Society of U. S. Naval Flight Surgeons

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PRESIDENT'S COLUMN

I want to thank my colleagues for the honor of serving as your Society President for this year. I did have some reservations about accepting the office since I have received orders to report to Sixth Fleet in October. However, Ron Ohslund has promised to be the on-site coordinator in the event that immediate response is needed for any reason. The first step that he took was evidenced by his column in the last issue of the Newsletter. Thanks for the nice, smooth cover, Ron.

As Flight Surgeons, we are charged with the care of all aviation personnel. Most of the time we think of the pilots, NFOs, aircrewand air traffic controllers when this is mentioned. These are the high visibility people who daily operated in a tension-filled, potentially dangerous environment. But what about the guys and gals out on the flight deck, the flight line and those who are working in the shops? When was the last time you took a good look around the ship, flight line or squadron shops? These are the people who make sure that that wonderful, exciting piece of metal functions properly to accomplish the assigned mission. They repair, clean, fuel, and direct movement of the aircraft that you may also be riding in one day.

Following a recent incident on the flight deck, I checked with the Air Boss to see if we both knew who was or was not qualified to work on the flight deck and at what level. I also asked if the supervisors knew which personnel required glasses to meet their qualifications. I leave you to guess the results. I would recommend that all of you consider checking with your Maintenance Officer to determine the status of all personnel working on the flight decks or on flight lines.

While on this subject, what are your thoughts about one of the shop personnel working on aircraft or components (such as the ejection seat or parachute or rotor head) while taking any of the medications that routinely result in temporary removal from flight status for aircrew? Have you talked to shop supervisors suggesting that they ask what happened when Airmen Jones went to Sick Call? Check six!

I hope by now that everyone has seen and reviewed that pocket reference on Aircraft Mishap Investigation prepared by the Aeromedical Division of the Safety Center. Super job!

There are big plans for the meeting in October. If at all possible, you should really try to be in Pensacola and attend. Besides the opportunity to socialize with some great people who share your enthusiasm for aviation and the chance to stoke up on good seafood, the knowledge that you will gain from the presentations will also make you feel **good.**

CAPT GILL VASQUEZ

SECRETARY-TREASURER NOTES

The response to the note in the last newsletter has been very good. A number of you have responded with back dues payments, as well as with address changes. Thank-you for your cooperation. I failed to indicate that dues are $10 per year, for both members and subscribers.

If you know of flight surgeons who would desire to become members of SUSNFS, please have them contact me for an application.

Plans are to have a table at which you may update dues and addresses at the October Aeromedical Problems Course. 14K gold flight surgeon wings can still be ordered. Payment at the time you place the order will expedite the process. Prices are currently $50 for the lapel pin with diamond, $100 for mess dress wings, $115 for mess dress size with diamond, and $295 for regular size. Delivery takes approximately six weeks.

Once again, thank you for your enthusiastic response to the request for updated dues and address changes.

LCDR C. JOHN NICKLE
NAMI (Code 32)

A VERY FEW PARTING SHOTS

This will be my last contribution to the Newsletter under the Code 42 byline. I leave this office with some regrets but it is time to get back into the reality outside of the hallucinogenic symbolic substitution of electronic voices, microfilmed records and congressional inquiries. I do have a few thoughts that I would like to share with you before I go.

There will be a final version of the Flight Surgeons Quick Reference that will go out to the fleet in October. It is stressed that this is not NAVMEDCOM or CNO policy but is instead a compilation of guidelines which reflect the majority of decisions made when each case is considered as an individual event.

NAVMEDCOM continues to be plagued with the submission of inadequate physical exams.

One major problem is a simple lack of communication. The physical simply does not say what it needs to say. When you are dealing with tens of millions of dollars, terseness is not a virtue.

Another problem is fuzzy thinking (Diabetes Mellitis = NCD??) on the part of the flight surgeon. Listen to the voice of experience -when you make a stupid error, do not go to great lengths to defend it, but blame it on cerebral flatulence, correct it and push on.

