



The Society of U.S. Naval Flight Surgeons Newsletter

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<http://www.aerospacemed.org>

April 2000

President Elect's Column

I will start my first President's Column by thanking CAPT Terrence L. Riley for his outstanding service to our Society. His intellectual prowess and focus on challenging us to always seek ways to be leaders in Navy Medicine has propelled our Society to new heights. CAPT Riley's commitment to NAMI has laid the foundation for her return and the realization of the opportunity of NOMI to encompass all of Operational Medicine. I know I speak for all members, we are better for your service and wish you well as you transition to another career as a retired Navy Doc.



Additionally, there is current discussion with both the USMC and BUMED 05 about taking on additional responsibilities.

Now to NAMI. We have been functioning as an institute since April 1999, thanks to CAPT Riley and CAPT Fahey. Here are the key players and the command structure. Code 02, Clinical Directorate, has not changed and is headed by CAPT Natalie A. Willenberg. Code 03, Academics Directorate, has been divided into three departments. CAPT Mike R. Valdez is the Director of the Residency in Aerospace Medicine (RAM) and is assisted by CAPT Nick A. Davenport. CDR Terry L. Puckett currently heads the Medical Corps Department, Flight Surgeon Course, and he will be relieved this summer by CDR

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Over the last 20 months I have had the privilege of being back in Pensacola working with the professionals who are the leaders in Naval Aviation Medicine. There has been a tremendous amount of change at the command and I want to take this opportunity to clarify where we currently are and where I see us going. Hopefully, by the time you are reading this, NAMI is back as a command. The seven-year transition from NAMI to NAOMI to NOMI and now to NOMI and NAMI has been confusing to say the least. As CAPT Bercier envisioned the need for a Naval Medicine Institute to coordinate all of Operational (Expeditionary) Medicine, NOMI is taking shape. NOMI currently is an echelon three command overseeing the Naval Undersea Medical Institute (NUMI), the Naval Surface Warfare Medical Institute (SWMI), the Fleet Hospital Operations and Training Center (FHOTC), the Aviation Survival Training Centers (ASTC), East, Central, and West, and the NOMI headquarters, of which NAMI is a part.

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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. Subscription memberships are available. Dues are \$15.00 per year, or \$225.00 for a lifetime. Contact the Secretary or Treasurer for more information or a membership application form.

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Jay S. Dudley. LCDR Brian D. Swan oversees the Medical Service Corps and Hospital Corps training programs. Last but not least, Code 04, Physical Standards Directorate, is headed by COL Cesario F. Ferrer, who will be relieved by CDR Jeffrey R. Brinker this summer. The reason I included everyone's middle initial is that our e-mail addresses will be changing soon. Everyone working at NOMI will have an address utilizing their first and second initial attached in front of their last name. This will be in front of the @nomi.med.navy.mil. For example, my e-mail will change from namioic to flanzalone@nomi.med.navy.mil.

Back to the future, our opportunity to truly effect change in aviation medicine has never been greater. We are aggressively reviewing all waivers to see if we can do without them or at least bring the requirements up to date and as consistent with our sister services as possible. I challenge each and every one of you to take a critical look at how we address waivers and recommend improvements. The process for submitting waivers has been completely revised to an Aeromedical Summary, and the frequency of submission has also been updated. Specifics on the Aeromedical Summary should have already reached you or will in the very near future. Our involvement with everything from Anthropometrics to PRK to RAM billets to Sustained Operations has presented new challenges and our community has risen to that challenge.

In closing, I am very proud and honored in being your President and will do everything in my power to continue to improve our organization's ability to effect change for the safety of our aviation community. I challenge each and every one of you to become involved in this change and take every opportunity to recruit your peers to join, not only SUSNFS, but also our Flight Surgeon community. Over the next year, I look forward in working with each of you to "Get 'em Up - Keep 'em Up".

CAPT Fanancy L. Anzalone, MC, USN

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From the Secretary

As my term draws to a close, I wish to thank you for the opportunity to serve as your Society's Secretary. Although it involves a lot of hard work, I have to admit that I enjoyed it and feel justifiably proud of the improvements that have been made over the past year.



The membership database has been redesigned and improved. Duplicate entries have been eliminated and much of the inaccurate or incomplete information has been corrected. Included in this newsletter is a Directory of Members and Subscribers, which has not been printed since April 1998. Please send corrections and continue to keep your membership information up-to-date by using the Secretary's e-mail address. Remember that forwarding your newsletter costs the Society additional postage fees.

The Society's web site, www.aerospacemed.org, has been completely redone this year by LT Brian Wells. The membership/order form is available there, as well as pictures of the SUSNFS merchandise. The site has links to a number of valuable flight surgeon resources including the Waiver Guide, the Flight Surgeon

Handbook, and the Mishap Investigation Guide. Numerous aviation, medicine, and military sites are listed on the Links page. Information on the Aerospace Medicine Residency is available on the RAM Page. Something that we hope to have set up soon that I'm very excited about is the ability for the members to order merchandise and pay dues online by credit card. This should make it much easier for you to keep your dues current. Bravo zulu to LT Wells for a fantastic job with the web site.

I'd also like to take this opportunity to thank LCDR Tim Halenkamp for doing a great job this year filling merchandise orders for us. And thank you to my fellow Society officers, especially the Treasurer, LCDR Dave Kleinberg. He has worked extremely hard this year "fixing" the financial database, looking hard at the Society's operating expenses and accounts, and coming up with proposals to improve SUSNFS's financial health. You may notice that he is running for re-election on this year's ballot.

Speaking of the ballot, please find yours attached in this newsletter. Note that you must be a designated flight surgeon, a member of the Aerospace Medical Association (AsMA), and have your SUSNFS dues paid at least through May 2000 in order to be eligible to vote. Unfortunately, the newsletter is going to print late and you may have little or no time to send in your ballot prior

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An F/A-18F Super Hornet Takes a Trap (US Navy Photo)

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to the AsMA conference starting 14 May. If you prefer, I will accept e-mail votes sent to gibson@nomi.med.navy.mil if you clearly identify yourself by name and rank. All votes are subject to verification of your membership status/eligibility. New officers will be announced at the AsMA conference in Houston, Texas. The Annual Business Meeting is planned for 1600 on Sunday, 14 May. Note this is a half-hour earlier than in years past.

Dues are payable in May. If your dues expire this year (see your mailing label), please send them in **along with a completely filled-in renewal form**. We still have incomplete information on many members and subscribers. A proposal to increase dues appears on this year's ballot. Our Treasurer's analysis has revealed that dues payments currently do not cover the Society's operating expenses, or even the cost of the newsletter alone. We have been relying on merchandise sales to cover the shortfalls – not a very sound business practice. Please consider the proposal carefully.

Switching to my Associate Editor's hat, I will say that I have also very much enjoyed editing the SUSNFS Newsletter. I feel that I have been able to make a number of improvements and increase the consistency of the newsletter's format, but what I have really tried to work hard at is to make it useful to our members. Editing and appearance are important, yes, but I have discovered that the best improvements are made by actively soliciting and finding quality material to include. A thank you also goes to LCDR Dave Weber for his help with this newsletter. He will be taking over as Associate Editor, but I expect to have a hand in the July newsletter. Knowing Dave, the newsletter will continue to solidify its position as the source for dissemination of the latest developments in aerospace medicine for Naval Flight Surgeons.

Thank you again for a rewarding term as Secretary and Associate Editor for the Society of U.S. Naval Flight Surgeons.

LCDR Dave Gibson, MC, USNR

Resident in Aerospace Medicine (Class of 2000)

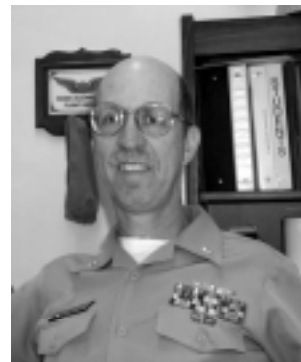
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From the Treasurer

Another year has passed and I am pleased to inform you that we have had a pretty good one. Sales have been steady and the Society continues to move forward toward becoming a credit card business. We still have to get the web page engineered so that we can do business from there. We have tried to reduce our inventory to the items which seem to generate the greatest interest. The result has been that we still have everything we started with including some sweat clothes with NAOMI logos. You may have noted some sale prices in the last newsletter. These will continue until the items have all been sold... so get them while they are hot!



Your Society appreciates your support and we want to encourage you to continue purchasing our wares. As you probably know, by the time you read this, the AsMA conference will be right around the corner. We hope to have a good turnout for this year's conference. We have had at least one award given to the AVT of the year, HM2 (AW) Matthew R. Allen. This is one of the ways you as flight surgeons show your appreciation for the folks that support you. Your nominations are key to the recognition of their outstanding efforts and achievement. We have several endowed awards each year, but the nominations come from you. Don't forget your staff when it comes time for awards.

I wouldn't be the Treasurer without mentioning dues, so here's the pitch. Dues are one of the ways we keep the Society in business. We have had numerous calls regarding the newsletter and find that many have let their dues lapse. While we would like to continue sending the newsletter to everyone, it has become difficult to do so for two reasons. The first and most distressing reason is that we get SO MANY newsletters back because of incorrect addresses. This is such an easy fix. Just send us one of your change-of-address cards when you move. Or better yet, send us an e-mail when you get your new home/duty station address. Each returned newsletter costs an additional \$.50, so you can imagine

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Specialty Leader (MED-23)

MED-02 Update. CAPT Steve Hart, MC, USN has assumed MED-02 duties and has “hit the deck running.” Although the learning curve is “steep” right now, CAPT Hart has taken the Operational Medicine and Fleet Support helm like a “duck in water.” Our new Deputy Director (MED-23B), CAPT John Jemionek, MSC, USN, has taken duties over from CAPT Gary Breeden, and Executive Assistant (MED-02A), LCDR Stan Cope, MSC, USN, relieved CDR Jennifer Town, NC, USN, who has transferred to NMC Portsmouth. We miss the collective wisdom and expertise of RADM Engel, CAPT Breeden, and CDR Town, and wish them well in their new positions, and we welcome the enthusiasm and dedication already demonstrated by their relief.

