



The Society of U.S. Naval Flight Surgeons Newsletter

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President's Column

Transition is a hallmark in Naval Aerospace Medicine. This year's annual convention of the Aerospace Medical Association marked the inauguration of Admiral Donald C. Arthur, Deputy Surgeon General of the Navy, as the President of AsMA. I know it will be an exciting year for Aerospace Medicine with him at the helm. Another **transition** that occurred this year was official stand-up of the Naval Aerospace Medical Institute (NAMI, yet again) as a formal detachment of the Naval Operational Medicine Institute, with Captain Natalie Willenberg as Officer-in-Charge. She assumed OIC duties from Captain Mike Valdez. Many thanks go to Captain Mike Valdez for his outstanding service as OIC. CAPT Valdez not only wore the NAMI OIC "hat," but also continued full duties as Aerospace Residency Program Director. Parenthetically, Mike continued his efforts as our SUSNFS Newsletter editor and chairman of the Awards Committee. Kudos Mike! I know CAPT Willenberg will continue Mike's legacy of strong leadership and commitment while at the helm of NAMI.

Still yet another **transition** was my assumption of duties as President of SUSNFS, succeeding Captain Fanancy Anzalone. Captain Anzalone was a strong leader and spearheaded significant changes to the organization during his tenure as Vice President and then as President. He will be greatly missed. I have big shoes to fill and much for which to thank him. I wish him continued success as Commanding Officer of Naval Hospital, Naples, Italy.

This year's AsMA convention was an outstand-



ing success, with major revisions to the "All Navy Luncheon" that were a resounding success and made the event a truly ALL Navy Luncheon. There are many people to thank for the success of this luncheon. The luncheon committee was truly "ecumenical" this year—CDR Ed Feeks (MED 23 rep), CDR Andy Bellenkes (AEP rep), CDR Mitch Brown (AO rep), LCDR Brian Swan (Society of U.S. Naval Aerospace Physiologists—SUSNAPS rep) and LCDR Dave Weber (SUSNFS rep). Great job guys!

This year promises to be another year of **transition** for SUSNFS. I am initiating a membership cam-

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THE SOCIETY OF U.S. NAVAL FLIGHT SURGEONS
P.O. Box 33008
NAS PENSACOLA, FL 32508-3008

2001-2002 SOCIETY OFFICERS

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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.

paign to bring every designated Flight Surgeon into the organization. We need to be more aggressive in our recruiting affairs. Commander Glen Merchant has taken the Chairmanship of the Membership Committee and plans to actively seek out our Flight Surgeons and bring them into the fold. Further, he is dedicated to having every Flight Surgeon SUSNFS subscriber become a member of AsMA, thus affording them full voting membership status in SUSNFS. Exciting!

Another *transition* will be initiation of a SUSNFS Historian. There is much in our aviation and space medicine legacy that needs to be captured, recorded, and preserved. Our story needs to be told and exhibited in the National Naval Aviation Museum in Pensacola, Florida. More later...

Transition is a fact in our Society. Without transition there is stagnation and with stagnation comes inevitable demise. We must continuously and aggressively seek out opportunities to improve ourselves, SUSNFS, and the Aerospace Medicine community. I look forward to our "making it so!"

Godspeed/ Charlie Barker

Congratulations 2001 SUSNFS Award
Winners

The Society of United States Flight Surgeons annually recognizes the best in our community with awards sponsored by the Society. Annually a message is released via the Naval Message service announcing the awards and the criteria. This year there were many outstanding applicants for each of the three awards provided. Congratulations to those who were nominated as well as to the three winners of this years awards!

2001 Ashton Graybiel Memorial Award - For outstanding and significant contributions to the scientific literature leading to advances in the field of Aerospace Medicine.

CDR David G. McGowan, MC, USNR

2001 Sonny Carter Memorial Award - For outstanding contributions towards improving the health, safety and welfare of operational forces by promoting communication and teamwork among the aeromedical communities.

LT Alexander S. Brough, MC, USN

2001 Richard E. Luehrs Memorial Award - Naval Operational Flight Surgeon of the Year.

LT Sean P. Barbabella, MC, USNR

From the Secretary

Greetings!!! The AsMA conference in Reno was a great opportunity to meet many in our community, and I look forward to getting to know more of the Flight Surgeons out in the fleet as my year as SUSNFS secretary progresses. Please, keep SUSNFS informed about your needs and we will strive to meet them. E-mail is a great way to get your questions and observations to us. The SUSNFS Newsletter will continue to be the essential source for timely, relevant aerospace knowledge as long as the operational Flight Surgeons continue to provide updates on the needs of the aviation community.



I must thank LCDR David K. Weber for his strong work as the secretary last year. He has done an outstanding job on the newsletter and put on a great show at AsMA. Dave has also been a great mentor teaching others about the ways of SUSNFS and left many tools to make the secretary's job easier in the years to come. LCDR Weber and his predecessor, LCDR David W. Gibson, have put in place processes that will continue to strengthen the effect of SUSNFS on aerospace medicine in the Navy.

Our new president, CAPT Charles O. Barker, is well known to SUSNFS readers for his frequent MED-23 articles keeping Flight Surgeons abreast of the newest happenings in our field. Upon accepting office at AsMA, he stressed two of his priorities; membership and history.

We need to continue to shape the organization so that it is relevant to both first tour Flight Surgeons as well as those with many tours under their belts. We are a diverse group with many isolated and far-flung members. Membership in SUSNFS allows Flight Surgeons to thrive in a close-knit supportive community that provides a strong professional image to the Navy. Those that have gone on to other residencies are important to keep in our Society. Once a Flight Surgeon, always a Flight Surgeon. The further training only increases the ideas they can contribute to aerospace medicine. Continue your membership in the Society and look for oth-

ers who would benefit by becoming members. I will work to educate the newly graduating Flight Surgeons about the Society. In return for your input, SUSNFS will disseminate the knowledge gained by its members to the Flight Surgeon community.

CAPT Barker will be looking to get a Flight Surgeon history display at the Naval Aviation Museum. I know this has long been a goal of this society and many Flight Surgeons have worked on this project at one time or another. We will keep plugging away at it and in the meantime begin to develop some of our historical material for dissemination through the website.

The website has added new information such as links to the new Flight Surgeon Duties and Responsibilities Document as well as the 5th Edition Pocket Mishap Guide put out by the Naval Safety Center. Please look at the site and provide feedback on ways to make it more useful to you. We are trying to develop a historical list of Flight Surgeons in each billet over the years as well as information about the billets. Send me any information that you have that will fill in the plentiful gaps. Also, make sure you go to the new NAMI site at www.nomi.navy.mil and sign up for the Flight Surgeon mailing list. CDR Jay Dudley is using the list to send out timely information on issues relevant to our community.

I look forward to my duties as secretary of SUSNFS and hope to continue on the strong work of my predecessors. Input from Flight Surgeons actually working with the aviators is as important to us as information provided by those here in Pensacola. Continue to send in information ranging from short questions to full articles so that SUSNFS can remain the premiere resource for Flight Surgeons.

LCDR William S. Padgett, MC, USN

wspadgett@nomi.med.navy.mil

DSN 922-5497/4740/4285

(850) 452-5497/4740/4285

From the Treasurer

Greetings One and All,

It was great to see so many of you at the annual AsMA conference this year. Once again, the AsMA folks put on a terrific "spread" of CME for all of us.



The new fiscal year is upon us and we have some changes in the officers of SUSNFS. Those of you who voted to change the By-laws will remember that we instituted some important changes. The biggest of those is that we now have an assistant treasurer, LT Anne White. Anne works in Code 26 doing one of the truly important jobs of our command, examining applicants for aviation. She certainly is a welcome addition to the team. Of course we want to welcome CAPT Charlie Barker to the front as our new president and CAPT Jim Fraser as the President-elect for next year. We look forward to a rewarding year with them at the helm.

The weather is getting hot here in Pensacola so we want to encourage all of you to increase your wardrobe with some of our fabulous new Tee shirts, designed by one of our RAM's, LT Brian O'Neal. Bryan has been responsible for the shipping of our wares this past year and we are very grateful for his help.

