to shoot, move, and communicate. Rest assured, they are still medics who merely retain the right to self-defense. They're just better at it than most of us, because they're more likely to be in a position to need those skills. These capabilities come with a price of a long training tail and, at times, frequent deployments.

Still other specialized AFSOC flight surgeons support our special tactics squadrons as embedded medics. Their focus is on keeping combat controllers, pararescuemen (PJs), and special reconnaissance airmen healthy and in the fight. They don't usually accompany their special tactics squadrons downrange, but their job is vital to ensure we have the capabilities these operators provide. For this position, we need flight docs who have not only strong clinical skills, but also strong people and management skills, because they also serve as medical director for the PJs. Don't bring anything but your A game to the PJs.

Not many folks advertise the ability to perform battlefield surgery, but Special Operations Surgical Teams do just that. These teams are lightweight, mobile, and extraordinarily capable. Their mission is to perform emergency resuscitation and stabilization surgery near the point of injury, effectively expanding the "golden hour" until a patient can reach definitive care. These teams include emergency physicians, general surgeons, nurse anesthetists, critical care nurses, surgical technicians, and respiratory therapists. If you've seen photos, you no doubt noticed they look like operators. This is not a coincidence. Assessment and selection are challenging, because the training and job are challenging.

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Finally, AFSOC puts two distinct spins on international health specialists. First is Medical Security Cooperation through Global Health Engagement (GHE). Most international health specialists have language and cultural skills, but their interaction is at headquarters or embassy level. AFSOC's GHE teams go to work at the boots-on-the-ground level, interfacing with local medics in their territory, in a low-threat environment. With the second version, you take it a step further with combat aviation advisors. Here, we place that medical capability in the context of a deployed unit supporting all air operations of friendly, partner, and allied forces, in a higher threat, semi-permissive environment. They essentially do a GHE mission alongside their line brothers and sisters while supporting FID, SFA, or UW.

There you have it, a high-speed tour of AFSOC medicine. It's a broad spectrum of operational medicine. It's the kind of work our non-military friends think we all do, but is only found in AFSOC. If you're interested in crossing over, give us a shout. We'd like you to have a chance to make some real memories in your Air Force career! 🇺🇸



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

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## The ACC Perspective

**Joe “Darth” Zhang, Lt Col, USAF, MC  
MQ-9 Pilot**

**Howard “Beaver” Givens, Col, USAF, MC  
ACC/SGP**

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The Air Combat Command (ACC) has been at the forefront of America’s conflicts and is the backbone of the line fighting units in the USAF. ACC has a broad scope and global reach, with 35 wings consisting of 1,371 units at 262 locations. Although individually different, each unit brings its own laser focus to execute the flying missions of the USAF.

ACC was created on 1 June 1992 and operates some 1,097 aircraft around the world with 156,620 active duty, civilian, and reserve Airmen. ACC is the lead command for fighter aircraft; command and control such as airborne battle management aircraft; intelligence, surveillance, and reconnaissance; personnel recovery with pararescue; persistent attack and reconnaissance aircraft utilizing both manned and unmanned aircraft systems; and electromagnetic, cyber, and information warfare operations. Headquartered at Joint Base Langley-Eustis, it has the support of 12 MTFs within the continental United States. ACC is home to all of these assets and continuously deploys forces to support the missions of the various geographic commands around the planet.

ACC flight surgeons have two major roles that they fill: home station support or deployed medical element. When their flying squadron is at their CONUS base, the focus is on training with a heavy emphasis on readiness. Flying units are always in high demand and must react at a moment’s notice to shifting geopolitical events.

When deployed with a squadron, flight surgeons really start to come into their own. They might find themselves on missions supporting a fighter unit operating on an improvised highway landing strip in Eastern Europe, riding along on an AWACS monitoring distant battlefields, or training pararescuemen in Japan on advanced trauma care. Combat and support missions to the Middle East, Europe, and Asia are all common as are drug interdiction missions to South America. If attached to an air demonstration team, such as the legendary USAF Thunderbirds, flight surgeons might find themselves supporting their units at major sports events across America or at large overseas air shows.

