Society of U. S. Naval Flight Surgeons

Naval Aerospace Medical Institute, Code 32
Naval Air Station, Pensacola. FL 32508-5600

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VOL. XIII, NO. 2 **NEWSLETTER** **APRIL 1989**

PRESIDENT'S COLUMN

THE PROUD AND THE FEWER

One of the major recommendations of the Medical Blue Ribbon Panel was to assign Graduate Medical Education first priority. To quote: "GME remains the foundation of Navy medicine. It must receive Navy medicine's first priority for resources, including the top physicians and other providers, even at the expense of operational or overseas requirements. A full and vigorous GME program safeguards both peacetime and wartime capability."

The flight surgeon community has already begun to feel the pressure as the above recommendation is put into effect. The pool of potential student flight surgeons, the Navy interns (approximately 264), was cut drastically this year when over 90 interns were accepted directly into residency training. Our fair share will be roughly 55, as compared to the 73 we will train this year. Although the following figures are only estimates, here's the forecast:

Flight Surgeon Billets - 305
Flight Surgeons Today - 278 (-27)
SFS Classes 89001,89002 - 37 (+10)
Accepted for Residency - 53 (-43)
Released from Active Duty -37 (-80)

Back to paragraph one, and we read where operational and overseas billets will take their share of the shortfall. This belt tightening will become apparent by July 1989, and will not get better until we can once again meet our goal of 90 new flight surgeons each year, a number that essentially replaces the turnover but does not provide any growth.

On the positive side, we will have 15 Residents in Aerospace Medicine in training next year. If we could convince higher authority that the basic student flight surgeon course is considered GME (as is our residency), we could get well fast.

NAMI is still looking for a flight surgeon psychiatrist to keep CAPT Baggett from decompensating, a flight surgeon/internist/cardiologist to replace CDR Hunt who leaves for a residency, and a mid-gradeflightsurgeon to replace LCDR McDonough in Physical Exams.

Hope to see as many of you as possible at ASMA in Washington, DC, on Sunday, 7 May, for our Society meeting, and the Monday luncheon.

CAPT GIL VASQUEZ
CAPT R. K. OHSLUND

SECRETARY-TREASURER NOTES

This represents my last column to you as the Secretary-Treasurer of SUSNFS. It has been my pleasure to serve in this capacity during the 1988-1989 year. I hope that you have found the services of this office to be satisfactory. A formal report of the Society's financial and membership status will be presented at our annual meeting occurring concurrent with the AsMA meeting in May. I will close with a couple reminders to our membership.

It has been the policy of SUSNFS to have non-deliverable newsletters returned to the Secretary-Treasurer, as this has provided the only means of receiving updates on address changes for our roster. This results in a not insignificant expense to the Society. When forwarding addresses are indicated on the returned newsletters, these changes are then entered on our official roster. Timely and accurate address changes may be made more effectively if you will notify the Secretary-Treasurer directly when you have an address change. Roster updates are submitted to the printer approximately 15 days prior to the mailing of each newsletter. You can assure uninterrupted delivery of your newsletter if you submit your address change before that deadline.

Enclosed within this issue of the newsletter, you will find a copy of the ballot for this year's elections, as well as a return envelope. I must remind you that your member dues must be up-to-date (paid through April 1989) in order to be an eligible voter. Your dues status may be checked by looking at the address label. The last two digits of the year through which your dues are paid is indicated in the top line of your address label. To be a voting member of SUSNFS, as opposed to a subscriber, you must also be a member of AsMA. Ballots may be either mailed to me, or presented at the time of the annual meeting.

Once again, I consider it a pleasure to have served as your Secretary-Treasurer this past year. I look forward to a continued close relationship with the Society in the ensuring years.

CDR C. JOHN NICKLE
NAMI (Code 32)

ORGASMIC BACKLASH - PAIN AND SUFFERING OF THE OVERSTIMULATED
(PARAPHILIAS)