We also have a new Ultimate CD this year. Included in the CD is the all-new, re-organized "Gouge for Doing Flight Physicals" and waivers. We hope this will help all of you with your administrative duties. We welcome your comments and suggestions.

As usual, it wouldn't be the treasurer's page without a plug for dues and finances. If your newsletter indicates that your dues expired, you will not be able to receive the next issue until they are paid. On another note, we have continued to have problems getting the newsletter to some of you who have moved since you gave us your address when you joined. We REALLY need to have a current address for you in order to get your newsletter to the correct address. We have to pay \$.50 for every newsletter that we get returned by the USPS and that is beginning to add up. If we get two newsletters returned because of an inaccurate address,

we will have to wait for you to inform us as to your address change before we will send any further issues. (Enough complaints, Huh?)

Altogether, this year was a good year. Of course, as a non-profit organization, we continue to NOT turn a profit, but other than that, business was better than in years past. We appreciate all your support at the AsMA conference as well as through the year. As usual, jewelry and reference materials continue to be the best sellers. Clothing has remained a distant third. We still have some remaining sweat clothes and will probably mark these down to get them out of the inventory. More on that later. If any of you have any suggestions as to what the society should provide as a service to the membership, please do not hesitate to let us know. We welcome suggestions for improvement as well. Diplomacy of course, will be the most successful method for change...

Just to let you know we WILL be sending the new "Pocket Reference to Aircraft Mishap Investigation" to the printer as soon as we get the green light from the Safety Center folks. They are waiting for the reality check from a number of sources before clearing it for printing. The new Mishap Reference Guide will contain the Human Factors format and guidance that was developed by the Safety Center and this will place the Aeromedical Analysis in the spotlight of the mishap investigation, so don't be the last to get your copy.

It has been a pleasure to serve you during these past two years and I look forward to a rewarding third year.

*Volanti Subvenimus = We Support The Flyer
Done Right-First Time-On Time*

Semper Fi, shipmates

LCDR David C. Kleinberg, MC, USNR

NOMI, Physical Qualifications
Code 42 (MED-236)
code265@nomi.med.navy.mil
DSN 922-2257 ext. 1075
(850) 452-2257 ext. 1075



NASA



News

Navy flight surgeon and astronaut CAPT Lee Morin called me recently from the Sonny Carter Neutral Buoyancy Laboratory (NBL) at Johnson Space Center to discuss his upcoming mission in STS-110. Scheduled to launch in the orbiter Atlantis on 28 February 2002, the crew will install the S0 (that's S-zero) truss on the US-built laboratory module of the International Space Station.

Making his first space flight, Lee is the only medical doctor in the seven-astronaut crew, which consists of four veterans and three rookies. And he will get to do what every astronaut covets, participating in two of the four extravehicular activities (EVAs).

You may have heard about the newly-installed "inchworm" robot arm. Lee will become well acquainted with it, as his role calls for him to attach his feet to one end of it, as it positions him to effect installation of the truss. Designated S for starboard and 0 for its amidships location (not unlike shipboard compartment nomenclature), the structure will be installed perpendicular to the long axis of the Station, as the center section of its main structural cross-piece. More sections will be added on later flights. The truss, when fully assembled, will serve as the point of attachment for the large solar arrays, but in the meantime, it will play an essential role in the construction of the Station.

The truss is fitted with tracks on which a four-by-six foot robotic platform, not unlike a two-man railroad cart, will run back and forth, powered by a one and one-half-inch flat ribbon cable. Known as the Mobile Transport (MT) cart, it has a power receptacle for the "inchworm" robot arm, thus allowing the robot arm to be slid back and forth across the station as, crane-like, it puts the "big pieces" in place as the Station takes shape.

The installation of the truss, like any EVA, is quite complicated, and requires meticulous orchestration, not only among the players, but also among the various systems and their limitations. One of the most serious constraints is thermal. In the cargo bay, with doors open, and the orbiter turned with the bay facing the earth, the temperature equilibrates at about 70F, from the earth's radiated heat. But once the truss is taken out of the orbiter's cargo bay, it will rapidly lose heat into space, and



CAPT Lee Morin, MC, USN
Official NASA Photograph

will literally freeze if it is not installed and connected in time to its electrical power, which supplies its internal heating systems. At the other extreme, objects left in direct sunlight for too long, especially if they are in a place where reflections can focus together on one spot, become so hot they can damage gloves that touch them and weaken their pressure integrity.

Orchestration this delicate requires months of painstaking practice, much of which is done in six-hour time blocks in the NBL. Named in honor of another Navy flight surgeon and astronaut, the late CAPT Manley Lanier Carter, the facility boasts a forty-foot-deep pool that enables the astronauts to work in simulated weightlessness on full-size mock-ups of the vehicles and structures they will be using in space. Breathing a mixture of 45% oxygen and 55% nitrogen enables them to operate indefinitely at the pertinent depths with essentially no risk of decompression sickness or oxygen toxicity. Nevertheless, there is a decompression chamber there, as the risk of arterial gas embolism cannot be completely eliminated.

You can learn more about STS-110, and follow its progress, by visiting its website at <http://science.ksc.nasa.gov/shuttle/missions/sts-110/mission-sts-110.html>. If you lose the address, just enter STS-110 on a good search engine.

CDR E. F. Feeks, MC, USN
BuMed 23B
effeeks@us.med.navy.mil

News from the Residency

It's that time of year again, and we said goodbye to our latest crop of eleven graduating residents. Graduation ceremonies were held 1 June in the National Museum of Naval Aviation, where staff, family, friends and RAMS gathered to enjoy a fine meal along with a bit of good-natured ribbing and departing shots between juniors, seniors, and the remaining staff. Guest speaker Florida State Representative Jerry Maygarden's thoughtful comments were appreciated. The names of our graduates and the duty stations they've selected are listed on page 22. We'll miss 'em. After working closely with these folks over the past two years, we've been impressed with their accomplishments and celebrated their successes, and we know they'll do great things for Aerospace Medicine out in the Fleet and with the Marines.

This year marks another milestone for the RAM program, in that we graduated our first Army RAM, LTC Monica Gorbandt. Monica is an Army Flight Surgeon, boarded in Internal Medicine, and will return to Ft. Rucker for her follow-on assignment as head of their Aeromedical Standards Department. Two other Army residents, CPT Sam Sauer, and MAJ Jack Husak will become seniors this year, and we're expecting six Army residents to join us this summer. LTC Otto Boneta joined us last year on the residency staff as Army Liaison Officer, and helps us keep up with these folks dressed like trees. Welcome aboard, Army!

The RAM program was well represented at this year's annual Aerospace Medical Association meeting in Reno. In addition to twelve RAMS presenting intriguing cases at the Aeromedical Grand Rounds sessions, RAMS presented a variety of talks on such topics as sea-based MEDEVAC, viral hepatitis and cholelithiasis in aviators, the waiver process, aviation medicine history, and others. With many of our RAMS having years of clinical and fleet experience, and possessing certification in other specialties and subspecialties (internal medicine, emergency medicine, family practice, pediatrics, infectious disease, and under-sea medicine in this current class, and others in prior years), they speak authoritatively on a variety of subjects.

Additionally, we have prior aviators and NFOs in the mix. Currently, RAMs from the F-14, E-2, and helicopter communities, each with hundreds of hours of flight experience, are adding their unique insights to the program. This spring, the reestablished Dual Designator Program chose LCDR Ed Park (RAM '99) as a select and LCDR Dave Weber (RAM '01) as an alternate. The combined talent and expertise of these classes is impressive. The challenge for us and the other staff at NAMI is to try to keep up with this bunch!

The Aerospace Medicine Residency remains the primary clinical specialty route to operational medicine, and as a result has also attracted and continues to attract an impressive list of clinicians out of civilian practice into the Navy and the fun of operational medicine. Off the top of my head, I'm thinking of such folks as CAPT Mike Krentz, past-president of the American College of Emergency Physicians, who completed the RAM program in 1997 and is now Chairman of Emergency Medicine and the residency program at NMC Portsmouth. CDR Lee Mandel joined us from his practice in internal medicine, completed his MPH at Pittsburgh in 1998, and is serving as SMO on the USS TRUMAN. LCDR Jay McMahon, a board-certified clinical psychiatrist on the teaching staff at Harvard and Emory Universities joined us in 1998, and is now serving as SMO on USS VINSON. CDR Wes Farr, our current Chief RAM, returned from his faculty position at West Virginia University where he was practicing infectious disease. CAPT Jesse Monestersky, an occupational medicine specialist, will join the RAM program from the U.S. State Department this coming year, and we're currently recruiting an enthusiastic internist in private practice who will join us as soon as we can free up a training billet. There are others.