Aerospace Medicine Strategic Plan Updates Session at the 40th Navy Occupational Health and Preventive Medicine (NEHC) Workshop and 2nd Annual Combined Operational and Aeromedical Problems Course – a Great Success. MED-23 (yours truly), MED-231 (CAPT Matthews), and the NOMI Commanding Officer (CAPT Fahey) reported the current status on numerous BUMED and NOMI level issues. Among these issues were NOMI’s overarching structure and function for all operational medical training, BUMED’s GMO/Flight Surgeon specialization plan, the corneal refractive surgery program, the Navy’s PRT Ship Shape program, the TMIP-Maritime development and implementation plan, the recently BUMED approved Performance Maintenance Manual for continuous flight operations, future CVNX medical department configuration, professional leadership development, and Navy Medicine’s MTF patient safety program.

Thirteen other Aerospace Medicine leaders shared what their working groups have done toward specifically defined objectives. In the area of “Force Health Protection,” objectives updates included medical readiness (CAPT Ferrara), aviation safety (CAPT Fraser), operational risk management (CDR Bellenkes), medical surveillance and non-battle disease and illness reporting (CAPT Fulton), research and development (CAPT Hain), non-medical personnel self and buddy aid training (CAPT Callan), and standardized mass

casualty training on larger deck ships and telemedicine (CAPT Bailey). In the area of “People” objectives, updates included the dual designation program (CAPT Hiland), BUMED’s GMO/Flight Surgeon specialization initiative (CAPT DeVoll), and recruitment and retention (CDR Puckett). Under the area of “Health Benefit,” although not present at the meeting, CAPT Bohnker sent information concerning plans to increase Flight Surgeon and Aerospace Medicine Specialist TRICARE knowledge and skills, and plans to facilitate aeromedical physicians becoming effective Primary Care Managers (PCMs). CDR Beane updated everyone on progress toward Navy Medicine’s capture of Flight Surgeons’ and Aerospace Medicine Specialists’ work in the non-clinical setting. We do much that is not captured in Navy Medicine’s ADS or MEPRS databases.

Finally, in the area of “Best Practices,” CAPT Anzalone reported progress with identifying, acquiring, and integrating technologies that have the greatest benefit to train aerospace medicine health care personnel. A number of distance learning initiatives are in progress at NOMI. For more PowerPoint bulletized details on all these presentations, go to <http://bumed.med.navy.mil/MED23> and click on Strategic Plan/NEHC AM Strategic Updates.pps.

Mark your calendars now! Because of the success of the NEHC Workshop session, another Aerospace Medicine Strategic Plan session is scheduled for all day Saturday, 13 May 2000 at the AsMA Scientific Meeting in Houston at the Westin Galleria Hotel. We have scheduled a full day of information exchange, objectives updates, and identification of additional objectives and action officers. Unlike the NEHC session, this will be a working meeting with some “breaks-outs” intermingled with reports and updates. Meetings begin at 0800 and end at 1600. A more detailed schedule will be distributed to the Aerospace Medicine leadership and will be available at <http://bumed.med.navy.mil/MED23>. CAPT Matthews and I will be working out the details of the meeting. Anyone interested in assisting with the meeting arrangements, being a moderator for break-out sessions, or being an action officer or subject matter expert on specific objectives, please let me know. There is still much to do and plenty of opportunity. Our strategic plan will always be “a work in progress.”

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CAPT Donald C. Arthur, MC, USN, Chief of the Medical Corps, Addresses Medical Corps at NEHC Workshop. CAPT Arthur took time from his busy schedule in Washington, DC to drive to Norfolk specifically to address our group on a number of Navy Medicine issues. One issue was DOD(HA) TMA and Navy Medicine's efforts to "optimize" the Medical Healthcare System (MHS). PCM-by-Name is one aspect of this optimization plan with which Flight Surgeons and Aerospace Medicine Specialists will most likely be involved. CAPT Arthur has strong Operational Medicine credentials and experience. He understands the unique operational requirements medical providers must meet to support the fleet. He also understands the difficulty aerospace medicine will have in becoming a full participant in the optimization PCM-by-Name plan. Our strategic objectives are in place for us to seriously and conscientiously address our role in this area. Plans are to work diligently with Navy Medicine to realize optimal health care for all our beneficiaries.

Current Milestones/Issues:

MED-23

- RAM Recruitment: This summer we begin a heightened effort at recruiting Residents in Aerospace Medicine (RAMs), with special focus on end of first tour and second tour Naval Flight Surgeons. Previously, we have recruited RAMs by approaching our more experienced flight surgeons by word of mouth and by soliciting interns through operational medicine seminars during internship training. We have picked up a number of excellent straight-through interns this way. Despite these efforts, however, we are currently having difficulty filling aircraft carrier Senior Medical Officer (SMO) requirements. This problem has become even more acute due to mandated GMO/Flight Surgeon conversion of some flight surgeon billets to specialty billets. We now

have 80 Aerospace Medicine specialty billet requirements compared to 43 previously. Thus, we need to ensure that not only are there sufficient numbers of aviation medicine experienced RAMs graduated to fill critical positions, such as aircraft carrier SMO billets, but also sufficient "baby RAMs" or straight-through interns graduated to fill less critical, but still very important billets that require credentials over and above the general flight surgeon. Straight-through interns completing the RAM program will not be able to go to carrier SMO billets

until after a first utilization tour. During this first tour, they gain much needed aviation medicine experience. Parenthetically, until sufficient numbers of flight surgery experienced residents are graduated to fill the carrier SMO billets, previous carrier SMOs may be looking at a second or third tour at the deckplate. (Please don't throw me into the briar patch, right?!) We all need to be solicitous and encourage our end of first tour flight surgeons to seriously consider and apply to the RAM program.

- Photorefractive Keratectomy (PRK): The Corneal Surgery Physical Standards and Waiver Policy, published in BUMED

Message 291330Z SEP 99, will most likely be relaxed even further in the near future. By the time you receive this newsletter, changes may have already been promulgated. Go to http://navymedicine.med.navy.mil/refractive_questions.htm for updates as they occur.

- Manual of the Medical Department (MANMED) (NAVMEDP-117): The Virtual Naval Hospital web page at <http://www.vnh.org/Admin/MMD/10MedExam/65Aviation.html> has now been updated with the new version of Chapter 15-65, Aviation Physical Standards.
- Performance Maintenance During Continuous Flight Operations – A Guide for Flight Surgeons: The guide has been briefed at OPNAV, RADM Mark Gemmill, at the CAGWARCOM conference in Norfolk, Virginia, and at the Air Board, 9 March at NAS



F-14 Tomcat Instrument Cluster (US Navy Photo)

Oceana. The CNO will consider the guide for use in the fleet as a tool that may be used by squadron Commanding Officers to maintain performance in continuous flight operations. Although a number of questions still need to be addressed through research, the line has been very receptive and positive toward use of the tool now. POC: CDR Kris Belland, MC, USN, Naval Strike Air Warfare Center (NSAWC), Fallon, Nevada, (775) 426-5210 /3910, bellandk@ftr.navy.mil.

MED-231/02T (Aviation Physiology) – CAPT Robert A. Matthews, MSC, USN, (202) 762-3457.

- MANMED Chapters 14-12 through 14-16 have been submitted to BUMED-914 (Directives) for revision.
- Water Survival Training Facility MILCONs: OPNAV support for Pax River underwater egress trainer secured. Final design meeting to coordinate 'user/designer' issue completed. Expect groundbreaking late 2000.
- Centrifuge-Base Flight Environment Trainer electrical/structural issues are being addressed while Aviation Survival Training Center Lemoore staff work to maintain basic training capabilities to meet Fleet training requirements.

MED-233 (Enlisted Aeromedical Programs Manager) – HM1 (FMF) Thomas S. Schaefer, USN, (202) 762-3450.

- The FY 2000 FAILSAFE Conference was conducted at NAS North Island on 7-11 February. Congratulations to the following personnel for awards received:
 - PR1 (AW) Seal: Bob Graham Enlisted Award
 - CDR Jim Norton: Special Award in Naval Aerospace Physiology
 - LCDR Mike Venable: Naval Aerospace Physiologist of the Year
 - Mr. Jim Lewis: Naval Aerospace Physiology Civilian Award
- Search and Rescue Medical Technicians (HM NEC 8401): Search and Rescue Medical Technicians are currently an OJT awardable NEC. This is the only HM NEC without a designated "C" school. Suggestions have been made to combine the HM

NECs 8401 and 8409 (Aerospace Physiology Technician). This plan would be detrimental to these communities. MED-233's current recommendations to MED-00HC are to develop a CNO approved training pipeline for Search and Rescue Medical Technicians to include placing an NEC awardable "C" school at NOMI. This would return a well-trained extremely valuable asset to the Fleet.

- Aerospace Physiology Technician (HM NEC 8409): Current manning levels for Aerospace Physiology Technicians are at 85.5% and declining due to recent commissioning and drop in retention of enlisted personnel. Some Aviation Survival Training Centers (ASTCs) are approaching critical manning levels. To overcome the problem I have requested an increase of "C" school seats and tasked LCPOs of the ASTCs to recruit personnel from local MTFs and local Fleet assets. Anyone interested in becoming an Aerospace Physiology Technician should contact the Enlisted Technical Leader, HMC Roach at DSN 267-6185.