The Psychiatry Department usually has to deal with droll and sometimes depressing areas of human behavior such as psychosis, depression, suicide, and personality disorders. Over the past several years, however, paraphilic behavior has been observed to be surfacing quite frequently as a reason for psychiatric evaluation. Even though paraphilic behavior has not been studied in the Naval Aviation population, it probably is not of a greater frequency than that seen in the average civilian adult population. When paraphilic behavior does occur in an aviator or aviation designated person, it creates significant administrative turmoil and can terminate abruptly an otherwise successful career. Paraphilic behavior evaluated in the past four years at NAMI has consisted of exhibitionism, voyeurism, illicit nudity, and pedophilia. Paraphilias, as described by DSM-III-R, are recurring, intense sexual urges or sexually arousing fantasies that generally involve (1) non-human objects, (2) the suffering of humiliation of oneself or one's partner or (3) children or other non-consenting persons. In many cases, these objects or situations are neutral in and of themselves but have an acquired sexual connotation. The brief discussion is being presented to give the Flight Surgeon a better understanding of paraphilic behavior to be able to do an initial evaluation, to make proper referrals and to discuss intelligently with the identified patient and his command the concept of paraphilic behavior.

As noted above, paraphilic behavior is quite common in an adult population. Difficulty arises when (1) the paraphilic behavior becomes socially or legally unacceptable, and then it is legally classified as a "Perversion" or (2) the paraphilic behavior offends or impacts on the aesthetics of a sexual partner. In the vast majority of cases, paraphilic behavior is not only innocuous but a benign source of pleasure and gratification. There are at least forty recognized paraphilic behaviors that include frotteurism (rubbing against a stranger), voyeurism (illicit peeping), exhibitionism (indecent exposure), fetishism (use of inanimate objects for erotic stimulation). The more dangerous paraphilias include asphxiophilia (use of near strangulation to heighten a sexual orgasm), sadism (injuring or humiliating of a sexual partner) and masochism (the need to be humiliated or injured). In the military environment, the male paraphilic is more commonly identified. Research indicates that it most likely is equally distributed in both sexes. Men may be prone to more action oriented paraphilias where women tend to be prone to the more fantasy and verbal paraphilic behaviors.

Paraphilic behaviors have been described in the literature for quite some time along with their various psychoanalytic theories. One dynamic theory discusses an infant or small child's becoming emotionally attached to an object rather than a person. Over a long period of time, he learns to achieve sexual gratification from this object and later associating it primarily with erotic stimulation. Recent research indicates that there is probably a biological substrate necessary for later social adaptation or "imprinting" of paraphilic behavior. This leads to difficulties in treatment. Previous studies have shown that psychoanalytic therapy or psychodynamic therapy is almost useless. Behavioral therapy consisting of aversive conditioning is helpful in some cases. In the Scandinavian countries, surgical or chemical castration has been used, especially in those cases where paraphilic behavior is associated with sexual aggression. It is very important to remember that innocuous paraphilic behaviour in and of itself does not lead to sexually aggressive behavior. An individual with a benign paraphilia of pictophilia (erotic pictures of films) does not evolve into exhibitionism, pedophilia or sadism. As with all behaviors, the individual exhibiting paraphilic behavior is responsible for his actions. This often leads to the dilemma seen in the military setting in which an otherwise benign paraphilic behavior has resulted in charges of unofficer-like conduct. If there are definite UCMJ or civilian legal charges, those have to be resolved. If the concerns are more of a social consequence, many times a thorough psychiatric evaluation can lead to appropriate recommendations. The goal would be to prevent further recurrances of the behavior or prevent recurrences that might cause the individual adminstrative difficulties. It is difficult in the military setting at this time to provide intensive, ongoing therapy, however, several alternate avenues are available. These include (1) couples therapy - many times marital discord can lead to an exacerbation of otherwise well controlled paraphilic

behavior; (2) many civilians do offer behavior modification and short term, intensive treatments for compulsive sexual behavior. Individuals having difficulty with their impulsive behavior are strongly encouraged to participate in group therapy support and in sexual behavior support groups much in the same format as Alcoholics Anonymous.

Using a combination of techniques and understanding supportive therapy by the Flight Surgeon, most individuals with benign, non-assaultive paraphilic behavior can learn to bring this under control so as not to cause continued difficulties within the military career. Many cases of paraphilic behavior do not make it to NAMI for evaluation. We are interested in occurrences that are brought to official attention in the Fleet. If you have had any cases in the last three years, we would be interested to know the type of paraphilic behavior, age group, sex, and designation of the individual. At some point in time, a more official study might be warranted.

