FLIGHTLINES

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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

Every flight surgeon, a member.

COVID gives me the opportunity to serve as the shortest-tenured presidency in Society of USAF Flight Surgeons' (SoUSAFFS) history. Col Tess "Feelin" Goodman handed the gavel over in August 2021 at our annual business luncheon during the Aerospace Medical Association's (AsMA) conference in Denver. The conference meets every May, but COVID forced the cancellation of the 2020 conference and delayed the 2021 conference. My 9-month tenure will focus exclusively on growing the membership. We therefore adopted the mantra: *Every flight surgeon, a member.*

The plan:

1. Identify every flight surgeon, whether in an active flying billet or not.
2. Reconcile membership data for each flight surgeon to one of three categories:
   a. Member of both AsMA & SoUSAFFS
   b. Member of SoUSAFFS only
   c. Non-member
3. Target every flight surgeon with repeated contact to encourage membership.
4. Promote Society engagement.

The plan is both simple and obvious: deliberate, by-name targeting. Organizations commonly stray in pursuit of often-worthy goals, but do so frequently at the cost of routine organization-sustaining activities. The LEGO Company exemplifies how an organization begins to pursue other objectives while ignoring its core competitive advantage. In the mid-2000s, LEGO was on the brink of bankruptcy. Today, LEGO is the most valuable toy company in the world. LEGO's near demise originated from multiple pursuits to expand its product line. The brink of bankruptcy led the team to refocus on the "power of the brick," the brand's core competency. Customers came back in droves.

What is SoUSAFFS' core competency? *Membership is family.* Yes, SoUSAFFS does create flight surgeon manuals and mishaps guides, while also issuing several *FlightLines* issues each year. The "stuff" we do is icing on the cake. Membership fosters family. That's the real value. We need to grow the family.

The relationships I've cultivated through SoUSAFFS have, over the years, led me to where I am today and where I will go in the future. That's also why I'm bullish on the future of Air Force flight surgeons. Our community took a few blows in the recent past. Remember: "It ain't how hard ya hit, it's how hard you can get hit and keep moving forward. That's how winning is done." – Rocky Balboa. Fortunately, we proved that our value to our patients and the operational community is incomparable. Now is the time to "buy." That's why I'm staying in the market.

So, join our family. *Every flight surgeon, a member.—Doogie*

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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.

From the Editor

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

Greetings from Tinker AFB.

Team, I am still basking in the rays from the Aerospace Medical Association (AsMA) convention held this past August in Denver, CO. This was my first AsMA convention after being in the business of flight medicine over the last 8 years. The experience was great; to meet and share experiences with old, not so new, and new brothers and sisters in the profession of air, space, and operational medicine was nothing short of fantastic. I had to ask myself why it took so long to attend an AsMA convention. I have come to two conclusions: I did not see the value in it, and that value was not shared or mentored into me as a young flight surgeon. In retrospect, as I served as chief of aerospace medicine and then a commander, I realized I, too, fell short of promoting our craft to junior flight surgeons under my influence. Unfortunately, it was not until I entered into the RAM that I took stock into AsMA and SoUSAFFS. I now find value and understand the importance of the membership and the family that comes along with it.

During the convention there were not many captains or majors in attendance. I find their attendance to be a necessity if we are to develop, mentor, and ensure the relevance of our craft as aerospace medicine experts for line of Air Force operators. I challenge every flight surgeon to seek out opportunities to attend an AsMA convention, source the funding for at least one junior flight surgeon yearly, and maybe present research or a case study. We have to take opportunities such as AsMA to be renewed, gain nuggets of knowledge, and cross pollinate good ideas that could be valuable to operations and your career. I am now a believer, so COME to AsMA 2022, 22-26 May, Reno, NV; it will be well worth it.

The last edition of *FlightLines* discussed Code 2 by Colonel Dave "Pfieffur" Duval. My take on the column expressed the value of truly understanding the operations we support and those personnel. The knee jerk reaction for the decision for UP or DOWN is a question taken into consideration at each face-to-face visit, shop visit, and squadron roll call. The key to make that determination and risk is to see and gain the experience in the training, operations, and casual setting of the operator, so one can make the judgment call. Realizing that those making these judgment calls are not always flight surgeons enforces the value of being involved outside of clinic operations and the interdependence of Team Aerospace.

OMRS commanders (formerly AMDS) and chiefs of aerospace medicine must find and protect opportunities for our junior flight surgeons, operational docs, providers, and aeromedical technicians to see the mission at grass root levels and get involved in the business. The interdependence must be shared collectively to advance with the goal of living between Code 2s and 1s. As a larger organization supporting the warfighter, "the essence of organizations is interdependence, and it is not news that all of us need to obtain the assistance of others in order to accomplish our jobs," according to Pfeffer, Managing with Power-Politics and Influence in Organizations (1992). So understanding the mission, developing trust across blurred lines, and getting out of our silos go a long way in aerospace and operational medicine, and it takes a family to make the business run, so stay with family, and enjoy the ride.

Need to Update Your Membership?

To update your society membership or contact information, please visit 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.

Flight Surgeon Consultant's Corner

Holding the Line

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

Since March 2020, it has seemed like we are speeding down a bumpy, wet, and winding road, in the dark, and with no headlights. Our PHEOs (SGPs) have been thrust into the spotlight and have been in high demand. We've had flight surgeons out on immunization augmentation teams, and we've deployed flight surgeons in support of OPERATION Allies Welcome. Throughout it all, we've also supported deployments to CENTCOM, AFRICOM, and SOUTHCOM. And we've done it all, despite being undermanned. In short, we've been holding the line, and we've been doing it for far longer than COVID.

Our staffing is perpetually challenged. We chiefly rely on the unpredictable largesse of others to obtain flight surgeons – general medical officers (GMOs) and crossovers from other career fields. While we do have a dedicated pipeline (OGME), it only helps so much. Since we lose 20-30 48Gs per year to residency (which is where we want our GMOs to go), it only just about covers those losses. All told, we have been operating at a net loss for the last several years, to the point where we always have significant deficits. This shortage magnifies the issues we face with manning FOMC and BOMC in the face of all our deployments.

