

UNITED STATES DEPARTMENT OF DEFENSE

DEFENSE HEALTH BOARD

CORE BOARD MEETING

Fairfax, Virginia

Friday, November 13, 2009

ANDERSON COURT REPORTING

706 Duke Street, Suite 100

Alexandria, VA 22314

Phone (703) 519-7180 Fax (703) 519-7190

1 PARTICIPANTS:  
2 REV ROBERT G. CERTAIN  
3 JOHN DAVID CLEMENTS, Ph.D.  
4 WILLIAM E. HALPERIN, M.D.  
5 EDWARD L. KAPLAN, M.D.  
6 WAYNE M. LEDNAR, M.D.  
7 RUSSELL V. LUEPKER, M.D.  
8 THOMAS J. MASON, Ph.D.  
9 DENNIS O'LEARY, M.D.  
10 MICHAEL N. OXMAN, M.D.  
11 MICHAEL D. PARKINSON, M.D.  
12 GREGORY A. POLAND, M.D.  
13 ADIL E. SHAMOO, Ph.D.  
14 JOSEPH SILVA JR., M.D.  
15 DAVID H. WALKER, M.D.  
16 ALLEN W. MIDDLETON  
  
17 COMMANDER EDMOND FEEKS  
18 VICE ADMIRAL JOHN MATECZUN  
19 KENNETH W. KIZER, M.D.  
20 FRANK BUTLER, M.D.  
21 COLONEL JOANNE MCPHERSON  
22

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1 PARTICIPANTS (CONT'D):

2 COMMANDER JIM HANCOCK

3 CHARLES SCOVILLE

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## 1 P R O C E E D I N G S

2 (7:45 a.m.)

3 DR. LEDNAR: Good morning, everybody.

4 I'm Wayne Lednar, one of the two Vice Presidents  
5 of the Defense Health Board. Welcome to day two  
6 of our Defense Health Board meeting. What I'd ask  
7 is for Mr. Middleton as our Designated Federal  
8 Official with us today, Mr. Middleton, if you  
9 would please open the meeting.

10 MR. MIDDLETON: Good morning. As the  
11 Alternate Designated Federal Official for the  
12 Defense Health Board, a federal advisory committee  
13 and a continuing independent scientific advisory  
14 body to the Secretary of Defense via the Assistant  
15 Secretary of Defense for Health Affairs and the  
16 Surgeons General of the military departments, I  
17 hereby call this meeting of the Defense Health  
18 Board to order.

19 DR. LEDNAR: In keeping with the  
20 practice of the Defense Health Board as we meet,  
21 we'd like to take a moment to stand in silence to  
22 remember and recognize those whom we serve.

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1 (Moment of silence.)

2 DR. LEDNAR: Thank you. Please take  
3 your seats. This is an open session meeting of  
4 the Defense Health Board. What I'd like to do is  
5 to have all of us here in the room introduce  
6 ourselves. If you would please state your name,  
7 your affiliation and if you are a member of the  
8 Defense Health Board, if you would also include  
9 the kind of position that you serve with the  
10 Defense Health Board. If I might ask Mr.  
11 Middleton, would you mind starting and we'll go  
12 around this way?

13 MR. MIDDLETON: I'm Allen Middleton.  
14 I'm the Acting Principal Deputy Assistant  
15 Secretary of Defense for Health Affairs.

16 DR. POLAND: I'm Greg Poland, Professor  
17 of Medicine at the Mayo Clinic, in Rochester,  
18 Minnesota, one of the VPs of the Board and Chair  
19 of the Infectious Disease Control Subcommittee.

20 Col BADER: Good morning. Christine  
21 Bader. I serve as a Senior Advisor to the  
22 Assistant Secretary of Defense for Health Affairs.

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1                   REV. CERTAIN: I'm Robert Certain.  
2 I'm an Episcopal priest in Atlanta and retired Air  
3 Force Chaplain.

4                   DR. HALPERIN: Bill Halperin. I'm Chair  
5 of the Department of Preventive Medicine at the  
6 New Jersey Medical School and Chair of the  
7 Subcommittee on Occupational and Environmental  
8 Health for the Board.