J.C. BAGGETT
CAPT, MC, USN
Head, Psychiatry Department

CODE 42

1) LIMITED DUTY BOARDS/FULL DUTY BOARDS (MMD 18-12 refers)

When someone on flight status has a limited duty board for any reason, a copy of this board, a current SF-88 and NAVMED 6120/2 (or SF-93) must be forwarded to NAMI. A flight surgeon analysis of the situation with prognosis for return to flight status, permanent grounding, disability requiring waiver, etc. would be helpful. This gives us a heads-up to be looking for further information on this individual. NAMI Code42 will then notify NMPC/CMC that the member is NPQ at this time. This will preclude overpayment of flight pay (with subsequent payback) and transfer of the member to another flight billet.

Once a medical board returns an .individual to full duty ,submit the full duty board with all consults, operative reports, narrative summaries and other pertinent documentation as well as a new SF-88 and NAVMED 6120/2 (or SF-93) to Code 42 to “close the loop”. Remember, a full duty board finding of “fit for full duty” does not address flight status. If the individual is fit for full duty, but NPO for aviation-related duties, a waiver must be requested (if appropriate) via the normal channels. We will then make a recommendation that the member be returned to flight status. This will restore his* flight pay and make him available for reassignment.

2) OPNAV INST 6110.1C

Just a note on our favorite topic, weight control and the overweight aviator. In aviation personnel, weight control must be a coordinated effort between the member, the AVT, the flight surgeon and the command fitness coordinator. In order to minimize the potential for lost flight pay due to overweight/obesity, these individuals must be identified before their annual flight physical. Often couseling someone that he may lose flight pay because of this extra poundage may be the added incentive for them to get serious about physical fitness. If you oryourAVT know of one ofyoursquadron members who is obviously overweight (or even suspected to be so), don’t wait for his physical to roll around to discuss it. Call the individual in and counsel him, then refer to the command fitness coordinator as appropriate. A review of your squadron’s PFT results by you or your AVT may also give you valulable insight into your aircrews’ fitness. Discovering that your hot shot aviator who is PO SGI cannot do his PFT due to medical problems may be an eye-opening (and grounding) experience for both you and the individual.

6110.1 gives a member 6 months to lose the weight. However, we cannot endorse a physical as PQ if the member is not within standards when we get the physical. Remember, physicals come to us for MEDCOM endorsement only every 3 years. Don’t wait until the last minute to do something about your aviator’s weight. If he has been out of standards all that time, he could conceivably lose 3 years of flight pay. He won’t be a happy camper (nor will you).

3) FLIGHT SURGEON/GMO/PA/FAMIL Y PHYSICIAN COMMUNICATION

We recently received a call from a distraught detailer who was ordering an individual on flight status overseas. It seems that on reviewing the medical record, it was discovered that the individual had 2 DWI’s, had been sent to level II treatment, and was on antabuse. All of this was done by the local GMO and the flight surgeon’s last contact with the person in question was a flight physical in March of 1988 with a finding of “PQ for aviation related duties”.

If you are practicing flight medicine in an area where other practitioners may also be seeing your aircrew personnel, it behooves you to communicate with the other physicians/PA’s/nurse practitioners. Regular communication regarding the need for them to keep you informed as to the health status of your aircrew that they may see through emergency rooms, acute care clinics, family practice clinics, etc. is essential. You should also be stressing the need for your aircrews/ATC’s to inform you of any visits they have had to other health care professionals. Scheduling a squadron AOM brief on this topic and intelligently explaining why this is necessary will go a long way toward subverting problems such as described above.

* All references to the male gender are generic and meant to apply to all sexes -male, female or otherwise.

CODE 42 Speaks!!
R.A. WEAVER
CAPT MC USN

BIRTH MONTH MEDICAL SURVEILLANCE A MEDICAL SURVEILLANCE PROGRAM THAT WORKS

At the risk of gross understatement, trying to administer an efficient, effective medical surveillance program whether ashore or afloat is a pain in the aft section. There are too many programs, too few PMT's and too little cooperation from the individual or his command. What I present here is not necessarily a unique or totally new idea, but it is an idea developed into a plan that works on USS AMERICA and should work on any CV/CVN and probably any shore-based command.

The program has been in effect twelve months now with a compliance rate of nearly 100%; yes, that's right, nearly 100%, and at the same time it demands less time to administer and is headache free. The key elements are its simplicity and most importantly, the fact that it is a package which can be sold to the command (CO, XO) that will gain full commmand support.