A hybrid of the two roles is also possible given the unique mission of RPA aircraft, intel, and cyber operations within ACC. These platforms are usually deployed in place within CONUS, but their battles are unceasing and in high demand across all theaters. While the level of security involved in their work may seem intimidating at first, there are several embedded medical programs currently available that allow for a select few to gain unprecedented insight into the most clandestine of our combat forces.

As part of the USAF transition to focus on near-peer competition, ACC coined a concept called Bring the Future Faster. This priority essentially highlights the need to reduce vulnerabilities across all domains of combat, organize ongoing efforts to consolidate isolated programs, and apply the latest and best practices in science, technology, and informatics across every weapon system. To this end, a new branch was recently formed called Aircrew Performance. Recently created in October 2021, this branch helps to streamline different embedded health promotion programs and bridge the gap between

operations, research, and medical. Aerospace physiology was also recently detached from its traditional home in medical and integrated into this new branch by direction of the Secretary of the Air Force.

This reorganization has caused flight surgeons to be in higher demand than ever to join these embedded teams or provide their clinical expertise as consultants. Many of these new innovative teams seek to bring the best of sports medicine, physical therapy, cognitive performance, and mental health straight to the warfighter’s side. For example, physicians might be asked to provide clinical oversight for programs such as Optimizing the Human Weapon System, which is currently established at most fighter bases across ACC, PACAF, and USAFE. This role challenges the clinician with learning the best practices that aim to reduce short- and long-term neck and back injuries seen with high-G maneuvers in the fighter pilot community.

Programs like Optimizing the Human Weapon System have built out several training centers located at or near their assigned fighter squadrons and apply the most up-to-date practices from multiple disciplines. These training sites offer comprehensive training services that promote a warrior-athlete model seen in Olympic and Division One sports teams. In partnership with AFRL, they have created a new standardized battery of tests for the fighter pilot. These tests serve as updates to the older aerospace physiology Fighter Aircrew Conditioning Program and add new cognitive measurements. This collection of tests, called the Aircrew Readiness Mobility Optimization Result version III, is offered starting at UPT and runs through the pilot’s entire life cycle.

There are many opportunities for a flight surgeon’s growth within ACC. Choose your own path with deployments that span the globe in every modern combat platform available, clinical development at major stateside MTFs, or push scientific innovations with applied field research in embedded operations. ACC offers flight surgeons roles at the cutting edge of the fight in whatever fields most interest them. ✪



Heritage flight of A-10, F-16, F-22, and F-35 over Davis-Monthan AFB, AZ (USAF photo by SrA Jacob T. Stephens).

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E-3 Sentry AWACS from the 964th Airborne Air Control Squadron, 552nd Air Control Wing, Tinker AFB, OK, and E-8C Joint STARS from Team JSTARS at Robins AFB, GA, participated in a joint exercise (USAF photo by SMSgt Roger Parsons).



MQ-9 432<sup>nd</sup> Wing, Creech AFB, NV (USAF photo by TSgt Robert Cloy).



OHWS fitness training, Joint Base Langley-Eustis, VA (USAF photo by SSgt Delaney Gonzales).



Distributed Common Ground System (USAF photo by DCGS April 2014).

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A-10 from 442<sup>nd</sup> Fighter Wing, Whiteman AFB, MO, landing on highway in Estonia (USAF photo by SSgt Melissa Sterling).



38<sup>th</sup> Rescue Squadron, Davis-Monthan AFB, AZ, PJ conducting jungle warfare in Hawaii (USAF photo by SSgt Devin Boyer).



48 PJs performing night time MEDIVAC Davis-Monthan AFB, AZ (USAF photo by Maj Mark Truxillo, flight surgeon).

## Notice

### 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:

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# Aeromedical Ops & Medical Standards

## What's New in the Medical Standards Directory?

**Paul "METRO" Vu, Maj, USAF, MC, FS**  
**AFMS Chief, Medical Standards Policy**

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The USAF Medical Standards Directory (MSD) has been with us for almost 9 years! It was published toward the end of 2013, following a 3-year herculean effort by Dr. Lynn Berry (Chief of Physical Standards Development). AFI 48-123, published concurrently, empowered the MSD to set the medical standards. Arranged this way, updates to medical standards did not undergo the extensive coordination required for policy rewrites. That being said, changes to the MSD require a large collaborative effort from flight surgeons and medical standards experts across the MAJCOMs, the Aeromedical Consult Service, the Accession Medical Waiver Division, AFPC, and various specialties. Digging through old emails, it's neat to see the discussions between people hashing out MSD language. This article aims to give readers a glimpse into the recent work that went into updating the MSD on mental health and pregnancy.