While we may not have any control over the numerator (faces), we can affect the denominator (spaces). My mantra since becoming Consultant has been that flight surgeons need to be doing flight surgeon things, and the positions on our books have to be valid requirements. To that end, we here at AFMRA are working with USAFSAM's BOMC division to analyze workload and determine what BOMC Next looks like. We are trying to determine how many flight surgeons are actually needed to do flight medicine-specific tasks in BOMC. We are also in the middle of a SME study with the AF Manpower Analysis Agency to validate SME positions. Some SMEs are assigned to training squadrons that should be fully supported by the base MTF. Others are assigned to flying squadrons that do not take their SME when they deploy. We are working to identify and remove those authorizations. We are also looking at other SME manning models. Bases with rescue squadrons are assigning SMEs to the OSS, giving them more flexibility in flying unit support. This model may work at other bases, too.

Another drum that I constantly beat on is career progression and taking rank-appropriate assignments. We need all flight surgeons to expect to take on greater roles or greater responsibility as they rise through the ranks. We absolutely need the right experience at the right level. This is why I undertook a grade rebalance for SGP billets across the AFMS. O-4s should start at smaller, lower complexity aeromedical programs, then progress to larger ones. We want to set everyone up for success and prepare them for bigger and better things. That is why we have restarted the Aerospace and Operational Medicine Executive Development Symposium, have updated the PRAP and occupational medicine courses, and are continuing to refine the Aerospace Medicine Primary Course and the Residency in Aerospace Medicine, which is on solid footing with the ACGME. We envision delivering quality training through the life cycle of aeromedical providers (flight surgeons, APAs, and ANPs).

There is reason to be cautiously optimistic. Based on current projected gains/losses, we *might* be able to decrease our manning deficit by 20-30%. To extend the metaphor, this might be like stopping the bleeding and getting a unit or two of blood. However, this may be a "COVID phenomenon": flight surgeons may be delaying separation or retirement during uncertain times. That is why it is imperative that we get after these structural issues now to improve manning across the Enterprise. If we can do this, work burden and OPSTEMPO might improve. If that happens, stress and burnout may decrease, resulting in improved retention and overall manning, thereby creating a virtuous cycle. As I said, I am hopeful.

I assure you that we understand the strain and appreciate your dedication. We realize that we have a narrow window of opportunity, and we are working diligently to bring relief. I want to thank each and every one of you who are out there holding the line during these unprecedented times. Your efforts have not gone unnoticed or unappreciated.

Stay strong, take care, and don't hesitate to reach out if you have questions.

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:

mark.dudley.3@us.af.mil

Moving, need your *FlightLines* sent to another email addresss? For *FlightLines* distribution/email update, please contact the Executive Editor, mark.dudley.3@us.af.mil.

Help Us Grow!

Flight Surgeons, have you joined SoUSAFFS yet? The Society of Air Force Flight Surgeons is a constituent organization of AsMA that more specifically supports the needs of AF Flight Docs, with a focus on education, mentoring, and networking. We are reaching out to our cadre of young physicians to make our organization one that is essential to be a part of. Not only will SoUSAFFS membership afford you invaluable networking opportunities, but it will also make you eligible for retreats/trips to other bases to experience other missions/airframes and bond with your fellow Flight Docs! We want to grow our organization, and we can't do that without bright ideas from excited young docs! Join us today at www.sousaffs.org.

For more information, please contact Col Stefanie Nance at membership@sousaffs.org.

MAJCOM Perspectives

Air Force Global Strike Command

Todd P. "Quattro" Huhn, Col, USAF, MC, SFS
Division Chief, Aerospace and Operational Medicine
Air Force Global Strike Command

I was very excited when I was approached and asked to write an article discussing the Air Force Global Strike Command (AFGSC) for *FlightLine*s. As anyone who has attended my AFOM 101 lectures knows, I love to talk about AFGSC. Couple that love with the sweeping modernization across the command, and it's going to be hard to keep this to just one page!

For those of you who haven't heard me bragging, Global Strike is the premier long-range precision option, for both conventional and nuclear strikes. We allow the United States to maintain global stability for our allies … or are prepared to exert a heavy toll on our adversaries should the need arise. Simply put, AFGSC makes the thought of open war with the United States, or our allies, too terrifying to even consider.

But, sure … other than MERELY ensuring world peace, what has AFGSC done lately? The National Defense Strategy recognized that after years of focus on counterterrorism operations, the age of strategic competition has returned. As a result, our MAJCOM is undergoing a sweeping modernization effort across two legs of the nuclear triad.

The B-21 Raider is being designed to replace our current B-1 and B-2 fleet as a long-range, highly survivable bomber capable of both conventional and nuclear payloads. This is particularly exciting, as the next few years will bring this nuclear-capable aircraft to Ellsworth and Dyess AFBs, replacing the current conventional mission of the B-1. This transition brings challenges to the medical groups, as they retool to support the PRAP mission as well as support the new shops and human system integration that come with a new platform.

AFGSC is also upgrading the most responsive leg of the nuclear triad – our fleet of intercontinental ballistic missiles (ICBM). The Minuteman III has been on alert for more than 50 years, but will be modernized to the new Ground Based Strategic Deterrent (GBSD). The GBSD is not just a new missile; it is a whole new infrastructure system that brings modern command and control features to the table. We can expect that the existing missile alert facilities will continue to serve after they are refitted, so our medics will continue to consult on matters of fatigue management, operational risk management, and the other human factors that we mitigate for our nation's missileers.

We also have a new rotary wing platform coming on-line, the MH-139 Grey Wolf, which will replace the aging UH-1N Hueys used in our ICBM fields. The past few years have seen the rotary mission expand from security and occasional transport to being fully integrated into a multi-layered defense. Additionally, while not part of their primary mission, our helicopters are often called on to fly DSCA search and rescue missions in the northern tier, and our AFGSC medics have frequent opportunities to participate.