Medical surveillance, for purposes of this program, consists of regularly recurring preventive medicine events such as PPD's and PPD follow-ups (48-72 hours), immunizations (Typhoid anddt's), annual audiograms and non-physician involved physicals (respirator, asbestos, food service, laundry, barbers, etc.).

The traditional CV protocol for medical surveillance is to notify (by memo or phone) an individual's department/division as the individual "comes due"; the periodicity of which is defined by the initial encounter (first immunization, first audiogram, etc.). Such an approach requires the member to visit Preventive Medicine 3-4 times per year. There are 3 major disadvantages to this traditional approach:

a. The Preventive Medicine Technician spends excessive time in "list generation" and deliquency tracking.

b. The member spends excessive time away from his work center.

c. Compliance is a never-ending enforcement problem. Commanding Officers and Executive Officers are reluctant to throw their weight behind an administratively cumbersome program.

A solution, which eliminates each of these major disadvantages is a Birth Month Medical Surveillance Program (BMMSP) where most regularly recurring events are accomplished at one visit (Influenza shots and HIV testing are two exceptions).

A one visit approach, because it connotes efficiency and managability to the CO/XO and therefore garners full command enforcement, has the following advantages:

a. Compliance is very high -essentially 100%.

b. The Preventive Medicine technician is relieved of individual memo generation and delinquency tracking, thereby freeing him for more productive tasks.

c. Compliance with Preventive Medicine programs will, by definition, prevent disease. Disease prevention will realize cost saving through work hours, lessened legal liability, and a more battle ready force.

d. The various departments can efficiently schedule their own assets.

e. Time is saved for the individual member.

f. Money is saved in lost work days. Computed on a $30.00 daily norm for 3,000 people, a saving of 35-40,000 dollars is realized.*

Table one is the rationale used to sell the program to the command. Keep in mind that the times listed are not the time required to do that specific exam but rather is the time the man is away from his job - this is the key. You are doing a serviceforthe managers by keeping his men on the job. If you consider time spent by the member shooting the breeze with his shipmates on the way to medical and on the way back, these times are probably conservative.

**3,000 people is based on ship's company. Given SLEP's, SRA's, work-ups, etc., integration of the airwing is neither necessary, nor desired.*

CV MEDICAL SURVEILLANCE MAN-HOURS

EVENT (TRADITIONAL)	# PERSONS	HOURS*	EVENT TOTAL MAN HOURS
PPD and follow up	3000	3.0	9000
Immunizations			
Typhoid	1000	1.5	1500
dt	300	1.5	450
Annual Audiogram	1500	2.0	3000
Non-Medical Officer Physical Exams (Resp. AMSP, Food Service Barber, Laundry, FLT Deck)	1200	2.5	3000
			16950
EVENT (BMMSP)			
All Applicable	3000	3.0	9000
			9000

**Time spent away from work center, i.e.; leave work*

center, walk to medical, check out Health Record, walk to Preventive Medicine, receive event action, return Health Record, return to work center, resume productive work. Some of the individual events under the BMMSP actually take less time than before due to streamlining.

The BMMSP is set up like this:

1. At the beginning of the month, the Medical Department Leading Chief delivers to all Departmental Leading Chiefs an "Alpha Roster" by department and division those persons having birthdays that month. The dept LCPO's then pass the division rosters to the division LCPO's who have the latitude to schedule their people to come to Preventive Medicine anytime during the month that best suits the division - this is a benefit to the division **and** allows for no excuses for non-compliance. Department heads are reminded at Department Head Meeting to ensure their officers comply.
2. Preventive Medicine maintains a master "Alpha Roster" and checks off the members as they **complete** their visit, i.e.; **after** they have had their PPD read.
3. A warning/advisory list containing those personnel yet to present, is distributed to each division 3 days prior to the end of the month (3 days is minimum since the need for a 48-72 hour window to read PPD). A copy of this list is given to the Command Master Chief.
4. Those division chiefs with delinquencies after the last day of the month answer to the Command Master Chief who answers to the XC. Division Officers answer to their Department Heads who answer to the XC. This is the beauty of it. A division chief or division officer does not want to explain why, when given 30 days to get 5 to 10 people to Preventive Medicine, he can't get it done.
5. Integrating the ship into a birth month cycle is not difficult; so what if a man gets two PPD's or two audiograms done in same year. After twelve months, the entire ship is in synch. New check-ins are given whatever they require so as not to lapse before their birthday month and then applicable events are repeated on the birth month, then they are in synch.