Another problem is the receipt of vast reams of xerox copies of third carbons of hospital lab chits and scribbled consults as a substitute for a coherent typed narrative summary by the flight surgeon. I understand the quiet joy that comes from a l ittle passive aggression and tolerate some of it but not when it is counterproductive.

Many physicals are inadequately reviewed and when pink sheeted the sheets are either rat holed in some dark place or returned with caustic remarks. When you write back a nasty sarcastic note, you are depending on my good will and support to keep me from sending a copy of the pink sheet with a coldly formal letter to your CO putting you in an embarrassing and indefensible position. I just thought you would like to know.

Delays are excessive and often cost aviators thousands of dollars and canceled orders.

It is my personal opinion that this sorrowful state of affairs customarily is not due to any moral degeneracy on the part of the flight surgeon although I have known some pretty worthless winged and acorned individuals in my time. (They know who they are) I would bet the problem is due to overwork, no local leadership, and inadequate hospital support. Why do I make such "unsubstantiated" statements? Well, I have a fairly good memory for one thing and flight surgeons talk to me frankly for another. I remem ber a certain NAS where the SMO steadfastly refused to see any patients (the only firm stand he ever took) and a west coast town where the hospital's major concern was to see that no one wore Khaki uniforms and a certain warm place in the desert which so far as I know still does not have a decent slit lamp. On the other hand I also remember Cecil Field where the Flight Surgeons and Physiologists and the Wing Staffs worked together as a efficient team of concerned professionals. I remember NIMITZ where to be SMO was both a privilege and a delight.

So, I do not understand your problems. None the less, I have not accepted substandard work in the past and I am sure my successor will not. Recently we have sent a list of outstanding pink sheets to the Officer in Charge of the dispensaries. Hopefully this will bring forcefully to his attention the problems in the aviation exam room which he is charged to maintain and support. In all fairness the OinC needs your help. Report shortcomings to him in writing.

Do not accept substandard work from anyone; yourself, your AVT, your OinC, or the Naval Hospital. You can make a change. In the immortal words of Davy Crockett "Be sure you're right, then go ahead".*

*Yes I know that only his words were immortal and that while going ahead doing what he was sure was right, he was skewered. It's still a good phrase.

CAPT A.F. WELLS
NAMI CODE 42

NAVY AEROMEDICAL PROBLEMS COURSE

I certainly hope that you have made all the necessary arrangements to attend the third annual Navy Aeromedical Problems Course scheduled for 18-21 October in beautiful Pensacola.

It looks like an interesting and informative program at the very least. Expect to see a good bit of emergency medicine topics which are useful no matter what your duty assignment may be. Look for a lot of information on what is planned if the Middle East heats up and we are called upon to go there. (A Secret level clearance will be required for attendance at one of these sessions, so your command needs to send NAMI a message listing attendees and level of clearance). There will be clinical sessions, tycom reports and working luncheons, status reports on computerization efforts at NAMI and in the fleet, some organized and independant research efforts and new technology being delivered to the operating forces and NASA.

Social events are planned for Tuesday evening at the COMO annex of the BOQ between 1800-2000, and the banquet will be Wednesday evening the 19th. Other social events will undoubtedly occur, limited by individual attendee age and endurance. Plan to have lunch on Tuesday with your Tycom, Safety Center or COMNAVAIRESFOR.

The message outlining the final details is on the street. Call us as soon as possible to let us know what you will

require in terms of billeting, transportation, social functions and so forth. We will then be able to pre-register you and smooth the check-in process. NALO flights will be requested. Your choices for pick-up locations will be forwarded to NALO. The final information regarding pick-up locations and times will be forwarded to AIRLANT (AV564-7028) and AIRPAC (AV951-6251). Do not expect them to have any flight information much before the 13th or 14th of October, that's just the way NALO works. We will ask for airlifts to Pensacola on Monday the 17th and from Pensacola on Saturday the 22nd. Perhaps you should consider alternate forms of transportation just in case.

