The Society of U.S. Naval Flight Surgeons Newsletter

Volume XXIV, Number 3 **http://www.aerospacemed.org** **July 2000**

President's Column

As the last three months have zoomed by, we have witnessed another transition in our society. I want to again thank CAPT Terrence L. Riley for his leadership and correct an error from the last newsletter. CAPT Riley has not retired and is practicing as both a staff Neurologist and Flight Surgeon at Naval Hospital, Pensacola. CAPT Charlie Barker is our new president-elect and I am looking forward to continuing to work closely with him on our strategic plans. LCDR Dave Gibson has completed both an impressive tenure as our Secretary and the RAM program and will be reporting to the USMC at Beaufort, SC. LCDR Dave Weber is our new Secretary and will be bringing an aviator's perspective to our team. Our Treasurer will continue to be LCDR Dave Kleinberg and for all of you who utilized the credit card capability that we now have, Dave is to thank. This team will continue to do its best to serve you, please provide any recommendations that could make us better.

There are three areas that I want to concentrate on during the next 9 months. First, the Aerospace Medicine Strategic Plan that CAPT Barker has been spearheading. As detailed in our last issue, this has greatly facilitated our focusing on all aspects of Aerospace Medicine, which in turn has made us the leading specialty in Navy Medicine. The workshop prior to the AsMA Scientific Meeting was well attended and extremely productive. Details can be found in other sections of this newsletter.

Second, optimization of our direct health care responsibility. As Navy Medicine struggles with the ever-increasing cost of delivering high quality services to our many beneficiaries, we must look for every opportunity to be an active part of this effort. Our understanding of TRICARE is essential to our ability to support the operational forces. I challenge each of you to become 'the expert' on TRICARE so you can best advise your command on all aspects of our system. This will necessitate us working closely with our clinic-based peers so that the families of the Sailors and Marines that we are responsible for will receive the best care, in an appropriate time, at a convenient location.

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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. Subscription memberships are available. Dues are $20.00 per year, or $300.00 for a lifetime. Contact the Secretary or Treasurer for more information or a membership application form.

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Finally, recruitment of junior flight surgeons into the Residency of Aerospace Medicine (RAM) is my third point of interest. Every RAM must take on this challenge and at every opportunity mentor our junior FS's. As most of us fell in love with being Flight Surgeons during our first tour, and we can point to one or two RAMs that made the difference in the direction that we took our medical careers. In my case, CAPT Frank Dully, CO, NAMI and CAPT Rob Dean, AIRLANT Medical Officer, came to my rescue at Naval Hospital, Roosevelt Roads, PR, in 1984. This is a long story that I will not put in print, however, their commitment and support, saved a young LT and pointed me in the right direction. For our junior Flight Surgeons, seek out a RAM, explore the possibility of attending the RAM program. Our abilities as force multipliers are well recognized by our line bosses, exemplified by their support of a near doubling of RAM billets.

The never-ending saga of NAMI continues. As I type this article on 21 June, 2000, NAMI is one step closer to being a reality and hopefully by the time everyone receives this, she will be back. CAPT Barker has been driving this issue and I give him my personal appreciation for all his efforts.

In closing, my career has taken another turn this week and I will be leaving NAMI in July to report as the CO of Naval Hospital, Naples, Italy. I thank all the members of NAMI and NOMI for their support and friendship. It has been a true honor in serving with the experts of Aerospace Medicine during the time NAMI was reborn. If any of you find yourself in the Mediterranean, please give Deb and me a call. We would love to visit with old friends and make new ones. Until next time, "Get 'em Up, Keep 'em Up".

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From the Secretary

I begin my term as secretary with great appreciation to my predecessor, LCDR David Gibson. His intellectual ability combined with his dedication to SUSNFS has made for a much improved newsletter and a database that is streamlined as well as efficient. I know that I am not alone in thanking him for his grand accomplishments as both secretary and Associate Editor of SUSNFS.

The SUSNFS Newsletter has seen great improvements over the last year, under the leadership of the Editor, CAPT Mike Valdez and the direct Associate Editorship of LCDR Dave Gibson. The quarterly newsletter is informative and timely, requiring a great amount of time and energy. One of the improvements spearheaded by CAPT Anzalone and CAPT Valdez has been the replacement of LCDR Gibson with two Associate Editors of the newsletter. LCDR William Padgett and LT Merrill Rice have valiantly volunteered to become associate editors for the newsletter along with me. LCDR Padgett is a PGY-3 in the RAM program and LT Rice is a PGY-4. With their help, I feel that we can create a newsletter that can rival the quality you have seen this year by LCDR Gibson.

The next year promises to be an exciting time for SUSNFS and I hope to meet the high standard of support for our members. Together with your Treasurer LCDR Dave Kleinberg and merchandiser LT David Webster (that's right, our names are very similar), we hope to provide a more customer oriented selection of SUSNFS Gedunk. LT Webster, building on the solid machine that LCDR Halenkamp has built as Merchandiser, has new innovative ideas, which should improve sales and marketability.

LT Dan Hohman is aggressively taking the reins of the SUSNFS website (www.aerospacemed.org) from LT Brian Wells, who completely revised the site in record time and with Herculean effort. LT Wells will be missed, but I am certain that the SUSNFS members will see great things from LT Hohman, a man of limitless talent and enthusiasm.

The annual SUSNFS meeting at AsMA was a resounding success and much new business was undertaken. First and foremost, CAPT Anzalone took over as President and CAPT Barker was elected Vice President. A big piece of business that affects each member, was an affirmative vote to increase the annual dues to twenty dollars per year. The lifetime membership fee will be 300 dollars and is still the best deal in town for a "Lifer". **Please note the change in annual dues fee on the renewal and application form.**

The SUSNFS membership is strong, with 457 members and subscribers. However, we can do better! Every newsletter contains a SUSNFS application and "Gedunk" sales form. Let's not waste trees. Pass on the application to one of your peers that isn't a member. Concurrent membership in AsMA is desired, thus making the individual a member in full status. However, anyone can become a subscriber by filling out the application and sending his or her twenty dollars. That twenty dollars buys them the quarterly newsletter, containing some of the most up-to-date information that can be found on Naval Aerospace Medicine.

Please keep in touch regarding changes in address or pertinent information.

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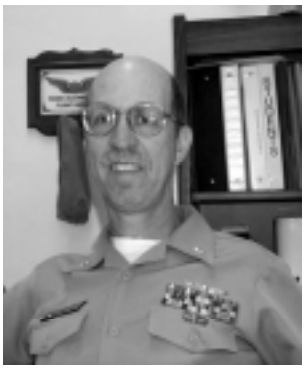
V-22 Osprey (US Navy Photo)

From the Treasurer



Greetings from the Treasurer. It was great to see so many of you at the AsMA conference in Houston. As many of you may have noticed, we made some significant changes this year.

First, we started credit card capability so you can now pay your dues and order merchandise easily with your credit card. This should significantly decrease our response time.

Second, the membership voted to increase the dues from $15 to $20 a year. That means your dues are changed as of 1 May 00. The life membership of course increases with this change to $300.

T34C Hard Landing (US Navy Photo)

In addition to these changes, we have decided to change our procedure for welcoming new Flight Surgeons to our ranks. In the past, we sponsored a reception at the Officers Club which was generally not well attended by the membership. We didn't really see any significant change in membership as a result. So, we will be taking a different approach. Starting with the next Flight Surgeon class, we will sponsor a reception for the graduation on the flight deck of the National Naval Aviation Museum. We believe this will make a better impression on the new Flight Surgeons and they will enjoy it more when they can share their joy with their parents and loved ones.

Our financial status is improving with the success we had at the AsMA conference. Our most successful items seem to be the Ultimate FS resource CD, the Mishap Reference Guide and jewelry for the ladies. The tee shirts and polo shirts are still popular and we are in the process of adding a new design. Before we actually print the new design, we will publish the options on the web page and let you pick the one you like best. If you would like to contribute a design, please send them to us at NAMI. Hopefully, this will continue to give us a positive image in the aviation community.

Keep 'em Flyin' Safely, Semper Fi

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CH53 Sea Stallion (Defense Visual Information Center)

Specialty Leader (MED-23)

05 March 2000

Military Healthcare System Optimization (MHSO) A Brief Introduction

I have a few questions I'd like to ask our flight surgeons. How many of you find yourselves in the clinic changing the paper on your examination table? How many of you go out to the waiting room to get your next scheduled patient or have to go find a "stand-by" for a special exam? How many of you have two examining rooms separate from your office? Do you have an assigned corpsman or nurse to assist you one-on-one with seeing patients and taking care of administrative tasks? How many of the clinic patients you see are actually assigned to you and know you as their "Doc" or as their primary care manager (PCM)? I dare say the answer to each of the first two questions is "yes" and to the last three is "no." These are certainly my answers to these questions as I think about the clinic where I see patients each week at NNMC Bethesda. But, it's getting better…. Needless to say, this *modus operandus* for me is personally frustrating and for the system both inefficient and cost expensive.

I'd like to digress in this issue from my usual laundry list description of BUMED activities—although each activity is important. I will also temporarily divert from my series on High Performance Organization Leadership—although HPO leadership principles are surely needed in implementing the novel plan I'm about to describe. I'd like instead to focus on Navy Medicine's recent initiative to optimize medical care for all our TriCare beneficiaries—active duty, operational forces, retirees, and family members. Much planning has already taken place, and although late in coming to the "table," Navy's operational medicine and aerospace medicine communities are now full players with Military Treatment Facilities (MTFs) and BUMED in planning and implementing Department of Defense Health Affairs (DOD HA) Military Healthcare System Optimization (MHSO) Plan.

The questions I posed above to you are the same ones posed by RADM Don Arthur, Deputy Surgeon General of the Navy, as he introduced Navy Medicine's plan to implement DOD(HA)'s MHSO. Foremost in the plan is to shift our business practice focus from acute care to preventive care. To do this requires more emphasis on health promotion programs and Putting Prevention into Practice (PPIP). It requires an increase in preventive medicine and primary care providers—physicians, physician assistants, nurse practitioners and independent duty corpsmen. Navy Medicine is committed to this shift through MHSO. The admitted bottom line of MHSO is to "recapture lost market share" from outsourcing and TriCare civilian contracts. The thought is that by preventing illness and disease, beneficiaries will require fewer appointments, thus decreasing demand and increasing Military Treatment Facility (MTF) capacity to enroll additional beneficiaries. In addition to increasing enrollment, MHSO calls for more personalized care through a Primary Care Manager by Name (PCM by Name) policy in which each beneficiary knows who his/her "doc" is and how to get in touch with him/her. Many questions have been raised about PCM by Name—like definition, duties and responsibilities, TAD and leave coverage, composition of PCM by Name Teams, etc.