And these are just the manned weapon systems! Hypersonic weapons are being built that will change the combat landscape with the ability to hold high-value/highly defended targets at risk. These can be delivered from penetrating bombers or standoff platforms and will make any adversary think twice about being "untouchable." And, our current inventory of B61 and B83 bombs are being consolidated and updated with a refurbishment to the B61-12 that will allow our dual-capable aircraft continued superiority.

All of this from the USAF's youngest MAJCOM. Truth be told, with our Strategic Air Command legacy, I tend to consider us to be the USAF's oldest MAJCOM. If you consider the "bombers-will-get-through" strategy of WWII, you could say we actually predate the USAF!

Or, as I like to say, "Fighters make movies, but bombers make history…"

https://twitter.com/AFGlobalStrike/status/1424036059273474052

Air Force Materiel Command (AFMC)—A Very Brief Overview

Maureen Williams, Col, USAF, MC, CFS
Chief of Aerospace and Operational Medicine
Air Force Materiel Command

AFMC MISSION: Powering the world's greatest Air Force, AFMC develops, delivers, supports, and sustains war-winning capabilities.

AFMC VISION: One AFMC – collaborative, innovative, trusted, and empowered –indispensable to the nation, disruptive to U.S. adversaries.

This article gives an overview of AFMC missions and aerospace and operational medicine (AOM) opportunities. Since I could not say it better myself, I shamelessly copied most of the following from the AFMC Fact Sheet that HQ AFMC/PA graciously supplied to me.

Headquartered at Wright-Patterson AFB, Ohio, AFMC is a major command (MAJCOM) created July 1, 1992. The command conducts research, development, test, and evaluation and provides acquisition management services and logistics support necessary to keep Air Force weapon systems ready for war. Often regarded as the origin of Air Force innovation and the bedrock of all things accomplished within the service, AFMC's centers and lab play a pivotal role in the acquisition life cycle – from a technology's earliest inception to its disposition from the Air Force inventory.

There are eight AFMC host bases located across the country: Arnold AFB, Tennessee; Edwards AFB, California; Eglin AFB, Florida; Hanscom AFB, Massachusetts; Hill AFB, Utah; Robins AFB, Georgia; Tinker AFB, Oklahoma; and Wright-Patterson AFB. In addition, AFMC has tenant units operating on several non-AFMC bases. Between October 2021 and October 2022, AFMC will take over support functions at U.S. Space Force bases including support for their military treatment facilities.

The command has six centers that execute its core mission areas, similar to numbered Air Forces in other MAJCOMs. These centers include:

- Air Force Research Laboratory (AFRL)
- Air Force Test Center (AFTC)
- Air Force Life Cycle Management Center (AFLCMC)
- Air Force Sustainment Center (AFSC)
- Air Force Installation and Mission Support Center (AFIMSC)
- Air Force Nuclear Weapons Center (AFNWC)

AFRL: This center leads the discovery and development effort. AFRL is the Air Force's only organization wholly dedicated to leading the discovery, development, and integration of warfighting technologies in air, space, and cyber for the U.S. Air and Space Forces. AFRL leverages a diverse science and technology portfolio that ranges from fundamental and advanced research to advanced technology development. The lab also provides a wide range of technical services to joint acquisition, logistics, aerospace medicine, and operational warfighting communities. AFRL's technically diverse workforce of more than 10,200 employees works across more than 40 operating locations worldwide. The U.S. Air Force School of Aerospace Medicine falls under the 711th Human Performance Wing (HPW), a part of AFRL.

AFTC: This center leads test and evaluation. AFTC conducts developmental and follow-on testing and evaluation of manned and remotely piloted aircraft and related avionics, flight-control, munitions, and weapon systems. It has flight-tested every aircraft in the Army Air Force's and the Air Force's inventory since World War II. AFTC also operates the Air Force Test Pilot School, where the Air Force's top pilots, navigators, and engineers learn how to conduct flight tests and generate the data needed to carry out test missions.

AFLCMC: AFLCMC is the single center responsible for total life cycle management of all aircraft, engines, munitions, electronic systems, and even uniforms. AFLCMC delivers affordable and sustainable war-winning capabilities to U.S. and international partners, on time, on cost, anywhere, anytime, from cradle to grave. AFLCMC's workforce of nearly 26,000 is located at 75 locations across the globe—from Peterson AFB, Colorado, to Oslo, Norway.

AFSC: AFSC provides sustainment and logistics readiness to deliver combat power for America. The center provides globally integrated, agile logistics and sustainment to the warfighter through depot maintenance, supply chain management, and installation support. AFSC employs more than 40,000 military and civilian personnel and provides installation support to more than 141 associate units with more than 75,000 personnel. The three air logistics complexes (ALC) located at Hill AFB, Robins AFB, and Tinker AFB are experts in world-class, comprehensive sustainment of air and space systems – from circuit cards to aircraft – and provide support to other Defense Department services and allied-nation aircraft.

AFIMSC: Established in April 2015, AFIMSC serves as the single intermediate-level headquarters responsible for providing installation and mission support capabilities to 77 Air Force and Space Force installations, 8 MAJCOMs, and 2 direct reporting units. The AFIMSC cross-functional team provides globally integrated management, resourcing, and combat support operations for Airman and family services, base communications, chaplain programs, civil engineering, contracting, logistics readiness, public affairs, security forces, and financial management. The consolidation of more than 150 capabilities at AFIMSC also helps commanders focus on their primary mission areas.