On Leadership III. "Onward and upward" with leadership... In my last article we presented leadership philosophy as a basic premise to development of High Performance Organizations (HPOs), a goal I think we all agree is one worthy of our efforts. We concluded that participatory leadership is the optimal philosophy for an HPO. If your organization has the "right stuff," i.e. the optimal philosophy, how should it go about its "business" to achieve true HPO status? This "business" is what we call the "work of leadership." In this issue, I would like to spend a few minutes talking about the "work of leadership," especially in the context of an HPO. There are five major areas constituting the work of leadership: 1) strategically identifying and analyzing customer value; 2) connecting vision/values with strategy, structure, and systems; 3) integrating suprasystems and in-culturing stewardship; 4) continuously learning, thinking, changing, and renewing; and 5) continuously enabling, empowering, and energizing. Sounds formidable? Yes, but do-able and the goal is worthy.

Just as the successful NIKE corporation must identify who its internal and external customers are, any successful HPO must identify and analyze customer value. Who are its customers? Who should they be?

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What are their demographics? What do they like? What do they value? What do they need, but don't necessarily know they need, now and in the future? What does the "food chain" of customers look like? What is the broader market or environment like with the same customers? What are the political issues? HPO leadership will address each of these areas in detail and will integrate the data appropriately into its business plan.

Secondly, HPO leadership must connect its vision and values to its strategy, structure, and systems to produce "performance." The work here includes asking and answering a number of questions. What does "high performance" mean for us? What higher moral purpose are we trying to serve? And what values will guide us in achieving it? Answering these questions should lead to shared vision/values being formulated, articulated, and "lived out." Certainly we can all identify here with Navy's vision and core values of Honor, Courage, and Commitment. Whatever we do at "our" level, i.e. aerospace medicine, should "nest" within Navy Medicine, just as Navy Medicine's vision/values should "nest" within Navy and Marine Corps vision/values. This "connecting" should lead to strategic thinking, resulting in a strategic plan that in turn leads to a "tactical" operational plan that connects resources, goals, and objectives, with monitoring and correction as appropriate, which all translate into "performance." Our aerospace medicine community has done much of the work of leadership in this area, as seen in our strategic plan and tactical operating objectives as recently reported in the updates session at NEHC. But we still have much work and "fine tuning" to do. As previously stated, this will always be "a work in progress."

Third, the work of leadership many times involves taking the parts of the organization and putting them back together in such a way as to accomplish the vision and mission. This requires establishing mechanisms that align the parts to form an integrated whole. A key component in this work requires "stewardship" from each participant. Everyone must rise above "turf" to serve and be responsible for the larger whole, to link with others to address cross-organizational issues to achieve the vision/goals/strategic and tactical objectives. The conceptualization, formation, and implementation of NOMI is a prime example of this kind of leadership work.

Fourth, HPO leadership must stay on the "cutting edge" both individually and as an organization. It must constantly be in a learning, thinking, changing, and renewing mode. This work is creative and best accomplished through benchmarking, best business practices analysis, re-engineering, and continuous improvement analysis. I can cite a few obvious examples here for our aerospace medicine community. Some of these include working to realize NOMI, working Flight Surgeon re-engineering, working GMO/Flight Surgeon specialty conversion, and our future commitment to Navy Medicine's and DOD HA's MHS Optimization Plan. There are many more. Our community is vibrant and continuously looking for improvement at the leading edge – we need to stay that way.

Finally, and as important as any of the other four areas described above, HPO leaders must enable, empower, and energize the HPO's members, whether individuals or subordinate organizations. Leaders must be proactive. They must remove barriers to empowerment. They must diplomatically, but firmly be "bureaucracy busting." They must provide the knowledge, skills, and information required to make good decisions. They should be teachers, mentors, motivators, and facilitators.

In summary, to date we have talked about the general concept of High Performance Organizations (HPOs), the ideal HPO leadership philosophy, and, in this issue, the functions or "work" of HPO leadership. In the next issue we will turn to "the form" of leadership. So stay tuned...

Godspeed!

CAPT C.O. Barker, MC, USN

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Naval Safety Center

Best Flight Surgeon Practices

As the Assistant Naval Safety Center Surgeon, I'm fortunate to have the chance to help evaluate the safety programs of many of our fleet squadrons. I'd like to share some of the innovative and proactive practices that I have observed over this past year.

We all know that at least 80% of our mishaps are caused, at least in part, by human factors. In order to prevent these kinds of mishaps, most of our squadrons are doing monthly (USMC) or quarterly (USN) human factor reviews of their aircrew. In the past several years, we've had several mishaps in which lives and aircraft were lost due to maintenance malpractice. Some of our more progressive flight surgeons feel that human-factors councils don't address this risk. Therefore, they have included their maintenance personnel into human factors reviews. The squadron Safety Officers and Flight Surgeons report that this only adds approximately five to ten minutes to the review process. They ask the NCOICs of each maintenance shop to attend the meeting and to review a list of all their personnel. They discuss only those personnel for whom they have special concern about their personal lives, current work performance or behavioral patterns. Just as with our aircrew, identified personnel with problems are removed from their maintenance duties and given the time and support they need to resolve their difficulties prior to returning to their "wrench turning duties." It seems to be a trivial investment of time and energy to prevent a catastrophic mishap, doesn't it?

The **#1 killer** of our enlisted Navy and Marine Corps personnel is traffic accidents. Most of these occur at night and on weekends. The major contributing factor used to be alcohol, but we seem to have made progress educating our personnel about the dangers of drinking and driving. Currently the biggest offender is fatigue. Recently, a young E-4 had a three-day weekend and decided to drive 600 miles home to see his family and then return in time for work Monday morning. This unfortunate trip ended 12 miles short of his home base during the early morning. We have all read messages involving the tragic endings to several of these trips. Our flight surgeons should put as much effort into protecting

their enlisted maintainers as they do their aircrew. For example, some squadrons are having NCOICs review a required "driving plan", which is submitted with leave/liberty chits. Many also do a cursory vehicle inspection to ensure there are no gross irregularities (e.g. bald tires, etc.). At a minimum, this increased attention should heighten the awareness of our sailors. As we know, sometimes this is the only "preventive medicine" that is needed. Based on the body count, there is no area more in need of preventive medicine among our at-risk personnel than traffic safety.

Many of our flight surgeons are responsible for administering to many squadrons – a monumental task. Some of our more industrious members have found a way to increase their "presence" in their many squadrons by increasing their written communications within the squadron. These flight surgeons are contributing regularly via a variety of different mechanisms. I have seen creative use of regular submissions to the Plan of the Week (or Month), aeromedical/safety bulletin boards, quarterly squadron aeromedical publications and also the use of intranet postings. Even if the doctor can't make it to the squadron spaces as frequently as he/she would like, they are still "seen" in the squadron spaces as playing an active role in the safety program.

Clinics might consider sharing the load by assigning a month to each flight surgeon. For example, in December Dr. Totz might write a few paragraphs explaining the TRICARE system, and the following month Dr. Godinez shares information on cold weather preventive medicine, and the following month Dr. Williams writes about... you get the picture. Each flight surgeon in the clinic can then send this information to their individual squadrons with their signature at the bottom.

There are many proactive preventive medicine practices that can be easily implemented by our squadron safety/aeromedical departments if we'll overcome the inertia to get them started. I would welcome innovative flight surgeons sharing your "best practices" with the Naval Safety Center at gtanner@safetycenter.navy.mil so that we can in turn share them with the fleet during our surveys.

CDR Gary Tanner, MC, USN
gtanner@safetycenter.navy.mil

Operational Risk Management in Aviation Medicine

“By its nature, the uncertainty of war invariably involves the acceptance of risk... Because risk is often related to gain, leaders weigh risks against the benefits to be gained from an operation.” (*NDP-1: Naval Warfare*).

“We rely on the judgment of individual Commanders to balance the requirements of mission success with the inherent risks of military action. Naval leaders have always practiced risk management in their operational decision making. However, the approach to risk, and degree of success in dealing with it, has varied widely depending on the leader and his/her level of training and experience. The principles of Operational Risk Management can be taught and effectively applied throughout the Navy and Marine Corps to enhance the decision making capabilities of our personnel.” (*OPNAVINST 3500.39: Introduction to Operational Risk Management*). (Editor’s Note – OPNAVINST 3500.39 is available online at http://neds.nebt.daps.mil/Directives/3500_39.pdf).

Problems with the human link in the operational chain may present the greatest risk or set of risks to mission readiness. Operational Risk Management (hereafter, ORM) has quickly become recognized throughout the Department of Defense (DOD) as one of the best means to minimize these risks. Indeed, as noted above, ORM is now an integral part of our warfighting doctrine; it’s a way of doing business such that, in this time of limited manpower and resources, we do everything we can to minimize losses. ORM is one very potent way of making this happen.

To date, the principles and processes of ORM have been applied mostly to Line operations. Now, however, it becomes increasingly clear that our Navy/Marine Corps aeromedical personnel require this training as well. Whether it be on the flightline, in the cockpit, or in the clinic, our Flight Surgeons, Aerospace Physiologists, and Aerospace Experimental Psychologists are often faced with questions involving risk and mission readiness: Are squadron personnel physically and emotionally fit to carry out their missions? Are certain medical procedures

carried out in such a way as to incur unnecessary risk to our patients or us? Does the use of certain pieces of protective gear decrease or increase the chance of an aircrew’s survival? Is the design of a piece of cockpit instrument panel avionics facilitating or preventing a pilot from obtaining critical target information? All of these are potential life-and-death questions which are addressed daily by our aeromedical personnel. In general, ORM forces us to ask a critical question, “Are we making decisions in such a manner so as to maximize readiness whilst minimizing unnecessary risk to our aircrews, our support personnel, and our patients?” It also provides us with a means to answer that question. How?

First and foremost, ORM is a decision-making tool that can be used by personnel at all levels to increase operational effectiveness. The use of the ORM process increases the ability to make informed decisions by providing the best baseline of knowledge and experience available. ORM also minimizes risks to acceptable levels by systematically applying controls to each risk that is not acceptable. The amount of risk we will take in war is much greater than that we should be willing to take in peace, but the same systematic process should be used to evaluate risks in both situations. To date, there have been many examples documenting the outstanding success of ORM. It is a proven quantity. Thus, it becomes even more paramount that all aeromedical and safety personnel become ORM specialists. Let me next propose a way to do just that.