But, despite these questions, everyone agrees the idea of PCM by Name is good. Another benefit of MHSO will be to increase MTF caseload and patient mix, both vitally needed to maintain PCM by Name provider skills and for our military residency training programs. A third and less obvious benefit is a more efficient, cost effective way of doing business. To realize this benefit, the plan calls for increased clinic support to its PCM by Names—two exam rooms and 3.5 support staff per provider. With increased support each provider should be able to take care of up to 25 patients per day and have an enrollment base of about 1500 patients. Our Surgeon General, VADM Nelson, wisely states these numbers are only a guideline and that each MTF will have to decide how it will optimize provider support based on its provider and facility resources. However, the SG indicated if shifting resources within Navy Medicine becomes necessary to achieve Navy MHSO, then re-allocation and re-alignment among MTFs will take place.

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At a recent BUMED sponsored MHSO workshop in Hagerstown, MD, operational and MTF leaders shared ideas, experiences to date, and concerns about MHSO plans. RADM Jim Johnson, TMO of the Marine Corps, presented an excellent summary of who Navy Medicine is today and how MHSO plans can be best implemented. He stated the military healthcare system is unique and cannot be compared to civilian medical systems. Our uniqueness is based in the fact that we not only have to provide peacetime medical care to all our beneficiaries, but we have to constantly be prepared to deploy and support operational contingencies ranging from all-out war to humanitarian and disaster relief. He emphasized several times that Navy Medicine no longer has the luxury of expecting everything to be taken care of in the MTFs when we go off to war, but in fact we have to do both the peacetime mission and the wartime mission at the same time. So, bottom line for us is that TriCare is OUR Program. It's not THEM (MTFs) versus US (Operational), but WE (TriCare), and WE have to make the system work for all of us; we have to "optimize" how we take care of all those entrusted to us. Point made.

So, I now make a special CALL TO DUTY from each of you. If MHSO is to work, it will clearly require the individual and collective efforts of each of us in aerospace medicine. It will mean working closely with not only our fellow flight surgeons, but also with our other professional colleagues—GMOs, PAs NPs, IDCs, and MTF specialists—in the operational arena, but also in the MTF. Success requires a positive attitude and a willingness to be full participants in PCM by Name Teams and to go the extra mile, always with our Patients, Sailors, Marines, Soldiers, and Airmen at the center of our concern. Sure, there will be problems and special circumstances as MHSO is implemented, but a positive attitude, collegiality, self-sacrifice, a little extra energy and persistence will overcome any problems and difficulties we encounter. Honor, Courage, Commitment…yeah, we've heard all this before, right?!! It does work and brings with it special recognition.

I'm sure you will be hearing a lot more about MHSO and PCM by Name and will be called to help plan and implement MHSO in your local area by your MTF leaders as well as by your operational TYCOM or MAW surgeon. They should be receiving additional guidance soon from the Operational MHSO Executive Committee (Deputy Surgeon General, CINC Surgeons, TMO, and MED 02, i.e., ADM Arthur, ADM Potter, ADM Johnson, CAPT Bumgardner, and CAPT Hart are members). This will be an on-going process or "work in progress." All inputs and feedback are not only appreciated, but requested and needed. One last note: our Aerospace Medicine Strategic Plan (AMSP) specifically addresses our objectives in the area of MHSO. I encourage you to review our strategic plan and objectives, especially goal groups 3 and 4, Health Benefit and Best Business Practices respectively. You can find our plan and objectives at http://navymedicine.med.navy.mil/MED23. In addition, a copy of the AMSP objectives list is included in this issue of the newsletter.

More later….Godspeed!!

(PS: By the time you read this article, CAPT Fanancy Anzalone will be on his way to Naples, Italy, to become NH Naples Commanding Officer. I know each of you join me in saying "job well done at NAMI" as well as "Bon Voyage" and "Godspeed" in your duties at Naples. We all know you will do well!!)

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Aerospace Medicine Strategic Plan

Vision: Superior air warfare and peacetime readiness through excellence in aerospace health services, training and research.

Mission: As the Aerospace Medical community of the Medical Department of the United States Navy, we support air combat and aviation peacetime readiness of the uniform services and promote, protect, and maintain the health of all those entrusted to our care.

Guiding Principles:

- Navy's Core Values are the bedrock of Navy Medicine.
- Health is a state of physical, emotional, and spiritual well being.
- Our people are our most important resource and their dignity, worth, and cultural diversity are invaluable assets.
- Quality health care, training, and research must be provided in an atmosphere of service, professionalism, compassion, teamwork, trust, and respect.
- Our success will be judged by our customers.
- Meeting the unique needs of Navy and Marine Corps aviation is vital to our success.
- Continuous improvement must permeate all aspects of the aeromedical enterprise.
- Working jointly with other active and reserve medical personnel will achieve more effective results.
- Navy Aerospace Medicine must be run effectively and responsibly based on sound clinical and business practices.

Overview:

PILLAR	GOALS
Total Force Health Protection	Optimize the Health and Fitness of the Aviati
	Optimize Performance, Minimize Casualties, Resources Through Effective Surveillance, P Training, and Research
	Maximize Readiness to Deliver Effective Cas Anywhere, Anytime, Everytime
People	Enhance Job Satisfaction
	Train to Requirements
Health Benefit	Communicate the Benefit and Educate our B
	Provide Quality Preventive and Restorative C
	Implement and Refine Clinical Practice Strate
Best Practices	Identify and Benchmark Sound Business Pra
	Identify, Acquire & Integrate Technologies tha Greatest Benefit

NAVY AEROSPACE MEDICINE OBJECTIVES

Obj No	Strategic Goal	Goal	Objective	Action Officer(AO)
1.1.1	Total Force Health Protection	Optimize Performance, Minimize Casualties, Preserve Resources Through Effective Surveillance, Prevention, Training, and Research	95% of aviation units will have named representation to established participate in Health Promotion Programs (line or BUMED) by 2001	CAPT Dwight Fulton
1.1.2	Total Force Health Protection	Optimize Performance, Minimize Casualties, Preserve Resources Through Effective Surveillance, Prevention, Training, and Research	95% Aviation units will perform Birthmonth Recall Audits / Medical Readiness Updates by2001	CAPT Bill Ferrara
1.2.1	Total Force Health Protection	Optimize Performance, Minimize Casualties, Preserve Resources Through Effective Surveillance, Prevention, Training, and Research	By 2004, reduce Class A aviation mishap rate attributable to human factors by 50% per year relative to FY00	CAPT Jim Fraser
1.2.2	Total Force Health Protection	Optimize Performance, Minimize Casualties, Preserve Resources Through Effective Surveillance, Prevention, Training, and Research	By 2005, reduce attrition of SNAs by 50% compared with FY200 attrition using Aviation Task Specific Predictors	LT Hank Williams (or successor)
1.2.3	Total Force Health Protection	Optimize Performance, Minimize Casualties, Preserve Resources Through Effective Surveillance, Prevention, Training, and Research	By 2002, 100% of FS/APs/AEPs will have received standardized training in Operational Risk Management	CDR Andy Bellenkes
1.2.4	Total Force Health Protection	Optimize Performance, Minimize Casualties, Preserve Resources Through Effective Surveillance, Prevention, Training, and Research	By 2002, 50% of all aviation treating units will report DNBI data [in an electronic format]	CAPT Dwight Fulton
1.2.5	Total Force Health Protection	Optimize Performance, Minimize Casualties, Preserve Resources Through Effective Surveillance, Prevention, Training, and Research	By 2002, survival training shall be included in the Training and Readiness Matrix	CAPT Bob Matthews
1.2.6	Total Force Health Protection	Optimize Performance, Minimize Casualties, Preserve Resources Through Effective Surveillance, Prevention, Training, and Research	Review and report annually the progress of the Future Naval Capabilities IPT in those areas affecting the air warfare community	CAPT Bob Hain
1.3.1	Total Force Health Protection	Maximize Readiness to Deliver Effective Casualty Care--Anywhere, Anytime, Everytime	By 2002, 90% of aviation units will have received training in combat stress / operational stress reaction prevention and incorporate into the NAMI training syllabi	CDR Bob Koffman
1.3.2	Total Force Health Protection	Maximize Readiness to Deliver Effective Casualty Care--Anywhere, Anytime, Everytime	By 2002, 90% of personnel in aviation units will have been trained in self-aid / buddy aid as documented in training records.	CAPT Dan Callan

Obj No	Strategic Goal	Goal	Objective	Action Officer(AO)
1.3.3	Total Force Health Protecti-on	Maximize Readiness to Deliver Effective Casualty Care--Anywhere, Anytime, Everytime	By 2002, there will be a standardized doctrine and evaluation of mass casualty training on large deck ships, air stations and Expeditionary Air Fields as evidenced by descriptive document of doctrine and evaluation metrics	CAPT Dean Bailey
2.1.1	People	Enhance Job Satisfaction	Increase/enhance recognition for academic, professional and military accomplishments! Step 1-Identify all applicable awards. Have a list by SEP 2000 Step 2-Increased participation and visibility of awards program. Increased # on nominations for 2001 awards by 10%	CAPT Matthews
2.1.2	People	Enhance Job Satisfaction	Have career progression guidelines for all corps. Step 1-Aerospace Physiologists (complete) Step 2-Aerospace Experimental Psychologists Step 3-Aerospace Medicine (FS/RAMs)	CAPT DeVoll CDR Puckett
2.1.3	People	Enhance Job Satisfaction	Detailing by personnel with operational experience. Step 1-Identify detailer 'positions'. Have a list by SEP 2000 Step 2-Assignment of personnel to those positions by OCT 2001	CDR Puckett
2.1.4	People	Enhance Job Satisfaction	Prioritize Billets DELETED	
2.2.1	People	Train to Requirements	Have correct and valid credentialling for Flight Surgeons and Residents. Step 1-Correlate 'core' competencies (SEP 2000) Step 2-Coordinate with Prev Med & Occ Health (JAN 2001) Step 3-New credentials accepted (May 2001)	CAPT Davenport
2.2.2	People	Train to Requirements	Have a billet structure based on "requirements." Step 1-Survey of requirements (complete) Step 2-Submit TFMMS packages for correct coding (July 2000) Step 3-99% of billets correctly coded by OCT 2000	CAPT DeVoll
2.2.3	People	Train to Requirements	Have defined CME Requirements. Step 1-Establsih guidelines for continuing credentialling for FS and AM Step 2-Establsih guidelines/program for re-establishing credentials for FS	CDR Jay Dudley
2.2.4	People	Train to Requirements	Have a strong Aeromedical Program at USUHS. Step 1-Approval of Phys courseware (SEP 2000) Step 2-Tri-Service enrollment in MPH programs (JUN 2002)	CAPT Johanson CDR Merchant

