The Society of U.S. Naval Flight Surgeons Newsletter

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President's Column

I am looking forward to working with the membership and the Council over the next year. Having studied things this past year as VP, I have the feeling that the membership is generally satisfied with SUSNFS. It appears people like the newsletter especially – and several members have told me that is the main reason they belong to SUSNFS: for the information channel. Members also like to buy the really neat stuff we sell by mail order or at ASMA. So, in my tour as president, I don't expect the membership is looking for major changes. Nonetheless, here are my three goals for this year: (1) Dialogue and discussion with the membership about what you ***want*** from this organization, (2) Work towards meeting any changes identified in the discussions, (3) Continue and, if the membership wishes, expand the Society's advocacy roles for flight surgeons – doctors who practice aviation medicine in the Sea Service. You all may know that I am by nature cantankerous and argumentative, so in various discussions I have tried to find out how members feel about what our society does and where we should be headed. In the past few months, I have found that most of the members are pretty satisfied. That is a great reflection on our leaders over the past several years, including Captains Rose, Hiland, Arthur, Bohnker, Dalton, and Hain. So, we are probably not going to see large changes in the direction of the organization, but we'll take our direction from what we learn in the discussions.

In the past few years, we have as an organization questioned whether there was more we should be doing or whether we should branch off into new territory. Sometimes we have initiated forums or discussions about strategic planning for aerospace medicine in the Navy, and on other occasions, we have debated whether we should expand our vision to Operational Medicine more broadly than aerospace medicine. In my tenure as president, I want to revisit the discussion from the membership about what you want from this organization for the next few months, up 'til about the Marine Corps Marathon, then work on forming consensus that we will publish for the membership around the beginning of the millennium. Then, with the Council and volunteers from the membership, reaffirm plans or committees or teams to assure we will follow through on this consensus. We are a pretty spread-out group! So the discussion will have to be done primarily electronically. We will try to set up a bulletin board on the SUSNFS web page. If that is too hard to do, or unwieldy, we can have an e-mail chain. The e-mail addresses of the members of the council are published in this copy of the newsletter. Feel free to contact any or all of us.

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THE SOCIETY OF U.S. NAVAL FLIGHT SURGEONS
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The Society of U.S. Naval Flight Surgeons is a non-profit organization. Its purpose is to advance the science, art, and practice of aerospace medicine and the mission of the U. S. Navy and the U. S. Marine Corps; to foster professional development of its members; and to enhance the practice of aerospace medicine within the Navy and the Marine Corps.

Membership is open to all flight surgeon graduates of the Naval Operational Medicine Institute. Associate memberships are available. Dues are $15.00 per year, or $225.00 for a lifetime. Contact the Treasurer at the address above for more information or membership application form.

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For starters, here are a few of my personal thoughts. As the famous disclaimer says, "these are solely the opinions of the author and do not represent the views of… [anybody else]." Our charter does say that the membership is limited to naval flight surgeons, and a few other unusual groups of naval aviation specialist doctors. Although in the past we have discussed expanding to include Aviation Physiologists and Aviation Experimental Psychologists, those professionals do have their own professional advocacy/representation groups. So in my opinion it is not exclusionary or inhospitable of us to continue to reserve membership in SUSNFS to flight surgeons.

The next points are certainly heavily tinged with Riley philosophy and could be unappealing to some members. We are a society of physicians, ***doctors***. There are important values in taking care of ***patients*** that are central to our profession, and to the ***practice*** of aviation medicine. These values include a special relationship with a patient, which fundamentally ***differs*** from the relationship with a ***customer*** or a ***client***. There are elements of science at the core of medicine (beyond the nebulous field of "healthcare"). These elements of science have reproducible, mathematical, and deterministic dimensions, and so accordingly they are not ***perceptual***, but sometimes they are simply ***truth***. We have scientific tools to demonstrate and confirm such truth. In a world where the sentence "Perception is reality" is repeated so often, doctors need to stand up and point out the occasional difference between perception and reality. It is called science. In my opinion we doctors – others call us providers – have allowed the Oslerian (and for our osteopathic siblings, the Stillian) principles of medicine to be overlooked sometimes in the last decade or so. Here and there perhaps our Society can take up that cudgel. Our advocacy role may lead us to consider giving inputs or position papers to various medical or military organizations on issues of concern to doctors, in particular in our case issues of concern to Naval Flight Surgeons.

The preceding paragraph is only a stepping off point for discussions. What are your opinions on these subjects? Is this general area relevant to our particular organization, or to what we want from our organization? What would you like to see us do over the next few years? What would make SUSNFS more useful to you?

Finally, please share with me in thanking last year's officers for a very busy year. CAPT Rose, CAPT Hiland, CAPT Valdez, CDRs Gillis, Frick and Rocereto, and LT Savoia-McHugh did a ***lot*** of work for our Society. Check out our web site periodically, and we will keep you informed about the Bulletin Board. If we cannot get one started, we will use the e-mail method.

Respectfully,

Terrence Riley, Naval Flight Surgeon and Polymath

From the Secretary

First let me wish a heartfelt 'fair winds and following seas' to my predecessor, CDR Dave Gillis, who has left us to take the helm of the medical department on the USS John C. Stennis (CVN-74) in San Diego. He was a stellar Chief Resident and will be sorely missed. It is a daunting task to follow him as Secretary of the Society. That said, this is an exciting time at NOMI and I am looking forward to seeing our Society become better and stronger. After all, we'll have more residents here than ever to assign collateral SUSNFS's duties to!

The rest of the new SUSNFS officers and Board of Governors are listed inside the front cover. In the current electronic age, communication is easier than ever, and the Society wishes to be no exception. At the President's request, therefore, I am publishing the available e-mail addresses for the Society:

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I have two initiatives that I would like to undertake as I begin my year as Secretary. The first is to redesign the membership database. The current database is somewhat unwieldy with a number of outdated and unneeded components. This effort is already underway. It should be transparent to the membership except to hopefully improve service. Please e-mail your address corrections to the Treasurer or me so that we can keep the database as up to date as possible. You may notice that the membership form inside the back cover has changed (as well as the merchandise prices). I have updated it to reflect more accurately the information that needs to be entered into the database. It would be helpful if you use it as a guide when e-mailing updated info to us. Forwarding the newsletter costs the Society a moderate amount of money that would be saved if we had accurate addresses.

The second initiative is to improve the Society's web site, www.aerospacemed.org. It has not been significantly updated in some time. My fellow RAM, LT Brian Wells, will be assisting me (when he returns from his Tropical Medicine rotation six weeks from now!). I have a number of ideas on how to make it more useful to our members. I would welcome your input and suggestions via e-mail, as well as reports of errors and broken links on the site. Look for improvements over the next few months, but please be patient as I am just learning how to do this!

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In closing, I would like to put on my Associate Editor hat and point out that this is your newsletter. Articles from 'out in the fleet' are always welcome. I would also be happy to receive more Letters to the Editor and promote a more interactive discussion in the newsletter. Contributions can be e-mailed to me, preferably in Word 97 format. Keep 'em flyin' safely!

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From the Treasurer

Greetings from the new SUSNFS treasurer. As you have probably figured out, there have been some changes in the organization that we hope will be able to continue the great work of our predecessors. When it comes to work, I have to tell you that the job of treasurer was a real surprise. When I was originally approached, I was asked "Hey, Dave...would you be willing to be the next SUSNFS secretary, if elected? I said in my usual swamped Code 26 voice, "sure, why not?" So, then one day I was going through the mail and what did I find but the SUSNFS newsletter. So, I eagerly opened it and low and behold, there was a ballot with my name as candidate for TREASURER. By this time it was too late to even discuss it, because the next thing I knew was everyone coming back from the AsMA meeting with the great news that I had been elected TREASURER. I remembered back to the days as a member of the medical staff of St. Michael Hospital, where if you didn't show up for the annual staff meeting, you got elected because you weren't able to defend yourself in your own absence.

In carrying out my new responsibilities I have been analyzing the finances of the society and have made some startling discoveries. I will preface this by saying that I am aware that the society is almost exclusively comprised of physicians, who are among the highest paid members of our armed forces. When I looked at the books, I realized that LT Savoia-McHugh is a brilliant mind and she organized this so well that I would be able to understand it. Secondly, I found that the society operates on more money than the usual income from dues and some occasional sales. That is to say, we depend on the sales of our goods to subsidize our costs. Fundamentally, I think this is not good business and I am going to recommend to the board that the dues be raised. My guess is that it may go as high as $25. Life memberships will probably increase as well.

I know the reaction you are having and I share it, but...it is clear that without the operation of our "Lands End look-alike-contest-winner mail order catalogue sales department", we would not be able to continue life as we know it for very long.

Our funds are used in a number of ways, such as cash awards, for which we are endowed partially. The problem is that we depend on the sales to make up the remainder of the revenue in order to stay in business. While this is fine when folks are motivated to buy our wares, changes in buying habits could be disastrous to the life of the society. Furthermore, the operating costs of the society are funded primarily by the new student naval flight surgeons who pay their dues. While this is the main group that benefits from the activities of the society, such as welcoming parties, it is not perpetuating good fiscal habit. We often have to "depend on the kindness" of members of the society.

I would also like to ask your indulgence with your mail order expectations. We need to expand our staff and do some training (i.e. I need to learn what the heck is going on, and how to use Quickbooks.) We are also going to be working with a new staff person (to help with mail order sales and packaging) so please as the saying goes "allow 6-8 weeks for delivery" until we can get the machine back into a well oiled state.

The good news is that we are all enthusiastic and working hard to keep a wonderful society alive for future generations. We hope that the membership will continue to support the work of the officers they have elected. If you have any suggestions or questions, I can be reached by phone or e-mail. Keep those cards and letters comin' Folks! Fly Safely.
//BT//

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Navy Luncheon Guest Speaker 70th Aerospace Medical Association Meeting 7 May 99

When Terry asked me to speak, I was somewhat surprised, as I've been quite out of the aerospace medical loop since retiring nearly six years ago. So I am obviously in no position to speak to you about hot button items of contemporary import to the Society or to naval medicine in general. But I do feel qualified to share with you some observations concerning a longtime passion of mine: leadership and its corollary, followership.