Last year the AVT's made a good showing, and so far it appears that the numbers will be even larger. Please help ensure that your AVT's get the opportunity to attend. Last year, there were some who took **leave** to attend and paid expenses out of their own pockets. They deserve better support for their continued training. Phone now while it is fresh in your mind. P.O.C. is ENS Patnaude, NAMI Academics, AV 922-2457/2458/2741.

CDR G. G. REAMS
NAMI CODE 324

AEROMEDICAL ADVISORY

The Aeromedical Advisory Council convenes under the direction of CAPT WELLS as chairman to consider aviation medicine policy changes, new medications, new surgical procedures, and any other changes that may affect both designated aviators as well as candidates for flight training.

The following is just some of the information discussed this year by the AAC.

1. ASYMPTOMATIC 1st DEGREE SPONDYLOLISTHESIS without Spina Bifida - is NCD.
2. ARTIFICIAL INTRAOCULAR LENSES, SURGICALLY IMPLANTED - Member will be considered NPQ with NO WAIVER RECOMMENDED. Special Board of Flight Surgeons may be requested by members command.
3. ACL REPAIRS - Will be considered NPQ with NO WAIVER RECOMMENDED for all **AVIATION CANDIDATES.** Designated Aviation personnel requiring knee surgery will, after release from Orthopedics, be found NPQ with WAIVER RECOMMENDED.
4. CHOLELITHIASIS - A coincidental finding of asymptomatic gall stones is NPQ, BUT WAIVER RECOMMENDED in most cases where the member is asymptomatic. If the member is, or, becomes symptomatic, he is NPQ with NO WAIVER RECOMMENDED until stones are removed and member has been released by the Surgeon.
5. 24 HOUR URIC ACID LEVELS -The NEW acceptable upper limits of normal for 24 hour uric acid excretion has been increased to 800mg for males and 750mg for females.
6. H.I.V. POSITIVE AVIATION PERSONNEL - NPQ with NO WAIVER RECOMMENDED. All H.I.V. posi- tive aviation personnel must have a Flight Physical forwarded to NAMI-42.
7. ORTHO K - NPQ ALL SERVICE GROUP I, II, III PERSONNEL with NO WAIVER RECOMMENDED. Member may be reconsidered for return to flight status 3 months after stopping Ortho K **IF** refractive error remains stable.
8. Allergy Immunotherapy - a) AIT will be considered NPQ with NO WAIVER RECOMMENDED all Aviation candidates. Candidate may be considered for a waiver after AIT has been discontinued and has been off medication through one blooming season (May -Aug). Current ENT consult and sinus films to accompany. b) Designated personnel - NPQ. Waiver recommended **if** on a stable maintenance dose and free of symptoms. Current ENT consult and sinus films should accompany waiver requests.

Drugs

1. Dyazide - NPQ. No waiver.
2. Lopid - NPQ, Waiver may be recommended. Must be on stable dose with no side effects for 2 months prior to consideration.
3. Clomid - NPQ, Waiver may be recommended. The waiver is based on asymptomatic **males** on doses of 50mg per day or less. Waiver is **not** recommended in women because of higher doses used in women and the resulting increased frequency of side effects.
4. Mevacor (LOVOSTATIN) a cholesterol lowering agent.

   NPQ, waiver may be considered if:
   a) Cholesterol has not responded to diet and exercise.
   b) Liver enzymes and serum chol./trig. are measured prior to initiation of therapy and at six month intervals. (more frequently if medically indicated)
5. KWELL - (1) Naval aviation personnel be grounded a minimum of two days after Kwell preparations are washed off.
   (2) If adverse effects are experienced, a period of two symptom-free days are required to return to flight status.
   (3) Flight surgeons are to insure that warnings concerning over-application and over-exposure to Kwell products are heeded.
6. Mefloquine - Should not be used in Malaria Chemoprophylaxis of Aviation personnel, unless its use is dictated by operational requirements. The restric-

tion is not because of toxicity, but rather due to the potential for development of mefloquine resistance. Use of Meloquine for treatment is dictated by medical considerations.