Obj No	Strategic Goal	Goal	Objective	Action Officer(AO)
2.2.5	People	Train to Requirements	Dual-Designator Program Step 1-Establish coded billets, submit coding request to PERS (JUN 2000) Step 2-Hold selection board (AUG 2000) Step 3-Update Inst and NATOPS (SEP 2000)	CAPT Hiland
3.1.1	Health Benefit	Communicate the Benefit and Educate Beneficiaries	Have FS fully knowledgeable in TRICARE Step 1-NAMI will provide basic TRICARE education as part of basic SFS Course and RAM Training (JUN 2000) Step 2-All operational FS will receive local provider TRICARE brief within 6 months of reporting (AUG 2000)	CAPT Anzalone
3.2.1	Health Benefit	Provide Quality Preventive and Restorative Care	Have FS identified by name as Primary Care Managers of aviation units and personnel. Step 1-Non Claimancy 18 FS identified by MTF Step 2-Claimancy 18 FS identified to support local aviation community	CAPT Anzalone
3.2.2	Health Benefit	Provide Quality Preventive and Restorative Care	Have PPIP implemented in all aviation units. Step 1-Utilize and improve Birth Month Recall (AUG 2000) Step 2-Implement check-in HRA (JAN 2001)	CAPT Dwight Fulton
3.2.3	Health Benefit	Provide Quality Preventive and Restorative Care	Have all FS's and RAM's trained in PPIP. Step 1-NAMI will provide basic PPIP Education as part of Basic SFS Course and RAM Training (AUG 2000) Step 2-NAMI will establish web based PPIP resources (JAN 2001)	CDR Jay Dudley
3.3.1	Health Benefit	Implement and Refine Clinical Practice Strategies	Have current standards and waiver requirements available on NAMI website. Step 1-All lectures available on website (AUG 2000) Step 2-Waiver guide updated annually with a minimum of 1/3 completed each year (OCT 2000)	CDR Jay Dudley CDR Jeff Brinker
4.1.1	Best Practices	Identify and Benchmark Sound Business Practices	Train Personnel in Best Practices Methodologies and Tools	CAPT Mike Valdez
4.1.2	Best Practices	Identify and Benchmark Sound Business Practices	Capture aviation unit aeromedical activities within TRICARE system. Discover Metrics to measure cost of non-clinical HC services (Prevention, Operational, Exec Med functions)	
4.1.3	Best Practices	Identify and Benchmark Sound Business Practices	Benchmark AM Practices of Successful AM Providers	CDR Rick Beane
4.2.1	Best Practices	Identify, Acquire & Integrate Technologies that have the Greatest Benefit	Develop Best Training Technologies fo AM HC Personnel and non-HC personnel	CDR Rick Beane
4.2.2	Best Practices	Identify, Acquire & Integrate Technologies that have the Greatest Benefit	Develop Best Practice for Clinical Telemedicine	CAPT Dean Bailey

Physical Qualifications and Standards (Code 42)

Many changes have been occurring over the past several months. Colonel Ferrer has transferred and I have assumed the role as director. He did an outstanding job over the past three years and his shoes will indeed be hard to fill. For those who don't know me, I am CDR Jeff Brinker. My most recent tour was with Training Air Wing FIVE at NAS Whiting Field. I am Aerospace Medicine and Family Practice board certified and have enough experience as a naval flight surgeon to understand the demands of your duties. I intend to be as receptive to your needs as possible and thanks to the hard work by Colonel Ferrer many new developments are in progress, which will ultimately serve you in the fleet.

First, let's discuss TriMEP. It is not a perfect SF-88/93 forms generator. It evolved from the earlier Micro-88 program. Soon version 1.0e will be released which will be the last update. Look for it on CD-ROM or for download from the NMIMC website in late July 00. The goal of Code 42 is to be completely paperless. Over the next year we will be undergoing computer system upgrades, completion of the Aeromedical Information System (AIS), and development of Internet web-based software for SF-88/93 generation and transmission into the NOMI AIS database. The goal is to enable all flight physicals, waiver requests and supporting documents to be processed as paperless as possible and to minimize waiver and application processing. I know what an adverse impact it can be to a command when an aviator is subjected to administrative delays in the return to flight status.

Next, I need to address waiver requests. My goal is to provide the best support possible to you. The Aeromedical Summary has replaced the previous waiver package submission. While it is similar to the Local Board of Flight Surgeons, it is a more streamlined process. It requires only information pertinent to the problem at hand and does not require a complete long form SF 88 and 93. LCDR Kleinberg will be transmitting guidance and a format via e-mail to all registered UIC's who have provided Code 42 with e-mail addresses. I will also ensure it will be available on the NOMI website under the Aeromedical Reference and Waiver Guide. I do ask, however, complete and required data be submitted to Code 42 which will allow an informed decision be made when considering a request for waiver. Do not, for example, jot down some mildly elevated lipid levels, report the aviator being on Zocor with no specified dose, and write "waiver recommended" on his annual flight physical. I use this example as it is all too common and unfortunately requires the physical to be returned for "remedial action". Don't punish the patient for what amounts to a minor administrative expenditure on your part. Let's work together.

My other ongoing project is to provide an up-to-date Aeromedical Reference and Waiver Guide on the NOMI website. Look for an update in the next few months. Until the next SUSNFS newsletter, I wish you all the best. Remember, there are no bad flight surgeon billets, so enjoy all your opportunities.

Aeromedical Summary (AMS)

The AMS refers to the paperwork replacement for the Local Board of Flight Surgeons. The Aeromedical Summary will be used for submission to Code 42 (BUMED 236) to summarize the findings of the Local Board of Flight Surgeons. See the template below for information required in the AMS.

The Local Board of Flight Surgeons (LBFS) is a process. The LBFS must still meet to issue an Aeromedical Clearance Notice, following the traditional process of a LBFS. If the local Flight Surgeon issues an Aeromedical Clearance Notice for a condition which requires a waiver, and for which a waiver has not yet been granted by BUPERS/CMC, two Flight Surgeons' and one other physician's (who may also be a Flight Surgeon) signatures are required on the AMS for initial waiver application. If an Aeromedical Clearance Notice is not issued, only one Flight Surgeon signature is required on the AMS for initial waiver application.

An AMS is required for an initial waiver and for waiver continuation. However, alcohol abuse and alcohol dependence waivers come under the specific guidance of BUMEDINST 5300.8 and are handled differently. For these two waivers only, an SF88 and SF 93 ***are***

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still required with submission of the initial waiver application and with waiver continuation during the three year aftercare period. Put another way, with the exception of ETOH abuse and ETOH dependence waivers, the only item required for initial waiver application or for waiver continuation is the AMS. Therefore, care must be taken to ensure that the AMS is thorough, complete, and accurate. Submission of administrative data will be required via TriMEP (see below).

Submission of the AMS does not release the Flight Surgeon from the regular physical examinations required by BUMED (Annual Short Form or the 5 year SF88 and SF 93). The Flight Surgeon shall ensure that the Annual Short Form or the 5 year Long Form examinations are placed in the member's medical record. For all waiver applications and waiver continuation packages, the completed SF88 and SF93 are no longer required to be submitted to code 42 (except for ETOH and aviation applicants).

Code 42 (BUMED 236) Submission Requirements

Submission of the complete SF88 and SF93 (including TriMEP full electronic transmission) ***is required for:***

1. All aviation applicants (including those applying for a waiver)
2. ETOH Abuse/dependence waiver (first three years of aftercare)
3. Separation/retirement physical exams.

Submission of administrative information from TriMEP is required with the AMS.

Submission of the Annual Short Form is no longer required.

Submission of the 5 year Long Form physical exam is no longer required.

Only **copies** of the AMS, SF 88 and SF 93, *or* an electronic version (e-mail, fax, or scanned and sent as an e-mail attachment) shall be submitted for review**. DO NOT SUBMIT ORIGINAL PAPERWORK TO CODE 42 (BUMED 236).** Originals are no longer required for endorsement and will not be accepted. Do not submit originals of the SF 88, SF 93, or the AMS. Originals shall be placed in the member's health record. All original commissioning physical exams must be forwarded to BUMED 25 for commissioning endorsement first. Only copies of physical exam *with BUMED 25 endorsement* may be submitted to BUMED 236 for aeromedical endorsement.

The electronic AMS should be submitted to code427@nomi.med.navy.mil

TriMEP administrative data, or the complete SF 88 and SF 93 (when required), shall be submitted electronically. A password issued by NOMI is required to permit transmission through the NOMI firewall. Passwords may only be obtained by telephone.

NOMI: code427@nomi.med.navy.mil.
DSN 922-2257 ext. 1068
(850) 452-2257 ext. 1068
Fax: DSN 922-2708
(850) 452-2708

Administrative Data Required for Submission with the AMS

All facilities submitting an AMS for review are required to obtain the TriMEP 1.0e version and send an electronic administrative data submission (from the 1.0e version) to Code 42 (BUMED 236) . This electronic submission will automatically load administrative data into the NOMI database. The TriMEP administrative data should be sent ***prior*** to AMS submission, or at the time the AMS is submitted. Specifically, the items requiring submission are:

Social Security Number
Name (last, first, middle)
Sex
Review Type
Class of Physical
Purpose of Exam
Exam Facility UIC
Organization UIC
Rank/Rate
Component/Service (USN, USNR, USNR-R,

USNR-TAR, USMC, USMCR, USCG)
Birth date

Other information on the TriMEP physical examination is not required for submission with the AMS.

PLEASE NOTE that AMS packages submitted with or after electronic submission of TriMEP administrative data will receive **priority processing** at BUMED 236.