9                   DR. KAPLAN: I'm Ed Kaplan, Professor of  
10 Pediatrics at the University of Minnesota Medical  
11 School, a Core Board member, and a member of the  
12 Infectious Diseases Subcommittee.

13                  DR. OXMAN: I'm Mike Oxman, Professor of  
14 Medicine and Pathology at the University of  
15 California, San Diego, a Core Board member, and a  
16 member of Infectious Diseases and Pathology  
17 Subcommittees.

18                  DR. PARKINSON: Good morning. Mike  
19 Parkinson. I'm Past President of the American  
20 College of Preventive Medicine and currently  
21 working with a number of health care organizations  
22 on quality and performance. I'm a Core Board

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1 member and also a member of the Subcommittee on  
2 Health Care Delivery.

3 DR. KIZER: Good morning. I'm Ken  
4 Kizer. I'm the Chairman of the BRAC Advisory  
5 Committee that we'll be hearing from later this  
6 morning.

7 DR. SHAMOO: I'm Adil Shamoo, Professor  
8 at the University of Maryland School of Medicine  
9 and member of Health Care Delivery and Chairman of  
10 the Medical Ethics Subcommittee.

11 COL MOTT: Colonel Bob Mott from the  
12 Army Surgeon General's office. I'm the Army  
13 liaison.

14 COL KRUKAR: Good morning. I'm  
15 Colonel Michael Krukar, the Director of the  
16 Military Vaccine Agency.

17 COL HACHEY: Wayne  
18 Hachey, Director of Preventive Medicine, OSD  
19 Health Affairs, Force Health Protection and  
20 Readiness.

21 CDR SCHWARTZ: Commander Erica  
22 Schwartz, Coast Guard Preventive Medicine liaison.

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1                   LtCol GOULD: Lieutenant  
2 Colonel Philip Gould, Air Force Liaison.

3                   LCDR SPRINGS: Lieutenant  
4 Commander Julia Springs, U.S. Marine Corps  
5 Health Services.

6                   CAPT LEE: Captain Roger Lee. I'm on  
7 the Joint Staff, J4 Health Service Support  
8 Directorate.

9                   CDR SLAUNWHITE: Good morning.  
10 I'm Commander Cathy Slaunwhite. I'm a Canadian  
11 Forces medical officer in a liaison role at the  
12 embassy in Washington, D.C.

13                   CAPT NAITO: Captain Neal Naito, Navy  
14 service liaison.

15                   Col MCPHERSON: Colonel Joanne  
16 McPherson. I'm the Executive Secretary for the  
17 DOD Task Force on the Prevention of Suicide by  
18 Members of the Armed Forces.

19                   DR. BUTLER: Good morning. Frank  
20 Butler, Chair of the Committee on Tactical Combat  
21 Casualty Care and today sitting in for Dr. John  
22 Holcomb, Chair of the Trauma and Injury

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1 Subcommittee.

2 DR. FOGELMAN: Charlie Fogelman, Chair  
3 of the Psychological Health Subcommittee on the  
4 Board.

5 DR. WALKER: David Walker, Chair of the  
6 Department of Pathology at the University of Texas  
7 Medical Branch at Galveston and a member of the  
8 Core Board and Infectious Disease Control  
9 Committee.

10 DR. SILVA: Joe Silva, Professor of  
11 Internal Medicine and Infectious Diseases,  
12 University of California at Davis, and Dean  
13 Emeritus, Core Board member and also member of the  
14 Infectious Diseases Subcommittee.

15 DR. O'LEARY: Dennis O'Leary, President  
16 Emeritus of the Joint Commission, a Core Board  
17 member, and member of the BRAC Subcommittee.

18 DR. MASON: I'm Tom Mason, Professor of  
19 Occupational and Environmental Health, the  
20 University of South Florida College of Public  
21 Health and I'm a member of the Subcommittee on  
22 Environmental and Occupational Health.