We have all studied the various principles of leadership, but in many such sources the concept of followership is not covered. This is too bad, because a leader must begin as a follower... all of them do. Even more strongly, I would offer that good leadership has, as it's primary prerequisite, good followership. Finally, every leader, save the one at 1600 Pennsylvania Ave., is a concurrent follower of those above him in the chain of command.

There are numerous ways in which leaders and followers interact, but I will discuss primarily one - to me the most vital and the one of most import for any command, and indeed the entire naval service: the area of innovation and/or dissent and the implications of each for both leader and follower.

What I know of these things I initially learned from my dad, a career dental officer, my first teacher. I have learned much also, both good as well as bad, from the many leaders and followers who touched my career over its 30 years, but most especially those of the Fleet Marine Forces, officer as well as enlisted, who provided me the most enduring leadership lessons which prepared me for command.

Lt. Gen. Victor Krulak, father of the current Commandant of the Marine Corps, and under whom I served in Vietnam, called this area of innovation and/or dissent "a soldier's dilemma" for reasons which will become apparent.

How then does a junior, a follower, put forward a new idea, an innovative approach to accomplish a mission-essential task, an idea which may be radically divergent from established procedure? Or a dissent from established procedure or doctrine? But let's cast this in more personal, 'gut-level' terms: how does one propose to change or challenge that which the leader himself may have originally conceived or, at the very least, long espoused, without violating leadership's cornerstone, loyalty? This can be daunting stuff, especially when the follower is very junior, and the leader is very senior. Hence, General Krulak's term, 'soldier's dilemma.'

The first imperative is that our innovator believe in his idea completely. He must have a clear idea of exactly what he wants to accomplish, and he must be willing to persevere. The military system is so large that there is much built-in inertia. But I believe it is, for the most part, ultimately fair and just. The idea or dissent must be clearly thought out, put on paper, and brought to his immediate senior with the aggressive idea of not merely getting concurrence, but of having the immediate senior adopt the idea as his own. My former boss, General Al Gray, used to say, "I don't care who gets the credit, just so the Marine Corps gets the goods." This fine gentleman was a true servant of his Corps, and not of his ego.

Now, this approach may not work; the immediate senior may not buy in, and this is where the timid and fainthearted usually throw in the towel. The next step is to rewrite and redirect the paper, ensuring it is devoid of all emotion and is clear and succinct. Remember, the quality and skill with which the idea is proposed weighs enormously in the outcome. (During my three years as NAMI's director of training, I lectured 15 hours to every class of student flight surgeons; I would give and personally grade subjective, essay-type exams. Sure, it took a lot of time, but I really got a feel for young officers' ability to clearly express ideas in writing. I can tell you that many of them are badly in need of remedial writing skills. It would seem that our schools and universities of late are more into training than into education. A professional military officer needs such skills and, if lacking after 20+ years of formal schooling, he better get himself fixed. Otherwise, his ideas are likely going nowhere.)

The newly recast proposal is now addressed to the highest senior in the chain of command having cognizance over the matter in question. Such action may not delight

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the immediate senior but that's just the cost of doing business. He should respectfully be told that the author understands his position and expects his negative endorsement. But the idea is now out in the open, within the chain of command, with the hope that someone up the line will see merit and favorable action will be taken.

Remember that if a contrary idea is being proposed, an alternative must be proposed also. Otherwise, his idea is merely a complaint, and will be dead on arrival.

While I have noticed that the proposal's journey up the chain and back down again is usually a slow one, it can be greatly accelerated in the event that the senior addressee responds with favor despite a series of negative endorsements en route to him. In this eventuality, it is amazing how a second look by previously unfavorable endorsers results in more favorable consideration going back down the chain. It's a beautiful thing!

Remember also, there is nothing wrong in questioning policy, as long as it is done within the chain of command, never outside. Prior to a policy decision, of course, one is free to publish ideas in any suitable publications such as the SUSNFS Newsletter, Marine Corps Gazette, Naval Institute Proceedings, etc.

By the way, I find the 'letters and replies' section of op-ed pages of any periodical are frequently the most interesting part. I usually read these first, much like eating dessert before the entrée (which I don't do). I suggest that it would be worthwhile to consider the establishment of a forum page(s) in the Society's newsletter as a means of facilitating this process. While we're on the subject, my compliments to the editor, Mike Valdez, and the regulars of the SUSNFS newsletter. It has become a much better pub than it was back in the days when I was its editor.

Okay. Having done all this, what if his idea goes nowhere or is rejected? This is perhaps the most important part of all. If our innovator is able to suck up his disappointment and wounded pride and to give his very best effort and dedication to the old way, then he should do so, to the very best of his ability. We all owe as much to our service. But he should never forget his convictions and should continue to express them at every reasonable opportunity. If he cannot accept the decision to the point of 100% effort, then he should quit - resign and take his ideas with him into the civilian world where he is free to publish or promote to whomever he wishes. This career ending act is obviously a radical one, and only for those whose passion for their way is strong enough to sap their enthusiasm for 100% effort in support of the status quo. I have often wondered how the post-Tailhook excesses might have been altered had a leader at or near the top of our organization taken this course during the congressional feeding frenzy that followed.

So much for the innovative or dissenting subordinate. But what of the senior who must deal with him? While all in uniform are bound by their honor to give the very best of themselves to their organization, sometimes even at significant personal risk, the senior has the greater responsibility. Because, without innovation and change, we are bound to the status quo, and progress becomes impossible. A worthy leader realizes that positive change begins with ideas, not all of which are good. However, not all are bad either, and the leader with the wisdom to discern between the two, in a climate of free and open exchange, is one of inestimable value to his service. This type of leader will not merely permit, but will openly encourage, his subordinates to bring forth ideas to better the organization and its mission capability.

However, no amount of innovation or brilliance will succeed where the leader is devoid of innovative spirit himself, where he sees new ideas as problems to be dealt with rather than the nuggets of opportunity which they are. Such a leader is, in my view, unfit for command.

The worthy leader will not necessarily mind a rocking boat. He will possess the wisdom to realize that there are two reasons to rock a boat. One is, for some, the sheer joy of upsetting things, or throwing them into the air. He will be quick to recognize this and deal with it in a manner both swift and terrible. The other reason to rock a boat is to come about into a more sure and steady course, even into the wind if need be, and this type of boat rocker is to be prized and nurtured, for he is destined to be the leader of the future. The worthy leader will realize, even more than his subordinates do, that he does not possess all the answers. Thus, he will be a facilitator of innovation and communication within his command.

Some commanders forget that communication has two separate phases: transmit and receive. One cannot occur while the other is in progress. In order to reap the rich harvest of new ideas, which are surely out there, the wise leader will spend much quality time switched into the receive mode. Another way of saying this is that it's tough to learn with your mouth open.

The worthy leader is perceptive enough to realize that mistakes will be made. I would much rather clean up after an innovative follower whose idea went awry than to bask in the peace and quiet that is the result of timidity and self-serving careerism. To try and fail is the price for innovation. The worthy commander knows this and will protect his best and brightest from the wolves who seem to thrive by feeding upon failed initiatives. The zero defects mentality has no place in a military organization; it is the product of managers, not leaders, and almighty God, please, save us from managers!

Every leader will be aware of those among us who are careerists, the exact opposite of the innovator. The careerist will never face the soldier's dilemma, because his greatest fear is of being out front and risking making a mistake. A variant of this fellow is the sycophant (Greek: *sykon* = fig + *phainein* = to show; one who shows the sign of the fig; a gesture of disdain or contempt, made by placing the thumb between the index and middle fingers or, alternatively, placing the thumb under the upper teeth). We've all known this type, and our distaste for him is outweighed only by our disgust with a senior officer who tolerates him. The sycophant's survival skills are phenomenal, but are less the result of his own ability to ingratiate himself with a receptive senior than it is a measure of the weakness of the senior himself. It is not difficult to spot a commander who would rather hear his own voice played back than to deal with the challenge of fresh, even controversial ideas. But a leader whose history includes well-developed followership skills will rarely fall prey to the sycophant. The one who does becomes ineffectual, a pitiful example of leadership failure, and one urgently in need of retirement.

In the context of this interplay of innovation and dissent between followers and leaders, I want to say a word about corps-based parochialism. In our business most occurs between officers of the MC and the MSC, both in the blue and green communities. Neither corps has a lock on sound leadership and innovation; both have their fair share of stars as well as slugs. Fortunately the former far outweigh the latter. But when I have seen a fine idea squashed because it was originated by 'a twig', or unappreciated because it came from some 'dumb-ass-doctor', I have become really agitated. I recently buried a MSC officer who had been my friend for over 20 years. We were constantly in competition and good-natured rivalry over most things we were about together. But you know that's not the thing I'm addressing here. My target is something that is really ugly and damaging. I've attempted to teach my followers to accept that the guy from the other community can do certain things that I can't. And vice versa. It's not that I can't learn those things, any more that it's not that he couldn't learn to do what I do (because I've got a surprise for any real ego trippers out there who are wearing one nut in the middle of their oak leaves: anyone with average intelligence can do the medical school thing. I know, because that's all I've got and I did it.) Treat them with the respect due professionals and use their skills for the improvement of mission readiness. Any other approach is unworthy of a leader.

One of my former leaders once told me: "the most important part of my job is to prepare you to do it." I, his follower, never forgot this, because it hit upon the essence of the concept of the 'stewardship of command.' In old English, a steward was one who ran an estate or other organization for another or others, with their authority. The commander holds the flag only for a time. Too soon, he must hand it to another, hopefully to one who has learned good followership and is now ready to become the steward himself. And so it goes. In a real sense, then, a commander's stewardship includes the tending, nurturing, and occasionally disciplining his followers. Because from among them will be chosen the one to whom he will one day pass the flag of command.