For any questions, call Code 42:

code427@nomi.med.navy.mil
DSN 922-2257 (ext. 1073)
(850) 452-2257 (ext. 1073)

Alcohol Waiver Requirements:

Initial waiver:

1. AMS (format replaces the flight surgeon narrative assessment, but must include same information).
2. Complete SF88 and SF93.
3. Commander's endorsement.
4. Psychiatric evaluation by a privileged psychiatrist or clinical psychologist.
5. DAPA's statement to document aftercare including AA attendance.
6. Copy of Level II or III Treatment Summary.
7. Internal Medicine consult (as indicated).

Continuance of waiver (for first three years of after aftercare):

1. AMS. Must document visits to Flight Surgeon (monthly for first 12 months, then every three months for remaining two years).
2. Complete SF88 and SF93.
3. Psychiatric evaluation by a privileged psychiatrist or clinical psychologist.
4. DAPA's statement to document aftercare (monthly visits for the entire 3 years with documentation of AA attendance).

Continuance of waiver after the first three years of aftercare:

1. AMS (must document abstinence).

Aeromedical Summary (AMS) Template

Date:

Patient Identification: LT John Doe, 000-00-0000/ XXXX(designator), (ensure that member is USN, USNR, USNR-R, USNR-TAR, USMC, USMCR, USCG) is a 24 y/o Caucasian male aviator, with 3000 flying hours in the F14, etc. Current job is flying F14s and he has flown 100 hours in the last six months. Member is stationed at_____. The purpose of this AMS is to request a waiver for_____ (diagnosis).

Member's Organization's name and UIC/RUC:_____.

Treatment Faciltiy (MTF) name and UIC: _____.

Aeromedical Email point of contact: _____ with phone_____.

Member's designation code is: _____.

Purpose of exam (as in TriMEP): _____.

Class of exam (as in TriMEP): _____.

Previous Waivers and Status: Please give the status of *all* previous waivers and *updated required information* (i.e., member has a previous waiver for HTN granted in 1995. Member is stable on HCTZ and blood chemistries were normal on 14 May 99).

Significant Medical History: same as History of Present Illness.

Consultant Reports: Need dates, consultant diagnosis, prognosis, treatment, and follow-up. In some cases (high risk, high profile waiver requests) NOMI Code 42 may ask for copies of consultant reports.

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Physical Examination: Include vital signs, and a targeted physical exam that focuses on the waiver(s) requested (i.e., neurology exam for migraine headache waiver).

Lab Test: Review lab tests that are pertinent to the evaluation of the disqualifying diagnosis.

Information Required: Consult the ARWG for required medical tests and consults for both the waiver requested and any previous waivers. Review all prior SF88 and SF507 for required information to be included from a previous waiver.

Diagnosis (ICD-9): Use current ICD-9 diagnostic terminology only.

Aeromedical Recommendations: Include appropriate aeromedical justification for each recommendation.

Command Endorsement: The member's commanding officer is aware and concurs with this member's diagnosis, prognosis, waiver requirements and waiver recommendation in this Aeromedical Summary. Official command endorsement is required for alcohol waivers (with SF 88 and 93 as per BUMEDINST 5300.8).

FS Signature
FS Signature *** Physician Signature***

***Read note on previous page on AMS signature

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F/A-18 Hornet over USS Carl Vinson (DVIC)

Psychiatry (Code 21)

Aviation Alcohol Waiver Standards

With many thanks to our RAM, LCDR Halencamp and our psychologist extraordinaire, CDR Ellis, the WAIVER GUIDE has recently be updated to incorporate all of the current requirements and to try to simplify your life a bit. Watch for these on the web. There are no *policy* changes, this just incorporates eight years of clarifications into one form and we hope we can make this convoluted process easier for you.

A summary of the primary changes/deletions/clarifications include:

- ANYONE who is aircrew and diagnosed with alcohol abuse must attend at least Outpatient Treatment (IMPACT is not adequate for aircrew).

- A full PE is required only with the first submission. Although we still need the accompanying documents per BUMED 5300.8, a short form PE is fine for the 2nd and 3rd years.

- Have the member submit a personal statement where he/she states the actual specific requirements of BUMED 5300.8 that they are meeting (not merely, "I am in compliance with all requirements of BUMED 5300.8"), indicate their unqualified acceptance of their diagnosis, and that they are committed to abstinence (not just *you* saying that they have remained sober).

- Give all aircrew diagnosed with abuse or dependence a copy of BUMED 5300.8 and document that you have reviewed it with them.

- Reference BUMED 5300.8 on any LBFS related to alcohol.

History of Current Standards

Here is some info to help your Line colleagues understand why we do things differently:

There are many factors that led to the 1992 changes in

the alcohol waiver standards. Prior to the original BUMEDINST 5300.8, an aviator diagnosed with alcohol abuse followed the same aftercare requirements as any Sailor or Marine with the diagnosis. BUMEDINST 5300.8 changed this and ensured similar standards for those diagnosed with alcohol abuse and alcohol dependence. Please refer to the updated Alcohol Waiver Guide on the NOMI Website (very shortly!) for detailed information on the waiver process. The biggest difference after 1992 is the requirement for sobriety for ALL aviation personnel diagnosed with Alcohol Abuse.

The two primary reasons behind this decision are:

1. Human factors continue to be present in 80% of aircraft mishaps – obviously these are not necessarily alcohol related in even the minority of cases, but a conservative approach is taken for many reasons. Some are: the measurable degradation in performance when there is even a nonmeasurable blood alcohol level (as it may still effect the vestibular system as long as 48 hours after cessation of drinking), the effects of alcohol on REM sleep with resultant fatigue, and the multitude of other problems which are alcohol-related and may be factors in aircraft mishaps. The current guidance is no alcohol within 12 hours of flight planning (Bottle to Brief). Those without an alcohol misuse problem would never consider violating this; ensuring the sobriety of those *with* an alcohol diagnosis is crucial.

2. The underdiagnosis of alcohol dependence by physicians. There have been numerous examples of cases where a pilot was diagnosed with alcohol abuse rather than dependence due to the lack of knowledge of the physician or a sense of peer pressure and intimidation. To be an effective flight surgeon, the physician must wisely tread the line between doing what is medically and ethically correct and alienating their squadron-mates. This incentive to underdiagnose was effectively removed by the 1992 change. The change was particularly prescient given the increased difficulty in diagnosing alcohol abuse and dependence with the change from DSM-III-R to DSM-IV (requiring an identified pattern within a 12 month period). Physicians in general are *not* given effective training in the accurate diagnosis of alcohol abuse and dependence. Their training in medical school, internship, and residency is focused on the recognition and treatment of the acute effects and the chronic sequelae of alcohol – ***not*** on how to recognize the early abuse/dependence diagnosis. The Navy no longer sends their student flight surgeons through a two-week visiting professional program, and many (most?!) physicians have never been to an AA meeting. We strongly encourage that all flight surgeons pursue this additional training experience at their duty stations, but it is often those most in need of the training that do not.

AV-8 Harrier (US Navy Photo)

"It Isn't Fair"

There are occasionally those who have been diagnosed with alcohol abuse who adamantly oppose the policy for sobriety. I have even encountered a commanding officer who called and angrily expressed his belief that it "wasn't fair" that his pilot couldn't drink (do we note some enabling?). Our response is, "To fly for the US Navy or Marine Corps is not a right, but a privilege." I always add that the aviator has a choice – if it is more important for them to drink than to fly – they may choose the former. Of course, that provides more evidence of their disease.

A Brief Comment on Medical Ethics

One of the main tenets of medical ethics and a consideration in any medical treatment decision is "DO NO HARM" (technically known as nonmalfeasance). We have at times heard the comment that some aviation personnel are getting "overtreated." My response is, "So?" If you are providing a treatment that has a significant risk, you only want to treat those who have been diagnosed with a high degree of accuracy (no, we don't recommend office trephination for a headache). But honestly, have you EVER met a human who cannot benefit

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from a 12-Step program? Also, we teach our student flight surgeons to adamantly adhere to DSM-IV to make a diagnosis. Even though we have a high index of suspicion with the first DUI and absolute surety with the second, if it is not in a 12 month period, and there is NO other evidence of abuse or dependence (after a very thorough eval), you cannot make the diagnosis.

Why Not Impact?

As a follow on to the above comment. . . If an aviation person has been diagnosed with even mild alcohol abuse, we insist they receive, at a minimum, Level I, Outpatient treatment - even if their non-aviation counterpart would get only IMPACT. Remember, they have the same aftercare requirements as those with alcohol dependence and as noted above, developing growth from involvement in a 12-step program will help those who may actually have early dependence – and not harm those with abuse who choose to return to responsible drinking when they leave aviation. The development of insight is *not* harmful.

Semper Gumby!

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NOMI Ejection Seat Trainer

Operational Risk Management

In the last edition of the SUSNFS, CDR Andy Bellenkes wrote a very detailed overview of the Navy program in Operational Risk Management (ORM). If you have not read it, please dig it out and give it a perusal. Over the next several editions, I would like to provide you with several sessions entitled, " ORM for Docs" which will help you learn how to incorporate ORM into your daily decision-making, prioritizing, and data-gathering processes.

First, it is important to address a medical syndrome that can at best be termed, "Acronymic Ennui." For those of us around in the late 80's and early 90's, many are in chronic treatment for the psychic damage caused by the three letters, TQM. For many of us, there is a Pavlovian conditioned gag reflex activated when these three letters are encountered in sequence. It anecdotally occurred to one Navy Captain while feeding his granddaughter Alphabits®. Actually, total quality management left a legacy with many valuable tools. Unfortunately, many shunned learning the tools (and threw the baby out with the bath water) because we were told to "DO IT" without any demonstration how using TQM could possibly improve our personal or professional lives.

ORM, like the other acronyms, can inspire a sense of repulsion if crammed down one's unprimed throat. I would like to win you over to use this tool at times by showing you how it can help make your life easier (and maybe help you make better decisions consistently). Please remember that ORM is a tool and nothing more. It is also only as effective as the humanoid using the tool. The goal of ORM is to offer an aid in the decision-making of anything where there is some inherent risk. The applicability ranges from an operational decision where lives are at stake, to an off duty decision affecting your family.

How many of you have a Leatherman® Tool? Although you can use a dime to unscrew many things, when you need a Phillips' head, it is really helpful to have a Leatherman® in your desk or car. Same with ORM. If you are making everyday decisions that have little to no inherent risk, it would be silly to spend even

the 20 seconds on ORM. But if there is a decision to make that has potential risk to persons, organization, reputation, etc. it doesn't hurt to have the right tool handy, in this case, ORM. Most of us like to think we make very good reasoned judgements all the time (HA!). What about when there may be other factors that might affect your judgement; deficient training or experience, peer pressure, subtle influences, illness, differing values, personality, politics, etc. Why not take the free opportunity to toss these variables out the window.