Continued on page 6

AFNWC: This center supports, you guessed it, nuclear systems management. Established March 31, 2006, AFNWC synchronizes all aspects of nuclear materiel management on behalf of the AFMC commander in direct support of Air Force Global Strike Command. Headquartered at Kirtland AFB, New Mexico, the center has about 1,400 personnel assigned at 18 locations worldwide and consists of 5 major execution directorates: Air Delivered Capabilities; Ground-Based Strategic Deterrent Systems; Minuteman III Systems; Nuclear Command, Control, and Communications (NC3) Integration; and Nuclear Technology and Integration. It also has several functional directorates and its commander is dual-hatted as the Air Force Program Executive Officer for Strategic Systems.

As you can see, there are no copy-and-paste mission sets or bases in AFMC – each location is unique, and so are the opportunities for AOM medics. AFMC is the initial flying class physical and waiver disposition authority for flight test engineers, and thereby influences medical standards for this subset of flyers. AFMC makes up 41% of the Air Force's civilian workforce (about 70,000 personnel), so civilian health and wellness is an important focus area essential to AFMC mission sets. As a result, AFMC leads the way in initiatives such as Civilian Health Promotion Services, of which it is the program manager, as well as line-funded mental health support embedded in units at two of our three ALCs. The nature of the command's mission means that AFMC has a strong occupational medicine presence with the only three stand-alone occupational medicine clinics in the Air Force at the ALCs. Finally, the 711th HPW is the premier consultant for all things human factors in any human-machine and human-environment interaction and is also heavily invested in training and sustaining AOM medics.

That was the whirlwind tour of AFMC, who we are and what we do, and our AOM opportunities. If you are looking to improve today's or influence tomorrow's weapon systems, enhance the human-machine/environment interface, or shape policy/procedures that maximize human performance, this is the place to be.

Information for this article sourced from AFMC Fact Sheet, AFMC At-A-Glance, and the 2020-2022 AFMC Communication Strategy.

To learn more about AFMC:

- AFMC Heritage Video
- AFMC Mission Video
- AFMC 101 Video

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.

Aeromedical Ops & Medical Standards

Mellow Yellow, Calming the Raging Bull

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

Flight surgeons are standards experts. The responsibility of the flight surgeon to apply a standard can place the patient/doctor relationship in an awkward position. As a young captain, I remember DNIFing a seasoned U2 pilot for an H3 audiogram right before an important training mission. He yelled while storming out the door, "I've been around jets for 25 years and I'm supposed to hear a mouse fart?!" That got me wondering … Should mouse farts replace pure-tone audiometry? Does it better approximate real world? What is an appropriate standard? What could I have done to better explain medical standards?

The Medical Standards Directory (MSD) is the companion document to DAFMAN 48-123, *Medical Examinations and Standards*, and I have it saved on my desktop for quick reference. D25 in the MSD has an "X" below Flying Class II, indicating a DNIF for the pilot in the above anecdote. It's often viewed dichotomously as either you're good to fly (green) or DNIF (red), and it's the red that provokes the raging bull. However, most DNIFs are actually yellow – and there's a waiver for that!

Picture the American stoplight – it's red, yellow, and green. Green means you're good to go—standards are met and you can sign another Up 2992. Yellow means to slow down, no speeding—DNIF, but work the waiver. For full transparency, I still have to resist the urge to speed through a yellow light, both metaphorically and on the streets. However, it's gotten easier as I've mellowed with age and appreciate the safety of yellow. And red, well that's the hard DQ. Running the red may be catastrophic. This isn't a novel concept; refer to Dave "Pfieffur" Duval's "Code 2" in the 2021 spring/summer *FlightLines*.

The stoplight analogy can also be used to discuss retention. An AMRO referral is the yellow light. If a code 37 is triggered, the yellow light may linger for a quite a while as the MEB process unfolds. Flight surgeons are familiar with flying and retention standards, but it is also useful to be aware of accession standards as outlined in DODI 6130.03 volume 1.

People seeking entry into military service must meet the standards applied by the docs at DODMERB and MEPS. Green—standards have been met and they're good to enter service. If standards aren't met, it's not necessarily red, it might be yellow, as maybe they can get an accession waiver.

The Accession Medical Waiver Division in San Antonio is the central waiver authority for all USAF accessions. Having all waiver requests funneled there allows for streamlined and consistent handling. This team operates in the yellow, as each case gets thoughtful consideration to truly weigh the risks and benefits of granting a waiver. Although we don't have one centralized waiver authority for flying, the process for a flying waiver is similar. If a disqualifying condition is found, the flyer waits for a waiver while he or she is DNIF; if the waiver gets approved, they're returned to flying duties.

Flight surgeons need to get comfortable basking in the yellow light. Communicate that this yellow light helps keep us safe and that most yellow lights return to green after careful consideration and mitigation of risk. Maybe if I had introduced the yellow light DNIF to the U2 pilot years ago, he wouldn't have been so upset. U2 pilots are used to yellow by the way; their full pressure suits are yellow. I am happy to report that he did get a waiver and eventually retired with his fini-flight. Not sure if he was ever able to hear a mouse fart again, though.

Pics of some of the best people I've gotten to work with … All photos by Paul Vu, permission granted for use by *FlightLines*.

Airman Availability Management System

Lindsay A. Johnston, Maj, USAF, BSC
Aeromedical Physician Assistant Base Operational Medicine Clinic
Development Division, USAFSAM

The Base Operational Medicine Clinic (BOMC) is introducing the new Airman Availability Management (AAM) system. AAM is a complete overhaul of the current medical profiling system. The first takeaway here is that the look, processes, and capabilities of the old system are all being updated in an effort to standardize profiling processes. The most important difference between the new process and the existing one is that the updated profiles are *conditions* based, as opposed to the current process that lumps diagnoses together. Given the change in focus, it is highly recommended users check the system that houses AAM (ASIMS) regularly as an essential part of the daily routine.

All updates align with AFI 48-133, *Duty Limiting Conditions* (Aug 2020) and the AAM Guide. In addition, the system's initial messaging was routed through MAJCOM medical leadership. Given the new and detailed information associated with this program, it is highly encouraged that all medical personnel pay particular attention to the documents that relate to AAM.