7. Antibiotics - Aviation personnel who are on antibiotics may be considered for up chit prior to cessation of therapy if:
   a) The condition being treated has resolved in all aspects that might affect flight performance.
   b) No adverse reaction that might compromise safety of flight.

Those antibiotics so approved are

- Ampicillin, Amoxicillin, Penicillin VK
- Erythromycin preparations
- Tetracyclines **except** minocin
  (Potential vestibular side effects).

CDR J.W. ROSE
RECORDER
AEROMEDICAL ADVISORY COUNCIL

EDITOR'S COLUMN

Well, this is my first and last attempt as editor of SUSNFS, sandwiched between CAPT Angelo, who officially retired 31 Aug., and CAPT Dalton, whose arrival is tentatively scheduled for around 1 October.

What I have noticed in this rather short period of time is the difficulties attendant to solicitation of material for publication in the Newsletter. Either there is nothing worthwhile going on out there, or everyone is too busy putting out the fires we all see on a daily basis. My conclusion is the latter. For those who contribute regularly, thank you. Forthose who do not do so regularly-I know there is good stuff out there. Witness the July 88 issue *A Dizzy Tale* and this issue's *Aeromedical Advisory.* A good example of input from the field which was addressed, considered, acted upon, and now published. The mechanism to effect changes in policy is in effect, and SUSNFS is in a position to disseminate results.

CDR REAMS

THE WING OF ASMA REQUESTS NOMINATIONS FOR HONORARY MEMBER 1989

Each year a committee and the Executive Board of the Wing of the Aerospace Medical Association consider nominations for selection to Honorary Member. The nominee must be a woman distinguished in the field of aviation medicine, aeronautics or related activities which could include areas of education and operations. A candidate does not necessarily have to be an astronaut, flight nurse, or scientist to be nominated.

Any member of the Aerospace Medical Association and all members of the Wing of the Aerospace Medical Association including all of the Wing Honorary members are welcome to submit a short biography of a woman they believe deserves recognition.

Nominations should consist of a brief biography and a description of the nominee's specific achievements in and significant contributions to the field of aviation medicine, aeronautics or related activities. Please include the nominee's current address.

The 1988 recipient, B. Gen. Claire M. Garrecht, NC, USAF (Ret.), was presented in May in New Orleans.

Nominations should be mailed to the Chairman of the Honorary Membership Committee by December 1, 1988.

MRS. GEORGE C. (GINNY) ROMANO
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TAKING CARE OF OUR AVT'S

Our AVT's are a critical part of quality aviation medicine support. Yet this is one area where I accomplished least as a squadron flight surgeon. I did not spend enough time supporting, counseling, encouraging and protecting the AVT's, particularly the assigned OPDET AVT's. Those corpsmen seemed to get lost in the shuffle between accomplishing their assigned squadron support missions and clinic personnel priorities. Part of my responsibility should have been to act as a division officer to represent those skilled corpsman. They were not supposed to be working in dependent medical records or admin., and ambulance response runs should not have replaced squadron responsibilities. I encourage the fleet flight surgeons to take more interest in the welfare and performance of their AVT team members.

BRUCE K. BOHNKER
LCDR, MC, USN (FS)
Resident, Aerospace Medicine

UPDATE OF SYPHILIS MANAGEMENT

Concern as to what constitutes appropriate therapy for neurosyphilis continues, heightened by diagnostic and management problems recently reported in HIV positive syphilis patients.