When the courses in ORM are taught locally, take one if you haven't already. We are now providing the rudiments to all student flight surgeons and residents in aerospace medicine. We are starting to apply the tools of ORM to our higher risk decisions at NAMI. Even if after you have taken the steps to learn how to use these simple tools, you think it's dumb, you still need to learn it. Why? Very simply it is the language of your line commanders and is valued by the CNO. If you want to gain credibility, you need to learn to speak the language of the culture you have joined. And besides, there is no downside to it – other than the syndrome of Acronymic Ennui – if you let yourself succumb. Remember, not all three letter acronyms are boredomogenic.

LESSON ONE:

The Basic Tenets of ORM:

1. ***Accept risk when benefits outweigh the cost*** – this does not mean full steam ahead regardless of cost. It means that the reason the CO makes the big bucks is because regardless of what the staff recommends, he or she is the one to make that decision. If you as the aeromedical advisor can offer specific recommendations on the risks involved in a particular situation, in their language, you will better accomplish your mission.

2. ***Accept no unnecessary risk*** – this does not mean take no risks. It does mean that you assess risks adequately, and if you determine that a specific aeromedical choice (or one in your personal life) has a risk analysis code of "2," or "serious," to give it a long hard look before acting, and maybe get a second opinion.

3. ***Anticipate and manage risk by planning*** – Well, DUH.

4. ***Make risk decisions at the right level*** – below is an example of how this principle correlates with our processes of aeromedical decision-making.

In flight surgery training, we all learn about the criteria for PQ and NPQ. We also learn what at times may be a safe deviation from norms and when it is *never* OK to do so. But much of the day to day decisions are left up to you. You may find it fairly easy to make a decision to deviate from an absolute when there is little risk. Here is the perfect example of an increasing hierarchy of increasing the level of decision-making when the risks are greater.

At your level, if someone is clearly PQ or there is minimal risk from a temporary problem, you can make the decisions.

If someone is NPQ but meets all of the requirements for a waiver, the decision can be made at the level of the Local Board of Flight Surgeons (LBFS) (with appropriate specialist input and follow up formal waiver request). Remember, the waiver guide is presumptively based on decisions and policy made using data and a higher level of determining how much risk is acceptable.

If someone is NPQ and does NOT meet waiver guide criteria, some of these cases are selected to be presented to a Special Board of Flight Surgeons (SBFS). The SBFS is instructed to consider the aeromedical risks *only*: the risks of the condition to the mission and risks of flying to the person with the condition.

If the SBFS does not recommend a waiver for a member, then it may go to a Senior Board of Flight Surgeons. It is at this higher level that they also take nonaeromedical information into account (importance of the individual's mission to the Navy/Marine Corps, etc.).

And finally, the CNO or CMC has the final say.

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What better illustration of making the decisions at the right level for the degree of risk involved.

Next newsletter in Lesson TWO I will offer you the nuts and bolts with several practical examples of how to use ORM.

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F-14 Tomcat (Official Navy Photo)

ENT (Code 22)

June 15, 2000

First: For those of you who go to the NOMI web site to consult the Waiver Guide, a completely revised and updated ENT section will soon be posted. The information will be more current than that on the recent edition of the "Ultimate Flight Surgeon's Guide" CD.

Second: An interesting, if unfortunate, case history.

A 24 y.o. student NFO was referred to the NOMI ENT Department after suffering his second left frontal sinus block in a month. He was very close to getting his wings, being only four hops from completing the syllabus, but his symptoms made it impossible to continue training. He gave a history of a lengthy grounding almost 10 months earlier because of a severe upper respiratory infection with persistent productive cough, but once he resumed flying he had no problems until the first episode of sinus barotrauma a month prior to being seen here.

Physical examination was unremarkable, but routine sinus films were grossly abnormal with evidence of sinusitis involving all sinuses. A sinus CT was obtained, which confirmed the presence of marked mucosal disease in all sinuses. The patient was diagnosed with chronic pansinusitis, placed on clindamycin, and referred to the ENT Department at the Naval Hospital.

He underwent functional endoscopic sinus surgery two weeks later, and six weeks after the surgery the surgeon and I cleared him for a medical run in NOMI's low-pressure chamber. Unfortunately, he had significant left frontal sinus pain on descent from 10,000 feet, and could not at that time be recommended for a waiver.

Flexible nasal endoscopy showed no obvious reason for his sinus pain in the chamber, so another CT was ordered. The CT was entirely normal, showing that virtually all preoperative mucosal disease had resolved. The patient's surgeon saw him again, and felt there was no indication for further surgery. It

was decided that he deserved another medical run in the chamber, and this was done two weeks after the first. This time he had absolutely no problems, so a waiver was recommended in anticipation that his squadron flight surgeon would convene a Local Board as soon as possible. This was on a Friday.

Saturday morning the student's father called me from Maryland saying that his son was in the Naval Hospital Emergency Department undergoing evaluation for "a couple of blackout spells". My immediate concern was that he may have suffered a CNS decompression hit in the chamber, or, equally unlikely, developed a pneumocephalus.

He apparently had been staying at his grandparents' home, and his grandmother found him slumped, apparently unconscious, between the bed and the wall on Saturday morning.

A consulting neurologist felt that he has suffered a seizure of some sort. Although he had not urinated, bitten his tongue, etc., he did appear post-ictal when first seen at the Naval Hospital.

An MRI scan of the brain done later that day revealed a frontal lobe cavernous angioma, which was felt to be the culprit. There was no evidence of any significant bleeding, but because of the possibility of catastrophic hemorrhage at some time in the future, it was felt that he should undergo neurosurgical removal, and this was safely accomplished during a six-plus hour surgery at Bethesda two weeks later.

The patient is doing very well at present, and although his flying career ended just shy of him getting his wings, he does have a chance of being returned to full duty at some later date.

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102ND ANNIVERSARY OF THE NAVY HOSPITAL CORPS

17 Jun 2000

CORPSMAN UP!

Up at the front and filled with fear,
He pleads with God, "Don't leave me here!"
Wounded and bleeding, hunched with pain,
Thrown on his back in the mud and rain,
Others went down, some hit, all scared!
No one moved, no one dared,
We'd move swiftly through the paddy mire,
And then it happened, enemy fire!

It's "CORPSMAN UP!" when things get hot,
The nearest thing to God we got,
"CORPSMAN UP!" to save a breath,
"CORPSMAN UP!" in the face of death.
Stop the bleeding, treat for shock,
No time for hesitation, "DOC!"
Patch him up and get him back,
Back to the rear, call a medevac!

You joined the Navy to learn a trade,
You went to school, and made the grade,
It's "CORPSMAN UP!" when rounds are flying,
CORPSMAN UP!" when men are dying.
You're one of us a grunt or grit,
Like it or not, you just can't quit.

"CORPSMAN UP!" STEP OUT OF RANKS,

"CORPSMAN UP!" AND ACCEPT OUR THANKS...

Tom Bartlett, MSGT, USMC
Date Unknown

From the Fleet

Laser corrective eye surgery keeps pilots flying

By JO3 Brad Pulley, USS Abraham Lincoln Public Affairs

USS ABRAHAM LINCOLN, At Sea (NWS) —

For most USS Abraham Lincoln (CVN 72) Sailors, May 17 was a day like any other. But for Lt. Cmdr. Kevin Mannix, an F/A-18 Hornet pilot for Strike Fighter Squadron (VFA) 25 on board "Abe," the day was all too special.

Mannix had become the first pilot with laser corrected vision to trap aboard an aircraft carrier. Vision is a major factor in the day-to-day activities on board the carrier, and no one knows that more than the Navy's finest fighter pilots.

Their vision is by far the most important sense they have and for some of the most skilled pilots, that sense may be degrading.

For years, Mannix has been plagued with deteriorating vision, having to wear as many as six different pairs of eyeglasses a day, each for a different purpose. One pair for walking, one for driving, one for day-flight, one for night-flight and so on.

This was the case, until just six weeks ago. That was when Mannix received corrective eye surgery. Laser corrective eye surgery to be exact.

"My vision was normally around 20/100, but by the time I got the surgery, I was at about 20/200," Mannix said. "Six weeks later, my vision is better than perfect at 20/12."

"The requirement to get the surgery done was vision worse than 20/50, so I more than qualified," Mannix said. "I decided to go in for the eye exam and took it from there." Following the three-hour-plus exam, it was concluded that Mannix could go ahead with the surgery.

"The hardest part about the whole thing was the exam. It seemed like it lasted forever," Mannix said. "The actual surgery itself lasted about 20 minutes."

According to Mannix, the doctor's motto is "20/20 in 20." The doctor Mannix refers to is Lt. Cmdr. David Tanzer, an optical specialist and refractive surgeon at the Naval Medical Center in San Diego.

"What I basically do is sit the patient down and we go through it all," said Tanzer. "I run a slew of different tests on the patients, looking at every possible problem they have with their eyes and then we base the surgery on the results."

One thing that all service members need to know is that this treatment is available to all active-duty personnel.

"There's a waiting list," Tanzer said. "Depending on your job, how high-profile it is and so on, you could wait anywhere from three months to three years before receiving the surgery. However, if you can wait, it could save you about $5,000 in all, or about $2,500 per eye."

"I'm ecstatic about the results," Mannix added. "I truly wish that everyone could have this done. I'm seeing things that I've never seen before and it's amazing. Contrast and definition are enhanced; my peripheral vision is perfect. It almost seems like my sight is unlimited."

The only real problem with the whole process, according to Mannix, is he had 30 days of down time before he was able to go flying once again.

"Being able to come in and trap on the flight deck again was a great feeling," Mannix said. "It's been a while since I've been able to do that and I think I did pretty well."

Mannix also has an acquaintance in the world of corrective surgery. Capt. Douglas Dupouy, commanding officer of USS Abraham Lincoln, has also received the treatment. In fact, Dupouy was the patient directly after Mannix.

Now that some of the Navy's finest pilots are receiving such treatment, it's possible for the Navy to retain their time and experience in the cockpit, right where it belongs.

For more information about this kind of procedure, go to http://navymedicine.med.navy.mil, go down to "links" and click on "Corrective Eye Surgery Information."