Collaboration is key. Every few months, the Medical Standards Working Group (MSWG) convenes to discuss proposed changes with open dialog from champions advocating their recommended changes. Depending on the proposal, it can be a quick quad chart with brief discussion versus a detailed presentation followed by months of work to refine the MSD language. The revised Section Q: Psychiatry and Mental Health was a result of months of work between many stakeholders.

The Air Force Medical Readiness Agency Mental Health team alerted the Standards team that Section Q required revision, citing clamor from the mental health field asking for clarity and language to help destigmatize mental health disorders. The proposed overhaul of Section Q was drastic but received favorably by the MSWG in Oct 2021. However, more work was required to better align it with the rest of the MSD. Additionally, other documents had to be cross-checked to ensure the new Section Q wasn't in conflict. The process that unfolded was a line-by-line scrutiny of revised and current Section Q to justify conditions, comments, notes, and formatting between Standards and Mental Health – this took 6 months. For some historical perspective, the original 2013 Section Q had 40 items and 4 notes. Section Q prior to this recent rewrite had 42 items with 8 notes. The recently revised Section Q has 21 items and a small paragraph of notes. The new Section Q is an improvement in clarity and should help encourage our folks to obtain needed mental health care.

Discussions are ongoing with pregnancy (have been for years). Pregnancy was noted as "disqualifying" in the 2013 MSD. In the 2019 MSD, second trimester pregnancy within certain parameters was allowed to return to flight duties without a waiver. Additionally, "disqualifying" was revised to "temporary DOWN" – some argue that this quibbling over semantics isn't helpful in establishing/communicating risk to flyers, mission, and crew. However, keep in mind that the MSD is both a loved/despised document read by audiences beyond the flight surgeon community. All MSD language is quibble-worthy and getting the right language will pay dividends.

Although the pregnancy standard was changed in 2019, communication could have been better. Many flyers, flight surgeons included, were not aware of the change. Perhaps it's the amount of text in the comments for this item that discouraged reading or, if read, was not absorbed. Since 2013, pregnancy continues to have the most text in the comments of any Section J item. Unfortunately, the verbosity continues to grow, and it's beginning to look like an entire Waiver Guide chapter crammed into the comments! Pregnancy is complicated and much work continues...

Many hands go into improving the MSD. As your MSD champion, I strive to make it a better product. If there's an item that can be better worded, deleted, and/or is missing helpful punctuation, please let me know. If the proposal is discussed at the MSWG, you should count it as a bullet on your evaluation. For example, "- #x/x Lt Cols, #x/x physicians! DAF MSWG champion f/1.1M total force eyeballs--Med Stds chief now, Sq/CC next." 🍀

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# Clinical Insight

## In Case You Missed It...

David “BANJO” Navel, Lt Col, USAF, MC, FS  
Chief of Aerospace Medicine, Hurlburt Field, FL

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### COVID-19 Cardiovascular Health

Cardiovascular effects of COVID-19 once again take the spotlight. In response, the American College of Cardiology released a decision pathway for cardiovascular sequelae of COVID-19 in adults.<sup>1</sup> The guidance includes discussion of myocarditis and post-acute sequelae of SARS-CoV-2 infection management with return to play recommendations for both. Also included is a thorough discussion of deconditioning following infection and a graphic weighing risks and benefits of COVID-19 vaccination for those at highest risk of post-vaccination myocarditis.

### Things to Possibly Avoid

There is now a growing list of things with magnets that can kill you if you have a cardiac-implanted electronic device. At first, it was the iPhone 12.<sup>2</sup> Now included are AirPods, their wireless charging case, the Microsoft Surface Pen, and the newer Apple Pencil.<sup>3</sup> While this scenario doesn't apply often to the military flying population, it is a gentle reminder that we live in a world of conflicting technologies, like 5G and radar altimeters, that are likely to get worse before they get better.