Primary care managers (PCM), consultants, and specialists at the medical treatment facility (MTF) are responsible for inputting profiles (AFI 48-133, para. 2.7.1 & 2.8). While the primary purpose of profiles is to communicate with commanders, the profiles are also used to optimize recovery time for service members (SM) while also ensuring that they are able to contribute to the unit's mission and are ready to deploy. Collaboration between the PCM and specialists/consultants is highly encouraged for all aspects of a SM's care, including profiling. The AAM guide and all BOMC-related training can be found on the BOMC website https://hpws.afrl.af.mil/DHP/HP/AFMHSC/.

The MTF Chief of Aerospace Medicine and Chief of Medical Staff are responsible for updating medical staff on the AAM system and should be available to answer questions MTF staff and commanders may have.

Why profiles are being updated:

Profiling is a high-value target for the Air Force. A review of profiles done by the Air Force Audit Agency found that 9 of 10 MTFs failed to appropriately profile psychotropics. The BOMC Development Division was tasked with reviewing the current system, applicable policies, and working with the Air Force Medical Readiness Agency to update and standardize the profiling process.

- Ensure that needed follow-up care is accomplished to prevent lingering health care issues.
- Encourage SMs to seek additional care if a condition is expected to resolve in a certain timeframe but does not.
- Increase SM involvement in the profiling process.
- Provide leadership team visibility (without disclosing diagnosis/HIPAA-protected information) on the overall health status of the unit.
- Better data (ICD-10 diagnoses) will provide needed information on trends, which will allow for focused interventions (embedded care teams, change to equipment, etc.).

A few changes that are coming:

- Evidenced-based templates: Over 170 profile templates have been created for common conditions that were vetted and approved by specialty consultants.
  - ◊ Templates can be entered using provided restriction recommendations or edited to best fit individual patient needs. If a template is entered using the pre-filled recommendations, the profile will be complete in five clicks.
  - ◊ If a condition does not have a pre-filled template, staff will be able to "add a condition without a pre-filled template."
  - ◊ MTF staff will not be able to save, modify, or update templates for future use. Only the BOMC Development Division at USAFSAM may create or update profile templates.
  - ◊ If corrections/edits are needed for existing templates, or if additional templates would be helpful, a ticket can be submitted to the BOMC helpdesk for consideration.
- Profiles will now be tracked and visible to unit commanders. Two of the tracking types are "self-certify" and "follow-up" and will be selected by the provider. Tracking will be updated on the commander's view based on SM response in MyIMR.
- "Other" tracking is also available for conditions with varying profile requirements such as pregnancy, eye surgery, and shaving waivers.
- Leadership (i.e., CCs on G series orders or formal designees) will have visibility on who in the unit is on profile as well as SMs who are due/overdue to self-certify or follow-up with their providers.
  - ◊ Protected health information will not be visible to leadership.
  - ◊ Leadership may reach out to SMs to ensure they are staying engaged with their health care plans or to see if assistance is needed.

Profiles are now conditions based, which means:

- End dates no longer need to match.
- Ability to apply restrictions without concern for conflicting information with another condition.
- No longer limited to three diagnoses.

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- Each separate condition will require the same three levels of review and signature as in the Legacy system. All signatures for each condition must be entered before the 469 will be visible to anyone.
- If a new condition is added to an already existing 469, only the new condition needs to be signed off (no need to sign off on previously closed conditions).
- After signing off conditions, the 469 must also be reviewed and signed by the profile officer. The system will guide reviewers to complete this step.
- If there is a closed 469, and a new condition is added, the 469 will NOT be visible until the new condition is fully signed and the 469 is reviewed/signed to reflect all conditions.
  - ◊ HCP and MSME signatures will automatically be applied to the 469 when they sign the last open condition.
  - ◊ After signing all conditions, the 469 will need to be reviewed and signed by the profile officer to finalize the profile.

SM profiling actions:

- Self-certify: The SM has a "low-risk" condition that is expected to resolve on its own. For all self-certify profiles, SMs must certify their conditions in their MyIMR by selecting one of the following options:
  - ◊ "My condition has improved": certifying a condition has improved and no longer requires medical care.
  - ◊ "My condition has NOT improved": certifying a condition has not improved, which will result in being prompted to make a follow-up appointment.
- Follow-up: The SM has a condition that requires a follow-up appointment at a time designated by the provider. It is highly encouraged that follow-up appointments be made prior to the SM leaving clinic. This will help if there are limited appointments available around the time the provider would like to see the SM again and to help prevent the SM's tracking turning yellow and/or red on the commander's view.

Transitioning from Legacy (old system) to the new AAM system:

- Open, unsigned Legacy 469s should be closed out before AAM goes live at a location to prevent the need of manually converting profiles into AAM.
- During the transition between Legacy and AAM profiling systems, MTF staff must be aware if SMs have a profile in a different system than what is available at their base.
- ASIMS will not allow more than one active profile per member.

Detailed information on what to do prior to and during the transition between systems can be found in the initial AAM messaging noted above.

There is no definitive timeline for release of the new profiling system, but plans are to release in early 2022. Training and various aid materials will be available as the release of the update nears.

Clinical Insight

In Case You Missed It...

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Updates on Venous Thromboembolisms

The CHEST Clinical Practice Guidelines for managing venous thromboembolism (VTE) has received an update without much ado or practice-changing recommendations.[1] One area is already sparking a bit of discussion. The CHEST guidelines strongly recommend that unprovoked VTEs be offered extended-phase therapy beyond 3 months, ideally with low-dose apixaban or rivaroxaban. However, a recent study reviewed 14 clinical trials and 13 prospective cohort studies to find the incidence of major bleeding, and the morbidity and mortality associated with it.[2] Of particular concern were people with certain risk factors, such as age over 65, creatinine clearance less than 50 mL/min, history of bleeding, concomitant antiplatelet therapy, or hemoglobin less than 10 g/dL. That population saw an overall risk of death at 10 years of more than 2.4%, which exceeds the general risk of dying of recurrent VTE in that period at 1.4%. The direct oral anticoagulants are still too new to have much long-term data, so there are fewer talking points for those wanting to continue with preferred agents. The meta-analysis does have a good link to a talking paper that helps summarize their findings in lay person terms.