Start of PRK Study in Designated Aircrew

ADMINISTRATIVE MESSAGE ROUTINE R 101507Z MAY 00 ZYB PSN 872938J37

FM BUMED WASHINGTON DC//21//
SUBJ/LASER EYE SURGERY (PRK) IN DESIGNATED NAVAL MARINE CORPS AIRCREW
/CLINICAL STUDY ANNOUNCEMENT//

REF/A/MSG/BUMED/061344ZAPR2000//THE REFRACTIVE SURGERY POLICY IN THE NAVY AND MARINE CORPS//
POC/C.O. BARKER/CAPT/MED-23/LOC:WASHINGTON DC/TEL:COM 202 762-3451/TEL:DSN 762//

1. THE BUREAU OF MEDICAL AND SURGERY ANNOUNCES THE START OF A CLINICAL STUDY TO EVALUATE LASER EYE SURGERY (PRK) IN DESIGNATED NAVAL AND MARINE CORPS AIRCREW.

2. THE GOAL OF THE STUDY IS TO EVALUATE THE EFFECTIVENESS OF PHOTOREFRACTIVE KERATECTOMY (PRK) IN THE NAVAL AVIATION ENVIRONMENT. WHILE LASIK IS MUCH MORE COMMON IN THE CIVILIAN COMMUNITY, THIS PROCEDURE WILL NOT BE STUDIED AND WILL NOT BE CONSIDERED FOR WAIVER AT THIS TIME. THE PRK STUDY PROTOCOL WILL ALLOW ENROLLMENT OF NAVY AND MARINE CORPS PERSONNEL ON FLIGHT STATUS. PARTICIPANTS WILL RECEIVE PRK AT A MILITARY FACILITY AND WILL BE CLOSELY FOLLOWED.

3. PER REFERENCE A, NAVY AND MARINE CORPS PERSONNEL ON FLIGHT STATUS CAN BE CONSIDERED FOR A WAIVER FOR REFRACTIVE SURGERY ONLY IF ENROLLED IN THIS NAVY SPONSORED STUDY AND TREATED AT A NAVAL MEDICAL TREATMENT FACILITY.

4. CRITERIA FOR ENROLLMENT INCLUDE:
A. GIVE INFORMED CONSENT FOR PARTICIPATION IN THE STUDY
B. GIVE INFORMED CONSENT FOR THE PROCEDURE
C. ACTIVE DUTY NAVY OR MARINE CORPS PERSONNEL ON FLIGHT STATUS.
D. 1,000 HOURS TOTAL FLIGHT TIME; WITH 500 HOURS IN CURRENT TYPES FOR PILOTS. NFO AND AIRCREW HAVE NO FLIGHT HOUR MINIMUM REQUIREMENTS FOR ENROLLMENT.
E. MINIMUM OF ONE YEAR ACTIVE DUTY SERVICE OBLIGATION AFTER SURGERY.
F. COMMAND APPROVAL FOR THE PROCEDURE, 4 TO 6 DAYS OF CONVALESCENT LEAVE AND CONSIDERED "MED DOWN" FOR A MINIMUM OF ONE MONTH.
G. ABLE TO TRAVEL (AT PARENT COMMAND EXPENSE) TO EITHER PORTSMOUTH OR SAN DIEGO NAVAL MEDICAL CENTER FOR SURGERY AND IMMEDIATE POSTOPERATIVE EXAMINATIONS.
H. STATIONED IN PROXIMITY TO ONE OF THE DESIGNATED FOLLOW-UP STUDY SITES (SEE PARAGRAPH 8 BELOW).
I. AVAILABILITY FOR ALL POSTOPERATIVE FOLLOW-UP EXAMS. THESE EXAMINATIONS ARE AS FOLLOWS: 1 DAY 3 DAYS AFTER THE PROCEDURE, 2 WEEKS, 1,2,3,6, AND 12 MONTHS POSTOPERATIVE. MOST OF THESE EXAMS WILL BE APPROXIMATELY 60 MINUTES IN LENGTH, BUT SOME MAY BE AS LONG AS 2 HOURS. A QUESTIONNAIRE WILL BE ADMINISTERED DURING SEVERAL EXAMS.
J. MEET ALL MEDICAL INCLUSION AND EXCLUSION CRITERIA FOR THE SURGERY AS FOLLOWS:
    1) HEALTHY EYES.
    2) REFRACTION: MYOPIA: -1.00 TO -12.00 DIOPTERS(D), SPHERICAL EQUIVALENT AT THE CORNEAL PLANE, WITH LESS THAT OR EQUAL TO 4.00D OF ASTIGMATISM. HYPEROPIA: +1.00 TO +6.00, SPHERICAL EQUIVALENT AT THE SPECTACLE PLANE, WITH LESS THAN OR EQUAL TO 1.00D OF ASTIGMATISM.
    3) STABILITY: STABLE REFRACTION AS DEFINED AS LESS THAN OR EQUAL TO0.5D OF CHANGE IN EITHER THE SPHERICAL OR CYLINDRICAL COMPONENT OF THE MANIFEST REFRACTION OVER THE LAST 12 MONTHS.
    4) NOT CURRENTLY TAKING THE FOLLOWING MEDICATIONS: ISOTRETINOIN(ACCUTANE), AMIODARONE HYDROCHLORIDE (CORDARONE) AND/OR SUMATRIPIN(IMITREX).

5. STUDY CANDIDATES CAN BE SCREENED AND REQUEST ENROLLMENT THROUGH PARTICIPATING NAVY EYE CLINIC STUDY SITES (SEE BELOW.) SCREENING FORMS CAN BE OBTAINED EITHER THROUGH PARTICIPATING STUDY SITES, OR CAN BE DOWNLOADED FROM THE NAVY REFRACTIVE SURGERY WEBSITE AT:
HTTP://NAVYMEDICINE@US.MED.NAVY.MIL.
NOTE THAT THE SCREENING FORM IS SPECIFIC FOR AVIATION PERSONNEL, AND IS CLEARLY MARKED AS SUCH.

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(continued from page 21)

6. SURGERY WILL BE PERFORMED AT EITHER NAVAL MEDICAL CENTER SAN DIEGO OR NAVAL MEDICAL CENTER PORTSMOUTH. ADDITIONAL SURGERY CENTERS MAY BE AVAILABLE IN THE FUTURE.

7. REQUIREMENTS TO RETURN TO FLIGHT DUTY INCLUDE BEING CORRECTABLE TO 20/20 OR BETTER IN EACH EYE, HAVE NO VISUAL SYMPTOMS RELATED TO THE PROCEDURE AND HAVE STABLE REFRACTIVE ERROR. REFRACTIVE STABILITY IS DEFINED AS NO MORE THAN 0.50 DIOPTERS OF CHANGE FOR TWO CONSECUTIVE EXAMS SEPARATED BY AT LEAST TWO WEEKS. THE FIRST POSTOPERATIVE OPPORTUNITY TO MEET THIS WILL BE AT THE 1-MONTH POSTOPERATIVE EXAM. MOST STUDY PARTICIPANTS WILL BE ABLE TO RETURN TO FLIGHT DUTY AT ONE MONTH, HOWEVER PROLONGED HEALING TIME AND LOSS OF BEST-CORRECTED VISION ARE KNOWN RISKS AND THERE MAY BE A PROLONGED "MED DOWN" PERIOD IN A FEW CASES.

8. PARTICIPATING STUDY SITES INCLUDE NAVY EYE CLINICS LOCATED AT: NAS BRUNSWICK, NMC PORTSMOUTH, NAS CHERRY POINT, NAS BEAUFORT, NAS PATUXENT RIVER, NAS JACKSONVILLE/NAS MAYPORT, NAS PENSACOLA, NAS MERIDAN, NAS CORPUS CHRISTI, NAVAL HOSPITAL OAK HARBOR, NH PORT HUENEME, NAS LEMOORE/NAS FALLON, NAS YUMA, REFRACTIVE SURGERY CENTER NMCSD, MCAS MIRAMAR, NAS NORTH ISLAND, MCAS CAMP PENDLETON, NAS BARBERS POINT, OKINAWA, YOKOSUKA. ADDITIONAL STUDY SITES MAY BECOME AVAILABLE AS THE STUDY PROGRESSES

9. TO APPLY FOR ENROLLMENT IN THE STUDY:
A. OBTAIN AN AVIATION PRK STUDY SCREENING AND CONSULT FORM. FORMS CAN BE OBTAINED EITHER FROM A PARTICIPATING STUDY SITE OR THE REFRACTIVE SURGERY WEBSITE.
B. FILL OUT THE PATIENT INFORMATION SECTION OF THE FORM.
C. REQUEST THAT YOUR CO SIGN THE WRITTEN AUTHORIZATION SECTION OF THE FORM.
D. SCHEDULE AN APPOINTMENT TO HAVE A SCREENING AT A PARTICIPATING STUDY SITE THAT WILL THEN FAX COMPLETED FORM TO THE STUDY CENTER AT NMCSD FOR REVIEW.
E. YOU WILL BE CONTACTED BY THE STUDY CENTER BY MAIL, E-MAIL OR PHONE UPON RECEIPT OF THE SCREENING FORM, AND AGAIN IF SELECTED FOR ENROLLMENT.
F. SELECTIONS WILL BE BASED UPON PRE-DETERMINED LIMITS OF SUBJECTS FOR EACH STUDY SUB-GROUP.
G. IF SELECTED, YOU WILL BE ASSIGNED A SURGERY DATE, TREATMENT CENTER AND FOLLOW-UP STUDY SITE.
H. APPLICANTS MUST MEET ALL INCLUSION AND EXCLUSION CRITERIA OUTLINED IN PARAGRAPH 4 TO BE SELECTED.