### Two Big Schools, Two Big Findings

To start, Harvard University used the Department of Defense Serum Repository to match 801 cases to 1566 controls and confirm correlation between Epstein-Barr virus (EBV) and multiple sclerosis (MS).<sup>4</sup> For all EBV-positive versus EBV-negative, the hazard ratio for MS was 26.5. For service members who were EBV negative at the onset of the trial, the hazard ratio for MS with EBV seroconversion versus persistent seronegativity was 32.4. Then Stanford University found a possible mechanism: antibodies to EBV nuclear antigen 1 bind to the GlialCAM molecule heavily expressed in MS plaques.<sup>5</sup> This appears to be a key mechanism for developing MS and a great target for research, but causality should be cautioned given that most everyone gets EBV at some point but MS is relatively rare.

### New Guidelines and Recommendations

Included in the same issue as the post-COVID cardiology recommendations above, the American College of Cardiology, American Heart Association, and the Heart Failure Society of America released a comprehensive new guideline for heart failure (HF).<sup>6</sup> Primary prevention is emphasized for those at risk of HF (stage A) and those with pre-HF (stage B). Once in symptomatic HF (stage C), care is delineated based on the ejection fraction being reduced, mildly reduced, improved, or preserved. Sodium-glucose cotransporter-2 medications take the spotlight with a recommendation for use across the spectrum, but particularly with reduced ejection fraction, regardless of the patient's diabetes status.

The American College of Gastroenterology released new guidelines on the management of gastroesophageal reflux disease, encouraging proton pump inhibitors to be taken intermittently rather than routinely for those with chronic benign symptoms.<sup>7</sup> Additionally, the American Gastroenterological Association released guidance on de-prescribing chronic proton pump inhibitors that focuses on ensuring patients have valid indications for persistent use.<sup>8</sup>

Last, the Advisory Committee on Immunization Practices has released the Adult Immunization Schedule for 2022.<sup>9</sup> While this often does not involve much fanfare, anyone preparing for upcoming Board examinations should note that there are two new highly immunogenic pneumococcal vaccines to clutter those questions. For unvaccinated, the answers are easy: either PCV15 with PPSV23 in a year or a single dose of PCV20. For those who already received PCV13, continue with their vaccines as you would have in 2021.

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# Mentoring/Leadership Development

## The Operational Career Path—Level Two, Part Two

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Let us “spring” right back into where we left off last time as we continue our foray in level two of the operational career path. Last time we heard from base level SGPs, a theater validating surgeon, and NASA Astronaut Support. This installment we will hear from a squadron commander, an Aeromedical Consult Service (ACS) branch chief, and a MAJCOM SGPA. Without further ado, here...we...go!

### Squadron Commander

Anecdotally in the Medical Corps there is a penchant toward remaining clinical as long as possible. Historically, avoidance of completing rank commensurate PME was one way to dodge the talons of the Colonels Group, which informs the pernicious Game Plan (cue dastardly music). Or allegedly some would just decide to punch out from active duty service to avoid ascending into a command billet. This hurts us as a Corps on multiple levels: losing experience, and losing the opportunity to sit at the table with the other Corps to shape our future as the AFMS. Here we have a shining example of someone who chose to cross-train into the flight med realm and is now a sitting squadron commander.

- *Which job are you describing?* O-5 squadron commander.
- *How long were you in this job?* Currently 18 months in and will promote and move to an O-6 squadron command this summer.
- *What was your path to get this job?* Pediatrician (with lots of additional duties). Cross-trained to flight med, 3-year tour and a deployment as a flight doc, back to peds and flight command/medical director, SGH, and squadron commander.
- *What best prepared you?* As a pediatrician, the best thing I did in my career to prepare for leadership was cross into flight med to better develop my working knowledge of the line and their needs.
- *What are/were your top three priorities?*
  - ◊ Work as hard as I can wherever/whatever I am assigned to do.
  - ◊ Make a difference.
  - ◊ Take care of the patients.
- *What is/was your biggest challenge?* Finding time to do PME, my actual job, and still be a dad. I am one-third done with AWC and the fact that I haven't finished yet haunts me. Obviously, things have worked out, but in terms of feeling like I belong at the table, that part bothers me still. Not that I necessarily would do anything different; I already see my family less than I should...time management is difficult.
- *What is/was your favorite part?* I still feel like I am making the world a better place every day. Not in the same way as when I was directly seeing patients, but I can still see how my efforts improve lives. Also, the AF has been a gift for over 20 years now. I have really, honestly looked forward to every assignment so far. I count myself as very lucky.