COVID-19 One Year Later

Researchers in Wuhan looked at 1276 hospitalized COVID-19 patients, matched them to non-infected controls, and followed them at 6 and 12 months.[3] Not surprisingly, nearly half of COVID-19 survivors still reported at least one symptom sequelae at 12 months, including 30% with dyspnea, 26% with anxiety or depression, and 20% with fatigue. Interestingly, a random selection of patients from across the severity spectrum underwent lung function testing and CT imaging. The results were mostly as expected, and spirometric and lung volume parameters were even a bit reassuring, but lung diffusion capacity remained impaired in 23% of the people who did not require interventions during hospitalization and up to 54% in those requiring high-flow nasal oxygen or intubation. In terms of COVID-19's disability-adjusted life years impact, 12% of those employed before COVID-19 were unable to return to their original work.

Don't Touch the Hedgehogs

Forty-nine cases of *Salmonella* Typhimurium infections in children were reported in 2020, and they have been linked to hedgehog exposures.[4] Please add this adorable critter alongside turtles as a pet that should be avoided in children under 5 years old who cannot be trusted to wash their hands.

New Guidelines and Recommendations

The Centers for Disease Control and Prevention released its updated guidelines for the treatment of sexually transmitted infections.[5] The guidelines expand well beyond the traditional list of conditions and treatments and include lengthy reviews and discussions of specific populations and counseling practices, making a 187-page document in all. Key treatment practices from the tome include giving ceftriaxone 500 mg IM in a single dose for uncomplicated gonococcal infection in persons under 150 kg and co-treating with doxycycline 100 mg twice per day until chlamydial testing returns negative. Another change is the addition of metronidazole to the treatment regimen for pelvic inflammatory disease to cover the increasing number of cases caused by organisms of the vaginal flora.

The United States Preventive Services Task Force has calmed down from the rush of changes to colon cancer and lung cancer screening. It did affirm its prior 2014 recommendation for low-dose aspirin therapy after 12 weeks' gestation in women at high risk for preeclampsia.[6] The guidelines include a list of risk factors to review to make that decision.

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Mentoring/Leadership Development

REAL Flight Surgeons on How They Became "Trusted Agents"

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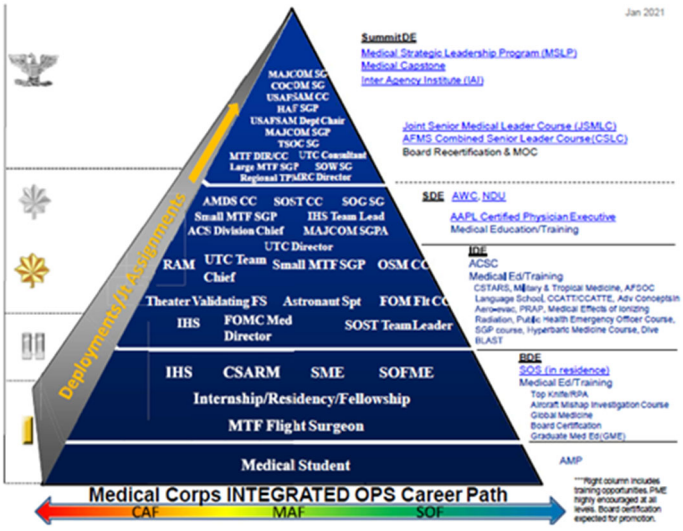

Medical Corps integrated ops career path (from *Air Force Medical Corps Overview,* AF Medical Corps Office, Office of the Surgeon General, Jan 2021).

Hello Flight Surgeons! Up to and just after departure from AsMA, your M&D committee has been soliciting data on what it's like to be you. Today's task is to start to climb the MC career pyramid, beginning after you have your school and internship in the rearview mirror.

Last time, we talked about what it means to be a good flight surgeon. The bottom line is to be a trusted agent. Think of that as being the kind of professional you want to be. But what will your daily job look like, and what can you look forward to as you move through different jobs? We are indebted to the flight docs who responded. Their candor is important for those who want to know what goes into doing some of these jobs. In fact, that sentence doesn't do justice to their efforts. It's important to know what life is like, and to know what kind of a physician you'll be called upon to be. Also, the astute reader will note we aren't covering all jobs. For instance, International Health Specialist is something we'll skip in this forum because it is not specific to flight med. Let's dive in.

For many of us, that first job was as an MTF flight doc, and it's figuratively on the bottom of this level of the pyramid. The medical group owns you. The AMDS or OMRS/CC is your commander. Nobody's path is the same, which is great. There are many ways to skin cats, if that's what you're into. Here's what one of you had to say about that job.

MTF Flight Surgeon

- *How long were you in this job?* 2 years in Yokota AB, Japan, attached to UH-1s for flying.
- *What was your path to get this job?* I had a rough assignment as a flight commander and the best way out was to volunteer for an overseas assignment.
- *What best prepared you?* Previous assignments as SME and flight/CC. Also, a residency in family medicine. I understood ops and flight med and how the MDG runs.
- *What are/were your top three priorities?* (1) Clinic flow (appts, templates, schedules), (2) patient care (as the only 48R, I was the de facto medical expert), and (3) making sure the clinic staff understood what they did and why it was important in the big picture (too much never looking outside the MDG makes it very hard to stay motivated to deal with the additional military-specific challenges).
- *What is/was your biggest challenge?* Balancing the clinic responsibilities with the rest of being a flight surgeon. There is always more stuff to do in the clinic. There is always great stuff going on across base.
- *What is/was your favorite part?* Changing the clinic and making people understand why they do things. Great for morale.
- *If you have completed this job, what next jobs did it set you up to hold?* Flight command (even though I did flight command first) and maybe SGP.