1. **Neurologic Manifestations in Secondary Syphilis.** Spirochaetal CNS seeding is common in secondary syphilis, however most cases are neurologically asymptomatic, do not require an LP, and respond well to standard therapy, i.e. 2.4 million units of benzathine penicillin G (Bicillin). Some cases do have neurologic symptoms, most commonly meningitis, uveitis (eye pain, blurry vision), hearing loss, other cranial nerve palsies, or transverse myelitis. These symptoms often respond to single dose Bicillin, but may recur. The VDRL/RPR, however, may revert to negative and stay negative, obscuring accurate diagnosis of the recurrence.

RECOMMENDATIONS

A. Secondary syphilis with neurologic manifestations should be managed as neurosyphilis.

B. The Centers for Disease Control (CDC) 1985 STD Treatment Guidelines gives three regimens for neurosyphilis:
   1) Aqueous crystalline penicillin G, 12-24 million units IV/day (2-4 million units Q4H), for 10 days. (Some authorities use 18-24 million units IV/-day, for 10-14 days.) This should be followed by benzathine penicillin G, 2.4 million units IM weekly, for three doses, (7.2 million units total).
   2) Aqueous procaine penicillin G, 2.4 million units IM **daily, plus** probenecid 500 mg p.o. **Q6H,** both for 10 days. This should be followed by benzathine penicillin as above.
   3) Benzathine penicillin G, 2.4 million units IM weekly, for three doses, (7.2 million units total)

Many infectious disease experts feel strongly only the first regimen is acceptable for documented neurosyphilis, however regimen 3) is effective in about 90% of cases. None of the three regimens has been adequately studied. In managing cases of secondary syphilis with neurologic manifestations, the following approach is suggested. Mild symptoms, which may not be due to syphilis, e.g. a mild, vague headache, can be treated with regimen 3), three doses of benzathine penicillin. More severe symptoms, or symptoms with objective manifestations (e.g. cranial nerve palsy) should be treated with regimen 1). (Regimen 2) is for cases where it is not possible to provide IV penicillin.) If in doubt, regimen 1) should be used.

C. The need for medical evacuation can only be determined on a case-by-case basis. Cases which respond well to treatment, especially if mild, probably do not need medical evacuation. They should be seen by an Internal Medicine or Infectious Disease consultant at the first opportunity. Cases which have not begun to respond, after a course of therapy, or whose response is unsatisfactory, should be MEDIVACed to an Infectious Disease specialist as soon as practicable. Cases involving only eye or ear symptoms may be MEDIVACed to an ophthalmologist or otolaryngologist, respectively.

D. Penicillin allergic patients with neurosyphilis should be managed by an expert in infectious diseases. If this cannot be done expeditiously, the patient should be started on tetracycline 500 mg p.o. Q6H, for 30 days, while undergoing medical evacuation. Evacuation should be carried out as soon as practicable. If the patient begins to respond to tetracycline, or the neurologic symptoms were mild and/or not clearly related to syphilis, it may be appropriate to complete the course of tetracycline without medical evacuation. The decision has to be made on a case-by-case basis, however data as to the efficacy of tetracycline are very limited. It is not considered the drug of choice. The patient should be monitored closely in an attempt to assure compliance in taking tetracycline for the full 30 days. If a decision is made to complete a course of treatment without medical evacuation, the patient shoould be monitored closely thereafter for recurrent disease. He or she should be evaluated by an Internal Medicine or Infectious Disease consultant, or ophthalmologist or otolaryngologist, at the first available opportunity.

2. **Syphilis in HIV-infected persons.** Several case reports and editorials have pointed out that significant immunosuppression may dramatically alter certain luetic features: a) Patients may be seronegative, even in the presence of a compatible rash, b) Disease progression may be greatly accelerated, developing neurosyphilis within months, c) Standard stage-specific treatment regimens may fail. Diagnosis, in some cases, has required biopsy of skin lesions and special stains. The efficacy of even 14 days of IV penicillin has been questioned, raising the specter of “maintenance” antibiotic therapy for syphilis. The significance, representativeness, and validity of these cases have been questioned, but clearly there are grounds for considerable concern.