- *If you have completed this job, what next jobs did it set you up to hold?* I am moving to an O-6 squadron this summer. Once I finish my PME I'll be set up for group command. If I wanted, at this point I could do several other jobs, but that is my most likely trajectory.

Next, we hear from the “black-box” of USAF aerospace medicine, specifically, from an ACS branch chief. No surprise that you'll need to display some serious clinical chops to land this job:

- *Job you are describing:* ACS branch chief.
- *How long have you been/were you in this job?* 6 years.
- *What was your path to get this job?* Prior to coming to the ACS, I was the ICU Pulmonary and Sleep Medicine Director at the 88th MDG and assisted the ACS with pulmonary and sleep evaluations until I officially joined ACS.
- *What best prepared you?* My first experience working with AF medical standards was in 2012 when I was asked to work on revisions to the MSD for sleep apnea. My goal at that time was to align our policies with the Army's, which at that time only required MEB/IRILO for OSA if it adversely impacted members' duties/daytime function. After much back and forth, ultimately it was decided to eliminate MEB/IRILO for mild OSA only. It took an additional 6 years to eliminate MEB/IRILO for moderate and severe OSA. This experience taught me it takes persistence and patience to change accepted standards.
- *What are/were your top three priorities?*
  - ◊ Facilitating communication with our stakeholders and partners.
  - ◊ Staying on top of the state-of-the art medicine, and clinical practice to better serve our stakeholders.
  - ◊ Contributing to aerospace evidence-based medicine through clinical research and collaboration with 711HPW and NAMRU-D partners.
- *What is/was your biggest challenge?* Making meaningful changes to our policies. As stated above, it takes persistence and patience to accomplish change. For example, within the first few months in this job, I was asked to do a presentation to the NATO aerospace medicine community on pulmonary screening policies in NATO. Gathering NATO policies, I learned the U.S. was the only NATO country not doing pulmonary function screening on all pilot applicants. As a direct result, one of my goals has been to implement pulmonary function screening in our pilot applicants so we can better assess and mitigate aeromedical risk. This goal quickly took on greater urgency with the increased incidence of physiologic events that have eroded pilot confidence in our airframes, increased asthma prevalence in USAF aviators, and

Continued on page 12

now with respiratory impacts post COVID. Although we got FOMCB approval for pulmonary function screening in pilot applicants in 2020, implementation has been delayed due to logistical hurdles COVID has created.

- *What is/was your favorite part?* Clinical research and collaboration with 711HPW and NAMRU-D to include working with the AF and Navy Physiologic Event Action Teams.
- *If you have completed this job, what next jobs did it set you up to hold?* My plan is to retire next year from this job but continue to work in aerospace medicine in some capacity.

Last, but certainly not least, we hear from a MAJCOM/SGPA. This person is the Chief of Flight and Operational Medicine at your MAJCOM. S/he handles your waivers, advises you on all things aerospace medicine, and tries to keep your flight surgeon billets full by advocating with your Aerospace Medicine Consultant.

- *Which job are you describing?* MAJCOM/SGPA.
- *How long were you in this job?* 14 months.
- *What was your path to get this job?* I have served as an AF flight surgeon for 21 years and as an SGP both in-garrison and deployed.
- *What best prepared you?* My time serving as SGP best prepared me for my position.
- *What are/were your top three priorities?*
  - ◇ Provide expeditious, medically sound dispositioning of aeromedical waivers.
  - ◇ Strategically place flight surgeons in AFSOC vacant positions.
  - ◇ Assist and support the AFSOC/SG and SGP with MAJCOM medical concerns.
- *What is/was your biggest challenge?* Learning all aspects of AFSOC. I PCS'd into my position without prior AFSOC experience.
- *What is/was your favorite part?* The frequent interaction with the flight medicine staffs across the MAJCOM.
- *If you have completed this job, what next jobs did it set you up to hold?* Special Tactics Training Squadron Medical Director.