At the Aeromedical Strategic Plans meeting held recently here in Norfolk, I briefly outlined draft plans for ensuring that 100% of our Navy aeromedical personnel will be ORM trained by the year 2002. There are two approaches that have been proposed to meet this goal; each based on the depth of training required for specific groups of aeromedical personnel. In the first approach, mid-level (Wing-level and above) and senior Flight Surgeons, Aerospace Physiologists, and Aerospace Experimental Psychologists would be provided with the in-depth ORM course offered by the CNO’s ORM specialist (N09K). In the second approach, our more junior (squadron-level) personnel would participate in the half-day introductory course provided by the Naval Safety Center. It is a splendid introduction to ORM and will provide a basis for further in-depth instruction at a later date.

“...100% of our Navy aeromedical personnel will be ORM trained by the year 2002.”

In-depth ORM Instruction: The CNO (N09K) has developed an ORM course that focuses on application and integration rather than purely academic instruction. The course is taught by the Transportation Safety Institute (TSI), an organization within the Department of Transportation. TSI has leveraged its experience in teaching risk management to USAF, USA, DOT, and private industry by developing a practical application course. N09K has contracted this special team to instruct our Navy/Marine Corps personnel in ORM.

In-depth ORM is an excellent two-day course that the TSI team takes on the road upon request to various major facilities. At the end of the course, attendees are regarded as ORM subject matter experts (SMEs), who, with the appropriate materials, can then implement this process in their own commands. N09K funds the course; those requesting it need only supply the facility, support gear, and the students.

Course attendees will receive comprehensive instruction in the five-step ORM process. By the end of the course, they will be able to:

(1) Identify Hazards – ORM SMEs will be able to outline or chart the major steps in their operational environment; that is, they will be able to perform an operational analysis unique to the missions of their unit or clinic/hospital. Next, the SME will be able to conduct a Preliminary Hazard Analysis by listing all of the hazards associated with each step in the operational analysis along with possible causes for those hazards.

(2) Assess Hazards – For each hazard identified, the SME will be able to determine the associated degree of risk in terms of probability and severity. This is accomplished by the use of one or more analytical ‘tools’, which the SME may elect (or not) to employ. These tools are described in the didactics portion of the course.

(continued on page 12)



This is an actual fly-by of USS Stennis (CVN-74). The pilot was reportedly appropriately admonished. (Source Unknown)



The Associate Editor's first mishap physical as an operational Flight Surgeon... on the LCPL driving this bus, who didn't quite clear the wing of a USAF B-1 Bomber visiting for an air show.

(continued from page 11)

(3) Make Risk Decisions – In addition to identifying risks unique to a particular mission, the SME will also be able to develop risk control options. The SME will start with the most serious risk first and select controls that will reduce the risk to a minimum consistent with mission accomplishment. With selected controls in place, the SME will then be able to decide if the benefit of the operation outweighs the risk. If risk outweighs benefit or if assistance is required to implement controls, the SME will then communicate with higher authority in the chain of command.

(4) Implement Controls – The ORM SME will be able to implement a number of measures designed to eliminate hazards or reduce the degree of risk. These include: (a) Engineering Controls – controls that use engineering

methods to reduce risks by design, material selection or substitution when technically or economically feasible, (b) Administrative Controls – controls that reduce risks through specific administrative actions, and (when appropriate) the use of (c) Personal Protective Equipment (PPE) – which serves as a barrier between personnel and a hazard. It should be used when other controls do not reduce the hazard to an acceptable level. A good recent illustration of this type of control is seen in the full-coverage protective garments worn by surgeons and support personnel when operating on patients having highly infectious diseases.

(5) Supervise – The ORM SME will also be trained on the best ways to conduct follow-up evaluations of the controls to ensure that they remain in place and have the desired effect. The SME will learn to monitor for changes

that may require further Operational Risk Management. If these occur, the SME will be fully able to take corrective action when necessary.

As noted above, the Naval Safety Center (Norfolk) offers a short introductory course in ORM. We turn to that next.

Introduction to ORM: The Naval Safety Center offers a superb half-day training course on the basics of ORM. The course consists of an initial 45 minute brief, providing an overview of ORM basics. Course attendees are then organized into nominal 30 man working groups for a two-hour period of ORM scenario applications. These working groups are facilitated by Safety Center ORM instructors. As noted above, it is a great introduction to the process, and would, I feel, be perfect for our new docs (especially the RAMs), Aerospace Physiologists, and Aerospace Experimental Psychologists. The course is taught at various commands – most commonly at squadron level. This would be a great opportunity for our squadron and clinic docs and other aeromedical personnel working at this level to join their folks at this class. To find out where you might be able to attend this ORM basics course, check the Safety Center's ORM training schedule as outlined in their recent message (262010Z JAN 00). (Editor's Note – for more Navy and Marine Corps ORM information online, including the training schedule, go to <http://safetycenter.navy.mil/orm/>).

If you have any questions or concerns about ORM training for you and your aeromedical team, please contact me here at AIRLANT at the address below.

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1999 AVT of the Year Award

The Society of U.S. Naval Flight Surgeons presented its annual Aerospace Medicine Technician (AVT) of the Year Award for 1999 at the 2nd Annual Combined Operational and Aeromedical Problems Course, held in conjunction with the Navy Environmental Health Center (NEHC) 2000 Workshop, 31 January – 4 February in Norfolk, Virginia.

AVTs in paygrades E-1 to E-6 are eligible for the award, and all commands and units are encouraged to submit a nominee. The award is designed to recognize individuals who have excelled in more demanding assignments, exhibited superior leadership, and displayed exceptional professional growth. The award includes a \$100.00 savings bond, a plaque and a letter from SUSNFS.

HM2 (AW) Matthew R. Allen, USN was selected for this year's award for service as set forth in the following CITATION:

For invaluable service to Naval aviation through outstanding professional performance as an Aerospace Medicine Technician. HM2 Allen is a model corpsman dedicated to the total health of his sailors. His professionalism and leadership with Strike Fighter Squadron 94 contributed greatly to the health and readiness of the squadron and Carrier Air Wing Eleven. Self motivated and exceptionally dedicated with outstanding initiative and superb medical skills. Through his excellent planning skills and creative problem solving Petty Officer Allen has consistently provided his 200 plus personnel squadron with the best medical support possible whether in port or deployed. His willingness to assist shipmates and integrate into the USS Carl Vinson (CVN-70) Medical Department are qualities that made a difference in squadron morale and success. He is motivated to excel as both a corpsman and a sailor and is a vital asset to the squadron's medical department. HM2 Allen's positive attitude, personal initiative, leadership, and selfless devotion to duty are in keeping with the AVT of the Year Award spirit and the highest standards of the Society of U.S. Naval Flight Surgeons.

The Editors

Psychiatry Code 21

Critical Incident Stress Management

I recently attended the PACFLT/MARFORPAC conference in Hawaii. (It was an arduous trip from Pensacola, but someone had to make the sacrifice). A hot topic was Combat Stress Control (CSC). CSC concerns the prevention, recognition, and management of symptoms experienced by Marines and sailors in combat and MOOTW. (MOOTW stands for “Military Operations Other Than War” and includes “peacekeeping” missions). Under certain arduous conditions, some military folks develop “Combat Stress Reactions.” These are emotional, behavioral, and cognitive symptoms that render one unable to perform the mission. These include the familiar symptoms of Acute Stress Disorder and Posttraumatic Stress Disorder (PTSD), as well as other overwhelming anxiety and depressive symptoms. ANYONE can develop combat stress reactions; these are normal symptoms that normal people experience under abnormal circumstances. You will hear more about this topic, because CDR Shirley Ellis, our NOMI Psychologist, is writing a comprehensive “Force Surgeon’s Guide to Combat Stress.” This manual will teach medical personnel about Combat Stress Control and will supplement existing documents for the Marines’ small unit leaders.



(US Navy Photo)

This article will discuss Critical Incident Stress Management (CISM) – tools that medical *and non-medical* personnel use to prevent and manage Combat Stress Reactions. Timely application of CISM techniques keeps Marines and sailors fighting, and helps temporarily overwhelmed operators return to duty. When combatants develop Combat Stress Reactions, it may seem humane to remove them from the theater. Experience indicates, however, that if this occurs, they are at significant risk of developing PTSD and other chronic psychiatric morbidity.

Critical Incident Stress Management includes several interventions. You are probably familiar with Critical Incident Stress Debriefing (CISD). Other techniques include Stress Inoculation (a preventive technique applied before the traumatic event), On Scene Interventions, and Defusing. These interventions are helpful whenever someone experiences a traumatic event – be it combat, an act of terrorism, a “friendly fire” mishap, a natural disaster, or a shipmate’s suicide. Other traumatic events might include physical injury, rape, a mugging, or a serious car crash. (One article concluded that as many as 30% of victims of severe motor vehicle accidents develop PTSD). If you participate in “peacekeeping” missions, your risk of developing PTSD is only slightly less than if you are in combat.

In a traumatic event, three types of potential victims may experience difficulties and may benefit from CISM. Primary victims experience the actual traumatic event. Secondary victims include emergency response personnel who treat the primary victims and bystanders. Tertiary victims are not directly exposed to the trauma, and include family members of primary victims and investigators who visit the scene after the traumatic event occurred.

The first CISM technique that we will discuss is **On Scene Intervention**. During an ongoing traumatic event, such as a mass casualty situation, emergency response personnel should be encouraged to take breaks to eat, nap, exercise, and discuss the disturbing situation. They should also receive reassurance that their feelings and thoughts are normal, that they will cope with the current crisis, and that they will function normally in the future.