The key players in this whole evolution are no different than the key players in any large corporation program -upper management, in this case, the XC. And why will the XO back it? Because it's saleable. It saves work time, it's simple, it allows divisions to manage their assets, and mandatory programs achieve compliance with minimal hassel.

Incidently, on the AMERICA, Dental has joined the program for annual dental exams and the Personnel Department is considering joining up for annual page 2 verification. This further strengthens the program support and saves the ship even more lost work time.

You provide the service, the line runs the program. You have a saleable commodity -sell it.

STEVEN E. HART
CDR MC USN
Senior Medical Officer
USS America (CV66)

RAM'S CORNER

Flight Surgeon Report Reviews

When embroiled in the administrative and logistics nightmare of an Aircraft Mishap Board, the astute Flight Surgeon might wonder exactly what good his Flight Surgeon Report is doing. Certainly, it is an integral part of the Mishap Investigation Report, a role recently given increased importance since now all factors considered pertinent in the FSR must be addressed by the entire MIR.

Safety Center figures indicate that the average Flight Surgeon will submit one FSR during his or her career. Some are fortunate enough to escape entirely; others gain substantial expertise through repeated practice. Feedback from Safety Center gives an individual Flight Surgeon some idea of how he performed (or failed to). Frequently, however, there is a dearth of guidance on how to approach the FSR.

For the last six months, the NAMI RAMS have resurrected a valuable teaching tool: circulating and reviewing among ourselves the FSRs forwarded to the CO at NAMI. We have learned a great deal from the work which you fleet folks having been turning in. Besides exposure to the lessons learned from the individual mishaps, they have provided an opportunity to observe how the individual FS approaches his or her report. The efforts traverse the field from truly outstanding to somewhat haphazard. Some of the disparity may arise from an uncertainty of what is expected (despite the efforts of Mike Dubik and the SAFCEN). Perhaps a few general reflections might be of assistance:

1. Know your audience: For the most part, those reading the FSR will include Safety Center personnel well trained in the aeromedical and human factors fields. The reader of the FSR probably has a substantial knowledge base in the area already. When telling the time, you don't necessarily need to rebuild the clock from scratch.
2. Don't get bogged down in detail: Details are necessary, and attention to detail is the hallmark of a careful and well done FSR. However, needless detail can weaken even the strongest presentation. Is it really necessary to include copies of all the pages showing when and where refresher water survival training was

done when it's already been listed on the appropriate form? Or to include the wardroom menu and attendance sheets for meals for three days prior to the mishap? We trust you are doing your homework and tracking down the details. It probably isn't necessary to leave a paper trail from every waypoint. Photos can be invaluable in portraying the setting, but please make sure the appropriate portions are clearly labelled to the narrative or analysis. For every photo (or piece of paper) ask yourself critically if it enhances understanding of the mishap or is it just a "gee whiz".

3. Be a Human Factors Expert: Overwork, missed meals, stresses at home, OPTEMPO, inattention to SOP - the nebulous would of Human Factors. As Flight Surgeons, WE are the experts here, and perhaps the onIy members of the board who can bring together diverse clues -injury patterns, pre-existing illness, the role of fatigue, physical conditioning and nutrition. Scrutinize those 72 hour histories, focus on rest, psychosocial stressors, interactions with peers and superiors. There can be a fine line between a "can-do" attitude and feeling intimidated by an Ops Officer who needs to get his sorties out. When you think these are pertinent, make your profesional opinions known.
4. Think creatively: One of the hallmarks of the Navy Flight Surgeon is the ability (and frequent need) to function independently. With this comes the opportunity to combine your professional medical knowledge and judgement, your aeronautical knowledge and experience (one of the reasons we learn to fly!) and a keen eye for human factors. From these, you should be able to draw some insightful conclusions. Don't parrot the general findings of the board. The FSR presents an opportunity to expand beyond the narrow confines within which the MIR operates. Use it to engage in a little informed, thoughtful speculation. Your ideas may influence the way the rest of us look at our aircrews, procedures, or approach our next AMB.
5. Keep the goals in mind: The sole purpose of the exhaustive exercise it to prevent future mishaps. Your FSR may alert the aviation medicine community to problems, attitudes and oversights which are dinging our airplanes and maiming ouraircrew. Your thoughtful investigation may uncover a factor which will help some aviator back to his bunk on the carrier instead of rafting in the 10 until the helo finds him. Your FSR may also be a vafuable way to demonstrate to your line colleagues how sharp you are, and why you should be intimately involved in the work they do. Your FSR also helps earn your reputation among your 6ble to tap the SAFCEN for advice when your squadron loses a Hornet in the Med, your fellow air- wing FS or Senior Medical Officer may be a valuable source of assistance or sounding board.
6. Be a Preventive Medicine Expert: in this realm, your role in Pre-Mishap Planning is essential. Make sure your unit has a plan and practices it occasionally. Be involved, and offer your insights on how to make a frenzied evolution smoother. Be sure that other potentially related personnel (plane captains, tower personnel, maintenance chiefs) are identified ahead of time. They may require evaluations, aircrew toxicology studies and interviews. These folks are frequently forgotten about until after they've gone home and had a few beers. The Pre-Mishap Plan should address these non-aircrew players. Many units are painfully unaware that many ground mishaps also require appointment of an AMB, sometimes long after perishable information has started to fade from memory. You might also review your local medical crash response protocol and see if it best meets the needs of your unit.