Is there life after the residency? Ask CAPT Lee Morin, who left the program in 1997 to be an astronaut. Lee has been selected for a prime Shuttle mission early next year (see preceding article), and we'll be following his progress with great interest and pride. For those of us not as talented and fortunate as Lee, the carrier SMO tour remains the best job in the Navy, and the more senior and experienced RAM graduates have first pick of these jobs. Gather any two or more ex-SMOs

in a room, and you'll hear an endless stream of tall tales about how great/ unbelievable/ awful/ scary/ thrilling/ or funny their tours were. If for no other reason, it's worth doing the SMO tour just to get the fodder for cocktail party conversation for the rest of your life.

Since the residency expansion in 1998 however, there are quite a few more graduates than SMO jobs available. We've recoded many of the intermediate flight surgeon jobs for RAMS, and many of our graduates will be practicing their flight surgeon duties with carrier Air Wings, Marine Aircraft Wings, and serving as consultants to their more junior flight surgeon associates at Naval Air Stations. Specifically trained with the tools to do population-based research and investigation, and practice preventive medicine, they'll be in unique positions to practice not only basic flight surgeon duties, but engage in research and teaching; mishap investigation, safety and trend analysis; serve as consultants for HFB's, FNAEB's and other administrative reviews; and practice in greater leadership roles. They'll also report with considerably greater clinical skills, based on rotations they were able to take during the Practicum Year (PGY-3) and Advanced Clinical Year (PGY-4) (burn, trauma care, emergency medicine, etc.).

Following the SMO tour, senior leadership jobs abound. In my RAM '96 year-group alone, CAPT Dwight Fulton is departing his job as OIC at EPMU-2 to become the Aerospace Medicine Specialty Leader, replacing CAPT Charlie Barker, who moves on to the XO job at Naval Hospital Puerto Rico. CAPT Natalie

Willenberg just took the job here as OIC of NAMI. CAPT Mark Edwards is serving as 3^d MAW Surgeon after practicing as emergency medicine staff at NMC San Diego. I'm feeling like the underachiever of my class as the Associate RAM Director, but hey, I love this job! Look at any other graduating RAM class, and you'll see similar successes in leadership and promotion. You'll have to go back to the graduating class of 1991 before you'll find even one RAM who has left the service before retirement (and there have been only four who have retired in the past 10 years). It appears retention in our specialty is unprecedented and we're all still having fun!

If you've enjoyed your flight surgeon tours and any of this sounds appealing to you as you make your career plans this summer, give us a call. We'll be happy to tell you more about the training opportunities in the RAM program and let you in on one of the best-kept secrets in Navy Medicine. And that's the truth.

Come join us.

CAPT Nick Davenport

Associate Residency Director
(850) 452-2695; DSN 922-2695
namiramadir@nomi.med.navy.mil
nadavenport@nomi.med.navy.mil

CAPT Michael Valdez

Residency Director
(850) 452-8125; DSN 922-8125
namiramdir@nomi.med.navy.mil



Oshkosh, and the EAA

Every now and then the Navy dumps a “good deal” in your lap. And I count such things as 2-week trips to the carrier with a squadron for flight time, a Det to Fallon, or SERE school as a flight surgeon-observer in this category. Hey, it’s the variety which keeps most of us in the canoe club, isn’t it?

So when I was approached about covering a lecture representing the Aerospace Medical Association and the Navy at the Experimental Aircraft Association meeting at Oshkosh last summer, I jumped at the chance. A bit of medical student recruiting would also be involved, but I figure that’s easy to do when you’re in the best outfit practicing the greatest specialty going.

I have known a little about Oshkosh and the EAA for many years. Well before getting into medicine or the Navy, like many other kids I had a fantasy of building my own plane or helicopter and taking to the sky. I even got so far as buying the kit plans for a Benson Gyrocopter on one occasion. As luck (bad or good?) would have it, the day they arrived, a gyrocopter crashed at our local airport, killing the pilot. “Send those back right now!” was my dad’s pragmatic response, abruptly terminating my budding career as successor to Charles Lindbergh. But I had found out about the EAA. This association is composed of people who build their own airplanes, and have the nerve to fly them. And if you’re into this sort of thing, you’ll find that there are all sorts of kits, craftsmen, and marketers supporting this industry, and they all get together once a year in the flat plains around Oshkosh, Wisconsin.

I arrived at Green Bay (the only place with an available motel) the day before my lecture, and after getting checked in and changing, it was only about 1430, so I decided to drive to Oshkosh to see the lay-out of the airfield and show. Sixty-three miles south on highway 41, I rolled into a massive traffic jam, but there were plenty of folks about directing autos and isolating approaches, so that it moved pretty quickly. We were directed to huge open grassy fields, roped off into parking lots, and I tucked my rental car into a slot next to several thousand other cars. It was then that the sheer size of this gathering began to dawn on me. What I had assumed was a small band of fanatical kit builders also included 750,000 visitors to this annual event and 13,000 planes! Next to the fields roped off for cars were bigger fields for parking planes. Cessna’s, Pipers and the like stretched to the horizon, most surrounded by tents and campers getting ready for the evening cookout.

I wandered the place, and at every turn there was more to see, stretching for miles. First were the planes. Thousands of them, neatly arranged by type, in row after row. Certain sections held homebuilts by designer Bert Rutan. Veri-ezee’s and Quickies and the like – these I expected to see. And then biplanes and real antiques. And newer versions of the old ones, some in acrobatic trim. But then came big airplanes – some which I’d not seen for years or had only seen in old photos. Serving the commercial fleet in the past – a Super Constellation with TWA markings just like the one I’d taken my first plane trip on at the age of 5. A NASA Guppy, the enormous transport specially modified to carry parts of the Saturn V rockets that took man to the moon. A Concorde would have also been there, if it hadn’t been for the crash the week before, suddenly calling into question the reliability of a plane which had flown for 35 years without an accident. Ford Trimotors and B-17’s still in flying condition and taking passengers (after all, each of these aircraft had flown here, not just been museum’d). Then a section of Warbirds – old military fighters, bombers, and the like. P-51 Mustangs, Corsairs, even a Spitfire. Each lovingly restored to pristine condition – probably looking better cared for than when new. Many carried their original squadron



markings.

I wandered the flight line, where more planes stretched off into the distance. Further out, were 50 year-old Beech Twins. Then some amphibians, and at least one PBY-Catalina, looking as if it had just flown in from the war in the Pacific Theater. I asked the group of people sitting under one wing who owned this monster. A guy drawled back some guys' name. An INDIVIDUAL owns this plane? If it took the resources of the wartime military to maintain and operate it when it was new, how the heck can an individual afford an amphibious transport from WWII today?

I'm distracted by the snarl of a small motor nearby, and whup-whup-whup goes a gyrocopter, doing lazy circles in the sky. I head toward his direction, and stumble into another whole area devoted to ultralights, helicopters, powered parasails, and gyrocopters. Here, a grass runway with reviewing stands, and announcers and spectators watch the airshow above, while the gyrocopter pilot demonstrates the handling and flying capabilities of these unique little aircraft. Nearby, tents hold the manufacturers who provide the kits for all sorts of exotic ultralight aircraft – tempting the hobbyist to realize his own dreams of flight and plunge in and build his own flying machine.

The following morning I reported in my pressed summer whites and set up for my spot in a series of medical lectures sponsored by the Aerospace Medical Association. Consistent with the barnstorming atmosphere of this whole show, tents and folding chairs in a field made up our classroom. An appreciative crowd of 50 or so pilots and experimenters collected to hear my humble observations on Hypoxia and Hyperventilation,

the topic I had agreed to present. Truthfully, I reckoned hypoxia was pretty far down on the list of hazards at this show, where the sheer numbers made traffic control and mid-air the number one threat.