(US Navy Photo)

A second technique is **Critical Incident Stress Debriefing (CISD)**. This is a formal group discussion that lasts from one to three hours and should occur within 72 hours after the crisis ended. At least two trained facilitators lead the intervention for groups of no more than 30 members. In the military, the Commanding Officer must grant permission for his or her personnel to participate in a CISD. These are the nine phases of a Critical Incident Stress Debrief:

- 1) Preparation Phase: The group facilitators gather information about the traumatic incident to minimize their shock and to identify group members at risk for stress reactions. A soundproof room is secured for the CISD and the chairs are arranged in a circle.
- 2) Introduction Phase: The group leaders assemble the participants and explain that the purpose of the meeting is to encourage discussion about the traumatic event to facilitate recovery and resumption of normal functioning. The leaders should stress absolute confidentiality and that they will NOT be members of the mishap or JAG investigation.
- 3) Fact Phase: When asked, each group member states his or her name, job, and version of the event.
- 4) Thought Phase: The group leader asks each person about his or her first thought after the crisis occurred.
- 5) Reaction Phase: This is the critical phase of the debriefing, because group members are encouraged to discuss their feelings about the disturbing event. Some members will experience and express strong emotions, including anger, sadness, and remorse.
- 6) Symptom Phase: This phase allows participants to begin to compose themselves following the reaction phase. Members should mention symptoms experienced following the critical incident. The group leaders should reassure the participants that these symptoms are normal reactions, and that they will feel better.
- 7) Teaching Phase: This phase continues the process of "normalizing" participants' symptoms. The group leaders should discuss the grief process, symptoms of severe stress reactions (like PTSD), and basic stress coping skills.
- 8) Reentry Phase: The group leaders should ask if anyone has additional concerns. They may mention difficult issues that were not discussed, such as anger at those deemed responsible for the critical incident. The leaders should also reemphasize that the participants are experiencing normal symptoms and that they will be able to cope. Handouts are provided on stress management and about how group members may seek additional assistance. (For example, the names and phone numbers of the Flight Surgeon, Chaplain, and the Family Service Center counselors are distributed).
- 9) Post CISD Processing Phase: Following the CISD, the group leaders should offer a snack to the participants, and mingle to identify those who appear most distressed and might benefit from additional counseling. Afterwards, the leaders should meet to discuss the CISD process.

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Defusing is the last CISM technique that we will discuss. This is an abbreviated version of the CISD and is suitable for larger groups of personnel exposed to a disturbing event. The Defusing typically lasts between 30 and 60 minutes and occurs within eight hours of the incident. It involves more teaching by the group leaders and less discussion by the participants. The facilitators should provide information about the critical incident, reassurance that symptoms are normal and will diminish, and information about stress coping techniques.

Imagine that two of your pilots are killed in a midair collision. You feel that a Critical Incident Stress Debriefing would be helpful. How do you arrange this?

First, you must convince your Commanding Officer that the intervention will assist your squadron members' grief process, provide coping tools, prevent long-term emotional difficulties, and result in faster return to "business as usual." Then, contact your squadron Chaplain, the local mental health department, or the Family Service Center to request a debrief. If the local folks are unable to help, request assistance from one of the Navy's SPRINT teams. (SPRINT stands for Special Psychiatric Rapid Intervention Team). Any Navy psychiatrist or psychologist should be able to assist you in contacting a SPRINT team.

I hope that you never experience any of the catastrophic events mentioned above. If, however, a tragedy occurs, you will be able to arrange an appropriate intervention to assist your squadron members with their grieving and recovery.

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Operational Medical Ethics

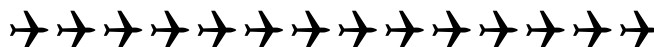
This is really a follow-on from the last issue (discussing the courage to "do the right thing"). In medical ethics jargon, this falls under what we call **BENEFICENCE** (you may be more familiar with the term, non-maleficence – do no harm).

You can read in any current medical journal about the many ethical issues that confront physicians today under the specter of managed care. They range from unwittingly signing a contract which includes a "gag clause," meaning that you are forbidden from telling your patients about care not offered by the health plan, to choosing to lie about your patients' diagnoses to ensure they can get the care you believe they need. Both of these examples are unethical (and illegal). Part of informed consent is *always* telling your patients about alternative choices, even if they pay out of pocket. You *never* lie about a diagnosis; you help the patient appeal – very loudly if need be.

Our military physicians are somewhat protected from these managed care pressures. YOU, however, our front line docs, face *daily* ethical dilemmas that make the above examples pale by comparison. It is important that you realize some of these hurdles; and initiate a thought process about how you will address them *before* confronted with these issues in real-time. To illustrate one example:

The "Down" Chit:

As you all know, when someone (anyone!) on flight status has the presence of any condition or symptoms that can negatively affect flight safety, they are to be grounded by the flight surgeon. It has come to light that there are some flight surgeons (a minority hopefully!), who are proponents of some alternative methods of "grounding" the aviator.

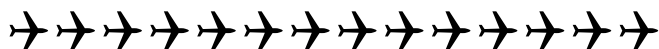


Pick the best answer:

Which of the following are considered appropriate ways of grounding aviation personnel?

- A. Tell the aviator to not fly for several days
- B. Give the aviator a "down" chit
- C. Tell the "Ops O" to "keep Cougar down for a couple days"
- D. All of the above
- E. None of the above

Do you remember what they taught you at Stanley Kaplan's course before you took your MCATs? Or any board review course? If you don't know, guess "B" – it is correct 40% of the time... True then; true now. Unfortunately several flight surgeons think "D" is correct.



Each answer explained:

B: The only correct way is to follow the guidance IAW MANMED Article 15-65 and OPNAV 3710.7R. Department of the Navy Manual of the Medical Department *clearly* states in Article 15-65 3.b:

"The Aeromedical Grounding Notice (NAVMED 6410/1) is the means to communicate recommendations for fitness to fly to the aviation unit's Commanding Officer. All aviation personnel admitted to the sick list, hospitalized, **or determined to have a medical problem that could impair duties involving flight performance** shall be issued an Aeromedical Grounding Notice. This grounding notice shall remain in effect until the member has been examined by a flight surgeon and issued an Aeromedical Clearance Notice."

The above is clearly reiterated in OPNAVINST 3710.7R in section 8.3.2.6:

"Acute minor illnesses such as upper respiratory infections, vomiting, or diarrhea can produce serious impairment of flight personnel. All illnesses shall be evaluated by competent medical authority. Recommendations for grounding shall be accomplished by the submission of a grounding notice."

This is pretty straightforward from my take, and does *not* give the flight surgeon discretion to follow answer "A" or "C." Unless the aviator is fit to fly, they should receive a down chit. Period.

A: Why not just tell the aviator not to fly for a couple of days...? In case you need something other than written policy to make your decision, read on:

Is it the aviator's responsibility to not fly or is it yours to ground them? Take the following scenario: It's Wednesday. Cougar (LTJG) comes in to ask for some decongestant 'cause he can't clear his ears due to a URI. He has a cross country in two days. He's right, ETD AU. What do you do? Say, "Hey Coug – you're right – you need to be down for a couple days 'til we can get you cleared. Hopefully 48 hours will do it but can't guarantee miracles. Here's a quickie down chit – stop in tomorrow afternoon and we'll check again."

Or you can say, "Hey Coug – you're right – you need to be down 'til you can clear – I won't give you a down chit ('cause I'm such a nice guy and don't want you to be upset with me), but stay off the schedule." What's wrong with that? Cougar goes back to the squadron and at 1530 is told to gear up to do a check ride. The Ops O, Thrasher (O-4) tells him he's the only one who can take the bird up and it has to be done. As Thrasher glares at Cougar, he says, "Any problem with that?" At that point, Cougar either says nothing and thinks (rationalizes), if doc really thought there was something wrong, he would've given me a down chit... Or, he could tell Thrasher, "Doc told me not to fly for a couple days." What does Thrasher do? "Yeah? I didn't see any down chit!"

If the flight is uneventful, no problem – other than you just got lucky. If, on the other hand, doing spins at 10,000 feet, Cougar gets an ear block, loses situational awareness, and takes a dive... Gee, how will that mishap investigation read? How will you feel? Do you feel lucky?

C: Great, stop by and tell the Ops O to not fly Cougar for several days. Of course, when you discuss the medical condition with the Ops O you are in essence violating confidentiality. What happens if the Skipper tells the Ops O to fly him? (See the answers above). What if the Ops O has to take emergency leave and someone else puts Cougar on the schedule? Of course Cougar will think – "I guess it must be OK if they're flying me..."

Policies and procedures are in place for a very good reason. To save lives and aircraft, and accomplish the mission. You are not given the discretion to violate policy.

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Where you have some discretion is in exactly how you execute policy. The aviator needs to know that when you evaluate them, what they see is what they get.

There are similarities between being a good leader, a good parent, and an effective flight surgeon. It really is a simple formula:

1. Let the troops/kids/aviators know *exactly* what their rights and responsibilities are.
2. Ensure that they understand them.
3. Walk the talk.
4. BE CONSISTENT.
5. Use common sense.
6. Manage by walking around (i.e. don't sit in your office).
7. Hold them accountable.
8. Set the goal of being respected rather than being liked – trust and confidence come from respect, not bonhomie.

Just like kids don't do well when they have parents who are inconsistent and trying too hard to be a friend instead of a parent, troops don't respect "nice guy" leaders who waffle when they have to make a tough choice, and aviators do not respect a flight surgeon who tries to be a "buddy" – particularly if it risks their lives.

There are many reasons why it's tough to confront many aviators with the fact that you are grounding them. In reality, anyone who comes to the flight surgeon knows that they may be grounded. The problem comes if you are inconsistent: ground some formally and not others. That gets around and then someone comes to you, gets a down chit, and they express a bit of "healthy" narcissistic outrage and indignation. Don't get caught up in it.

As we said last month, do the right thing.