We're intentionally skipping a description of a non-RAM clinical residency, as that's even broader than the jobs we are tackling today. Don't shy away from it, just decide whether it's your path and what piece of medicine interests you the most. Consider whether you'd like to return to flight med after residency (primary care and emergency medicine set you up for success) and look to other *FlightLines* articles for more information on operational residencies. This would be an excellent time to talk to a mentor.

Next on this level is something for the would-be snake eaters out there. Not that you'll spend all your time in the mud, but you do need a different mindset for this job, and the heart of a teacher is helpful. We received a couple of perspectives for you.

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Combat Search and Rescue Squadron Medical Element (CSAR SME) Flight Surgeon

- *How long were you in this job?* I was formerly in this job for 5 years (2010-2015).
- *What was your path to get this job?* I contacted the AFPC flight surgeon assignments officer and requested the job.
- *What best prepared you?* Spending time with the pararescuemen (PJs) and combat rescue officers (CROs) when I first arrived on the job and learning all that I could about their mission, challenges, and needs.
- *What were your top three priorities?* (1) Learning from and supporting the PJs/CROs, (2) contributing to their mission by supporting their physical/mental health needs, and (3) contributing to their mission by providing field medical teaching/instruction sessions.
- *What is/was your biggest challenge?* Being pulled between obligations at the med group/clinic and obligations at the operational squadron.
- *What is/was your favorite part?* Being a part of the PJ/CRO mission and supporting their operations.
- *If you have completed this job, what next jobs did it set you up to hold?* SGP job afterwards.

CSAR SME Flight Surgeon/PJ Medical Director

- *How long have you been in this job?* 9 months.
- *What was your path to get this job?* GMO SME FS for 2 years followed by FM residency training.
- *What best prepared you?* Residency – particularly trauma, ICU, and emergency medicine rotations.
- *What are/were your top three priorities?* (1) Take care of the squadron/families, (2) maintain PJ training/credentials, and (3) consult on real-world missions.
- *What is/was your biggest challenge?* I did not ask for this job and I feel pretty burned out coming out of residency. This kind of position is really suited for someone who is passionate about the mission, enjoys/is good at teaching, and wants to be pushed out of their comfort zone.
- *What is your favorite part?* You get to participate in a lot of training you would not otherwise be able to do – firing range, water operations, mock rescue missions, etc.

Next up is a job that's near and dear to the hearts of many flight docs out there. It's the position that hooked many of us into making this a career. The Squadron Medical Element (SME) flight doc. Again, multiple descriptions. Notice we have some repeat offenders. This job is what many consider the best.

SME Flight Surgeon

- *What is the job you're describing?* I've been an SME in Japan with the 14FS (fighter squadron) and now here with the 56TRS (training squadron). The Misawa job was more expeditionary with the 14th, went to/traveled through every base in PACAF minus JBER/Yokota, add to that the PACAF Viper Demo team doc stuff and that got us to Singapore, Malaysia, Philippines, other random places. It also included a stent with JPAC to Laos. So, a lot of travel medicine. All the other usual MDG prime care services. Misawa was remote, so early MEDEVAC knowledge.
- The TRS assignment is a little different, program director for TKII (Top Knife II), but the empanelment is huge, especially when the MDG flight docs are gone. So, I rotate through different jobs to include SGP/various clinical director positions, I support any of the 8-9 fighter squadrons that need TDY support. I also work in the internal med clinic as an internist (I guess it could be called an IM clinic, thanks DHS).
- *How long have you been in/were you in this job?* 14FS 2 years; TRS will be 3 years.
- *What was your path to get this job?* 14FS: GMO. TRS: residency/lots of fighter experience.
- *What best prepared you?* Had great AMDS/CC/SGPs at Misawa, same deal at Spang as a MDG doc. We've won the CC/SGP lottery going on 10 years now. Some of the support courses from USAFSAM were helpful, global med especially.
- *What are/were your top three priorities?* (1) TRS: Patient care (maintain IM skills), (2) TKII/support my CC at the TRS, and (3) flying.
- *What is/was your biggest challenge?* Learning how the Ops group functions, finding a good balance between the MDG/OG … maintenance of IM skills (the MDG/AF sets up roadblocks to moonlighting, nearly impossible now).
- *What is/was your favorite part?* Operational focus, being a part of something bigger than patient care.
- *If you have completed this job, what next jobs did it set you up to hold?* Theater validating flight surgeon is my hope, seems like a good fit with my background, would allow me to practice medicine somewhere at the same time. Base level SGP an option. I think those two fit the schema below … But honestly, I don't really know what the AF needs at this point for a guy with my background. Still weighing other options—civ med groups look highly on our experience as flight docs. The local reserve unit is looking for an AGR (Active Guard and Reserve). Fellowship is still an option, outpatient IM vs. PHX hospitalist. Just depends on what is available on the AF side, family and I are up for a 20 year, but also my commitment is up in 12 months.

- *What is the job you're describing?* Current SME Flight Surgeon for the 36th Fighter Squadron (F-16). Previously SME Flight Surgeon for the 12th Airborne Command and Control Squadron (E-8C).
- *How long have you been in/were you in this job?* 36th FS – 1 year. 12th ACCS – 4 years.
- *What was your path to get this job?* I commissioned through Air Force ROTC at the University of Central Florida in 2011 and went straight into civilian medical school. After completing medical school, I completed a 1-year transitional internship at a civilian hospital. During this intern year, I elected to pursue Flight Medicine. Upon graduation from my internship, I got my EAD orders to Robins AFB and immediately after went on TDY to Wright-Patterson AFB to complete 3 months of AMP (Aerospace Medicine Primary) course.