Finally, I would leave you with a couple of tight groups on some of the moral aspects of leadership. So that there is no confusion about what I'm saying, let's define the terms. A standard dictionary definition of morality is: "…principles of right or wrong in conduct; rightness or wrongness of an action."…or similar words to that effect. You will be quick to notice that this definition fails to state exactly 'who it is' that gets to decide which actions are right and which are wrong. *(continued on page 8)*

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The foundational documents of our country have something to say about 'who it is.' They use the term 'Creator.' Our currency and our pledge of allegiance say 'God.' The Navy hymn refers to 'Lord.' The Marine's hymn contains a stanza referring to 'Heaven's scene' (I interpret this to mean God's preferred mailing address). Now, I didn't come here to proselytize; I don't care which name one uses - throw in Yahweh, Allah, or great spirit if you like. The point is that morality, or rightness and wrongness is, and has been, properly decided by 'who it is.' And it isn't you and it isn't me. And it sure as hell isn't 1600 Pennsylvania Ave., and I don't even care what his definition of "is" is!

Much of the Western world is well on its way down a slippery slope called moral relativism, in which each person is free to write his own moral code, irrespective of 'who it is.' This seems to me a recipe for moral anarchy. This is why I feel not shame, but pride when the American military takes a moral stand to discipline one of our own for a serious moral transgression.

There is a huge difference between values and virtues. The former are defined by us creatures and, like us, are subject to change. The latter are defined by 'who it is' and, like Him, are immutable.

Moral leadership involves the leader's personal commitment to living, and leading, well in tune with the moral principles laid down by 'who it is' and not by current social whim. The incidents within our ranks of sexual promiscuity, with all its attendant fallout, i.e., out of wedlock pregnancy, STDs/HIV; also substance abuse, personal check fraud, real sexual harassment (not merely the politically incorrect kind), etc., all make it apparent that we have a need for strong moral leadership.

Listen to Admiral James Stockdale on leaders: "…they need to be moralists - not just posers who… exhort men to be good, but thinkers who elucidate what the good is. This requires a clear idea of right and wrong, and the integrity to stand by your assessment."

Or former CMC, General Al Gray, paraphrasing another former CMC, General John A. Lejeune: "…we must see to it that our people grow morally, spiritually, and physically. We need to ensure that our troops become better morally than… when we became their leaders…"

There are many other true and great military leaders whose words could be cited in defense of moral leadership, but I think you get the idea. Morality may not be much in vogue in the general marketplace of ideas in the larger society. But fortunately, we who wear our country's colors are, or should be, of a different stripe. Regardless of what's said within the beltway or on the Sally Jessie Raphael show, everybody is not doing it. And the great majority of the American people who entrust their sons and daughters to us expect that we who lead them aren't doing it either. May it always be so.

Well, I've enjoyed being with you again. Lead on and Semper Fi.

CAPT Charles H. Bercier, Jr., MC, USN (Ret)

(US Navy Photo)

1999 SUSNFS Awards

The Society of United States Naval Flight Surgeons presents five awards annually:

The Ashton Graybiel Award
The Sonny Carter Memorial Award
The Richard E. Luehrs Memorial Award
The Robert E. Mitchell Award
The Bruce W. Jackson Memorial Award

Ashton Graybiel Award

The Ashton Graybiel Award was initiated in 1991 in honor of Captain Ashton Graybiel, MC, USN. Dr. Graybiel was commissioned a Lieutenant Commander in 1940 and then designated a Naval Flight Surgeon in 1944. He was already recognized as an expert in cardiovascular medicine. He was assigned as Director of Research at NAS Pensacola during the formative years of aviation medicine. Dr. Graybiel's career spanned 40 years during which he made many pioneering contributions forming the foundation of modern aerospace medicine. These included current knowledge development of EKG techniques, experimentation with flight disorientation and the follow-up with the "1000 Aviator Study." All of these significantly advanced current aeromedical knowledge relevant to naval aviation and the space program. He is author of countless publications and a recipient of many national and international awards. He has been recognized as one of the world's foremost authorities on aerospace medicine.

This award is given annually to recognize outstanding contributions to the medical literature in support of some operational issue in aerospace medicine that has made a significant contribution with promise of long-term impact to the health and safety of aviation. Eligible recipients of this award should have conducted or been involved in an original research project and their papers published in the last year. By convention, only those papers published in the Aviation, Space, and Environmental Medicine journal are considered, unless the awards committee is made aware of papers published elsewhere. There were five papers considered for selection this year. The individual voted to receive the Graybiel award was involved in a study and publication of a paper that the awards committee felt was significant and crucial in changing the way NOMI Code 42 "does business."

The recipient of this year's Ashton Graybiel Award is: Major Carl M. Walker, MC, CAF for his paper entitled *Allergic rhinitis history as a predictor of other future disqualifying otorhinolaryngological defects*

Sonny Carter Memorial Award

The Sonny Carter Memorial Award was instituted in 1993 in memory of Captain Manley Lanier "Sonny" Carter Jr., MC, USN. The award recognizes the Medical Corps or Medical Service Corps Officer who has made the most significant contribution towards improving the health, safety, and welfare of operational forces by promoting communication and teamwork among the aeromedical communities.

Before his death in 1992, Sonny Carter was somewhat of a legend in aerospace medicine. As a Naval Officer, Naval Aviator, Flight Surgeon, and member of the Astronaut Corps, he was respected for his technical abilities, energy, and dedication to his profession, and probably most of all, for his ability to inspire others. The Sonny Carter Award recipient is judged not only on accomplishments in the last year but also on a career history of aeromedical community involvement.

Criteria for selection include: resourcefulness and dedication in promoting and accomplishing operational medical support, demonstrated leadership in forming and promoting teamwork among the various aeromedical specialties, demonstrated professionalism, integrity, unselfishness and respect for all aeromedical communities, demonstrated communication skills, and embodiment of the spirit of cooperation.

The recipient of this year's Sonny Carter Memorial Award is: Commander Glenn Merchant, MC, USN

The award consists of a plaque, $200.00, and a citation.

CITATION:

"The Society of United States Naval Flight Surgeons takes great pleasure in presenting the Sonny Carter

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Memorial Award to Commander Glenn Merchant, MC, USN for service as set forth in the following:

Commander Merchant is recognized for exceptional contributions in the area of teamwork, cohesiveness and promoting a sense of common purpose in the aerospace and operational medicine community. A former designated aviator who flew the AV8-A Harrier, he completed medical school, internship and returned to the aviation world as a flight surgeon, serving as flight surgeon to an AV8-B training squadron at MCAS Cherry Point, and as a flight surgeon with the 2nd Marine Aircraft Wing embarked aboard USS Nassau (LHA-4) during Desert Storm. He completed the Aerospace Medicine Residency and served as the Senior Medical Officer aboard the USS John C. Stennis (CVN-74). Commander Merchant is now assigned to the Department of Preventive Medicine of the Uniformed Services University of Health Sciences. In that capacity Commander Merchant has emphasized Navy Aviation Medicine to medical students there and has also traveled around the country recruiting future Navy flight surgeons. He also teaches facets of aviation mishap investigation at NOMI, impacting student flight surgeons, as well as student aerospace physiologists and student aviation experimental psychologists. His roles with AsMA and the AMA have garnered a positive image for Navy Aerospace Medicine for all of us. Commander Merchant's personal initiative and selfless devotion to duty are in keeping with the Sonny Carter spirit and the highest standards of the Society of United States Naval Flight Surgeons."

Richard E. Luehrs Memorial Award

The Luehrs Award is the longest running award sponsored by the Society. It was initiated in 1975 in honor of Captain Richard E. Luehrs, MC, USN. Dr. Luehrs' career spanned 32 years of exemplary service ending in his untimely death in 1974. Some highlights of his career include: service on ten separate aircraft carriers, first Senior Medical Officer on the first nuclear powered carrier - USS Enterprise (CVN-65), service on the USS Bon Homme Richard (CVA-31) where he was wounded by an exploding 20 mm cannon shell, service as Flight Surgeon for the Blue Angels Demonstration Team, service with the astronaut recovery team for the Mercury Project, service with the First Marine Aircraft Wing in Vietnam, a tour as Fleet Marine Force Pacific Surgeon, and receipt of the Harry G. Mosley Award as an Aerospace Medical Association Fellow in 1965 for his contributions to flight safety. He was serving as Senior Medical Officer at Andrews AFB when he died at Portsmouth Naval Hospital in May 1974.

The Luehrs Award is given annually to recognize outstanding performance in operational aviation medicine practice by a first or second tour Naval Flight Surgeon of the rank of Lieutenant or Lieutenant Commander. Selection is based on leadership qualities, dedication, initiative, resourcefulness, and industry in carrying out their duties with the operational forces.

This year's recipient of the Richard E. Luehrs Memorial Award is: Lieutenant Sean J. Murphy, MC, USNR

The award consists of a plaque, $200.00, and a citation.

Robert E. Mitchell Award

The Robert E. Mitchell Award was initiated in 1996 in honor of Captain Robert E. Mitchell, MC, USN for his 43 years of exemplary naval service and numerous contributions to naval aerospace medicine. Captain Mitchell is best known for his contributions to two long term aeromedical research projects, the "Thousand Aviators" study and the "Repatriated Prisoners of War" study.

The Robert E. Mitchell Award is designated to recognize an emeritus Naval Flight Surgeon for their career contributions to promoting and advancing the knowledge and science of aerospace and operational medicine.

The recipient of this year's Robert E. Mitchell Award is: Rear Admiral Daniel B. Lestage, MC, USN-Ret

The award consists of a plaque, $200.00, and a citation.