Now, some thoughts on *how* to ground someone when you don't want to destroy their trust. It isn't too hard when you have a nice neat little manly diagnosis like "nephrolithiasis" (that's the kind of thing that sounds good to aviators – they even take a bit of perverse pride in it). The opposite effect would occur if you put: "depression," "anxiety," "marital problem," "unresolved grief," or the like. What they (and others) would read

on the chit would be "wimp," "wuss," or "whiner." Once that gets around, NO ONE will come to you – ever. Most of you are good at using good judgement when it is a case of someone needing a couple days to get back on track when experiencing minor psychological symptoms. Most folks who have a variety of psych symptoms (with or without significant underlying conditions) have accompanying physiologic findings (that of course are documented on your SF 600). "Dehydration" may be present, "benign physiologic tachycardia" is always a favorite, "mild gastroenteritis" symptoms may accompany the other stuff, etc. This way, you can do the right thing without alienating those entrusted to your care.

P.S. – guess what? Absolutely no information on alcohol this SUSNFS newsletter! Phew! Take a breather!

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(US Navy Photo)

PRK in Naval Aviation

Aviator Retention and Accession Studies

In the last issue of the SUSNFS Newsletter (January 2000), an article discussing the Naval Aviator Retention and Accession studies was written by CDR Mitch Brown. A message announcing the Retention study and providing instructions for enrollment is undergoing final review, but has not yet been released as of the time of publication of this newsletter. The Accession study is still in the planning and coordination phase and may begin around late Summer or early Fall of this year. At present, there is no formal process for applying to the Accession study.

Two items are being included with this article. The first is a Flight Surgeon Refractive Surgery Gouge sheet, developed by CDR Bill Busch at NOMI Ophthalmology Code 23. The second is the Naval Aviation Refractive Surgery Consult Form, to be used by applicants to the Retention study, printed with the permission of CDR Brown. It may be available in the near future on the NOMI Ophthalmology web site (<http://www.nomi.navy.mil/code02/23page.htm>) and/or BUMED's Corrective Eye Surgery Questions and Answers web site (http://navymedicine.med.navy.mil/PRK/refractive_surgery_information.htm).

The Editors

FLIGHT SURGEON REFRACTIVE SURGERY GOUGE (Current as of 20 April 2000)

PRK AVIATOR RETENTION STUDY ENROLLMENT PROCESS	
1.	Pt. gets Aviation PRK Consult/Application Form from FS/MTF/Eye Clinic/Web
2.	Pt. fills out personal data and gets CO approval in writing on Aviation PRK Con/App Form
3.	Pt. and/or Flight Surgeon calls local Eye Clinic to schedule PRK work-up
4.	Pt. undergoes special PRK eye exam at local Eye Clinic/MTF by designated doctor
5.	Completed Aviation PRK Consult/App — faxed to NMCS D study coordinator Eye Clinic
6.	NMCS D processing — if selected pt. scheduled at closest treating facility — 1 to 3 months prior notice
7.	Med record, original paperwork — go with patient to treating facility
8.	Pt. goes TAD funded/permissive for \pm 1 week
9.	TAD: Day 1-travel, 2-eval, 3-paperwk, 4-treatment, 5-postop, 6-postop, 7-postop/travel
10.	Pt. back to FS and Eye Doctor to check-in for postop follow-up: 2 week and months 1, 2, 3, 6, 12
11.	FS make sure that pt. complies with all f/u protocols
12.	FS make sure Eye Doctor submits all exam paperwork to NMCS D investigators for each f/u exam
13.	All protocols of study will be complied with as scheduled — if not: aviator will be grounded
14.	Be flexible — beware timeline/operational commitments — things will change as process matures

*As of 20 April 00, Aviator PRK Retention Study Consult Forms accepted at NMCS D

**Aviator Retention Study officially commenced in March 2000

***Aviator Accession Study is projected to commence by FY-01

WAIVER CRITERIA	
1.	Must meet MANMED/NOMI published standards for appropriate Class/SG
2.	Refractive stability — less than 0.50 D change over 2 exams at least 2 weeks apart
3.	Post-op contrast sensitivity — TBD
4.	No symptoms related to procedure
5.	LBFS not less than 4 wks postop with NOMI Ophthalmology Code 23 as Virtual Member (proposed)

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Points of Contact

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Clinical Analysis	LCDR Dave Kleinberg	code265@nomi.med.navy.mil

Links and Other Resources

BUMED Web Page for Corrective Eye Surgery	http://navymedicine.med.navy.mil/refractive_surgery_information.htm
NAVADMIN MESSAGE 341/99 (R 212221Z)	Photo Refractive Keratectomy Surgery Program for Active Duty Service Members
NMC San Diego PRK Information Phone Line (Pre-recorded information only)	COM 619-524-0555 or DSN: 524-0555

**PLEASE DO NOT HAVE PATIENTS CONTACT ABOVE LISTED INDIVIDUALS.
THIS IS FOR FLIGHT SURGEON USE ONLY.
PLEASE USE E-MAIL WHEN POSSIBLE FOR ALL CORRESPONDENCE.**



(US Navy Photo)

NAVAL AVIATION REFRACTIVE SURGERY CONSULT FORM

FORM CON0003A01



1. Patient Input (Please print in black ink): 2. Unit CO's Input:

Last Name:	
First Name:	MI:
Suffix (Jr, III):	Call sign:
Rank:	<input type="checkbox"/> USN <input type="checkbox"/> USMC
Grade:	Birthdate (DDMMYY)
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Your SSN: - -
<input type="checkbox"/> PILOT <input type="checkbox"/> NFO	<input type="checkbox"/> AIRCREW Total Hours:
Primary Aircraft:	Time in type:
Primary NEC, MOS, Designator(s):	
Unit Name:	
Unit Address:	
Unit City:	Unit State (2 letters):
Unit Zip:	Unit Country (if not US):
Unit Tel:	x
Home Address:	
Home City:	Home State (2 letters):
Home Zip:	Home Country (if not US):
Home Area Code & Tel:	
Current <input type="checkbox"/> Yes Upchit: <input type="checkbox"/> No	Current <input type="checkbox"/> DIFOPS Billet: <input type="checkbox"/> DIFDEN
Next <input type="checkbox"/> DIFOPS Billet: <input type="checkbox"/> DIFDEN	
Date Beginning Work-Up Cycle (DDMMYY):	
Date Beginning Deployment (DDMMYY):	
Pay Entry Base Date (DDMMYY):	

I understand that the servicemember will be medically "down" for a minimum of 4 weeks: ☐ Yes ☐ No

Unit Co's Last Name:

Unit Co's Signature:

3. Ophthalmologist/Optometrlist:

Uncorrected Visual Acuity OD: 20/(xxx): UCVA OS 20/(xxx):

Sphere: Cylinder: Axis: (20/xx):

RX OD: x

RX OS: x

If visual acuity with current correction is worse than 20/20, please provide a manifest refraction & BCVA:

M OD: x

M OS: x

In your professional opinion, is this patient a good candidate for refractive surgery? ☐ Yes ☐ No

Δ \leq 0.50 D change in sphere or cylinder in last 12 months of realistic expectations about surgery

☒ No: ☐ Age < 21 years ☐ Pregnancy
☐ K, Sics ☐ Thyroid Disease
☐ Keratoconus ☐ Diseases affecting healing:
☐ H/o HSK, HZK DM, Atopy, CV, AI, ID

Clinic Area Code & Tel:

Oph/Optom Last Name:

Ophthalmologist/Optometrlist Signature:

4. Fax completed form to (619) 524-1731.

5. An e-mail confirmation will be returned to the servicemember and their unit.

Navy Refractive Surgery Center
Branch Medical Clinic
2650 Stockton Road
San Diego, CA 92106-6000

Tel: (619) 524-0555

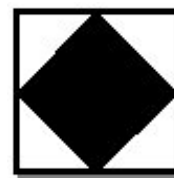
Fax: (619) 524-1731

DSN: 524-

URL: <http://navymedicine@us.med.navy.mil>



Unit Admin/Personnel e-mail:	@
Patient's e-mail:	@



**Naval Operational Medicine Institute
210th Flight Surgeon Graduation Ceremony
11 February 2000**

Navy "Wings of Gold" were awarded to a new class of Navy Flight Surgeons, Aerospace Physiologists, and Aerospace Experimental Psychologists at the National Museum of Naval Aviation on 11 February 2000. The commencement address was given by CAPT John H. Fahey, MC, USN, Commanding Officer of the Naval Operational Medicine Institute. The following is a list of the graduates and their new assignments.

Anchors Away!

Flight Surgeon Class 99003

CAPT (Sel.) Michael D. McCarten, MC, USN
CDR Stephen C. Archer, MC, USNR
LCDR Brian K. Berryman, MC, USNR
LCDR Charles A. Hughes, MC, USNR
LCDR Steven T. Knauer, MC, USNR
LCDR Rony R. Lee, MC, USNR
LCDR David S. Lesser, MC, USN
LCDR Wendell Q. Mew, MC, USN
LT Eric E. Belin, MC, USN

(Recipient of the **Surgeon General's Award for Student Excellence**)

LT Renee D. Brown, MC, USNR
LT John W. Dorunda, MC, USNR
LT Christopher J. Hejmanowski, MC, USNR
LT Andrew Kim, MC, USNR
LT David C. Krulak, MC, USN
LT Christopher T. Kusniewski, MC, USNR
LT James D. Landreau, MC, USNR
LT Scott D. McClellan, MC, USNR

(Recipient of the **Commanding Officer's Fox Flag Award**)

LT Michael T. Newman, MC, USNR
LT Jason J. Porter, MC, USNR
LT Brian C. Rasmussen, MC, USNR
LT Christopher H. Register, MC, USNR
LT John P. Santiago, MC, USNR
LT Erik J. Won, MC, USNR
LT Kristen D. Yakubisin, MC, USNR