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- *What best prepared you?* Of course, AMP prepared me for the job, but having familiarity with the aviation business definitely helps. Also understanding the lingo of an operational Air Force unit helps tremendously.
- *What are/were your top three priorities?* In this job, my three priorities were (1) supporting the mission by making sure the Air Force had healthy, qualified aircrew/operators to perform their duties, (2) ensuring these aircrew/operators had the best quality clinical care I could offer them, and (3) acting as a liaison between the flying/operational unit and the medical units. I wanted to ensure the operators were able to keep a majority of their focus on completing their operational duties.
- *What is/was your biggest challenge?* Understanding that sometimes you have to go against an individual's wishes to continue their duties (such as flying) when that individual has a medical condition that is incompatible/unsafe for them to continue doing so. This doesn't happen often, but it's a tough call to make when necessary. In addition, working through the bureaucracy of a large organization (although definitely not unique to this job!).
- *What is/was your favorite part?* The people or course! Got to make some great friends and meet some truly inspirational and wonderful folks. Beyond that, being able to get close to and learn about the operational mission, flying on all kinds of different aircraft in the Air Force inventory, and the travel opportunities are some other great perks!
- *If you have completed this job, what next jobs did it set you up to hold?* Still in this job now! However, I have been selected for dermatology residency. With the JSGMESB, having years of experience as an Air Force flight surgeon (in addition to operational experience) helps make applicants more competitive for residency selection.

- *What is the job you're describing?* SME Squadron Medical Element.
- *How long were you in this job?* 4 years as a GMO attached to C-130s in Yokota AB, Japan.
- *What was your path to get this job?* Straight out of internship and willing/begging to go overseas.
- *What best prepared you?* As a GMO, maybe I wasn't the most prepared for the position. I ended up in quite a few situations that would have been better handled by someone with more training. But I was willing to learn and learn fast. And I wasn't afraid to ask for help.
- *What were your top three priorities?* (1) Readiness for the flying squadron/operational group, (2) learning to be a good flight doc, and (3) personal readiness.
- *What is/was your biggest challenge?* Very few people understood my role. The ops side didn't really understand what I did and never noticed unless something didn't work out. The work of a good SME means that everything runs smoothly and doesn't get noticed. The MDG didn't understand my role outside of the clinic. When they needed something, I belonged to them. When I needed something, I belonged to the other guy.
- *What is/was your favorite part?* Operations. I learned a ton about operations, the mission, and what my role is to make that happen. I was part of the flying squadron and the flying/readiness mission.
- *If you have completed this job, what next jobs did it set you up to hold?* It set me up to be a better flight surgeon in general. I had a better grasp of how ops and medical fit together. Where the gaps are. What misunderstandings happen and why. And I learned to speak both languages.

Back to eating snakes! The Special Operations Forces Medical Element is not the same as a "normal" SME. We'll likely tackle some of the significant differences between "normal" Air Force and AFSOC in a later effort, but for now, just read what these cats have been up do and decide if it sounds like something you want.

Special Operations Forces Medical Element Flight Surgeon

- *What is the job you're describing?* SOFME flight doc.
- *How long have you been in/were you in this job?* Almost 3 years from the date I reported to Cannon.
- *What was your path to get this job?* I was an HPSP recipient in medical school and completed COT in 2014. After graduating civilian medical school in 2017, I commissioned to active duty and began my transitional internship at SAMMC at Fort Sam Houston. I first heard of AFSOC and SOFMEs during my medical student anesthesiology rotation at SAMMC in 2016 and reached out to more contacts during my intern year to get a more complete picture of what the job entailed. I then applied for the position during intern year via correspondence to the AFSOC assignments officer. I was selected for the position in April of 2018.
- *What best prepared you?* The military internship at SAMMC was very helpful for preparing me for life as an officer in the USAF. During my transitional year, we had a built-in flight medicine rotation at the Reid Clinic at Lackland, which was helpful to get my feet wet in flight medicine. Overall, the most helpful source of preparation came from prior SOFME flight docs who were moving on from their bases and willingly served as pseudo-mentors to me, answered all of my questions, and gave me advice.
- *What are/were your top three priorities?* My top priority is matching to an anesthesiology residency this cycle. My second priority is spending more time with loved ones and family after two Middle East deployments in the last 2 years. Top three job-related priorities are (1) maximize any/all OCONUS TDYs or deployment opportunities, (2) catch up on PME while I still can (such as SOS in residence), and (3) complete GME and become board certified in anesthesiology.
- *What is/was your biggest challenge?* Spending significant time away from friends/family due to the remote location of Cannon as well as nearly 1 year's worth of deployed time. I expected this and went into the job with eyes wide open; however, it was a challenge nonetheless. Another challenge was discovering that our downrange roles are more in line with BOS (base operational support) and zero CASEVAC (casualty evacuation) potential. I was not made aware of this prior to joining the OSM (operational support medical flight).
- *What is/was your favorite part?* The roles and duties of a SOFME flight doc are, in my opinion, far more interesting and rewarding than that of an MTF flight doc. We support the deployed mission directly and we have more opportunities to train both locally and on TDY.
- *If you have completed this job, what next jobs did it set you up to hold?* I still have 1 year to go, but I hope to begin anesthesiology residency and eventually become a regional or cardiac anesthesiologist.

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- *What is the job you're describing?* AFSOC DATA MASKED flight surgeon.
- How long have you been in this job? 2 years currently.
- *What was your path to get this job?* Previous AFSOC SOFME assignments.
- *What best prepared you?* Previous deployments and work in AFSOC.
- *What are/were your top three priorities?* (1) Do something impactful, (2) become as operationally relevant as I could be, and (3) have fun and stay out of the Med Group!
- *What is your biggest challenge?* Working in a non-traditional position that I can't talk about.
- *What is your favorite part?* Working with a special group of people that consistently make our nation a better and safer place.
- *If you have completed this job, what next jobs did it set you up to hold?* There are many different jobs in AFSOC, and many of them come down to relationships and personality. If you're able to build your peer network, hopefully you'll be able to find the right fit for you.

SoUSAFFS Website

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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 to your "safe senders" list].
- **Sign in with Google**: No more forgotten SoUSAFFS passwords! Sign in and link your SoUSAFFS website account with Google.
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