The flight medicine side of the Medical Corps is a pathway to many opportunities some consider unheard of. As such, it's obvious that there is no one "normal" job in flight medicine. We really run the gamut, and a curious doc ought to be able to find a place in our world. Speaking of nothing being normal, next time we'll delve into AFSOC jobs. Get ready to strap in tight. 🚀

## SoUSAFFS Website



### Colby C. Uptegraff, 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.

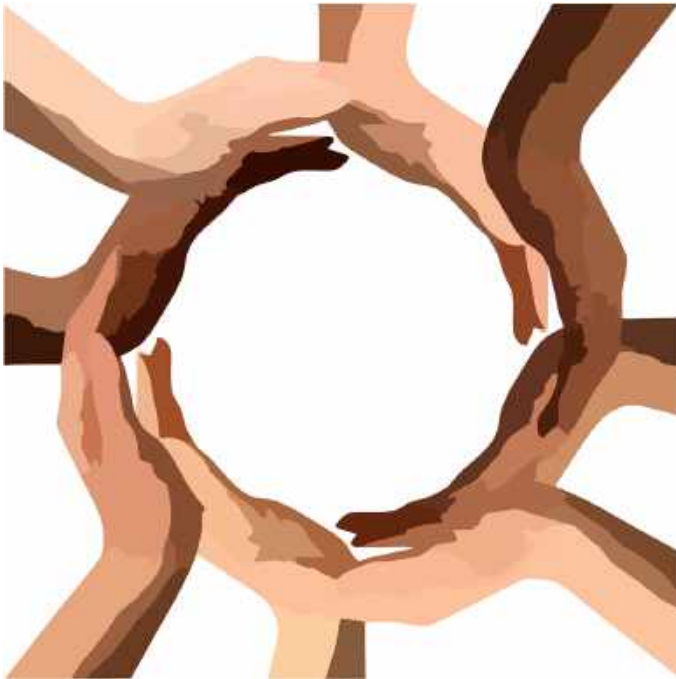
Please visit [sousaffs.org](http://sousaffs.org) to see and explore the new website yourself. If you have any suggestions on additional content or how the website can be improved, please don't hesitate to email us at [info@sousaffs.org](mailto:info@sousaffs.org).

# Diversity/Inclusion

## Diversity...has to be more than just a *buzz* word!

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RAM ‘17

If the COVID-19 pandemic taught us anything, it should have made clear that such a widespread and severe problem would take the whole world to solve it. You see, the coronavirus does not care what color you are, what religion you follow, which political party you belong to, your socioeconomic status, or your sexual orientation. It is truly an equal opportunity virus. The virus highlighted and compounded the problems of the already dangerously stressed medical infrastructure and health inequities in our country. It should have come as no surprise early in the pandemic that the African American death rate was 2.8 times that of Caucasians, nearly mirroring the maternal death rate for African American women that is 3 times as high when compared to Caucasians. This virus illustrated how much we had to become more inclusive on a global scale if we were to stop its spread. Even 2 years later, it is still requiring “all hands on deck” in one way or another.



Diversity adds power. I wish I could tell you that I have never felt I have been treated differently because of the color of my skin or my gender, but I cannot, because it would not be true. There are times I felt supported and recognized, but also times that I have felt devalued

and misunderstood. The opinions I hold because of my differences in culture and personality have not always been warmly accepted. Bearing the weight of being the only woman or only person of color, or both, becomes quite tiresome over time. What I can tell you is that the cultural climate of the Air Force is changing for the better. This did not happen by accident, but instead required deliberate action. Data barrier analysis groups were formed to scrutinize potential biases in promotion rates and selection boards. Air Force Women Initiative Teams revolutionized female hair standards to allow longer braids and bangs. Be encouraged.

Feel empowered. Know the unique qualities you possess matter and are value added. Unapologetically take your seat at the table but, even more importantly, know that you earned and deserve the right to sit in it. Representation matters! It does indeed take a village. So if I had one ask, it would be for each one of us, myself included, to take a hard look at ourselves to search for those unconscious biases we all carry. Take notice of someone standing alone and invite him or her to join your group. Do not judge people’s actions unfamiliar to you, but instead investigate what drove them to those actions. If you are already doing those things, do them more often to be even more impactful. “Be a part of the solution” comes to mind.

Remember, health equality means giving everyone the same amount of help, versus health equity, which involves giving the most help to those who need it the most.



We are the only ones who can create the inclusive environment our children and grandchildren deserve along with the collective sense of belongingness required to make **diversity...more than just a buzz word!** ✨



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