CITATION:

"The Society of United States Naval Flight Surgeons takes great pleasure in presenting the Robert E. Mitchell

(US Navy Photo)

Award to Rear Admiral Daniel B. Lestage, MC, USN-Ret for service as set forth in the following:

For his multitude of contributions to the Navy aerospace medicine community, which include his initial flight surgeon deployment with CVW-16 aboard USS Oriskany (CVA-34) to Southeast Asia, completing the Navy Aerospace Medicine Residency, and serving as Senior Medical Officer aboard USS John F. Kennedy (CV-67), deploying to the Mediterranean and North Atlantic. Subsequently he served with VP-30 and Naval Hospital Jacksonville, FL, and Director of the Aerospace Medicine Division at the Bureau of Medicine and Surgery. Rear Admiral Lestage commanded Naval Hospital Millington, TN; Naval Medical Command, European Region; and Naval Medical Center Portsmouth, VA and also served as Inspector General for the Bureau of Medicine and Surgery. He is a Fellow of the American College of Preventive Medicine, The American Academy of Family Practice, and the Aerospace Medical Association. He served as President of AsMA from 1988-1989 and is currently the President of the Fellows Group. His military awards include, five Legions of Merit, two Air Medals, and the Navy Commendation Medal. Rear Admiral Lestage sets an exemplary example of service and leadership for others to emulate in Navy Aerospace Medicine."

Bruce W. Jackson Memorial Award

This Award is given annually in recognition of outstanding contributions to the practice of aerospace medicine as a Reservist and service to those sailors and marines that depend on their flight surgeon for their health and safety in peacetime and war.

Captain Bruce W. Jackson graduated from Yale University School of Medicine in 1966, was selected as a Fulbright Scholar, and studied for a year at Cambridge University in England. He returned to the United States and completed his internship at Los Angeles County Hospital. Captain Jackson received his commission in the Navy and was designated a Naval Flight Surgeon in 1968. Captain Jackson served his initial flight surgery tour with a P2V Neptune Squadron at Cam Rahn Bay, South Vietnam and later in Okinawa. Following completion of his active duty, Captain Jackson transferred to the active reserve as a flight surgeon at NAS Alameda, CA. Captain Jackson completed his residency training in Family Practice at the University of California, Irvine in 1974. During his third year of training Captain Jackson completed the British Royal Navy course in Aviation Medicine at Farnborough, England. After returning to the United States, Captain Jackson returned to active duty as a flight surgeon with the Coast Guard until 1979 when he again transferred to the ready reserve. Captain Jackson practiced aviation medicine and family medicine

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for many years while serving in the Naval Reserves at NAS Alameda. In 1990, while serving as Commanding Officer, 4th Marine Aircraft Wing Medical, Marine Aircraft Group 42, Captain Jackson was diagnosed with pancreatic cancer and died in June 1990.

The recipient of the first annual Bruce W. Jackson Memorial Award is:
Rear Admiral James R. Fowler, MC, USNR-Ret

CITATION:

"The Society of United States Naval Flight Surgeons takes great pleasure in presenting the Bruce W. Jackson Memorial Award to Rear Admiral James R. Fowler, MC, USNR-Ret for service as set forth in the following:

For outstanding contributions to Naval Aerospace Medicine during a career that spanned 32 years of active duty and ready reserve service. He completed flight surgeon training in Class 110 in 1965 and deployed to Southeast Asia with HMM-163. Upon returning to the United States, he served as Flight Surgeon for VMT-103 and deployed aboard USS Saratoga (CVA-60). Leaving active duty, he continued to serve as a ready reservist while completing a residency in General Surgery and Plastic and Reconstructive Surgery, with a Fellowship in Hand Surgery. After entering private practice in Salt Lake City, he served with Marine Reserve Aircraft Group 42 at NAS Alameda. He was selected as Director of Health Services, Readiness Command 20, San Francisco, CA, the senior reserve medical billet in the southwestern United States. Following a successful tour at REDCOM 20, he became Commanding Officer of Reserve Fleet Hospital 9. He was then selected for duty as Deputy Surgeon General for Reserve Affairs (BUMED Code 07). During this time he also served as the medical advisor to Commander Naval Reserve Force, New Orleans, LA. He has been awarded six strike/flight Air Medals, the Legion of Merit, the Meritorious Service Medal, and two Navy Commendation Medals. He has been a constant advocate for Naval Aerospace Medicine and in particular, for Naval Reserve flight surgeons. Rear Admiral Fowler's unfailing devotion and dedication to Naval Aerospace Medicine reflect great credit upon himself and are in keeping with the highest standards of the Society of United States Naval Flight Surgeons."

Physical Qualifications Code 42 (BUMED 236)

Several very important events have or will occur in the next few months that will in some ways improve our waiver process, change the process, and/or delay the process. So here is the Good, the Bad, and the Unknown!

The "Bad" news is that Code 42 will have to move from our current building (664) to Building 1954 sometime this fall or winter. Several minor renovations and some major renovations will have to occur to ensure that we will still be able to communicate with the Fleet. It is a permanent move with all the problems of re-establishing computer lines, telephone lines, work places, etc. This may adversely impact our responsiveness to the Fleet and we are already making plans to try to minimize the impact to the Fleet and us.

The good news is that we are developing an electronic waiver recommendation to BUPERS or CMC. The same information will also be sent to the flight surgeon appearing on the physical exam or Local Board of Flight Surgeons. Turnaround will be faster and we hope to decrease the months of waiting that has plagued us in the past. Thanks to all of you who put your e-mail address on the LBFS. You'll be the first we try to notify of our waiver recommendation (hint for everyone else!).

NOMI (Code 14) delivered the long awaited MICRO 88 replacement (TriMEP: Tri-Service Medical Examination Program) to NMIMC in late March 1999. NMIMC is responsible for the distribution and training of this program and will hopefully make it available to all flight surgeon shops later this summer. Several clinics are already using the program. In a sense, it is still in development, but seems to be applicable to the smaller flight surgeon shops. The program takes longer to process a physical exam, but the standards analysis part of it will identify any missing information or requirements. It will also process US Army and US Air Force physical exams that use the SF 88 and SF 93. The flight surgeons should know what is required for completion of the physical exam or waiver before sending it to us. UNFORTUNATELY WE ARE STILL SENDING BACK OVER 50% OF OUR PHYSICAL EXAMS BE-

CAUSE THEY ARRIVE INCOMPLETE. Please review your SF88 for completion and ensure that the requirements for the waiver are completed.

The Aeromedical Advisory Council has been busy with many interesting aeromedical topics these past few months. They approved aircrew medication usage for Valtrex, Propecia, Proscar and metformin (DM Class II). A new evaluation for renal stones was approved which will make it easier for flight surgeons, but will require the addition of citrate and oxalate to the 24 hour metabolic workup. Of recent interest is the new "slimpack" parachute planned to replace the current parachutes in the P-3 and E2-C aircraft (planned for this year and next). The developers of the parachute state that the maximum weight limit (nude body weight) for the parachute is 245 lbs. The AAC decided that aircrew over 245 lbs. would be WAIVER NOT RECOMMENDED for these aircraft since the risk of injury would increase if they had to use the parachute in an egress situation. Again, please visit our web site to get the latest updates.

Finally, we have added a new e-mail address for folks who are trying to contact us for waiver status information. It is: code427@nomi.med.navy.mil

Until next time, "keep 'em flying safely"!

COL Ces Ferrer, MC, USAF
and
LT LeeAnne Savoia-McHugh, MC, USN

(US Navy Photo)

Psychiatry Potpourri
Psycho Waiver Bloopers

OK Folks!!!! As promised, here is another edition of your bloopers over the past 6-12 months. I'll keep the original categories and I hope you don't see yourself in these examples. Or better yet, recognize yourself and LEARN from the examples – we've all been there! If a package is done right the first time, *everyone* benefits: the aviator (first and foremost), your CO (the mission can proceed), you (your CO doesn't get a nastygram in the message traffic!), and us (we don't have these little bald spots resulting from pulling our hair out!)

One new item is we will give a special **BZ** to the most deserving flight surgeon for a job well done with their waiver packages. Although *tempted* to give a "worst package" award (Blooper Award!), that wouldn't be too productive or do much for the person's self esteem, now would it!? This time, it was a *very* easy decision to select a flight surgeon for the BZ. One flight surgeon stood out from the pack with two excellent packages. First, he accomplished something that very few have – submitted a package with a request for one of his sailors to have an NAA determination reconsidered, and second, for submitting a perfect alcohol waiver package (no small feat as you all know). As you read from my article in the winter edition about NAA, there are no waivers for this and rarely is the finding reversed. It requires excellent documentation of counseling with a concomitant sustained (2-3 year) change in the behavior/performance which led to the NAA determination initially. The **BZ** goes to **Lieutenant Ian Grover of VP-47!!!!!**

Although I won't name names, if there was to be a "blooper" award, it would be shared by three flight surgeons – three, because each signed a Local Board of Flight Surgeons (LBFS) for an aviator following alcohol treatment. The problem here was that the LBFS did not reference BUMED 5300.8 nor those items fully addressed. The *real* pie in the face came with the member's statement. This aviator wrote that he was "committed to drinking in moderation!" The member's statement was listed as an enclosure in the LBFS.

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Hellllo-o-o-o-o-o-o. . . . Clearly, the member had not been clearly briefed on the aftercare requirements for aviation nor was the member's statement read carefully. We were pretty incredulous with that one!

A little more scary was the case where a flight surgeon disagreed with a diagnosis made by a professional regarding alcohol abuse, did not contact us for an opinion or guidance, and on his own gave the aviator an up chit without even doing a LBFS. When this did come to our attention, we clearly agreed with the original diagnosis made by the specialist and recommended immediate grounding. Although you guys are out there and encouraged to exercise your clinical judgement, it can be very foolhardy to change a diagnosis made by a specialist (unless you are also a specialist of course!) without a second opinion, and then the support of your colleagues with a LBFS. Just a thought. . . .

We continue to see some typical errors in the submissions but generally the packages are looking much better. Please take a quick look at the categories as previously mentioned and remember these as you sign off on your 1000th waiver package of the day. . . . .