The majority of FSRs handle these topics well already. Perhaps knowing that your efforts are being studied and appreciated may add a little incentive to keep up that good work.

LCDR BILL FERRARA MC USN
Resident, Aerospace Medicine

PROBLEMS COURSE POSTER PRESENTATION

The 1989 Navy Aeromedical Problems Course will include an aeromedical poster session. We would like to see some of the interesting aeromedical cases from the fleet presented. The following format is suggested:

a. Chief complaint/presenting symptom
b. History of present illness, review of systems, family history, aviation history, etc. (pertinent).
c. Physical examinations and laboratory results (pertinent)
d. Differential diagnosis/discussion
e. Aeromedical disposition

This should be limited to 2-3 pages double spaced types. Accompanying photographs may be helpful.

The presentatons are meant to be low key. No formal review process is anticipated, rather the submissions will be screened at the conference. The posters will be viewed during breaks, with no formal poster session planned. Questions should be addressed to CDR Bohnker, NAMI Code 32, NAS, Pensacola, Florida 32508. Autovon 922-2457.

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

FROM THE LITTLE RED SCHOOLHOUSE

In reviewing our teaching files, it became apparent that we have a deficiency in our 35mm slides for teaching purposes. We have lots of slides covering lots of topics, but don't have any good ones of carrier operations, BDS's and other medical spaces. If you have some you would be willing to donate, we would be more than willing to accept them.

It is nearly time to begin the annual review of the Flight Surgeon training program for quality, content and relevancy to the Fleet need. Some of you have shared your opinions with me, and improvements to the syllabus have been made. We are still trying to work some way of providing an exposure to the alcohol rehab program and ATLS for those who need it, but no promises can yet be made. I invite your comments to help make this the best program possible.

CDR G. G. REAMS
NAMI Academic Department

ELECTION OF SUSNFS OFFICERS

In this issue you will find the official ballot for the election of our society's officers for 1989. For those of you who will be unable to attend the ASMA convention in May, please mark your ballot and get it in the mail early to make sure that your vote counts. For those planning to attend the convention, ballots will be available for you at our Sunday evening meeting after check in. Whether attending or not, it is a good time to pay membership dues. John Nickle will be more than happy to relieve you of your dues, or even sell you a lifetime membership.

This years candidates are a fine looking group who have all proven themselves over and over again. Some tough choices, anyone would be an excellent representative of the society over the next year.

Our thanks to those officers who have served so well over the last year. You have our gratitude, but also our expectation that you will continue to support the efforts of SUSNFS in the future.

I look forward to seeing you all in Washington in May.

CDR G. G. REAMS
Chairman, Nominating Committee
SUSNFS

1989 NAVY AEROMEDICAL PROBLEMS COURSE

It gives me great pleasure to announce the 4th annual Navy Aeromedical Problems Course to be held October 17 through 20 in Pensacola. This years course will be a jointly sponsored NAMI/NAMRL event with a somewhat different format from previous years.

We are privileged to have been selected as one of three sites in NATO for a special presentation of Neurological, Psychiatric, and Psychological aspects of Aerospace Medicine by the Advisory Group for Aerospace Research and Development (AGARD). This distinguished group of international experts from the NATO countries will present a number of topics ranging from neurologic disease and injury in aviation, to combat stress and family counselling. This three day short course will be preceeded on Tuesday the 17th by more Navy specific issues as in the past.