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1 DR. LUEPKER: I'm Russell Luepker and  
2 I'm Professor of Epidemiology and Medicine at the  
3 University of Minnesota, I'm a member of the Core  
4 Board and member of the Health Delivery  
5 Subcommittee.

6 DR. CLEMENTS: John Clements. I'm Chair  
7 of Microbiology and Immunology at Tulane  
8 University School of Medicine and also Director of  
9 the Tulane Center for Infectious Diseases. I'm on  
10 the Core Board and a member of the Infectious  
11 Disease Subcommittee.

12 VADM MATECZUN: Admiral John  
13 Mateczun, Commander of Joint Task Force CapMed and  
14 appreciative user of your services.

15 CDR FEEKS: Good morning.  
16 Commander Ed Feeks, Executive Secretary to the  
17 Defense Health Board.

18 DR. LEDNAR: Wayne Lednar, Vice  
19 President of the Defense Health Board and Global  
20 Chief Medical Officer of DuPont. If we can also  
21 do introductions in the remainder of the room.

22 COLONEL MCCLOUD: I'm David McCloud,

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1 Colonel retired, Army Medical Corps, and I am the  
2 Chief of the Prosthetic Cancer Research Project at  
3 Walter Reed and I'm very fortunate in having what  
4 we're trying to define as a world-class operation,  
5 not bragging here, but we value what we do and  
6 I've been in this military for 45 years.

7 DR. COHOON: I'm Barbara Cohoon. I'm  
8 Deputy Director of Government Relations for the  
9 National Military Family Association, and I'm also  
10 a member of the TBI Family Care Giver Panel which  
11 was briefed yesterday, and thank you for accepting  
12 our curriculum. Also I'm a member of the Health  
13 Care Subcommittee and the TBI Subcommittee.

14 DR. WARD: I'm Claudine Ward. I'm a  
15 Preventive Medicine Resident at the Uniformed  
16 Services University.

17 MR. RAYBOLD: Ridge Raybold, Office of  
18 the Director, Armed Forces Institute of Pathology.

19 MS. JOVANOVIC: Good morning. I'm  
20 Olivera Jovanovic. I'm DHB support staff.

21 MS. CAIN: Christina Cain, DHB support  
22 staff.

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1                   LtCol HOBBS: Laurie Hobbs, OSD Health  
2                   Affairs.

3                   COLONEL EDWARD: Colonel Adolphe Edward,  
4                   Chief of Staff at JTF CapMed.

5                   MS. JARRETT: Lisa Jarrett, Defense  
6                   Health Board support staff.

7                   MS. GRAHAM: Elizabeth Graham, DHB  
8                   support staff.

9                   DR. LEDNAR: Thank you. Again, welcome  
10                  to everyone. Before we start our first agenda  
11                  item, Commander Feeks has some administrative  
12                  remarks that he'd like to share. Commander Feeks?

13                  CDR FEEKS: Thanks, Dr. Lednar.  
14                  This is Commander Feeks. Good morning and welcome  
15                  everyone. Thank you for being here. I'd like to  
16                  thank the Hyatt Fair Lakes Hotel for helping with  
17                  the arrangements for this meeting. I'd like to  
18                  thank all the speakers who have worked hard to  
19                  prepare briefings for us. I'd like to thank my  
20                  staff, Jen Klevenow, Lisa Jarrett, Elizabeth  
21                  Graham, Olivera Jovanovic, Christina Cain, and  
22                  back at the home office, Jean Ward for arranging

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1 this meeting of the Defense Health Board. If you  
2 have not already done so, please do sign the  
3 general attendance roster on the table outside.  
4 The law requires us to keep a record of who  
5 attends the meetings. For those who are not  
6 seated at the tables, there are handouts provided  
7 on the table at the far end of the room.  
8 Restrooms are located down this way and turn left.  
9 If you need telephone, fax, copier or message  
10 services, please see Jen Klevenow or Elizabeth  
11 Graham. If you would please put your personal  
12 electronics in a silent mode for the duration of  
13 the session. Because this open session is being  
14 transcribed, I'd like to call your attention to  
15 Ms. Christine Allen over on my right. Notice  
16 that she is not typing. She is recording. So the  
17 person who's going to type this transcript will  
18 not recognize the sound of your voice, so each  
19 time you speak, please say your name at the  
20 beginning.