1. INCOMPLETE PACKAGES

✈ These are primarily for ETOH waivers that don't have one or more of the requisite supporting documents (e.g. member's request [please have them state their commitment to abstinence and knowledge of the requirements of 5300.8], flight surgeon statement, DAPA statement, CO's endorsement, psych eval, treatment summary). Always ask yourself, "If I was making the decision is there anything else I'd want to know?"

2. INTERNAL INCONSISTENCY

✈ Everyone is doing much better in this category which is mainly attention to detail.

3. UNSUPPORTED/INVALID DIAGNOSES

✈ Doing good here!

4. INCORRECT DIAGNOSIS

✈ One or two cited alcohol abuse when data supported dependence, but that's why the aftercare was changed in '92 – so folks didn't get treated differently if underdiagnosed.

5. UNSUPPORTED RECOMMENDATIONS

✈ Doing much better here too – only two NAA recommendations without supporting evidence of a personality disorder or maladaptive traits. . . . .probably by flight surgeons who trained before 1992 and are still using NAA to denote things like lack of motivation, etc.

6. INCORRECT RECOMMENDATIONS

✈ Only one mix-up of the NPQ/NAA determinations.

✈ One major psych diagnosis (Depression NOS) and member found PQ.

7. ADMINISTRATIVE OVERSIGHT

✈ Only minor stuff – see #1, which is also administrative. Please consider a checklist for your ETOH waiver packages.

ATTENTION!!!!!!ATTENTION!!!!!!

The **single** easiest thing you can do if you have even a minor question about a package (or ANYTHING even remotely psychoid!) is to call us or e-mail! Many of you have been taking advantage of the ease of e-mail where you avoid playing phone tag and annoyingly different time zones. Additionally, you get a WRITTEN record of what we have recommended which you can then include as documentation to support your plan (or of course disregard and toss if you are of that inclination. . . .not a recommended course of action usually ☺).

CAPT Mittauer (Yes, he is now an 06!!!! – congrats)**:**
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CAPT Wear-Finkle:
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CDR Ellis:
code216@nomi.med.navy.mil

REMINDER: Please check out our website for updated info/lectures/go-bys/etc., and let us know what you would like added to make your job easier. Please also let me know what articles you would find helpful in future issues of the SUSNFS newsletter.

CAPT D. Wear-Finkle, MC, USN
Psychiatry Department, NOMI

The View from the Residency

Well, Mike and I have been on the job about a year now as residency directors, and an exciting year it's been. Despite shifts in the prevailing winds and seas over the past couple of years, the residency has managed to stay on course and indeed prosper. We inherited a great program from our predecessors, CAPT Fitz Jenkins, CAPT Conrad Dalton and others, and we're continuing to shape it to the future.

Graduating RAMs

We're enjoying the pride of seeing our first crop of residents heading out into the world. CDR Bob Frick is now the SMO on the USS Roosevelt (CVN-71), on cruise in the Mediterranean. CDR Dave Gillis will join the USS John C. Stennis (CVN-74) in San Diego, CDR Frank Chapman will relieve CDR Jim Longstaff on USS Constellation (CV-64) headed to the Persian Gulf, and CDR Paul Rocereto heads to Norfolk to bring the USS George Washington (CVN-73) into work-ups. The former RAMs they relieve (CDR Kevin Brooks on the Roosevelt, CDR Kevin Gallagher on the Stennis, and CAPT Mike Krentz on the Washington) head to well-deserved post-SMO tours in fleet and hospital jobs where they'll use their experiences to better Navy operational medicine (and maybe get to sleep late on the weekends). Nice work, guys! LCDR Ed Park and LT Paul Antony have both selected flight surgeon billets at Patuxent River, and LT Matt Clark will be stationed at Whiting Field as the TRAWING 5 Flight Surgeon. Our two Canadian RAMs, MAJ Tarek Sardana and LCDR Dave Wilcox head back north to the frozen tundra, Tarek to Trenton, Ontario where he'll be the Wing Surgeon at 8 Wing, CFB Trenton, and Dave to Winnipeg, Manitoba as Division Surgeon at 1 Canadian Air Division HQ, Canadian Armed Forces. We'll miss them all, and we wish them well in their new jobs. If you can measure the value of a residency by the accomplishments of it's graduates, the program is clearly doing well. It's truly been a privilege to work this past year with such great people.

New Arrivals

We welcome 17 new RAMs to the residency this summer, after having completed their MPH year, and a diverse and talented group they are. The traditional mid-career to senior flight surgeons are CDR Lee Mandel, who joined us back in January, CDR Jim Black, LCDR Tim Halenkamp, and LCDR Robert Martschinske. LT Merrill Rice and CAPT Paul LaForce (Canadian) also bring flight surgeon experience to the residency. CDR Mike McCarten (FP), CDR Victor Catullo (Radiology), CDR John Lee (Anesthesiology) and LCDR Jon Umlauf (FP) all bring years of clinical experience in several specialties, but are new to the flight surgeon arena. LT Brad Douglas (RIO, F-14s), LT Dan Hohman (NFO, E-2s), and LT Dave Weber (F-14 pilot) bring a wealth of fleet aviation experience along with recent degrees as MDs and MPHs. And our newest and brightest, LT Theresa Buratynski, LT Edward Chin, LT Chris Perkins, and LT Dave Webster, make up in enthusiasm what they may lack in fleet or clinical experience. As you can see by the new class, the residency is broader and with a more diverse makeup that ever before.

The New Breed of RAM

It seems a good time for me to reflect where we are in the residency and where we hope we are going. Until recently, the residency was small, and virtually all RAMs were handpicked to serve as Senior Medical Officers aboard aircraft carriers following graduation. Choosing the residency meant choosing to be a SMO.

Now the population coming into the residency is much larger and broader with a wide variety of backgrounds and experience. We still have the "SMO Pipeline" for some of the more senior RAMs, depending on the number of carriers available in any one year. This track typically includes training in radiation health, trauma/critical care and emergency medicine, leadership, and operational medicine, along with other electives. LCDRs and above may look forward to being SMO candidates for assignment to carriers on graduation. But many of our new residents are more junior officers, or have no aviation or flight surgeon experience, and some come directly out of internship. Quite a few, who would in earlier years have selected flight surgery, are now

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successful in getting accepted directly to the residency. For these, flight training and basic flight surgeon skills must be taught first, followed by the wide variety of "integral parts" which make up the accredited year of training leading to board certification in Aerospace Medicine. For the new doctor out of internship, much of the year spent in the Master of Public Health and the practicum year are spent away from basic clinical care, so we have to boost these clinical skills before graduating the RAM back to operational medicine. Arguments as to whether preventive medicine specialists should also be clinically competent are irrelevant in our business. The Navy needs RAMs to have clinical as well as population-based skills.

As part of flight surgeon and residency re-engineering during 1996-1998, the third year of the residency was dropped. However, after implementing the accelerated two-year program (MPH plus practicum year), it became evident that despite our best efforts we could not accomplish all the integral parts training and flight training in that one accredited practicum year. In actuality, it was requiring 60 weeks minimum just to accomplish the basics, with no research or elective time. The new RAM graduate was certainly more comprehensively trained in aerospace than the traditional intern-flight surgeon was, although he/she had been away from clinical care for most of two years. The RAM could successfully pass the Aerospace boards, but would he be the "full up round" that the Navy needed to do operational, clinical, and possibly carrier SMO medicine? The community argued "no" and the Medical Education Policy Council and the Surgeon General agreed early this year. The third year was restored to the residency.

The Four Goals

So where is my convoluted discussion leading us? Basically, the residency is doing several tasks in training RAMs, which can be lumped into four categories: Aerospace Medicine Specialist preparation, SMO preparation, Operational Medicine competence, and Primary Care clinical capability. First and foremost, the residency is directed to giving the RAM the education and experience he/she needs to qualify to take the board exam and practice Aerospace Preventive Medicine. This has a long list of requirements and skills, the latest of which are spelled out in the June issue of the "Blue Journal" (Yasuhara, et. al., *Specialty Competencies for Residents in Aerospace Medicine,* Aviat. Space Env. Med., 1999; 70:609-11). The MPH and practicum years are largely devoted to this endpoint. But the Navy has needs beyond the aeromedical specialist, namely for clinically and operationally competent flight surgeons and ultimately, carrier SMOs.

The New Residency

So we're back to the three-year residency, but with big differences from the past. This summer, counting both year groups, we'll have 25 RAMs onboard! As you've seen, the incoming residents have a much broader variety of experience and qualifications, requiring that we tailor the program more to the individual needs of each RAM, while still maintaining the core "integral parts" required for accreditation. Also, since graduating RAMs occupy the whole range of flight surgeon jobs, the training is balanced as much as possible between all four areas: aerospace, carrier, operational, and clinical medicine. We think the result is a robust program, equal to the quality of the successful residents who are accepted.

Is this the right time for you to apply? I assume you enjoy operational medicine and flight surgery, or else you wouldn't be a SUSNFS member receiving this newsletter. You may be considering this career move, or perhaps you're one of the old salts who've taken this track already. From my view over the past 18 years, I think the residency is bigger and better than ever before, with RAM candidates second to none. If you want to be part of this tradition, your future in aerospace medicine begins here. Give either Mike or me a call, and we'll provide more information and answer your questions.

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RAM Corner

Lyme Disease

The History

The patient is a 22 year-old male SNA whose waiver request came to NOMI Internal Medicine. Although the case was not so difficult from a waiver request aspect, the history was intriguing. The patient was first exposed to Lyme disease in 1992 when he had a tick bite followed by a rash. He received no treatment until 1994 when he started experiencing memory loss and fatigue. This was evidenced by his poor performance in a particular class in which he had previously done very well. Diagnosis was based on clinical symptoms and confirmed by a positive PCD (DNA) LD test. The patient was treated with IV antibiotics (Claforan and Rocephin) and the symptoms subsided. The patient attended summer school and then completed the 1995-96 academic year with a 3.0 GPA (possible 4.0). The history accompanying the waiver request reported that the patient got another tick bite in the summer of 1995 that went untreated until symptoms again appeared in the fall of 1996. During the spring semester of 1997, according to the history, the patient was treated with IV antibiotics through the early summer. The patient again took summer school classes that were reportedly completed without difficulty. During the fall semester 1997, cognitive difficulties reappeared and continued through the 1997-98 academic year. The patient was then diagnosed with Stage 2 Lyme Disease in May 1998. Over the summer, the patient was treated with daily IV Vancomycin and adjunctive vitamin therapy for 60 days. At the time of the waiver request, the patient was still on activity restriction and reduced academic schedule.