The show just got better as the day progressed. It seems the feature event of each afternoon is a huge airshow, with each one getting more and more impressive as the week climaxes. Simulated air strikes by fighters and bombers of World War II, accompanied by ground explosions and pyrotechnics the envy of any Hollywood technician demonstrated what these venerable planes were capable of. With the throaty growl of massive radial engines chewing the air, nothing can quite compare to these old Warbirds rolling in for strike after strike.

The most nerve-wracking performance was reserved for the battle of the stunt pilots, however. Oshkosh attracts world famous acrobatic pilots, and then stokes their competitive edge by pitting each against the others. Toward the final round of competition, two performers will fly their shows on adjacent strips of the same runway, each trying to capture the attention of the judges and the thousands of gawking spectators by out-daring each other. Being an excellent pilot just gets you into this sort of contest. To win, it appears, craziness is required. Drilling a plane from 10,000 feet towards the runway, with 50-60 tight spins on the way down, then an outside square loop, followed by slicing a tape stretched 20 ft. above the runway with your left wing down in a 90 degree bank would seem to be required, and that's what the winner did. As a Flight Surgeon, I found it hard to believe anyone's labyrinthine system could tolerate all that, let alone maintaining control while avoiding becoming a smoking hole. I



stood gawking with the rest of the crowd at flying which seemed well beyond the scope of reason. No NATOPS here, believe me! About then, I started feeling light-headed from all the excitement. Probably hypoxia or something. I headed for the beer tent, the only remedy in sight.

Navy squadrons are known to send a plane or two to Oshkosh, and Flight Surgeons have been known to accompany their aviators, just to keep an eye on them. If you get the chance, stop by and visit. This year, its 24-30 July, and I'll be there lecturing again on Hypoxia and Hyperventilation. I'm going to keep doing this until I get it right....

Cheers,

CAPT Nick Davenport
namiramadir@nomi.med.navy.mil

Editors Note:

Captain Davenport is the Associate Director of the U.S. Naval Residency in Aerospace Medicine.



So You Want to Get Promoted?

As I get older and supposedly wiser, things get simpler. Complex, multi-factorial, conundrums of the past are reduced to bits of yes and no. After having sat on four promotion selection boards and most recently President of a selection board, I think selection for promotion boils down to "doing a good job at what you are doing."

Don't rely on accomplishments at a prior command or a prior job. And don't rely on what you intend to do in the future. Selection Boards want to see that you have enthusiasm, innovation, and drive in your present position.

So what is "doing a good job?" (Note: treading water is not it.) Keep in mind that we will be talking here about promotion, not selection boards for XO/CO or Flag. XO/CO and Flag selection boards have a more comprehensive precept of a career look and look at future Navy needs. XO/CO and Flag Boards will be the subject of a later OP-ED. Regular Promotion Boards focus on current achievement and really only do hard work when they get down to the last few remaining promotion slots and the 10-20 people that remain as candidates for 5-10 slots. This "crunch zone" defines the qualities of what it takes to get promoted.

Here's my take on crunch zone makers and breakers:

1. Something extra. Show the Board that you are capable and motivated to go beyond current job requirements. i.e. that you have something to offer that will give Navy Medicine a return on investment if you are promoted to the next rank. Committees, extra achievements, organizational leadership, innovation. You make things better than what you started with. This applies to pure clinicians and bench scientists as well as administrators. The Navy has a big investment in our specialists. (We don't want a pediatric neurologist to spend 50% of his or her time on Ball committees and the Combined Federal Campaign. But...neither do we want that highly trained subspecialist to be a purely inside-the-office clinician. So...make the patient care service better. Teach

- PALS. Decrease waiting time. Increase access. Develop protocols. Publish. Lead professional organizations. Think of it this way - give the Navy a reason to believe that your contributions as a CAPT will be more than your contribution as a LCDR.
2. PRT. Yes PRT. This is more of a don't than a do. Don't fail the PRT. Remember you are in the crunch zone. The Board is looking at 10 equally qualified Commanders for promotion to Captain. There are 5 slots left. You are the only one of the 10 that has failed the PRT. You will have put yourself at a clear disadvantage.
 3. Homesteading. Another don't. Don't do your career in one spot. The Navy values cross-training. Geographical and professional variation is valued by the corporation. Homesteading is permitted in that before this new thinking, one was forced to accept orders to other duty stations, now it is a way of the Navy to save money on PCS moves. BUT...if you elect to homestead, you are also accepting slow promotion. It is a disadvantage in the crunch zone.
 4. Operational Experience. A definite yes. This is what military medicine does. It shows commitment to the tenets of our organization. It shows future return on investment.
 5. Bad Things. Don't do bad things. Or if you elect to do bad things, don't stay up nights worrying whether you will get promoted. The bad things list is authored at levels way above anyone on the Selection Board. This is an area where "but he really is a good guy" doesn't mean much. Some examples: theft, DUI, adultery, fraternization, harassment. You know the list as well as I.
 6. Team Play. Leading a Team. More than ever before, team leadership, motivating a group, organizing a unit, is a much valued attribute. More so for XO/CO and Flag, but nevertheless, it shows you have team leader qualities that can

give a return on investment beyond individual achievement.

7. Picture. Yes believe it or not, sometimes a picture can make a difference. Imagine it this way: the Board is down to one slot and two candidates with equal credentials. One has a current picture; the other has none. Who do you assume has greater motivation? Who do you assume has greater commitment to the organization?

As a closing note let me mention letters to the President of the Board. Don't waste the Board's time with a letter to the Board that is a regurgitation of your career. If you have something to say that is not already in the record, OK. But be careful. Sending a letter with poor grammar, misspellings or straight out whining can hurt you, not help you.

Finally, if you get a chance to serve on a selection board, grab it. Celebrate your birthday some other time. Serving on a selection board will benefit you and the persons for whom you may have the opportunity to mentor.

ADM (sel) Steve Hart

Assistant Chief for Operational Medicine
and Fleet Support

Editors note: This is the second in a series of short messages that will be moved to the Mentoring Board Website at <https://bumed.med.navy.mil/med02/Mentoring/med.htm> for reference and retrieval.



WHAT IS SQUADRON TIME?

To answer this question, a survey of 29 flight surgeons with 3D Marine Aircraft Wing was completed over a 3 month period from November 2000 to January 2001. They were not on a deployment (garrison), and their total work time was split 50:50 between clinic and squadron time. Three were part of an air mishap board (AMB), and clinic time was replaced by AMB time (initially more than 50%, tapering to less later). Flight surgeons kept track of their activity in half hour increments on a checklist (kneeboard size to fit in flight suit pocket) that contained a grid with type of activity on one axis and date on the other axis. The survey results are listed below:

<u>TYPEACTIVITY</u>	<u>SQUADRON TIME</u>	
	(Garrison)	(AMB)
Office hours (office at squadron)	21%	11%
Curbside consults (at squadron)	16%	24%
Rounds (visit CO & departments)	14%	9%
Meetings	13%	8%
Waivers (prepare documents)	10%	6%
Exercise	8%	6%
Lectures	6%	0%
Monitor spaces (visit hangar, etc.)	5%	21%
Fly	5%	15%
Other	2%	0%

(bold = top 3 in column)

In garrison, the top three activities (office hours, curbside consults, rounds) had a common theme of availability at the squadron. During an AMB, the top activity was curbside consults. Visiting hangar spaces, especially ejection seat shop and life support equipment, became a priority during an AMB. As an AMB tapered off, flight surgeons utilized the extra time for flying more.

These results give a snapshot of actual activities during squadron time. It can serve as a teaching tool for student flight surgeons and a guide for designated flight surgeons.

CAPT Mark Edwards, MC, USN
3D Marine Aircraft Wing Surgeon



Taps for LCDR Lorimel F. Arabe, MC, USN

Lieutenant Commander Arabe passed away on April 20, 2001 due to complications from surgery.

Lieutenant Commander Arabe was born in the village of San Quentin, Pangasinan province, Republic of the Philippines. He moved with his family to California when he was five years old, eventually completing a Bachelors and Masters degree before attending Officer Indoctrination School at NATC Newport, Rhode Island in 1993. In June 1996, he completed his Doctor of Osteopathy degree at the College of Osteopathic Medicine of the Pacific. After finishing a transitional internship, he reported to Naval Medical Center in San Diego in July 1997.