Billet Assignment

RAM, NAS Pensacola, FL
BMC Arlington Annex, Pentagon, Washington, DC
MAG-31, MCAS Beaufort, SC
Reserves, NAMRL, NAS Pensacola, FL
MAG-26, MCAS New River, NC
Reserves, Orange Beach, AL
3rd MAW, MCAS Miramar, CA
BMC, NAS Fallon, NV
MAG-26, MCAS New River, NC

VP-9, Kaneohe Bay, HI
2nd MAW, MCAS Cherry Point, NC
1st MAW, Futenma, Japan
Naval Hospital, Yokosuka, Japan
MAG-13, MCAS Yuma, AZ
3rd MAW, MCAS Miramar, CA
CAG-2, Lemoore, CA
2nd MAW, MCAS Cherry Point, NC

COM CVW LANT, Beaufort, SC
1st MAW, Futenma, Japan
3rd MAW, MCAS Miramar, CA
VAW-120, Norfolk, VA
CAG-5, Yokosuka, Japan
MAG-39, Camp Pendleton, CA
3rd MAW, MCAS Miramar, CA

Allied Flight Surgeon Class 99003

Aerospace Physiologist Class 99003

LT Timothy A. Loomis, MSC, USNR

LTJG James C. Hunt, MSC, USN

(Recipient of the **MSC Director's Award for Student Excellence**)

LTJG Lewis P. Silverman, MSC, USNR

ENS Christopher P. Rinaudo, MSC, USNR

ENS Timothy J. Ringo, MSC, USNR

Billet Assignment

ASTC, NAS Pensacola, FL

ASTC, MCAS Miramar, CA

ASTC, NAS Norfolk, VA

ASTC, NAS Pensacola, FL

ASTC, NAS Jacksonville, FL

Allied Aerospace Physiologist Class 99003

2NDLT Linda A. Forward, Royal Canadian Navy

Canada

Aerospace Experimental Psychologist Class 99003

LT Joseph V. Cohn, MSC, USNR

LT Sidney G. Fooshee, MSC, USNR

LT Christian L. Hart, MC, USN

NAVAIRWARCEN, Orlando, FL

NOMI, NAS Pensacola, FL

NASC/AIR 4.0 Eng., Pax River, MD

Recipient of the Class' **"Golden Apple" Award** was LCDR Redfield, F-14 Tomcat pilot and Aviation Preflight Indoctrination (API) instructor.

In keeping with tradition, the Fox Flag is broken at the Naval Operational Medicine Institute flag staff to signify the launching of a new class of aeromedical personnel in support of Naval aviation and the Navy/ Marine Corps team. The Fox Flag is flown from an aircraft carrier's mast during flight operations. It tells other ships in the area that flight operations are ongoing. We at the Naval Operational Medicine Institute want the Naval aviation community to know that we are launching a group of graduates who take their wings to serve not only aviation personnel, but all those who comprise the Navy family.

The Editors

(US Navy Photo)

Reserve Corner

Stay Aboard!

Are you ready to leave active duty later this year and begin a residency? If so, you are strongly encouraged to continue your affiliation with the Navy as a Reservist. The Navy and Marine Corps needs your experience!

By and large, the active duty experiences of our Flight Surgeons are outstanding. For those of us who have moved down the pike, the memories of our days serving squadrons, carriers, and air stations are very fond. Upon entering a residency, some physicians may think... "Perhaps one day I will yearn to serve as a Flight Surgeon Reservist, and at that time contemplate returning to the ranks." I submit, however, that now is the time to take action to continue your connection.



USS George Washington (CVN-73) (US Navy Photo)

One option to consider is becoming attached to a PRIMUS (Physician Reservists in Medical Universities and Schools) unit during your residency years. If you fall into certain critical specialties, this program will allow you to continue both gaining time in service toward promotion, and earning drill pay for activities that are considered vital to your training program (such as ATLS and ACLS training, Grand Rounds, CMEs, and certain training conferences). Of importance, by affiliating as soon as possible after release from active duty, there is no break in service. It may indeed be more difficult, in some cases, to join the reserves after a significant break in service due to future billet restructuring. If you wish, you are also in a position to perform two weeks AT during the year. As a personal example, I had the privilege of serving as a Carrier Airwing Flight Surgeon during my active duty years. Subsequently, during my

civilian Emergency Medicine Residency in Washington, DC, I became attached to the Georgetown University PRIMUS Unit. I was able to shorten certain electives during my residency from four weeks to two, and take those two weeks to perform AT back at NAS Oceana, where I had previously been stationed. What a great opportunity to serve the Navy, share the camaraderie of aviators, immerse oneself in aeromedical issues, provide ready room briefs, train clinic staff and corpsman directly

with the latest medicine from my residency, and have an opportunity to FLY! Talk about an "energy boost" during the very busy days of residency! I returned to my program refreshed. It is important, of course, to educate residency directors on the merits of your continued military service... but don't let them know you are having too much fun! There are indeed many AT opportunities to serve various units and exercises within the confines of your residency schedule. As an aside, it is important to maintain your aviation

physiology and water survival qualifications, and annual flight physical, in order to receive DIFOPS orders for certain ATs. For additional information on PRIMUS, contact CAPT Nuar at BUMED at (202) 762-3065, DSN 762-3065, or by e-mail at flnuar@us.med.navy.mil. Some residents in critical medical specialties may also qualify for a Loan Repayment and STIPEND program. Visit the Naval Reserve Recruiting Command web site at <http://www.cnrrc.com>, or call 1-800-872-8767.

As your residency nears completion, contact COMNAVAIRRESFOR (Code N3M), Reserve Flight Medical Programs to inquire about billet availability. CAPT Vidacovich and HMCS (AW) Stackpole are excellent resources to assist you with this process. They can be reached at (504) 678-6305/9, DSN 678-6305/6309, or e-mail stackpol@cnrf.nola.navy.mil.

In some instances, a residency program may be flexible enough for you to hold a regular drilling Flight Surgeon billet, if available, in your locale. The opportunity to "REFLEX" up to 50% of drills in SELRES units adds another mechanism to accommodate residents in training. Advanced educational opportunities and CME may also be obtained based on funding.

The Naval Reserve Flight Surgeon community is committed to serving the needs of Navy and Marine Corps aviation. While the additional income (\$5,000-\$8,000+/yr based on rank, plus AT pay) and retirement benefits are factors to be considered, the most meaningful benefit is the personal satisfaction and pride gained with serving aviators and squadron personnel as we collectively "support the mission." We enjoy the opportunity to change gears from our regular medical practices, address aeromedical issues, and continue our part in contributing to national security. My Reservist

colleagues and I have had the opportunity to perform ATs throughout the U.S. and abroad, both at sea and ashore, in a host of exercises. It has always been my experience that Navy and Marine Corps Line Commanding Officers are highly appreciative of the work that Reserve Flight Surgeons provide to enhance the active/reserve "Total Force Concept."

So come join us, share the fun, and help keep 'em flying!

CDR Joe Dervay, MC, USNR

(281) 483-7302

jdervay@ems.jsc.nasa.gov

CDR Dervay is attached to Naval Reserve, 4th MAW Medical, MAG-41, NAS JRB Ft. Worth, Texas. He is a NASA Flight Surgeon at the Johnson Space Center, and an Emergency Medicine Physician at the University of Texas Medical Branch at Galveston.



The Air Force and Navy announced today that the first ever C-17 carrier landing has been a total success. In other news, the Air Force and Navy have launched a study to determine the optimal method for getting a C-17 OFF an aircraft carrier.
(Source Unknown)



(US Navy Photo)

In Memoriam

Martin “Trader Jon” Weissman

Taps Rendered for Naval Aviation Sea Daddy “Trader Jon” Weissman

Three F/A-18 Hornets flew the missing man formation as Taps was sounded for a Naval Aviation legend on 25 February 2000. Martin “Trader Jon” Weissman passed away in a Pensacola hospital on 18 February from complications of a stroke. Trader Jon owned and operated a legendary Pensacola military aviation bar called “TJ’s” for over 40 years, treating anyone who walked through its doors the same – with a warm welcome.



Wiessman, whose bar was a favorite among aviators, military personnel and celebrities, was a Pensacola legend. His popular bar, which is known for its aviation memorabilia, opened in 1953. It was never the most immaculate establishment, but Weissman coaxed people into coming back with his charm, fatherly way and remarkable ability to remember names.

Weissman was a World War II veteran, being a member of the elite paratroopers. His military career, however, was cut short due to a training accident, disqualifying him from further “formal” service to his country. He and his wife moved to Pensacola from south Florida in 1953, bought a small tavern in an old building

and renamed it “Trader Jon’s,” and built a legend. Generations of Naval Aviators found a warm welcome at Trader Jon’s and reciprocated by showering its colorful proprietor with aviation memorabilia, transforming its motif into an aviation shrine. Trader’s gradually became a beacon for aviation for all stripes and a unique experience for everyone who wears Wings of Gold.

Trader was gregarious by nature and generous to a fault. For 45 years, his familiar presence was behind the long oaken bar, personally welcoming all patrons with a wink and a smile, and conversation if he had a spare moment, whether his visitor was a sailor or stevedore, pilot or prince, movie star or sports legend. He was blind to skin color and class distinction; everyone was accepted simply for who they were. He was always a staunch supporter of the U.S. Navy and Marine Corps, and was purported to be the Blue Angels greatest fan... “Bee-you-tee-ful.”

A 40-year dedication to “his military boys and girls” was recognized by his burial in the Barrancas National Cemetery and his funeral at the Pensacola Naval Air Station Chapel, attended by over 150. Retired Admirals, city leaders and former patrons came from all over the country to remember. CDR Brian Scott, the last to be served a beer by Weissman, put it best, “We’re not mourning Trader today, we’re celebrating him.”

Weissman’s bar is no longer open, but a group of Naval Aviators known as the Trader Jon preservation Squadron is in negotiations with the family to purchase the bar and continue the tradition and history of Trader Jon’s.

“Trader Jon” Weissman is survived by his wife Jacki and daughters Cheri and Dahl.