21 Refreshments will be available for both  
22 the morning and afternoon sessions. We will have

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1 a catered working lunch here for the Board  
2 members, ex officio members, service liaisons,  
3 allied liaisons, support staff and speakers and  
4 distinguished guests. For those looking for lunch  
5 options, there is a restaurant here in the hotel.  
6 There are numerous other options both sit-down  
7 dining as well as fast food very close-by. Just  
8 ask a member of the hotel staff about that.

9 For those who need to take the Metro  
10 after this meeting, the hotel operates a  
11 complementary shuttle to the Vienna Metro station  
12 every 30 minutes, so please see the shuttle  
13 schedule at the registration desk or the hotel  
14 front desk for information about that.

15 The date and location of our next  
16 meeting has yet to be determined, but at that  
17 meeting the Board will receive updates from the  
18 various subcommittees and consider various issues  
19 for recommendations to the Secretary. That's all  
20 I have. Dr. Lednar?

21 DR. LEDNAR: Thank you, Commander Feeks.  
22 We'll go into now our first agenda item, and the

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1 board is grateful to have with us today Vice  
2 Admiral John Mateczun, Commander of the Joint Task  
3 Force, National Capital Region Medical. Admiral  
4 Mateczun has served as Joint Staff Surgeon and  
5 medical advisor to the Chairman of the Joint  
6 Chiefs of Staff as well as U.S. delegate to the  
7 NATO Committee on Chiefs of Medical Services.  
8 Present at the Pentagon on September 11, 2001, he  
9 subsequently served on the Joint Staff during  
10 Operations Noble Eagle, Enduring Freedom and Iraqi  
11 Freedom. Vice Admiral's Mateczun's ensuing flag  
12 assignments were as Chief of Staff, Bureau of  
13 Medicine and Surgery, Commander of Naval Medical  
14 Center, San Diego, and Deputy Surgeon General of  
15 the Navy. He has also served as Director of the  
16 Military Health System Office of Transformation  
17 and is a member of the congressionally mandated  
18 Task Force on the Future of Military Health  
19 Systems. Admiral Mateczun's awards include the  
20 Navy Distinguished Service Medal, Defense Superior  
21 Service Medal with Oak Leaf Cluster, Legion of  
22 Merit with Three Gold Stars, Bronze Star, Defense

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1 Meritorious Service Medal, Meritorious Service  
2 Medal with Gold Star, Navy- Marine Corps  
3 Commendation Medal, Army Commendation Medal and  
4 Navy-Marine Corps Achievement Medal. He has many  
5 ribbons. Today he will share with us the DoD  
6 response to the Achieving World-class report  
7 developed by the NCR BRAC Advisory Panel of the  
8 Defense Health Board as well as a progress report  
9 on the Walter Reed National Military Medical  
10 Center. Thank you for joining us, Admiral  
11 Mateczun.

12 VADM MATECZUN: Good morning,  
13 Dr. Lednar and Dr. Poland. Thank you. Mr.  
14 Middleton and distinguished member of the Defense  
15 Health Board, guests who are here today. It's my  
16 pleasure to be able to present to you the  
17 Department's response to the Defense Health  
18 Board's Subcommittee report on achieving world  
19 class and progress at the Walter Reed National  
20 Military Medical Center. Today I hope to provide  
21 you a briefing and overview of the Department's  
22 response to the report and give you an update as

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1 well on how some of the projects are going and  
2 then be able to answer any questions or engage in  
3 any discussion that you might have.