In January 1998, he was assigned to NAS Pensacola, Florida Flight Surgeon training. His first assignment was to Marine Heavy Helicopter Squadron 462, Marine Aircraft Group 16, Third Marine Aircraft Wing, Tustin, California.

During January 2000, he was deployed with HMH-462 for six months as part of the Unit Deployment Program at MCAS Futenma, Okinawa, Japan. While on deployment, Lieutenant Commander Arabe, visited the village of his birth as a part of Exercise Baliktan.

Lieutenant Commander Arabe's awards include: Meritorious Service Medal, National Defense Ribbon, Meritorious Unit Commendation, Sea Service Ribbon, and the Fleet Marine Force Ribbon.

He is survived by his parents, Emilio and Lauren, three brothers Emmanuel, Emilio Jr. and Neil Arabe and two sisters Marissa Balonza and Arabella Sprang.

Editors Note: Lieutenant Arabe passed away during complications suffered during a surgical procedure. The entire medical community mourns his passing and I know that we all greatly appreciate his honorable service to his country.

NAMI Flight Surgeon and Aviation Medical Technician (AVT) Listserv

Have you ever wondered if NAMI still thinks about you once you graduate? Have you ever felt "out of the loop" for recent developments, new waiver information requirements, or new aeromedically relevant message traffic?

The Naval Aerospace Medical Institute (NAMI) has recently stood up a Listserv on the NAMI website to provide timely tailored information to the fleet Flight Surgeons and AVTs. We have already received a significant number of enrollees and want to expand our ability to contact our operational community. By staying "connected" NAMI will be able to keep you updated with the information you need to keep your edge. Rest assured all e-mail POC information will be kept confidential and will be used only to disseminate aviation medicine relevant material. When entering your e-mail address be sure to double check your entry for correctness. Also, be advised that certain ISP providers (hotmail, yahoo, excite, MSM, junos, or other free e-mail providers) have a very restricted "in box" size for e-mail or do not accept attachments. I have received fatal errors such as "Requested mail action aborted: exceeded storage allocation" There are rumors that USMC e-mail addresses will not accept attachments – check with your computer/e-mail staff if you are not receiving information that other Flight Surgeons have received. Please call or e-mail me directly to discuss the situation.

To sign up for this Listserv the URL is <http://www.nomi.med.navy.mil/NAMI/index.htm>.

CDR Jay S. Dudley
jsdudley@nomi.med.navy.mil
(850) 452-5014
DSN 922-5014



Internal Medicine (Code 24)

A PECULIAR CASE OF CHRONIC DIARRHEA

A 27 year old male, Officer Candidate, presented with a six month history of watery diarrhea. He usually had two watery stools per day which were reddish brown, foul smelling and turned the water pink. Occasionally there was associated abdominal discomfort, nausea and rectal pain. Onset of symptoms occurred about six weeks after beginning a new job in a computer chip lab where many toxic chemicals, mostly solvents, were used. He did not recall anyone at this job with similar complaints. He was evaluated at his university's health clinic, and had some blood tests, but never returned for follow-up. The patient had suspected that this may be a food intolerance and he altered his diet several times to no avail. He noted a decrease in appetite, a ten pound weight gain, and significant fatigue. The patient also noted frequent urination of small volumes.

Past medical, surgical, and family histories are non-contributory. He takes no chronic medications, and has no known allergies. He denied using tobacco, has no history of drug use, drinks one to two beers a week, and denied drinking coffee. He has never traveled outside of the country.

Physical exam was wholly unremarkable. CBC, chem 7, LFTs, UA, TSH, fecal occult blood(x3), and serum heavy metal screen were ordered.

On follow-up, the patient complained of headaches since arrival at OCS which slowly resolved, and as the headaches resolved his stools became more formed. His fatigue had resolved, despite being an Officer Candidate. The lab results from his university were obtained, CBC, LFTs, serum electrolytes, serum glucose, UA, and ESR that had been ordered were all normal. The fecal occult blood tests from his first visit were normal, all three of them. Also of note, his hemoglobin was 15.2, HCT was 45.2, and all other labs were normal. On further questioning, the patient was asked specifically about sources of caffeine other than coffee, he admitted to consuming three or four soft drinks a day. His usual preference was for Diet Pepsi,

or Mountain Dew, in addition to this he usually had a few Red Bulls. That may not seem like a lot of caffeine, but the three or four drinks were in two liter bottles. Red Bull is a very high caffeine drink, with a lot of sugar, it also happens to be quite red.

The moral of this story? This individual was in a very intense academic program, and working many hours in a computer chip lab. He used the caffeine to stay awake, unfortunately it also kept him from getting a decent nights sleep, hence the fatigue. By the way, it is also a pretty good diuretic and cathartic. Officer Candidates are not allowed to have such luxuries as soft drinks, resulting in the caffeine withdrawal headaches and resolution of symptoms. The toxic chemical exposure helped start the zebra hunt. In the end, it just shows the importance of a good history. Getting a good drinking history is not just applicable to alcoholics anymore.

LCDR Pete Wechgelaer, MC, USN

Resident in Aerospace Medicine

pnwechgelaer@nomi.med.navy.mil



That Mysterious Paperwork

Unraveling the mystery of PRT Waivers, Limited Duty Boards, Medical Boards, Physical Evaluation Board and the Veterans Administration - A primer for all health care and command personnel in dealing with administrative disposition of military personnel.

As a junior Medical Officer (or even an experienced senior Medical Officer) there exists many terms that seem interrelated when it comes down to what to do with an injured/sick Sailor/Marine. Quite a bit of misunderstanding exists with what is an appropriate action given the existence of disease or injury.

PRT WAIVERS- are for those personnel that have a temporary problem that in the medical officer's judgement would be aggravated by the PRT and or place the patient in a hazardous situation. Examples would include ankle sprains, colds, other minor illnesses (or more serious problems). Patients can be excused from all or part of the PRT.

A patient may be excused numerous times for a similar or identical problem, as long as the number of waivers does not exceed 2 consecutive test periods. If a patient is excused a third time he may be administratively separated for non-compliance with the PRT program. Theoretically a member may be excused indefinitely if the problems are dissimilar. Members who are pregnant are not required to do the PRT (as opposed to waived).

Three waivers for a like condition (if felt warranted by the physician) is not a reason for referral to a Med Board or Limited Duty Board.

THE PRT is an ADMINISTRATIVE requirement for Military Service, and not a physical examination/physical qualification problem. The command may elect to keep or separate an individual as a command prerogative. Failures of the PRT are *not* a reason to convene a MEDICAL BOARD or a LIMITED DUTY BOARD, despite what the commands might request – it is an administrative problem. If a person has a medical condition that interferes with the PRT a MED BOARD/LIMDU BOARD might be convened to deal with the medical problem as a separate issue however.

LIMITED DUTY BOARD- are for those personnel with a medical condition that is likely to resolve within an 8-month (or 16-month period). The LIMITATIONS for the personnel are stated in the LIMDU Board and might include restrictions on lifting, running etc. These limitations *might* preclude the performance of the PRT. LIMDU restrictions should always be observed when evaluating a sailor/marine for the PRT. Personnel on a LIMDU Board (minimum of 8 months) may be returned to full duty prior to the expiration of the board.

Good examples include orthopedic procedures (pins, ORIF etc) that obviously require Limited Duty but have an excellent chance of returning to full duty in 8 months or less. Extensions of 8 months are possible for the rare cases of complications that extend beyond the initial 8-month period). If there is a possibility of the member not being physically qualified for general duty after 16 months a referral to the Physical Evaluation Board (PEB) is indicated.

MEDICAL BOARDS- MEDBOARD (Not an MEB!) are for those personnel whose ability to continue on full duty is in doubt, OR whose physical limitations preclude a return within a reasonable period (16 months). A medical Board has TWO possible outcomes: 1) FIT FOR DUTY or 2) referral to the Physical Evaluation Board (PEB). A MED BOARD cannot find a member UNFIT.

Reasons to convene a MED BOARD include:

- Permanent assignment limitations
- Temporary or Permanent inability to perform full duty
- Mental incapacity
- Refusal of medical care
- Continued service

Reasons DO NOT Include:

- Inability to perform the PRT – that's an admin (not MEDICAL DEPARTMENT) problem.