10. POINTS OF CONTACT FOR FURTHER INFORMATION ARE PARTICIPATING EYE CLINIC STUDY SITES AS FOLLOWS:
A NAS BRUNSWICK LCDR MATT NEWTON, 207-921-2506, DSN 476-2506, MENEWTON@US.MED.NAVY.MIL
B. NMC PORTSMOUTH MS. MARY MITCHELL, 757-953-2676, DSN 564-2676, MEMITCHELL@MAR.MED.NAVY.MIL
C. NAS CHERRY POINT LT JONATHAN NOBLE, 252-46-0259, DSN 582-0259, CHP1JRN@CHP10.MED.NAVY.MIL
D. NAS BEAUFORT LCDR JULIE MIAVEZ, 843-228-5478, DSN 335-5478, JLMIAVEZ@BEAUFORT.MED.NAVY.MIL
E. NAS PATUXENT RIVER LT JIM LYNCH, 301-342-1499, DSN 342-1499, JRLYNCH@PAX10.MED.NAVY.MIL
F. NAS JACKSONVILLE/NAS MAYPORT LT NICK ROAN, 904-542-3500 EXT 8848, DSN 942-3500, LNROAN@SAR.MED.NAVY.MIL
G. NAS PENSACOLA LCDR ANNA STALCUP, 850-452-2257, DSN 922-2257, CODE230@NOMI.MED.NAVY.MIL
H. NAS MERIDAN CDR RICK SAVOY, 601-679-2633 EXT 2597, DSN 637-2633, PSA1RSS@PSA10.MED.NAVY.MIL
I. NAS CORPUS CHRISTI LCDR LISA BISHOP, 361-961-3474, DSN 861-3474, CCH1LCB@CCH10.MED.NAVY.MIL
J. NAVAL HOSPITAL OAK HARBOR LCDR PHIL HEINEMANN 360-257-9811, DSN 820-9811, OKH1PCH@OKH10.MED.NAVY.MIL
K. NH PORT HUENEME LCDR VINCE POTTS, 805-982-6336, DSN 551-6336, HUEMAXP@HUE10.MED.NAVY.MIL
L. NAS LEMOORE/NAS FALLON LCDR STEVE COOLEY, 559-998-4459, DSN 949-4459, SCOOLEY@LEM10.MED.NAVY.MIL
M. NAS YUMA LCDR PETE DANHOFF, 520-341-5735, DSN 951-5735
N. REFRACTIVE SURGERY CENTER NMCSD HM2 DAVID CRAIN, 619-524-5515, FDCRAIN@NMCSD.MED.NAVY.MIL
O. MCAS MIRAMAR LCDR SHERIDAN MARTIN, 858-577-4652, DSN 577-4652, SAMARTIN@NMCSD.MED.NAVY.MIL
P. NAS NORTH ISLAND LT MITA RAHMAN, 619-545-0434, DSN 735-0434, NORTHISLAND OPTOMETRY@YAHOO.COM
Q. MCAS CAMP PENDLETON, LT CYRUS RAD, 760-725-5912, PEN1CNR@PEN10.MED.NAVY.MIL
R. NAS BARBERS POINT LT ELIZABETH MCLEMORE, 808-257-3365XT331,
ELIZABETH_M.MCLEMORE@TAMC.CHCS.AMEDD.ARMY.MIL
S. OKINAWA LT KEN LOFTUS, 011-81-611-743-7387, DSN 643-7387, LOFTUSKA@OKI10.MED.NAVY.MIL
T. YOKOSUKA LCDR DAN ROSENBAUM, 011-81-311-743-5371, DSN 243-5371

11. CAPT J.F. JEMIONEK SENDS.//

Dual Designator Selection Board

ADMINISTRATIVE MESSAGE ROUTINE R 231606Z JUN 00 ZYB PSN 341771J23

FM BUMED WASHINGTON DC//02//

SUBJ/FY-01 DUAL DESIGNATOR (DD) AVIATOR-FLIGHT SURGEON, AEROSPACE/PHYSIOLOGIST, AEROSPACE EXPERIMENTAL PSYCHOLOGIST SELECTION BOARD/CALL FOR APPLICATIONS//

REF/A/DOC/OPNAVINST 1542.4B/01OCT1999//CNO NAVAL AVIATOR/FLIGHT SURGEON/AEROSPACE PHYSIOLOGIST/AEROSPACE EXPERIMENTAL PSYCHOLOGIST (NA/FS/AP/AEP)PROGRAM INSTRUCTION WITH PROGRAM APPLICATION FORM//POC/K. M. BELLAND/CDR/NSAWC, TOPGUN/LOC:FALLON NEVADA/TEL:COM (775) 426-3112/TEL:COM (775) 426-3910/TEL:DSN 890/EMAIL:BELLANDK@NASWC.NAVY.MIL//

1. THE FOLLOWING INFORMATION IS PROVIDED TO POTENTIAL APPLICANTS IN PREPARATION FOR SUBJECT PROGRAM. REQUIREMENTS ARE:

A. FY-01 BOARD WILL CONVENE LATE NOVEMBER OR EARLY DECEMBER 2000. PER REFERENCE (A), SEND APPLICATIONS TO DIRECTOR, AEROSPACE MEDICINE, ATTENTION CAPT C. O. BARKER, U.S. NAVY BUREAU OF MEDICINE AND SURGERY (MED-23), 2300 E STREET NW, WASHINGTON DC 20372-5300, NLT 30 SEP 00. FORWARD VIA CHAIN OF COMMAND.

B. ALL APPLICANTS MUST

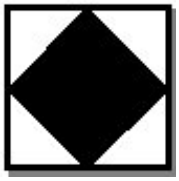
1) BE A DESIGNATED NAVAL AVIATOR, NAVAL FLIGHT OFFICER OR HAVE EQUIVALENT DESIGNATION IN ANOTHER U.S. MILITARY SERVICE. THOSE HOLDING AERONAUTICAL PILOT RATINGS FROM OTHER MILITARY SERVICES WILL BE CONSIDERED AS A SEPARATE CATEGORY DURING SELECTION BOARD PROCEEDINGS.
2) BE A DESIGNATED NAVAL FLIGHT SURGEON (FS), NAVAL AEROSPACE PHYSIOLOGIST (AP) OR EXPERIMENTAL PSYCHOLOGIST (AEP). NON-NAVAL AVIATOR, NON-NAVAL FLIGHT OFFICER FS/AP/AEP APPLYING FOR THE PROGRAM WILL BE CONSIDERED ON A CASE-BY-CASE BASIS.
3) SUBMIT APPLICATION PACKAGE VIA CHAIN OF COMMAND TO INCLUDE:

A) APPLICATION FORM AND CURRICULUM VITAE.
B) COMPLETE FLYING RECORDS, INCLUDING COPIES OF ALL CERTIFICATES FROM FORMAL COURSES ATTENDED, AND FLIGHT EVALUATION REPORTS.
C) A SUMMARY OF MILITARY/CIVILIAN FLIGHT EXPERIENCE INCLUDING FLIGHT HOURS IN TYPE, MISSION QUALIFICATIONS AND OTHER DESIGNATIONS.
D) SUMMARY OF ALL UNDERGRADUATE AND TRAINING.
E) TRANSCRIPTS FROM FORMAL MEDICAL TRAINING PROGRAMS.
F) LETTER OF APPLICATION STATING PERSONAL GOALS AND REASONS FOR REQUESTING DUAL DESIGNATOR STATUS.
G) WRITTEN RECOMMENDATIONS FROM AT LEAST TWO MEDICAL DEPARTMENT AND TWO LINE SUPERVISORS.
H) CURRENT FLIGHT PHYSICAL (SF-93 AND SF-88) INDICATING PQ SERVICE GROUP I, II, OR III FOR NA'S OR CLASS II DIF FOR NFO'S.

2. WIDEST DISSEMINATION REQUESTED.

3. CAPT STEVE E. HART, ASS'T CHIEF FOR OPERATIONAL MEDICINE AND FLEET SUPPORT SENDS//

Naval Operational Medicine Institute
212th Flight Surgeon Graduation Ceremony
23 June 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 23 June 2000. The commencement address was given by Rear Admiral Michael Bucchi, USN, Chief of Naval Air Training Corpus Christi, Texas. The following is a list of the graduates and their new assignments.

Anchors Away!

Flight Surgeon Class 20002	**Billet Assignment**
LCDR Mark D. Benton, MC, USNR	TRAWING 5, NAS, WHITING FIELD
LCDR David T. Beverly, MC, USN	COMAEWWING PAC, PT MUGU CA
LCDR Octavio J. Carreno, MC, USNR	2ND MAW FMF LANT, CHERRY POINT NC
LCDR Benjamin D. Freilich, MC, USNR	RESERVIST
LCDR Robert W. Johnson, MC, USN	VAQ 129, WHIBEY IS WA
LT Glen W. Barrisford, MC, USNR	COM CVW PAC DET, PT MUGU CA
LT Aaron M. Bates, MC, USNR	TRAWING 4, CORPUS CHRISTI TX
LT James R. Cacchillo, MC, USNR	COM CVW 3, NAS OCEANA, VA
LT Lily Chu, MC, USN	VP 10, BRUNSWICK ME
LT Robert A. Guardiano , MC, USNR	COM CVW 1, NAS OCEANA, VA
LT Joseph S. Hong, MC, USNR	MAW 39, CAMP PENDLETON CA
LT Walter D. Kucaba, MC, USNR	MAG 31 MCAS, BEAFORT SC
LT Kennett J. Moses, MC, USNR	3RD MAW UNITS ,MCAS MIRAMAR CA
LT Jennifer R. Nelson, MC, USNR	NAVAMBCARCEN, PT HUENEME CA
LT Brice R. Nicholson, MC, USNR	NAS, WILLOW GROVE PA
(Recipient of the **Surgeon's General Award for Student Excellence**)	
LT Nichole M. Olekoski, MC, USNR	3RD MAW UNITS MCAS, MIRAMAR CA
LT Brian R. Riley, MC, USNR	BRMEDCL, KEY WEST FL
LT Julie A. Ritner, MC, USNR	MAG 13, YUMA AZ
LT Steven C. Romero, MC, USNR	BRMEDCL ATSUGI JA
LT David N. Strauss, MC, USNR	NAS, ATLANTA GA
LT John A. Williamson, MC, USNR	2ND MAW FMF LANT, CHERRY POINT NC
(Recipient of the **Commanding Officer's Fox Flag Award**)	
LT Marc H. Willis, MC, USNR	MAG 26 NEW RIVER, JACKS NC
LT Timothy D. Wingo, MC, USNR	2ND MAW FMF LANT, CHERRY POINT NC
LT Gordon G. Wisbach III, MC, USNR	MAG 39, CAMP PENDLETON CA
LT Timothy P. Zinkus, MC USNR	VAQ 129 SEA DUTY COMP, WHIDBEY IS

Aerospace Physiologist Class 20002	**Billet Assignment**
LTJG Frank G. Ormonde, MSC, USNR	NOMI ASTC, WHIDBEY IS WA
LTJG Ronald Schoonover, MSC, USNR	NOMI DET WEST, SAN DIEGO CA

Aerospace Experimental Psychologist Class 2002	**Billet Assignment**
LTJG Amber Biles, MSC USNR	NOMI DET WEST, SAN DIEGO CA

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

Flight Surgeon Class 20002

Naval Operational Medicine Institute
Residency in Aerospace Medicine
Year 2000 Graduates

July 1st, 2000 marked the graduation of 12 residency trained Aeromedical Specialist from the Naval Operational Medicine Institute, the largest class ever. These specialists are trained to be experts in aeromedical analysis, treatment and policy. Many of the graduating residents are previously trained in other medical specialties along with their specific training in Aerospace Medicine. The residency consist of a PGY-1 clinical year in any specialty (Internship), a PGY-2 year obtaining a Masters in Public Health and PGY-3 and 4 years being trained in Aeromedical Policy, Hypo/Hyperbaric medicine, Safety and Occupational Medicine, etc.