Definition and Distribution

Lyme Disease is a complex, multisystem illness caused by *Borrelia burgdorferi* which is transmitted by certain ixodid ticks; *Ixodes dammini* (also called *I. scapularis*), *I. pacificus*, *I. ricinus*, and *I. persulcatus*. *I. dammini* is the principal vector in the northeastern United States from Massachusetts to Maryland and in the Midwestern states of Wisconsin and Minnesota. *I. pacificus* is the vector in the western states of California and Oregon. Distribution of the disease closely correlates with the distribution of the tick species noted above. In the U.S. the tick ranges from the tidewater area of Virginia, north through the Mid-Atlantic States, and into southern Vermont and New Hampshire, and from south central California to southern Oregon. The vector is also present in north central Europe and the Baltic coasts of Norway, Sweden and Finland.

The disease usually begins with a characteristic expanding skin lesion, Erythema Migrans. Symptoms suggestive of meningeal irritation may develop early when Erythema Migrans is present but usually are not associated with an objective neurologic deficit (Stage 1 - localized illness). After several weeks or months, about 15 percent of untreated patients develop neurologic abnormalities, including meningitis, subtle encephalitic signs, cranial neuritis (including bilateral facial palsy), motor or sensory radiculoneuropathy, mononeuritis multiplex, or myelitis alone or in various combinations (Stage 2 - disseminated infection). Possible manifestations of disseminated infection include secondary annular skin lesions, meningitis, cranial or peripheral neuritis, carditis, AV nodal block, or migratory musculoskeletal pain. Months to years later (usually after periods of latent infection), intermittent or chronic arthritis, chronic encephalopathy or polyneuropathy, or acrodermatitis may develop (Stage 3 - persistent infection). Most patients experience early symptoms of the illness during the summer, but the infection may not become symptomatic until it progresses to second or third stage. Despite regional variations, the basic stages of the illness are similar worldwide.

Lyme disease is now the most common vector-borne infection in the United States, with more than 70,000 cases reported to the Centers for Disease Control and Prevention (CDC) from 1982-1994. Cases have been reported in 47 states, but the life cycle of *B. burgdorferi* has been identified in only 19 states. Cases have occurred in association with hiking, camping, or hunting trips and with residence in wooded or rural areas. Persons of all ages and both sexes are affected.

Clinical Manifestations

In the United States, the usual disease presentation consists of fluctuating symptoms of meningitis

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accompanied by facial palsy and peripheral radiculoneuropathy. In Europe and Asia, the first neurologic sign characteristically is radicular pain, which is followed by the development of CSF pleocytosis (Bannwarth's syndrome), but meningeal or encephalitic signs are frequently absent. These early neurologic abnormalities usually resolve completely within months, but chronic neurologic disease may occur later.

Approximately eight percent of patients will develop cardiac involvement within several weeks after the onset of illness. The most common abnormality is a fluctuating degree of atrioventricular block (first-degree, Wenckebach, or complete heart block). Some patients have more diffuse cardiac involvement, including electrocardiographic changes indicative of acute myopericarditis, left ventricular dysfunction, which is evident on radionucleotide scans, or (in rare cases) cardiomegaly or pancarditis. Cardiac involvement usually lasts for only a few weeks but may recur. During this stage, musculoskeletal pain is common. The typical pattern consists of migratory pain in joints, tendons, bursae, muscles, or bones (usually without joint swelling) lasting for hours or days and affecting one or two locations at a time. Months after the onset of infection, about 60 percent of patients in the United States who have received no antibiotic treatment develop frank arthritis.

Although it occurs less commonly, chronic neurologic involvement may also become apparent months or years after the onset of infection, sometimes following long periods of latent infection. The most common form of chronic central nervous system involvement is subtle encephalopathy affecting memory, mood, or sleep and often accompanied by axonal polyneuropathy manifested as either distal paresthesias or spinal radicular pain. Patients with encephalopathy frequently have evidence of memory impairment in neuropsychological tests and abnormal results in CSF analyses. In cases with polyneuropathy, electromyography generally shows extensive abnormalities of proximal and distal nerve segments. Encephalomyelitis or leukoencephalitis, a rare manifestation of Lyme borreliosis, is a severe neurologic disorder that may include spastic parapareses, upper motor-neuron bladder dysfunction, and lesions in the periventricular white matter. The prolonged course of chronic neuroborreliosis following periods of latent infection is similar to that of tertiary neurosyphilis.

Lab

The development of the immune response in Lyme is gradual. After the first several weeks of infection, mononuclear cells generally show increased responsiveness to *B. burgdorferi* antigens. Evidence of B-cell hyperactivity is found, including elevated total serum IgM levels, cryoprecipitates, and circulating immune complexes. Titers of specific IgM antibody to *B. burgdorferi* peak between the third and sixth week after disease onset. The specific IgG response develops gradually over months, with response to an increasing array of 12 or more spirochetal polypeptides. It is by using ELISA and Western Blot lab tests that these polypeptides induce changes in the levels of particular IgG and IgM bands. According to current criteria adopted by the CDC, an IgM western blot is considered positive if two of the following three bands are present: 23, 39, and 41 kDa. In the Candidate's package which was sent to CODE 42, IgM levels were reportedly tested and found to be positive for the following IgM bands: 23, 31, 34, 35, 39, 83, while IgG was non-reactive. According to CDC, however, in persons with illness of longer than one month's duration, a positive IgM test result alone is likely to be false positive. This test was done on the Candidate in the spring of 1998. The limitation of serologic tests now becomes evident. They do not clearly distinguish between active and inactive infection. Patients with previous history of Lyme Disease, particularly in cases progressing to Stage 2 or 3 often remain seropositive for years, even after adequate antibiotic treatment. Some patients are seropositive because of asymptomatic infection; while some patients who receive inadequate antibiotic therapy early in the course of infection develop subtle joint or neurologic symptoms but are seronegative.

For serologic analysis in Lyme Disease, the CDC recommends a two-step approach in which ELISA first tests samples; equivocal or positive results are then tested by Western Blotting. During the first month of infection, both IgM and IgG responses to the spirochete should be determined, preferably in both acute- and convalescent-phase serum samples. Approximately 20 to 30 percent of patients have a positive response

detectable in acute-phase samples, whereas about 70 to 80 percent have a positive response during convalescence (two to four weeks later). After the initial phase, the great majority of patients continue to have a positive IgG antibody response, and a single test for IgG is usually sufficient. Lymphocytic pleocytosis (about 100 cells per microliter) is found in the CSF, often along with elevated protein levels and normal or slightly low glucose concentrations.

In the absence of these criteria, even in endemic areas of disease, the likelihood of a false-positive test is higher than a true-positive result. CDC has developed a set of diagnostic criteria for Lyme Disease for surveillance purposes, but these are also applicable to the clinical diagnosis of Lyme Disease (See table 1).

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Erythema migrans *(SmithKline Beecham Biologicals)*

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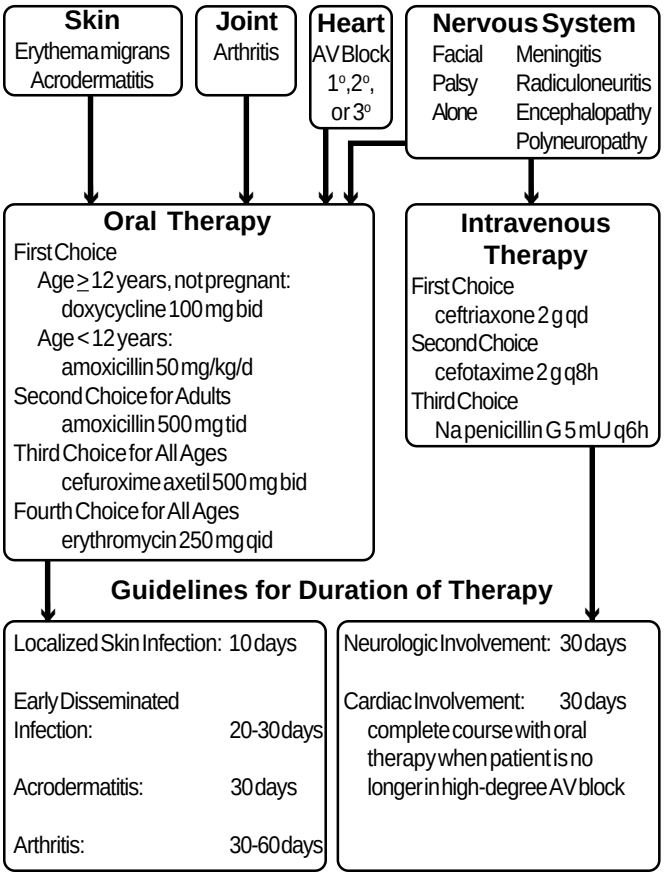
Treatment

Treatment is outlined in the algorithm below, the various manifestations of Lyme disease can usually be treated successfully with orally administered antibiotics; the exceptions are objective neurologic abnormalities, which seem to require intravenous therapy.