Because of the international nature of this years session, we will be opening our doors to the Army, Air Force and any NATO allies who wish to attend. I think we can promise you a number of other surprises which you will not want to miss. More specific details will be published in future issues of SUSNFS newsletters. We have no idea what level of response can be expected, but I would encourage you to begin making plans now, so that when pre-registration begins you can act quicly for billeting.

The A VT's portion of the course is scheduled at the same time, but the agenda is not established. As before your A VT's need your help and support to be freed up for this important continuation of their training.

CDR G. G. REAMS
NAMI Academic Department

BOOK REVIEW

AIRBORNE CARE OF THE ILL AND INJURED

Author: Edward L. McNeil, Springer Verlag Company
175 Fifth Avenue, New York, New York 10010

The interface between aviation medicine and critical care medicine is one of the most challenging yet rewarding aspects of our daily medical practice. We become the expert on matters related to aeromedical evacuation. Each transport is unique yet guided by overlying principles. The only reference I know on the subject is McNeil's AIRBORNE CARE OF THE ILL AND INJURED, which I recommend to flight surgeons.

From the basics of atmospheric environment to advanced cardiac life support requirements, the spiral bound book presents a spectrum of aeromedical evacua-

tion experiences. He does not always agree with the Navy Flight Surgeon's Manual (He recommends air filled endotracheal tube cuffs, with adjustment of pressure during flight and monitoring pressure with the proximal balloon on the air inlet tube). Various medical support equipment for civilian aircraft flight is listed, which may be helpful. Suggested contents are made for "fly-a-way" medical kits.

One limitation is that he approaches aeromedical evacuation from a civilian viewpoint. He does not discuss the risks of a cat shot on medical conditions or similar. The book provides a wealth of information on aeromedical evacuation considerations and should be useful in the library of the practicing flight surgeon.

BRUCE K. BOHNKER
CDR, MC, USN(FS)
Resident, Aeropsace Medicine

NAMI CODE 32

Four Residents in Aerospace Medicine complete the program in June. The projected assignments are:

CDR Jerry Rose (Chief Resident) --
USS ABRAHAM LINCOLN (CVN-72)
CDR Jim Graves --
USS INDEPENDENCE (CV-62)
CDR John Nickle -
USS JOHN F. KENNEDY (CV-67)
LCDR Fanancy Anzalone -
USS CARL VINCENT (CV-70)

Effective in July 1989, there will be fifteen RAMS in the program. Eleven will be training at NAMI and four will be in Full Time Outservice acquiring the MPH.

C.I. DALTON
CAPT, MC, USN
Director of Training

-- 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.

Correspondence should be addressed to:

CAPT CONRAD DALTON, MC, USN
Editor, SUSNFS Newsletter
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Code 32
NAS Pensacola, FL 32508

Society of U. S. Naval Flight Surgeons

OFFICIAL BALLOT
1989

Please Vote for Only One (1) Person For Each Office

INSTRUCTIONS: Do not put your name on this ballot. Please mark your choices and return it in the envelope provided. Or, you may vote at the 1989 SUSNFS Annual Meeting on Sunday evening, May 7, (to be held concurrently with the 1989 Annual Meeting of the Aerospace Medical Association in Washington, DC.)

NOTE: Dues must be paid up for ballot to be counted. Please check address label which should show "89-90" or greater, or “LI” for Lifetime members. Checks in the amount of $10.00 will be accepted with the returned ballot to bring dues current.

Vice President (President elect)

- ☐ CAPT Conrad Dalton
- ☐ CAPT Jefferson Emery
- ☐ CAPT Ron Lentz
- ☐ CAPT Richard Weaver

Secretary -Treasurer

- ☐ CDR Bruce Bohnker
- ☐ CDR Mike Valdez
- ☐ LCDR Bill Ferrara

Senior Member, Board of Governors

- ☐ CDR Mary Anderson
- ☐ CDR Steve Hart
- ☐ CDR Jerry Rose

Junior Member, Board of Governors

- ☐ LCDR David Becker
- ☐ LCDR David Shively
- ☐ LT James White

Emeritus Member, Board of Governors

- ☐ CAPT Don Angelo
- ☐ CAPT Pete Bigler
- ☐ CAPT F. R. Deane