The Residency in Aerospace Medicine is available to all U.S. Armed Forces Physicians, for which preference is given in the selection process. Prior designation as a Flight Surgeon is desirable, but not a requirement for selection. For application materials and procedures for this exciting operational specialty, contact the Naval Operational Medicine Institute.

These graduates have successfully completed their required training and now move to the Fleet to help increase readiness, provide leadership and to be source experts for the operational flight surgeon. The following is a list of the graduates and their new assignments.

Anchors Away!

Graduating RAM Class of 2000

from left to right: LT Buratynski, LCDR Halenkamp, LT Troche, LCDR McMahon, CDR Valbracht, LCDR Douglas, LT Wells, LCDR Gibson, LT O'Hara, CDR Lee, LCDR Smith, CDR Mandel

RAM Trained Aeromedical Specialist	Billet Assignment
CDR Lee Mandel, MC, USNR	SMO, USS TRUMAN (CVN-75)
CDR Lou Valbracht, MC, USN	SMO, USS LINCOLN (CVN-72)
CDR John Lee, MC, USN	SMO, USS ENTERPRISE (CVN-65)
LCDR Jamin McMahon, MC, USNR	SMO, USS CARL VINSON (CVN-70)
LCDR Brad Smith, MC, USN	1st MAW, Futenma, Japan
LCDR Dave Gibson, MC, USNR	MAG-31, MCAS Beaufort, NC
LCDR Tim Halenkamp, MC, USNR	MAG-39, Camp Pendleton, CA
LCDR Brad Douglas, MC, USN	COMFITWINGLANT, Oceana, VA
LT Jose Troche, MC, USNR	HMT-302, Navy Det, Jacksonville, FL
LT T.J. Buratynski, MC, USNR	NAVMEDCLIN, Pearl Harbor, HI
LT Brian Wells, MC, USNR	FITRON-125, Lemoore, CA
LT Timothy O'Hara, MC, USN	HC-5, Guam

We at the Naval Operational Medicine Institute want the Naval Aviation community to know that we are launching a group of graduates who take to the Fleet to serve not only aviation personnel, but all those who contribute to the Navy's mission and the mission success of the Fleet. Fare winds and following seas to our departing shipmates!

Home to a future RAM graduate....USS George Washington (CVN-73) (US Navy Photo)

Naval Operational Medicine Institute

Residency in Aerospace Medicine
Class of 2002 RAM's

On June 21st, 2000, NOMI welcomed a new class of Aerospace Medicine Residents to their post-graduate year 3 training. This is a diverse group of people who completed a Masters of Public Health at institutions such as Harvard, Johns Hopkins, Tulane, West Virginia University, University of Hawaii, University of Kansas, and University of Massachusetts. Among these residents are 3 Army members who signify the increased importance the program is placing on joint service training.

PGY-3 Residents	Previous Billet
CDR Gerry Goyins, MC, FS, USNR	Dept Head, Emergency Med, Naples, Italy
CDR Robert Wesley Farr, MC, FS, USNR	Staff Faculty, Infectious Dz, University WVA
CDR Charles A. Ciccone, MC, FS, USN	Dept Head, Primary Care, Groton, CT
LCDR Dave DeLonga, MC, USNR	Internship, NNMC Bethesda, MD
MAJ Monica Gorbandt, MC, FS, USA	C Co 626th FSB, 101st Airborne, Ft Campbell
LCDR Pete Wechgelaer, MC, FS, USN	HMH-464 Flight Surgeon
MAJ Jack Husak, MC, FS, USA	Chief, Occupational Health, Ft Belvoir, VA
LCDR William S. Padgett, MC, USN	Staff Pediatrician, BRMEDCLN, Key West
LT Charles Wilson, MC, FS, UMO, USNR	USS Frank Cable, Guam
CPT Samual W. Sauer, MC, FS, USA	BAT FS, HQ 2nd BAT, 25th INF, Hawaii
LT George Newton, MC, USNR	Transitional internship, NH San Diego
LT Christopher Lucas, MC, FS, USNR	MCAS, El Toro, CA
LT Brian O'Neal, MC, USNR	Internship, NNMC Bethesda, MD
LT Tarah Johnson, MC, USNR	Internship, U of Alabama at Birmingham

Class of 2002 Incoming RAM's

From left to right: LT O'Neal, LT Johnson, LT Newton, MAJ Husak, LCDR Padgett, LT Wilson, CDR Ciccone, MAJ Gorbandt, LT Lucas, LCDR Wechgelaer, CPT Sauer, LCDR DeLong. Not Pictured: CDR Goyins & CDR Farr

RAM Corner

Civilian Medical Facility Utilization by Naval Aviation Personnel:A study in Progress

Within the last year the Residency in Aerospace Medicine has forged many new inter-institutional agreements (IA's) for residency rotations with various educational and clinical institutions throughout the country. Perhaps one of the most promising relationships has turned up in our own back yard, the Escambia County Health Department (ECHD).

Because of this new medical alliance, it has come to the attention of the Naval Operational Medicine Institute (NOMI) that a certain number of aviation personnel over the last couple of years have been seen at the ECHD for sexually transmitted disease. While the idea of sailors and pilots obtaining sexually transmitted diseases (STDs) is not an extreme revelation, what is a relevation is that these visits were to a civilian medical facility.

In light of these anecdotal reports from ECHD staff, an anonymous cross match of social security numbers from NOMI's aviation physical database with the ECHD database was conducted. The ECHD database dates back to 1995, thus data accumulation is only for 5 years; however, there were still some very interesting results. From Jan 1995 - Jan 2000, there were 84 visits by local naval aviation personnel. Of the 84 visits, 79 charts were obtained and reviewed, names and SSNs were taped off for anonymity. Of the 79 charts reviewed, 100% of the patients seen at the ECHD clinic were for STD screening. The average age of the patient seen was 25.6 years. Race was broken down by Caucasian, 84.8%; African American, 13.9%; and Asian, 1.3%. Males were the predominant gender seen, 93.6% males versus females, 6.3%. Of the 79 patients screened 30 patients (38%) were ultimately diagnosed with an STD. Of the positively diagnosed patients, 14 (46%) were diagnosed with genital warts, 6 (20%) were diagnosed with Chlymdia, 4 (14%) were diagnosed with Herpes, 3 (10%) with Gonorrhea, and 3 (10%) with scabies or crabs.

Because ECHD is just one of many civilian medical institutions in the area, and STDs are just one of several diagnoses that aviation personnel might not want their Flight Surgeon to know about, it is suspected that utilization of civilian medical facilities by aviation personnel is widespread. To elucidate this problem further an anonymous questionnaire has been sent to over 1600 naval aviation personnel on both east and west coasts to determine the most common diagnoses and reasons for which our aviation personnel are seeking civilian medical care. Results of these questionnaires will be forthcoming in future issues of the Society of United States Naval Flight Surgeons Newsletter.

LT G. Merrill Rice III, MC, USNR
rice@nomi.med.navy.mil
DSN 922-2257 ext.1058
(850) 452-2257 ext.1058

Multiple Aicraft Types over the Pyramids *(Defense Visual Information Center)*

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

Sweetheart FS Wings Necklace, 14K Gold/Diamond Chip

Full Size 14K Gold Flight Surgeon Wings

The Society of U.S. Naval Flight Surgeons

PO Box 33008
NAS Pensacola, FL 32508-3008

Telephone: COM (850) 452-2257 ext. 1056 / 1075; FAX (850) 452-5194; DSN 922-

Address Change, Subscription/Membership Renewal, Price List, and Order Form (Jun 2000)

#	ITEM	PRICE		SUB-TOTAL
	(Indicate Size and Color Where Appropriate)	*Non-Member/Member*		
___	T-shirt: SUSNFS "FS - Yesterday and Today" (M, L, XL)	24.00	19.00	_____
___	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)	5.00	5.00	_____
___	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	5.00	5.00	_____
___	FS Wings 'Skrunchie'	1.50	1.50	_____
___	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		_____
Shipping and Handling:				
	For all items (do not include refrigerator magnet):	$4.00 for 1st item, $1.00 for each additional item		_____
	For jewelry items - postal insurance (add for 1st jewelry item only):	$2.00		_____
Membership or Subscription Renewal:		___ years at $20.00/year		_____
Life Membership/Subscription:		$300.00		_____
		Total Amount Enclosed		_____

Name and Address: Is this an address change? Y / N **Are You a Current Member of AsMA? Y / N**

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_____

CAPT Mike Valdez Named as Interim NAMI OIC

CAPT Michael R. Valdez, MC, USN was named the interim NAMI OIC on July 12th, replacing CAPT Fanancy L. Anzalone who is transferring to Naval Hospital Naples as the Commanding Officer. CAPT Valdez is currently the Director of the Residency in Aerospace Medicine at the Naval Operational Medicine Institute and will continue those duties concurrent with his new appointment. Electronic mail can still be addressed to namioic@nomi.med.navy.mil for business related to NAMI.

CDR Terry Puckett Named as Flight Surgeon Detailer

In an unexpected change of duty station to Millington Tennessee, CDR Terry Puckett, MC, USN was named as the new Flight Surgeon Detailer. CDR Puckett leaves his current billet as Department Head of Medical Officer Programs at NAMI. CDR Puckett can be contacted via the normal channels for detailing issues.

SUSNFS EDITORIAL POLICY

The views expressed are those of the individual authors and are not necessarily those of the Society of U.S. Naval Flight Surgeons, the Department of the Navy, or the Department of Defense.

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:

CAPT M.R. Valdez, MC, USN
Editor, SUSNFS Newsletter
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NAS Pensacola, FL 32508-3008

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