LCDR David K. Weber, MC, USNR

Resident in Aerospace Medicine (Class of 2001)
weber@nomi.med.navy.mil



(US Navy Photo)

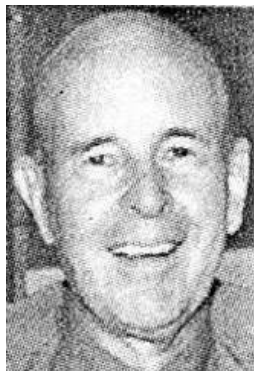
CAPT Philip T. Briska

CAPT Philip T. Briska, MC, USN (ret.) died at his home in Gulf Breeze, Florida on 21 February 2000. CAPT Briska was Head of NAMI's Ophthalmology Department from August 1978 to June 1988, when he retired and remained in the Pensacola area. Reprinted below is the obituary for CAPT Briska that appeared in the Pensacola News Journal on 24 February 2000.

The Editors

Philip Thomas Briska Captain, MC, USN, Ret.

Philip Thomas Briska died Monday, February 21, 2000, at his home in Gulf Breeze. He was born January 23, 1931. The first in his family to be born in a hospital. He was the son of Hermine Maria Abel (Briska) and Philip Michael Briska. Both emigrated from Slovakia in the early 1920's, were processed in the United States through Ellis Island and later met and married in New York City.



Philip attended Cardinal Hayes High School in New York, entered Harvard College having been awarded an R.O.T.C. Navy Scholarship and graduated with a degree in Physics in 1952. On that June day he was commissioned in the Navy. He spent six months on the USS Salem, Calif. 139; Flight Training NAS Pensacola, Fla. November '52 - March '54; Designated Naval Aviator March '54; Fighter Squadron Eleven March - June '54; Fighter Squadron 172 June '54 - March '56. After fulfilling his obligation he transferred to a Naval Reserve Squadron, and joined the G.G. Leeds Electronics Company located on Long Island, N.Y. as their Washington, D.C. representative. Philip married Patricia Maxwell Coolidge Mulligan of that city and South Brooksville, Maine, Friday, March 13, 1959. During his years with the Leeds Company he earned money to cover medical school. Philip had supported himself from age 14 and believed debt to be unconscionable.

Philip was commissioned in the Navy Medical Corps June '62; graduated from Columbia Medical School in N.Y. in '63; Naval Hospital St. Albans, N.Y. June '63 - July '64; Naval Aerospace Medical Institute, Pensacola, Fla. January - October '64; Naval Air Advanced Training Command, Kingsville, Texas February - May '65, after which he became a dual designated pilot/flight surgeon stationed with Air Test and Evaluation Squadron four at Point Mugu, Calif. May '65 - June '66 and

(continued on page 28)

(continued from page 27)

Navspace Systems Activity Los Angeles, Calif. August '66 - August '68. In 1968 Philip began a three year Ophthalmology Residency at Balboa Naval Hospital, San Diego, Calif. through September '71; Naval Hospital Camp Pendleton, Calif. September '71 - '74; Naval Regional Medical Center Oakland, Calif. July '74 - '78; Naval Aerospace Medical Institute Pensacola, Fla. August '78 until retirement June '88.

Philip was diagnosed with Non-Hodgkins Lymphoma cancer January 23, 1991 and tried to maintain a life with quality while going through one treatment after another. He was convinced his immune system became weakened and susceptible to cancer because of his use of a popular herbicide containing an agent orange component which is still being marketed today. In early 1999 a deadly Squamous Cell Carcinoma invaded his head, neck and liver areas, which subsequently led to his death.

Survivors are his wife, Patricia; one son, Michael Coolidge Briska; three daughters and sons-in-law, Catherine Coolidge Zbikowski and husband, Richard, Marguerite Maxwell Crozier and husband, Stanley and Elizabeth Rawson Briska McKee and husband, John; two sisters in the New York City area, Theresa Briska Havelka and husband, Frederic and Joan Briska Brinz Young and husband, Lawrence; four grandchildren, Nicolas and Erik Zbikowski and Franklin and Patricia

Crozier; one nephew, Frederick; three nieces, Joanne, Brenda and Patrice; a special friend of the family, Lynn Fiellin; and countless first cousins in Argentina and Slovakia.

Philip was foremost a patriot. A first generation American who appreciated the extraordinary opportunities and freedoms of the United States. He understood the sacrifices his parents made to ensure a better life for their children. He was devoted to his family, thrilled and entertained by his children and grandchildren and admired by his friends. He was thankful for so much kindness expressed by family, neighbors and friends throughout his lifetime, especially in these last years.

The family is abiding by Philip's wishes: memorial services will not be held after his death. At the time of Patricia's death, Philip's ashes will be mingled with hers and burial will be in Massachusetts. If friends wish to honor him in some way the family suggests donations to Hospice of Northwest Florida or the Gulf Breeze Library, a constant source of helpfulness and joy to Philip through the years. The family lovingly thank many precious medical professionals, especially Dr. Allen Patton at Baptist Hospital in Pensacola and the Air Force Hospitals involved with Philip's care in later years, Wilford Hall in San Antonio, Texas and Keesler Memorial in Biloxi, Miss.

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(US Navy Photo)

Selected SUSNFS Merchandise Items Catalog**T-Shirt: SUSNFS "FS - Yesterday and Today"****T-Shirt: FS Wings****Tank Top: SUSNFS "Leonardo"****Running Shorts****Sweat Shirt: SUSNFS "Leonardo"****Sweat Shirt: FS Wings**

Selected SUSNFS Merchandise Items Catalog



Sweat Pants: SUSNFS Logo, NAOMI Logo, FS Wings



Polo Shirt: FS Wings



FS Wings 'Skrunchie', Bow Tie, Tie; SUSNFS Patch



Pocket Reference, Travel Mug, CD: Ultimate FS Reference



Sweetheart FS Wings Necklace, 14K Gold/Diamond Chip



Full Size 14K Gold Flight Surgeon Wings



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	<i>(Indicate Size and Color Where Appropriate)</i>	<i>Non-Member/Member</i>		
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___	T-shirt: SUSNFS "Leonardo" (M, L, XL, XXL)	24.00	19.00	_____
___	T-shirt: FS Wings (children's XS, S, M; adult S, M, L, XL)	24.00	19.00	_____
___	Tank Top Shirt: SUSNFS "Leonardo" (M, L, XL)	24.00	17.00	_____
___	Running Shorts: (Blue with Gold SUSNFS Logo) (M, L, XL)	20.00	17.00	_____
___	Sweat Shirt: SUSNFS "Leonardo" (S, M, L, XL)	40.00	35.00	_____
___	Sweat Shirt: FS Wings (M, L, XL)	40.00	35.00	_____
___	Sweat Pants: SUSNFS Logo (S, M, L, XL)	30.00	24.00	_____
___	Sweat Pants: NAOMI Logo (S, L, XL)	15.00	15.00	_____
___	Sweat Pants: FS Wings (S, M, L, XL)	30.00	24.00	_____
___	Polo Shirt: FS Wings (M, L, XL) (Navy Blue, White)	38.00	33.00	_____
___	SUSNFS Patch	6.00	5.00	_____
___	FS Wings Tie	22.00	20.00	_____
___	FS Wings Women's Bow Tie	10.00	8.00	_____
___	FS Wings 'Skrunchie'	6.00	4.00	_____
___	Travel Mug: SUSNFS Logo	6.00	5.00	_____
___	CD: The Ultimate Flight Surgeon Reference (TriService)	20.00	15.00	_____
___	Naval FS Pocket Reference to Mishap Investigation	15.00	10.00	_____
___	Sweetheart FS Wings Necklace, 14K Gold/Diamond Chip	200.00	160.00	_____
___	Petite Sweetheart FS Wings Necklace, 14K Gold/Diamond Chip	150.00	120.00	_____
___	Sweetheart Physiologist/Psychologist Wings Necklace, 14K Gold	75.00	65.00	_____
___	Full Size 14K Gold Flight Surgeon Wings	240.00	200.00	_____
___	Mess Dress 14K Gold Flight Surgeon Wings	160.00	128.00	_____
___	Refrigerator Magnet: FS Wings (price includes shipping)	2.00	1.50	_____
	SUBTOTAL			_____

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(while
supplies
last!)

5.00

1.50

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each additional item

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___ years at \$15.00/year

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Name _____ Rank _____
(Last) (First) (MI)

Circle All That Apply: MC / MSC / MD / DO / PhD / USN / USNR / Active / Reserve / Retired / Other _____

Are You - a Flight Surgeon? Y / N - a Graduate of a Residency Program in Aerospace Medicine? Y / N

Street _____ City _____ State _____ Zip _____

Phone: Home (_____) _____ Work (_____) _____ E-mail _____

Command _____ Current Billet _____ Projected Billet _____

(continued from page 4)

how quickly that builds up. The Society spends an average of \$25.00 each time the newsletter goes out for returned mail with no forwarding address. Please help us control costs by sending your new address. The other problem is that because of a lapse in dues, we have had to cut costs and opt not to send newsletters to folks whose dues are over eight months in arrears. This allows for possible mistakes with mail handling. Hopefully this will be solved when we go to the credit card system shortly. But for now, if you didn't get a newsletter, look at your last one and see when your dues expire. If they expired, that may explain not getting the newsletter.

That is about all I have for now. It has been a great pleasure and honor to serve you as the Treasurer of the Society for this year. Thank you for the opportunity to participate in our Society as an Officer. I have enjoyed it immensely. "Keep those cards and letters coming folks," and most importantly "KEEP 'EM FLYIN!"

LCDR David C. Kleinberg, MC, USNR
NOMI, Physical Qualifications Code 42 (MED-236)
DSN 922-2257 ext. 1062
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This Newsletter is published quarterly by the Society on the first of January, April, July and October of each year. Material for publication is solicited from the membership and should be submitted via computer file on floppy disk or e-mail attachment in Rich Text Format or MS Word ©.

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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