RECOMMENDATIONS

A. All cases or suspect cases of syphilis in HIV-infected persons should be referred prompty for Infectious Disease/Internal Medicine consultation and management.

B. Cases felt to have neurologic manifestations of syphilis, should be managed as neurosyphilis.

C. All syphilis cases should have prompt evaluation for HIV infection, continuing for six months, especially if the manifestations of syphilis seem atypical, severe, or do not respond to treatment.

D. All HIV-infected persons with CNS symptoms should be evaluated for neurosyphilis, among other possible causes.

CAPT S.W. BERG
NEPMU-5, San Diego, CA

LOST TO FOLLOW-UP

The Newsletters for the following individuals have been returned without a forwarding address. If you know the location of any of these people, please advise them to notify the Secretary-Treasurer of their new address.

CAPT J.W. Brough
CDR John Mills
LCDR Glenn Bacon
LCDR Gregory Kniss
LCDR Jerry Linenger
LT Deborah Agles
LT William Gerardi
LT Steven Gold
LT James Lamm
LT Joshua Lieberman
LT Robert McManus
LT Robert Marsh
LT Kathleen Moeller
LT Sean Smith
Frederich Gardiner
Randall Sellers

THE SELECTION OF NAVAL AVIATORS

PENSACOLA PROJECT

Statement of Problem: In recent years a large number of the pilots in both the naval and the military services (estimated at 30 to 40 per cent) have failed to complete their course in aviation training. Also a large number of the accidents which have occurred during or after the training period have been attributed to pilot error. It is obvious that more reliable tests at the time of original selection might result in a great saving of time, effort, and money. Recently an attempt has been made to apply certain tests to civil and military pilots which appear to have a direct bearing on the physiological and psychological charactertistics of fitness for flying. Many of these tests have been used in vocational selection in industry and in various fields of medicine so that norms are available for those with special aptitudes, such as motor dexterity or the so-called emotionally stable or "normal" individual. In order to apply the tests to aviators for selective purposes, it has been necessary to administer them to groups of pilots known to be successful as well as to unselected groups in the early stages of their training. In this way, it has been possible to observe the characteristics of successful pilots and at the same time to study the traits of those who have failed.

One finds in the literature dealing with pilot selection as well as in the personal records of each aviator numerous statements as to the causes of failure. A number of the more common statements made by instructors about the pilots who fail are as follows: (1) "he is emotionally unstable," (2) "he is tense and unable to relax," (3) "he has poor motor coordination and cannot handle the controls accurately and smoothly," (4) "he is unable to perceive distances accurately," (5) "he has poor judgment," (6) "he is unable to think in difficult situations" or (7) "he lacks poise, military bearing, or the ability to command." Based upon the above statements, to mention only a few, the causes of failure are no doubt varied, and no single test will eliminate those who fail. Tests for detecting poor depth perception or emotional instability, for example, would naturally vary greatly from ones which might indicate poor judgment or inability to command. The former traits can be studied by objective tests while the latter depend more on personal opinion. Eventually a group of tests might be developed which will eliminate the poorest 10 to 30 per cent before they begin their training. The very nature of the problem implies that research specialists from various fields of clinical medicine, physiology and psychology should participate in such studies.

The Prerequisites of a Successful Pilot. Various attempts have been made to outline the prerequisites of a successful pilot. No attempt will be made to review the literature in this field. The following list of requirements for aviation candidates is based upon the collective experience of many instructors and flight surgeons in military and civil aviation. It is given here as a basis for the discussion which is to follow.