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CDR Paul Rocereto, MC, USN
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Special Board of Flight Surgeons

A Precedence Setting Case

A Special Board of Flight Surgeons was recently convened to consider a medical waiver recommendation in a very unusual case involving a 27 year-old student naval aviator with a history of traumatic injury to his left lower extremity with resultant complications. Two weeks prior to completing his jet training, this SNA was injured in a boating mishap, suffering a propeller injury to his left lower leg and ankle. He had successful reconstruction of his left ankle, but as a complication of the operative procedure, developed severe right lower extremity compartment syndrome requiring four compartment fasciotomies. Several days later, because of falling O_2 saturations and suspected pulmonary emboli, a Greenfield inferior vena cava filter was placed. (Ultimately, no pulmonary emboli were demonstrated, and in retrospect the filter was not indicated). As a result of the trauma and surgical procedures to both lower extremities, he developed permanent sensory deficits on the dorsum of both feet. The SNA underwent extensive rehabilitation and was found fit for full duty one year after the injury. A subsequent medical board submitted because of his foot numbness recommended a 40% disability retirement. The aviator filed a Petition for Relief of Finding of the PEB, which resulted in him being found fit for full duty. A Local Board of Flight Surgeons recommended a waiver to Service Group I with a return to flight training. At NOMI a waiver was not recommended, hence the Special Board of Flight Surgeons was requested.

The SBFS was convened to consider a waiver recommendation for the following diagnoses: 1) lower leg trauma and permanent neurologic deficits bilaterally, 2) retained internal orthopedics hardware, left ankle, and 3) Greenfield inferior vena cava filter. The SNA has completely recovered from his surgery and has no physical limitations, performing in the outstanding categories in all subsequent physical fitness testing. He has permanent non-progressive sensory deficits on the dorsum of both feet. It was demonstrated to the Board's satisfaction that the deficits would not interfere with rudder pedal control or with the application of toe brakes. He had only slight limitation of range of motion of the left ankle that was not felt to be of aeromedical significance. He has had no symptoms from his retained orthopedic hardware.

The remaining major aspect to be considered was the Greenfield filter. Greenfield filters have been used for over twenty years to prevent large pulmonary emboli. Insertion of these filters into the inferior vena cava infrarenally is indicated when anticoagulation cannot be undertaken because of active bleeding. Other indications include recurrent venous thrombosis despite adequate anticoagulation, prevention of pulmonary thromboembolism in patients with right sided heart failure who are not candidates for thrombolysis, and prophylaxis in extremely high risk patients. These tiny devices are made of titanium and measure 51 mm in height and are 38 mm at their distal opening. Each of the arms is 51mm in length and radiate out from their central cephalad junction. The legs each have a hook that is at an 80-degree angle that anchors into the internal wall of the inferior vena cava.

The medical literature was extensively reviewed, and input was obtained from other sources, including Dr. Lazar J. Greenfield, developer of the filter. Studies have shown that the titanium Greenfield filter is extremely durable and in vitro testing has shown no signs of metal fatigue after after 10,000,000 compressions. There have been 22 cases of unusual complications, most of which occurred less than a month after placement. In over 20 years experience with these filters, Dr. Greenfield has found non-clinically significant migration in eight percent of cases. The durability/resiliency of the filter, coupled with its extremely light mass (0.2 g) make the risk of complications (fracture or migration of the filter or IVC tear) extremely low. These characteristics are expected to give the filter a margin of safety, even when pulling high-G maneuvers or ejecting from aircraft. Lastly, the long-term safety of Greenfield filters makes it difficult to justify removal in any but exceptional cases.

It was the decision of the SBFS to recommend that waivers be granted to return the SNA to Service Group I and that he resume his flight training. This represents the first case of a waiver being recommended for an aviator who has had a Greenfield filter placed. The U.S. Army has no data on this subject, and the U.S. Air Force has granted two such waivers in the past. As our technology advances, more cases involving issues of intravascular filters, stents, etc. are likely to arise for consideration.

CDR Lee R. Mandel, MC, USNR
Co-Chief Resident in Aerospace Medicine

(US Navy Photo)

In Memoriam

It is with deepest sadness that I must notify the Society of U.S. Naval Flight Surgeons of the passing of Captain James K. Goodrum, MC, USN (ret.). Captain Goodrum died at his home in Oak Harbor, WA on May 20, 1999. Captain Goodrum served in a variety of flight surgeon billets, including tours with the Marine Corps in Okinawa and Beaufort, SC and the U.S. Antarctic Research Program. Following completion of the Aerospace Medicine Residency in 1987, Captain Goodrum served as the Senior Medical Officer on the USS Nimitz (CVN-68) making deployments to the Mediterranean. Captain Goodrum spent the last eight years of his Navy career at NAS Whidbey Island as the Wing Surgeon for the Attack and Electronic Combat Wings U.S. Pacific Fleet. Captain Goodrum retired from active duty service in December 1996.

Those of us who had the fortune to cross paths with Captain Goodrum will always remember his boundless enthusiasm for life, his deep love of nature, his steadfast dedication to the men and women of U.S. Navy aviation, and his endless devotion to his family. Each of us is better for having known Captain Goodrum. He will be sorely missed by all.

Captain Goodrum is survived by his wife of thirty-seven years, George-Anne; his sons, James and Paul; and two grandsons. In lieu of flowers, the family requests that donations be made in honor of Captain James K. Goodrum to the Fisher House Foundation, 24 Stokes Rd, Bethesda, MD 20814-5002.

CDR Richard A. Beane, MC, USN
Electronic Attack Wing, U.S. Pacific Fleet
NAS Whidbey Island

Naval Operational Medicine Institute
209th Flight Surgeon Graduation Ceremony
9 July 1999

Commencement Address

This year's commencement address was given by Captain Kenneth R. Zimmerman, the Commanding Officer of Naval Aviation Schools Command at NAS Pensacola, Florida.

Captain Riley, thank you for inviting me to be here today, and welcome and well done to all of the families and friends who are out there…your support is really what has made this all possible. I am truly honored to have the opportunity to address these 29 spectacular naval officers seated in front of me. They have already had the opportunity to learn one of the hardest lessons any confident and eager young naval aviator has to learn…and that is flying an aircraft can be extremely humbling, even for a doc. But what incredible opportunities await all of you, as you embark on careers that combine two of the most romanticized, challenging, and rewarding fields: aviation and medicine! Ever since Eugene Ely trapped the first Curtiss biplane on the armored cruiser Pennsylvania in 1911, and congress subsequently made the first appropriation of $25,000 for Naval Aviation, there has been a phenomenon clearly evident in the military aviation community, one which is often absent in many other professions. That phenomenon is a sense of excitement, of adventure, and of fun. Having completed medical school, internships, aviation preflight, and flight training, you have proven yourselves to be a cut above and our country has clearly recognized that fact. A recent survey taken in this country has indicated that the American people rank the United States military as the most trusted institution in this country…ahead of the church and the Supreme Court. Now I'm not saying that we are above God or the law but we certainly have earned the trust and confidence of the people in this country and I know you are proud to be a part of such an organization.

I would also like to pass my personal congratulations to Lieutenant Laurent Pierre of the French navy for his outstanding academic performance in preflight, and to Lieutenant Timothy Jones for his outstanding physical fitness performance. For both of you and your classmates, your next and possibly your most difficult challenge will be to become an integral part of the squadron ready room team while at the same time physically and psychologically evaluating its members. To successfully pull this off you must understand your role as both a team member and a team leader.

It has been my experience that those who practice aviation medicine are either made or broken on their very first tours with an operational command. This hard fact is also true for aviators. Captain Nader Takla, MC, USN wrote an editorial printed in the October 1994 Society of U.S. Naval Flight Surgeons Newsletter which discussed desirable leadership qualities in a Flight Surgeon. I have taken the liberty of expounding on some of his suggestions from a pilot's as well as a Commanding Officer's point of view and I will call it my "Five Leadership Recommendations for a Flying Doc."

Leadership is an art. It is not easy. It does not happen by accident. You do not learn good leadership skills in school. Good leadership skills, like good flying skills, are developed primarily through practice, and trust me on this one…humbling mistakes. But before you can be a good leader, you've got to be a trusted member of the team. As a newly winged pilot preparing to go to my first squadron, I had plenty of advice from senior pilots to keep me from making any critical political and social errors. Politics and social etiquette are unavoidable, particularly in squadrons. I do hope you find something in the following advice, which will make your transitions to the fleet as smooth and enjoyable as mine was some 25 years ago. Interestingly I have found some parallels between my advice and a few of the regulations issued by the U.S. war office in 1920 concerning the operation of aircraft.

1. My number one recommendation is to **get comfortable with your identity as a physician (or, "pilots will not wear spurs while flying")**. You may not be the top gun hero flying the aircraft, but you are an essential part, and I mean essential part, of that aviator's world. Make the command's goals your goals, be involved, go to the command functions. Take pride in your community's history. Historians cite Rear Admiral Clinton G. Defoney, MC, USN, as the first designated Navy Flight Surgeon. He had learned to fly prior to joining the navy, while stationed in France with the Army reserves. Serving as a flight surgeon here at NAS Pensacola between 1924 and 1931, he was given permission to continue his flying. During this period, the Navy was having a difficult time finding Captains for aircraft carriers, since early naval aviators were still junior officers. The Navy selected senior officers to be sent to a "crash course" in flight training: King, Halsey, Marshall, and Doyle - names that are now famous in American Naval history. Defoney was their flight surgeon. As an experienced aviator, he undoubtedly had a profound influence on these future household names. Remember that you, like Defoney, share a purpose with your ready room, regardless of specialty or experience level. The medical community has also proven to be capable of exceptional leadership decisions in crisis situations, as is evidenced by the many Medals of Honor that have been awarded to Hospital Corpsmen, Pharmacist's Mates, Medical and Dental Corps officers, and one Navy surgeon - Middleton S. Elliott in 1914. You must be capable of making unbiased and independent decisions, and be able to diplomatically explain and defend your decisions when your Commanding Officer questions you. When a Commanding Officer asks you for your opinion, let me assure you they are really asking for and need your personal opinion and advice.

2. My number two recommendation is…**stay within the boundaries of your authority and expertise (or, "never take a machine into the air until you are familiar with its controls and instruments")**. You can't possibly know everything. And if you think you do, you are probably a terrible listener. Just listening to my junior officers can be incredibly powerful. There have been many times that I have heard junior officers eventually solve their own problems as I listened to them describe the details. You will find that listening carefully to your patients and your fellow ready room members will result in increased trust, and will inevitably increase your credibility. Take every opportunity to build trust and credibility, and your reputation as an expert will be sound.