MEDBOARDS are a big deal and specific instructions can be found in MANMED Chapter 18. MEDBOARDS have very specific administrative requirements and timelines as well as a convening authority (NAVHOSP CO).

PHYSICAL EVALUATION BOARD- this is a board that has a mission of:

1. Maintaining a fit military force
2. Rate members whose injuries or diseases are incurred or aggravated while on duty
3. Compensate personnel who are unable to complete their careers AND...
4. Qualify for normal benefits

The PEB System consists of the Disability Evaluation System (DES)

1. Medical Evaluation (MEB)- documents medical status and limitations
2. Physical Evaluation (PEB)- determines fitness, and if unfit their entitlement to benefits
3. Counseling
4. Final Disposition

The procedure includes:

1. Submission of MEB
2. Informal PEB vote
3. Member receives prelim findings
4. If found FIT: accept or request reconsideration in light of new medical info
5. If found UNFIT: accept, conditional accept, demand formal PEB
6. Formal PEB held: accept, does not accept-petition for relief via the Board for Correction of Naval Records

Determination of Cases/Dispositions

Unfit, with benefits- If the disability is less than 30% and the member has less than 20 years service- disability severance pay.

Unfit Without Benefits- This rating is given if the condition was pre-existing and not aggravated by service, or due to the member's own misconduct, or the result of a hereditary or congenital disease (this restriction is currently under congressional revision) or not incurred while on active duty.

Temporary Disability Retired List (TDRL)-

This rating is given if the condition is temporary or unstable and rated at least at 30%. Member receives 50% pay for 5 years with every 18-month re-evaluation. After 5 years the determination is made for separation or permanent retirement.

Permanent Disability Retired List (PDRL)-

the unfitting condition is permanent and the member medically retired.

*******PRESUMED FIT-** This is a disposition used for those members who continued to perform the normal duties of office, rank, grade and rating until commencing processing for non-disability retirement or separation. It is presumed that these members were fit for duty. If the member attempts to claim medical disability through the DoD after the non-disability processing has occurred, a presumed fit rating WILL be given. This can only be overcome with acute and grave illness occurring during the processing for retirement. (i.e. got hit by a car in the clinic parking lot).

THE PEB SPECIFICALLY DOES NOT WANT PERSONNEL REFERRED FOR A PEB DETERMINATION AT THE TIME OF RETIREMENT!, see VA section below for these personnel.

As an unusual exception, Medical Officers (Doctors) and Flag Officers will NOT be found UNFIT unless their illness/injury would preclude the execution of their normal professional duties,...this means that a Physician could be found FIT FOR DUTY if he were diabetic, one legged, and on dialysis,...just so as he could see patients. (Makes it tough to pass that PRT though – again that is an administrative issue...so you are FIT but Admin Discharged with no benefits!!!)

The **Veterans Administration** disability system can be best thought of by military providers as a parallel disability system that is not related or bound by the military disability system. A strange but absolutely true example was that of a Reservist that was found 100% psychiatrically disabled by the VA but FIT FOR DUTY by the PEB prior to his discharge from active duty. At least they will find our one-legged Physician as rating a disability though.

An example might be a sailor that could see 20/20 when he came into the service, but during a training accident he scratched the cornea of his left eye to the point that he could only see 20/30 thereafter. He is FIT FOR DUTY because 20/20 vision in both eyes is not required for general service in the Navy but upon separation would be found to have a service related

Aviation Vision Standards Change

Routine

R 112050Z MAY 01 ZYB PSN 715885J34

1. Per OPNAV direction, Bureau of Medicine and Surgery chartered a Naval Aerospace Medical Institute (NAMI) aviation vision standards working group to review all candidate and designated aircrew vision standards based on best clinical and preventive medicine practices, safety of flight considerations, and operational risk management analysis. The working group produced a list of current standards with recommended changes. Working group membership was broadly representative of naval aviation. Participants included senior Flight Surgeons, ophthalmologists and aerospace optometrists, senior line naval aviators and flight officers, director, air warfare staff (OPNAV N78) and Naval Safety Center. The following summarizes, by category, both current vision standards and approved changes.

2. Student Naval Aviator (SNA):

- A. Slit Lamp Examination: No change.
- B. Phorias
 - (1) Current: Exo less than or equal to 6, eso less than or equal to 10, and hyper less than or equal to 1.5.
 - (2) New: Eso less than or equal to 6.
- C. Color Vision
 - (1) Current: Required by PIP or Falant.
 - (2) New: Alternative color test to include Ishihara color plates 12/14 to pass on a 16 plate test.
- D. Depth Perception
 - (1) Current: Required by AFVT through line D or Verhoeff 8/8
 - (2) New: Alternative stereopsis test to include Titmus or Randot to 40 seconds arc.
- E. Field of Vision: No change.
- F. Visual Acuity
 - (1) Current: Uncorrected monocular no worse than 20/30-0 on Goodlite letters
 - (2) New: Uncorrected monocular no worse than 20/40-0 on Goodlite letters.
- G. Maximum Refractive Error
 - (1) Current: Minus 1.00/plus 3.00 in any meridian with maximum of minus 0.75 cylinder;
 - (2) New: Minus 1.50/plus 3.00 in any meridian with maximum of minus 1.00 cylinder.
- H. Near Point of Convergence (NPC)
 - (1) Current: Less than or equal to 10 centimeters.
 - (2) New: No NPC requirement.
- I. Photorefractive Keratectomy: No change-disqualifying; however, waiverable if aviation vision standards are met and SNA is enrolled in accessions study.

3. Student Naval Flight Officer (SNFO):

- A. Slit Lamp Examination: No change.
- B. Phorias: No change.
- C. Color vision
 - (1) Current: Required by PIP or Falant.
 - (2) New: Alternative color test to include Ishihara color plates 12/14 to pass on 16 plate test.
- D. Depth Perception: No change.
- E. Field of Vision: No change.
- F. Visual Acuity
 - (1) Current: Correctable to 20/20-0 each eye.
 - (2) New: Correctable at least to 20/20-0 each eye (however, if AFVT or Goodlite letters are used, a score of 7/10 on the 20/20 line constitutes meeting visual acuity requirements).
- G. Refractive Error Limits
 - (1) Current: Less than or equal to plus or minus 5.50 sphere and less than or equal to minus 3.00 cylinder.
 - (2) New: Less than or equal to plus or minus 8.00 sphere in any meridian, no change in cylinder standard.
- H. Photorefractive Keratectomy: No change-disqualifying; however, waiverable if NFO vision standards are met and SNFO is enrolled in accessions study.

4. Aircrew Candidate:

- A. Helo Aircrew Uncorrected Visual Acuity: No change.
- B. Helo Aircrew Depth Perception
 - (1) Current: Required by AFVT or Verhoeff.
 - (2) New: No depth perception requirement.

5. Air Traffic Controller:

- A. Phorias
 - (1) Current: Exo less than or equal to 6.0, eso less than or equal to 10.0, hyper less than or equal to 1.5.
 - (2) New: NOHOSH.

6. General Aviation:

- A. Each Eye Visual Acuity
 - (1) Current: Correctable monocular to 20/20-0.
 - (2) New: Correctable each eye to 20/20-0. However, if AFVT or Goodlite letters are used, a score 7/10 on the 20/20 line constitutes meeting visual acuity standards (applicable to all aviation personnel except SNA and designated naval aviators).
- B. Color Vision
 - (1) Current: Required PIP or Falant.
 - (2) New: Alternative test of 16 plate Ishihara with 12/14 to pass.
- C. Depth Perception
 - (1) Current: Where required must pass AFVT or Verhoeff.
 - (2) New: Alternative tests with Titmus or Randot to 40 seconds arc.

7. Service Group I:

- A. Phorias
 - (1) Current: Exo less than or equal to 6, eso less than or equal to 10, and hyper less than or equal to 1.5.
 - (2) New: Eso less than or equal to 6.0.
- B. Uncorrected Visual Acuity
 - (1) Current: No worse than 20/70.
 - (2) New: No worse than 20/100.
- C. Refractive Error
 - (1) Current: Refractive limits: -1.50/+4.00 in any meridian.
 - (2) New: No refractive error limits.
- D. Depth Perception
 - (1) Current: Required AFVT or Verhoeff.
 - (2) New: Alternative test with Titmus or Randot to 40 seconds arc.