1. The candidate should be physically fit. Special emphasis should be placed on the normal functioning of the circulatory and respiratory systems.
2. He should have no serious visual defects. Normal space perception is of importance as well as normal ocular muscle, especially the vertical phorias, and visual acuity.
3. The candidate should have good motor coordination. This implies the ability to coordinate his hands and feet in controlling the plane and especially in carrying out sensory-motor tasks while thinking or making decisions.
4. He should have normal intelligence with a capacity for integrating past experience.
5. His capacity for sustained attention should be normal. Above all he should profit from simple mistakes and not allow them to become costly and serious errors.
6. The candidate should be emotionally stable and courageous and he should have the ability to remain well-poised under stress.
7. Most important of all, he should be eager to fly and enjoy being in the air under all kinds of circumstances.

The first two prerequisites mentioned above have been adequately covered in the medical examinations in the naval and military air services. Over a period of years the physical requirements have become progressively more exacting. In general, they are considered adequate and in the event of war the requirements will probably be less strict. Certain of the other prerequisites mentioned above, however, are not dealt with in the usual physical examination. In this investigation we have been con-

cerned with the development of aptitude-tests which might supplement the medical examinations, i.e., tests which might predict an ability to fly, such as neuromuscular coordination, emotional stability, space perception tests in landing, and the like. In civil and military aviation, aptitude for flying has been detected in an empirical way during many hours of flying. In many instances, this has been expensive and time-consuming. Tests which will indicate this lack of aptitude for flying should prove of great value in eliminating those least likely to become successful flyers.

The purpose of the investigation, therefore, has been to improve the methods of selection at the elimination bases and thereby reduce the number of failures at the training centers such as Pensacola. If reliable norms can be established for successful pilots it may be possible to pick out the ones most. likely to fail at the elimination bases. Although no single test or even group of tests are likely to provide a final. ..

AUTHOR UNKNOWN
CIRCA 1941

LITTLE RED SCHOOLHOUSE

The view from the training department here at NAMI is not always the correct one when looking at the needs of the folks who are operating in the Fleet. This is not due to any indifference on our part, but rather because of changing requirements, new weapons systems and other considerations.

The curriculum for training our future Flight Surgeons, Aerospace Physiologists and Psychologists as well as our AVT's and APT's is undergoing constant review and revision. This is not being done as an exercise for the sake of change, but rather, to provide the best possible exposure to the greatest numberof important aerospace medicine issues with emphasis on those which need special attention. For example, code 42 has reported frequently and sometimes loudly on the poor quality of work coming through by some of our number. It would appear that there is either little interest in doing things right, or a lack of understanding about the correct way to do our jobs. While I'm not sure which is true, it would seem that the Little Red Schoolhouse has an obligation to make sure that emphasis is placed on those areas where deficiencies have been demonstrated to exist. As a result, curriculum changes have been made, reducing the exposure to some areas of study and expansion of others, with introduction of new topics as well. We now have formal lectures on such topics as local and special boards, the waiver process, medical intelligence, the Aeromedical Advisory Council and others plus case studies on errors made and how to avoid them, proper conduct of the flight physical exam and the expeditious handling thereof.

The difficulty comes in trying to balance the amount of time spent on subjects relative to their importance in the day to day activities in the operational environment, particularly since that environment is ever changing. I therefore invite your review of our existing curriculum and solicit your input about the usefulness of that which is being taught. Some new topics currently undergoing consideration and staffing are ATLS and alcohol rehabilitation (since it looks like we cannot go back to the old program). Perhaps for those of you attending the problems course, a few minutes could be found to buttonhole me and speak your piece. For others, let me know by letter what you think we can do to make this the best training program possible.

G. G. REAMS
NAMI CODE 324

-- EDITORIAL POLICY--

The views expressed are those of the individual authors and not necessarily those of the Society of U.S. Naval Flight Surgeons.

This Newsletter is published quarterly by the Society on the first of January, April, July and October. Material for publication is solicited from the membership and should be typed **double spaced,** reaching the Editor at least one month prior to the scheduled date of publication. Unsigned material will not be considered.

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