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(US Navy Photo)

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3. My number three recommendation is…**adapt gracefully to criticism or avoidance by others (or, "if an emergency occurs while flying, land as soon as possible")**. You will find that many aviators avoid the flight surgeon, often without any logical reasons. Junior officers naturally don't want to be grounded and old guys like me hate to hear the bad news that we're not as young as we use to be. Try and respect the dignity of your patients and fellow squadron members, maintain a sense of humility and don't take offense when you walk into the ready room and everyone goes "quack…quack…quack". You may have more education than any other member of the ready room, but remember that you also may have the least operational experience. You may recall that the U.S. Navy's operational Flight Surgeon of the Year Award was established in 1975 in the name of Captain Richard E. Luehrs, MC, USN. Captain Luehrs is well known as the first flight surgeon assigned to the Blue Angels from 1955 to 1957. He was also assigned to the USS Enterprise as the Senior Medical Officer, and as part of the assignment process Captain Luehrs was interviewed by the infamous Admiral Hyman Rickover, who personally grilled all officers assigned to a nuclear platform. Captain Luehrs survived the interview. Certainly, if he wasn't humble prior to his meeting with Admiral Rickover, he never would have made it to the Enterprise. The problem of being avoided by pilots in particular can require you to exercise both discretion and persistence, especially when you are concerned over an individual's safety. In the end, that individual may owe you their life.

4. My number four recommendation is…**build and maintain alliances, rapport, confidence, credibility, and consistency (or, "never run the motor so that blast will blow on other machines")**. I cannot over-emphasize the importance of having squadron ready room credibility and reputation. Over 90% of you will go to operational commands following graduation. To be accepted by your command, you must show a genuine interest and concern for its members. Make communication one of your top priorities and build trusting relationships. It is almost impossible to be a powerful leader in America today without personal integrity, credibility, and consistency. Back in April of 1944, the BUMED newsletter ran an editorial from a flight surgeon serving in the South Pacific who was truly concerned about consistency and fairness. It is rather humorous to read today, but still illustrates my point. "Whisky is a good sedative for pilots but it cannot be given as a reward. It is only for those who need it, and interpreting this narrowly, there are few indications for its use. On shipboard, it cannot, in all fairness, be made available to aviators only without causing some hard feeling. You cannot explain to a hard working deck officer or engineer that the strain of aviation is emotional and different from that of hard labor. I do wish the responsibility was not with the Medical Officer. If a doctor is liberal with whisky, he could be accused of running a barroom." And not that I totally agree with this doc's decision but I must say it was fair and consistent.

5. And finally, my number five recommendation is…**stay in the aircraft (or, "riding on the steps, wings, or tail of a machine is prohibited")**. "In the field, afloat and ashore, the flight surgeon is not performing his duties satisfactorily unless he continues to fly at regular periods with the aviators under his supervision. Only by doing so, flying with aviators, the flight surgeon will be better able to judge and advise in order to keep them in a high state of physical and mental fitness which is required by their extra-hazardous duties." That was a direct quote from the School of Aviation Medicine's first newsletter, back in 1941. The spirit of those words is still alive for aviation docs today. Whether you aspire to eventually be like the late Captain Sonny Carter, MC, USN, and rack up 120 hours of space flight, or you simply want to meet your minimum four hours a month, you will eventually note one overwhelming truth: you are much more capable of listening to, understanding, and treating an aviator's medical and psychological problems if you have experienced the environment in which he works. Yes, it's true, all of us aviators want you to fly with us. Aviators would never pass up an opportunity to show off the aircraft and the skill of the crew. You'll have experiences you will never forget. But there is one thing that I just can't promise you…and that is that you'll like your call sign.

So my congratulations and best wishes to all of you as you join us in the fleet. As I said, I am envious of each one of you and the exciting and rewarding challenges that lie ahead…so fly safe, God bless each of you and God bless America and welcome to an elite team!! Fly Navy!!

Congratulations to the latest graduates earning their "Wings of Gold":

Flight Surgeon Class 99002	**Billet Assignment**
LT Phillip M. Adriano, MC, USN	3RD MAW, NAS Miramar, CA
LT Ann M. Buff, MC, USNR	NAVHOSP Guam
LT Christopher B. Chisholm, MC, USNR	NAVMEDCL Pearl Harbor, HI
LT Michael P. Dalgetty, MC, USN	NSAWC, NAS Fallon, NV
LT William R. Dodge, MC, USN	MWSG 37, 29 Palms, CA
LT Lena Friend, MC, USN	VP-26, NAS Brunswick, ME
LT Dana E. Gaffney, MC, USNR	MAG 39, Camp Pendleton, CA
LT Frank T. Grassi, MC, USNR	MAG 31, MCAS Beaufort, SC
LT Carlos S. Guevarra, MC, USN	MAG 31, MCAS Beaufort, SC
LT Erik M. Happ, MC, USNR	BMC, NAF Washington, DC
LT Timothy R. Jones, MC, USNR	TRAWING 1, NAS Meridian, MS
LT John H. Keogh, MC, USNR	VQ-4, Tinker AFB, Oklahoma City, OK
LT Victoria W. Kou, MC, USNR (Graduating Sep 99)	2ND MAW, MCAS Cherry Point, NC
LT David S. Lambert, MC, USNR	CVW 17, NAS Jacksonville, FL
LT Monique L. McCray, MC, USNR	TRAWING 4, NAS Corpus Christi, TX
LT David K. Moore, MC, USNR	2ND MAW, MCAS Cherry Point, NC
LT Kurt H. Mueller, MC, USNR	HM-14, Norfolk, VA
LT Michael D. Petrucci, MC, USNR	BMC China Lake, CA
LT Tyler M. Prout, MC, USNR	NAS New Orleans, LA
(Recipient of the **Surgeon General's Award for Student Excellence**)	
LT Amy A. Puloski, MC, USNR	BMC, NAS Ft. Worth, TX
LT Peter R. Shumaker, MC, USNR	NAVHOSP Roosevelt Roads, PR
LT Charles R. Smalling, Jr., MC, USNR	MAG 31, MCAS Beaufort, SC
LT Joseph E. Strauss, MC, USNR	BMC, NAS Willow Grove, PA
LT Eric L. Thomas, MC, USNR	HMT-303, Camp Pendleton, CA
LT Ann L. White, MC, USNR	NAMI, NAS Pensacola, FL
LT Amy T. Young, MC, USNR	CVW 11, NAS Lemoore, CA
LT Patrick E. Young, MC, USNR	VFA-106, NAS Oceana, VA
(Recipient of the **Fox Flag Award**)	
LT Scot A. Youngblood, MC, USNR	VQ-1, NAS Whidbey Island, WA

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Allied Flight Surgeon Class 99002

LT Laurent E. Pierre	French Navy
LT Allard G. Vandersluis	The Netherlands Navy

Aerospace Physiologist Class 99002

LTJG James A. Balcius, MSC, USNR	
LTJG Brian L. Bohrer, MSC, USNR	
LTJG Corey J. Littel, MSC, USNR	NOMI, ASTC Cherry Point, NC

Allied Aerospace Physiologist Class 99002

2NDLT Abram D. Mokaleng	Botswana

Aerospace Experimental Psychologist Class 99002

LT Cheryl C. Young, MSC, USNR	NAWC, Patuxent River, MD

Recipient of the Class' **Golden Apple Award** was CDR Jay Phelan from the NOMI ENT Department.

(US Navy Photo)

The Society of U.S. Naval Flight Surgeons

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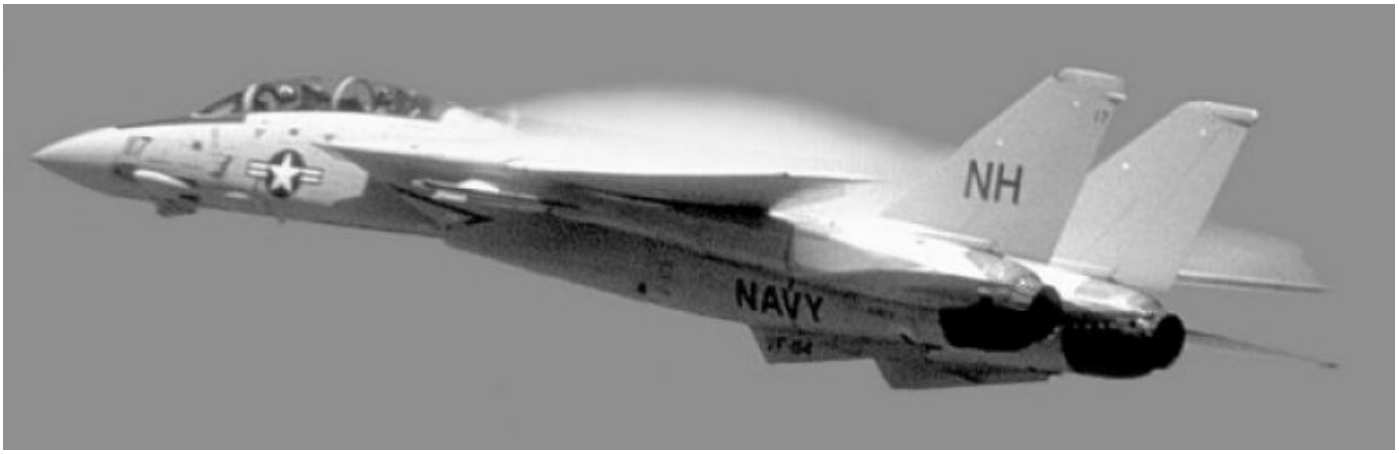

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Submissions should clearly indicate the author's return address and phone number. All submissions should reach the Editor one month prior to the scheduled date of publication. Correspondence should be sent to:

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