8. Service Group II:

- A. Uncorrected Visual Acuity
 - (1) Current: No worse than 20/100.
 - (2) New: No worse than 20/200.

9. Service Group III:

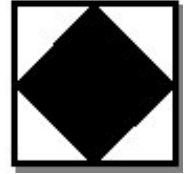
- A. Uncorrected Visual Acuity
 - (1) Current: No worse than 20/200.
 - (2) New: No worse than 20/400.
- B. Designated Aircrew:
 - (1) Helo uncorrected visual acuity: No change.
 - (2) Depth perception
 - (A) Current: Required by AFVT or Verhoeff.
 - (B) New: No requirement.

10. These new standards were determined to have negligible operational risk and will be re-evaluated following completion of The ongoing PRK study (OCT 2002). Standards not specifically cited are considered no change.

11. POC: CDR Jeff Brinker, NAMI (MED-236), 850- 452-2257 ext 1074, email: jrbrinker@nomi.med.navy.mil or LCDR Ken Uyesugi (NAMI Optometrist) at 850-452-2257 x1018, email: khuyesugi@nomi.med.navy.mil.



**Naval Operational Medicine Institute
215th Flight Surgeon Graduation Ceremony
29 June 2001**



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 29 June 2001. The speaker was CAPT Charles O. Barker, MED-23.

The following is a list of the graduates and their new assignments.

Anchors Away!

Flight Surgeon Class 0102

LCDR Jacqueline Bernard, MC, USN
LCDR James Grimson, MC, USNR
LCDR Robert Larys, MC, USNR
LT Jonathan Bingham, MC, USNR
LT Eric Cafini, MC, USNR
LT Scott Carlson, MC, USNR
LT Christopher Dolan, MC, USNR
LT Elizabeth Gray, MC, USNR
LT Jason Guillian, MC, USNR
LT Holly Hill, MC, USNR
LT Scott Hines, MC, USNR
LT Minal Jackson, MC, USN
LT Eric Lavery, MC, USNR
LT Lanny Littlejohn, MC, USNR
LT Ethel Longmire, MC, USN
LT Ryan Maves, MC, USNR
LT Craig McCormick, MC, USNR
LT Timothy Mickel, MC, USN
LT Laura Modzelewski, MC, USNR
LT William Mundy, MC, USNR
LT Sean O'Brien, MC, USNR
LT Michael Oakes, MC, USNR
LT James Primich, MC, USNR
LT Garrick Stride, MC, USNR
LT John Paul Trafeli, MC, USNR
LT Sean Wise, MC, USN

Billet Assignment

VP-30, Jacksonville, FL
NSAWC, Fallon, NV
Naval Hospital, Jacksonville, FL
2nd MAW Det, Naval Hospital Cherry Point, NC
MAG-26, Jacksonville, NC
Naval Hospital, Agana, Guam
NAWCAD, Patauxent River, MD
3rd MAW, Miramar, CA
MAG-31, Beaufort, SC
AGSE MWSG-37, Twenty-Nine Palms, CA
VF-101, Virginia Beach, VA
VFA-106, Virginia Beach, VA
NAS Keflavik, Iceland
2nd MAW, Cherry Point, NC
3rd FSSG DET, Naval Hospital, Pensacola, FL
CVW-17, Jacksonville, FL
MAG-39, Camp Pendleton, CA
Naval Medical Clinic, Pearl Harbor, HI
CVW-7, Oceana, VA
ADMINSUPU SWA, Manama Barian, SW Asia
NAVWPNTSTRON, China Lake, CA
VFA-125, Lemoore, CA
VP-8, Brunswick, ME
TRAWING-2, Kingsville, TX
NACC, Port Hueneme
Branch Medical Clinic, Fallon, NV

LT John York, MC, USN
Aerospace Physiologist Class 0102

Branch Medical Clinic, Willow Grove, PA
Billet Assignment

LTJG Christopher Cooper, MSC, USNR
LTJG Sean McCarthy, MSC, USNR

Aerospace Experimental Psychologist Class 2002

Billet Assignment

LT Jeffrey Alton, MSC, USNR

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 0102

Left to Right

Bottom Row: LT Mundy; LT Mickel; LCDR Larys; LT Wise; LT Littlejohn; LT Trafeli; LCDR Grimson;
LT Hill.

Second Row: LT Primich; LT Oakes; LT Gray; LCDR Bernard; LT Jackson; LT Longmire; LT Modzelewski;
LT Guillian; LT Hines.

Top Row: LT O'Brien; LT Bingham; LT Alton; LT Maves; LT Cosgrove; LT Dolan; LT Lely; LT Carlson;
LT Lavery; LT Cafini; LT McCormick; LT Stride; LT York



Naval Operational Medicine Institute Residency in Aerospace Medicine Year 2001 Graduates



July 1st, 2001 marked the graduation of 11 residency trained Aeromedical Specialist from the Naval Operational Medicine Institute. 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 2001

from left to right: LCDR Hohman, LTCOL Gorbandt, LT Chin, CPT LaForce, CAPT McCarten, CDR Black, LT Webster, LCDR Weber, CDR Umlauf, LCDR Martschinske, LT Rice

RAM Trained Aeromedical Specialist

CAPT Michael McCarten, MC, USN
 CDR James Black, MC, USN
 CDR Jon Umlauf, MC, USN
 LCDR Robert Martshinske, MC, USNR
 LTCOL Monica Gorbandt, MC, USA
 LCDR David Weber, MC, USNR
 LCDR Daniel Hohman, MC, USNR
 CPT Paul LaForce, CAF
 LT Edward Chin, MC, USNR
 LT David Webster, MC, USNR
 LT G. Merrill Rice, MC, USNR

Billet Assignment

SMO, USS Theodore Roosevelt (CVN71)
 SMO, USS John C. Stennis (CVN74)
 SMO, USS George Washington (CVN73)
 SMO, USS Nimitz (CVN68)
 Fort Rucker, Alabama
 1st MAW Kaneohe, Hawaii
 1st MAW Iwakuni, Japan
 14 Wing Med Clinic, Greenwood, Nova Scotia
 1st MAW Futema, Okinawa
 MAG-39 Camp Pendleton, California
 NAMRL Pensacola, Florida

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. Fair winds and following seas to our departing shipmates!

Aerospace Residency News

Residents arriving in Pensacola summer 2001

CDR Andrew Nelson	Tulane University	Flight Surgeon/Family Practice
LCDR Walter Dalitsch	Univ of Kansas	Flight Surgeon
LT Matthew Radimer	Harvard University	Intern
Major Ronald King	UTMB	Flight Surgeon/Family Practice
CPT Justin Woodson	UTMB	Flight Surgeon
CPT Austin Chhoeu	Tulane University	Flight Surgeon
CPT Katie O'Donnell	Johns Hopkins	Flight Surgeon
CPT Dan Johnston	Emory University	Flight Surgeon
CPT Dana Thomas	George Washington	Flight Surgeon

CAPT Jesse Monestersky - arriving in January 2002
 LT Mohammed Al-Thuwanay - arriving in January 2002

Flight Surgeon/Occupational Med
 Saudi Arabian Forces

Residents starting MPH summer 2001

LCDR Wayne Caroleo		GMO
CPT Fred Harris	UTMB	Flight Surgeon
CPT Jonathon Stabile	UTMB	Flight Surgeon
CPT Greg Lang	UTMB	Operational Tour

ECSTASY

(Methylenedioxymethamphetamine—MDMA)

Other MDMA Analogue Drugs

MDA “Love”, and MDEA “Eve”

Street Names

“E”, “X”, “XTC”, “Adam”, “M”, “hug-drug”

Also found with other drugs called

“Power Pack”, “Triple-X”

What is it?

Ecstasy is a central nervous system (CNS) stimulant that strongly activates certain centers in the brain (serotonin receptor sites). Listed as a Schedule 1 drug by the FDA with no current accepted medical use, it is an illegal drug in the U.S. MDMA is often referred to as a “club drug” since it is often available and sold at Rave dances and nightclubs.

What does it look like?

Most frequently MDMA comes in tablet form, but may also be sold as a capsule or a powder. Usually it is ingested orally and may be found mixed (cut) with other drugs. Ecstasy pills are unreliable in purity and may commonly contain other additives such as caffeine, ephedrine, or other amphetamine compounds. Tablets are found in a variety of shapes and colors, usually the size of a common aspirin tablet. The pills have various designs or motifs of hearts, animals or lettering imprinted on the tablet. Capsules may be referred to as “smurfs”. A standard dose is usually between 80-150 mg .

How it’s used

Most frequently ingested orally but can be snorted.

Effects of Ecstasy

The short-term Ecstasy effect depends on dosage. Onset of a “rush or high” varies with dose between ½

to 1 ½ hours and last approximately 2-3 hours. The unreliability of MDMA content and admixing with other drugs adds an element of risk for adverse reactions. Use with other stimulants or in association with prescribed medications can have undesired consequences. Individuals with a history of high blood pressure, heart, liver, or kidney problems who use Ecstasy are at risk for adverse medical events.

Shortly after ingestion, the user has an elevation of mood, a feeling of euphoria and energy along with a desire to socialize, to touch or hug people. Other reported effects are an openness toward others, a willingness to talk, impulsiveness, friendliness, empathy, and heightened sensory perception to sound, light and touch. Visual distortion due to involuntary eye movement or “twitching”, jaw clenching, teeth grinding and tongue and cheek chewing are common with Ecstasy use. Other adverse experiences commonly reported are an increase in body temperature, dehydration, salt imbalance (which may be associated with excessive water intake with concurrent salt loss from sweating), dizziness, headaches, and nausea. Individual response following Ecstasy ingestion vary. Individuals, with no prior adverse experience from repeated Ecstasy use, may experience a reaction requiring immediate medical support. Some users of Ecstasy experience a “downing of mood” or “crash” – an experience of being sad, annoyed, or feeling threatened. This may lead to another Ecstasy “hit” in order to regain the “high.” Medical publications from Europe, Canada, and the U.S. contain reports of fatal or near fatal medical outcomes associated with the ingestion of a single Ecstasy tablet. Many of the medical incidents can be related to the admixing (cutting) of various drugs in the Ecstasy tablet or reactions associated with the use of other prescription or over-the-counter medications. In other fatal or near-fatal outcomes undiagnosed underlying medical conditions were exacerbated by the use of even a single Ecstasy tablet.

Longer term effects

There is a decrease in cognitive and motor function associated with the use of Ecstasy. Many individuals commonly feel extremely drained of energy the day after Ecstasy use. A common event is a period of depression which generally occurs 2-5 days following

drug use. The depressive period can actually remain for longer periods of time and may be present months after frequent and repetitive Ecstasy use. Research into the effects of Ecstasy have been conducted primarily on animals under controlled conditions, but diagnostic procedures on individuals being treated for Ecstasy abuse clearly show neurological changes within the brain. The long-term effects of Ecstasy are still being assessed. The most compelling feature in many studies is the issue of polydrug exposure that aggravates the physiological and neurologic damage associated with Ecstasy abuse.

Operational Readiness Issues

The high-tempo environment of the deployed forces requires individuals who are mentally alert and physically capable of performing complex decisional tasks rapidly and accurately. These are clearly environments in which an individual suffering from an Ecstasy “hangover” threatens the safety and operational mission of everyone around them. The period of anxiety and depression are clearly contra-indicated for an individual responsible with the safe operation and handling of a high caliber weapon. The decrement in motor skills, mental agility, and perception associated with Ecstasy abuse make an individual hazardous to himself and his shipmates. The mental decrements associated with Ecstasy use compromises an individual's ability to understand and carryout orders, operate complex equipment, evaluate and make decisional responsibilities in situations of changing complexity. Ecstasy abuse is counterproductive to tasks common to military operations. Ecstasy compromises the safety of those using the drug and those around them – not just while they are “high” on the drug but also for long periods of time afterwards. Specific effects from Ecstasy use of confusion, memory loss, fatigue, decreased coordination, and exhaustion can have major impacts in the reduction in operational readiness. This effect does not stop at the individual sailor but has an influence affecting the safety, morale, readiness, and mission execution in the Fleet.

Myths Surrounding Ecstasy

There are several myths that Ecstasy is not harmful, that Ecstasy rapidly leaves the body and therefore not easily detected, and that the military does not test for Ecstasy. Nothing is further from the truth. As noted

above Ecstasy is a dangerous drug. While Ecstasy does clear the body rapidly, it is still detectable by procedures used in the military drug laboratories and the military drug laboratories screen all samples received as part of the random drug testing program for the presence of Designer Amphetamines, including Ecstasy. The military drug program has conducted testing for Designer Amphetamines since 1997. Over 400 Navy and Marine Corps personnel were identified as positive for Ecstasy in FY00. The penalty for Ecstasy abuse is severe. Distribution of as little as five Ecstasy tablets can result in 5 years military imprisonment. Use of Ecstasy will result in punishment, separation from military services and loss of military benefits.

For further information check the website at www.navdweb.spawar.navy.mil.

CAPT John Jemionek

p00bba@bupers.navy.mil
(703) 614-3448

Final Cruise for CAPT Peter V. Siegel, MC, USN

It is my sad duty to inform the members of The Society of U.S. Naval Flight Surgeons, that my father, Dr. Peter V. Siegel, M.D., died on April 6, 2001 at age 84. He was designated Naval Flight Surgeon No. OPFS-481 on 24 Jan 1947. He lived a long and full life and accomplished much in the field of aerospace medicine. A memorial service was held in his honor in Sedalia, Missouri on May 26, 2001.

Pete Siegel, Jr.
psiegeljr@satx.rr.com
San Antonio, TX

Editors Note: The Society sends our condolences to the family and deep appreciation for Captain Siegel's service to his country.

Selected SUSNFS Merchandise Items Catalog



Ya gotta get one-a-deese!

NAMI Belt Buckle - \$24.00



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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



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Address Change, Subscription/Membership Renewal, Price List, and Order Form (Jun 2001)

#	ITEM	PRICE		SUB-TOTAL
	<i>(Indicate Size and Color Where Appropriate)</i>	<i>Non-Member/Member</i>		
___	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	_____
___	NEW - NAMI Flight Surgeon Belt Buckle!!!!	24.00	24.00	_____
___	Travel Mug: SUSNFS Logo	6.00	5.00	_____
___	2001 The Ultimate Flight Surgeon Reference CD - NEW!!	25.00	20.00	_____
___	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 _____

continued from page 16

disability.

Yet another example is that of an aviator that lost the fifth finger of his left hand in a training accident. He was found FIT FOR DUTY by the PEB, and he even was returned to flying status. However, after separation from active duty the VA found him to have a rated disability. I think we all could agree that we could do our job in the military without our fifth finger on our non-dominant hand AND have a compensable claim to the VA.

The VA determines the service connection of an injury/illness and compensates for the loss of CIVILIAN earning potential. (PEB determines the medical fitness for MILITARY DUTY). In the VA any service connected disability is rated (The PEB rates only the Unfitting Condition). The VA ratings may change over time as a condition deteriorates (the PEB rating is static, unless on the TDRL).

This can all be very confusing and illustrates the importance of the VA form as a listing of all conditions (that might be compensable) as a member processes for retirement/separation. The SF88/93 only states the medical fitness for continued duty/separation/retirement.

Remember to get your SUSNFS Gedunk!

by using the order form
on the inside of the back cover



The Society of U.S. Naval Flight Surgeons
P.O. Box 33008
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Anyone who would like a Microsoft Windows 97 version of this explanation can email me at CTW2FlightDoc@yahoo.com and I will reply/email a copy to you. Please forward any questions through CHCS or by my email if you wish.

LCDR W.D. Agerton, MC USNR
Flight Surgeon, VF-101
CTW2FlightDoc@yahoo.com

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.

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

CAPT M.R. Valdez, MC, USN
Editor, SUSNFS Newsletter
P.O. Box 33008
NAS Pensacola, FL 32508-3008

FAX: COM (850) 452-5194 DSN 922-5194
E-mail: namiramdir@nomi.med.navy.mil

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