4 Background. In 2005 BRAC seems like a  
5 long time ago. 2007 and borne out of crisis, you  
6 may remember the "Washington Post" articles on  
7 Walter Reed Medical Center of February 2007,  
8 subsequent Dole-Shalala independent review group  
9 and other commissions that reviewed the situation  
10 within the National Capital Region. The  
11 Department had a National Capital Region Senior  
12 Oversight Committee to review those  
13 recommendations and take action. One of the  
14 recommendations was that there be a coordinating  
15 agency to oversee the BRAC realignments and  
16 integrate health care delivery within the National  
17 Capital Region. So the Joint Task Force was  
18 formed in September 2007, chartered by the Deputy  
19 Secretary of Defense, then Secretary England.

20 In November 2008 the FY 2008 NDAA  
21 required an independent review of the designs and  
22 plans for the new medical center to determine

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1 whether they would be world-class and that Panel  
2 submitted their independent review to the DoD and  
3 Congress in July 2009. Subsequent to that, the  
4 Department did an extensive review of the  
5 recommendations and findings of the Panel. I will  
6 tell you if you've seen the report, and I think  
7 most of you have, it's an extensive response.  
8 Usually the Department's response to  
9 Congressionally mandated reviews are a page or  
10 two. This was a very thorough review of all the  
11 recommendations that were made and I can tell you  
12 that it was coordinated at the highest levels.  
13 One of the things that's happening in the  
14 Department is there are a large number of new  
15 political appointees coming in to prominent  
16 positions, the Secretaries of the Services, the  
17 new Under Secretary for Personnel Readiness of  
18 course was just nominated, but all of these  
19 personnel wanted to personally review this and I  
20 spent a lot of time talking with a lot of people  
21 about the background and history of what was going  
22 on, so there is a lot of interest in the

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1 Department about this report and what's happening.

2           Additionally, since the Department's  
3 response has been submitted and included in the  
4 fiscal year 2010 NDAA as a follow on requirement  
5 to see how the Department is continuing to develop  
6 and implement those things which were recommended  
7 in the report so that the report was ready clearly  
8 by Congress as well who took a lot of the findings  
9 and recommendations, turned them into law and  
10 we'll be responding to those laws as we go  
11 forward. In particular, we have to develop a  
12 master plan. We have to recertify some things  
13 that they required previously, in particular that  
14 we haven't moved anything from Walter Reed until  
15 we have capabilities elsewhere. And we have to  
16 make sure that everything meets JCAHO standards and  
17 provide an assessment of risks and benefits to  
18 patient care associated with completing the  
19 realignment. It also requires a schedule for  
20 completion of requirements in our master plan and  
21 an updated cost estimate to provide world-class  
22 care within the National Capital Region.

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1                   We're working on those reports now.  
2           This is the conceptual drawing of Bethesda that  
3           you've seen.  Actually, the pictures that you see  
4           look kind of like that now.  I'm getting ready to  
5           go talk to the Chairman and the Joint Chiefs of  
6           Staff again on our progress toward the completion  
7           of the BRAC and this is a review of the  
8           construction that's going on on the Bethesda  
9           campus.  Two major construction projects, the top  
10          two bullets there, the top two green lights, are  
11          RFP 1.  That's the big buildings on either side of  
12          the tower at the Bethesda campus.  Construction is  
13          really going along.  It's getting close to  
14          two-thirds complete within the construction.  Down  
15          at the bottom is RFP 2.  The contract was awarded  
16          on RFP 2 and broke ground last Friday to start  
17          construction of those projects, and those are  
18          mostly administrative and support buildings  
19          particularly to take care of the wounded warriors.  
20          I got a couple of slides in the back and I'll show  
21          you some of the pictures of what's happening  
22          there.  All of that construction is on or ahead of

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1 schedule, not just on schedule. We're about 5  
2 months ahead of schedule on the Bethesda campus on  
3 construction, about 7 months ahead of schedule on  
4 the Fort Belvoir campus on construction. You see  
5 one yellow light up there, and that is that while  
6 we're doing new construction, we're also doing  
7 renovations within the existing hospital buildings  
8 on the Bethesda campus. Those are just started.  
9 They require a series of moves. The Deputy  
10 Secretary required that we minimize the impact on  
11 patients and staff and so there is temporary swing  
12 space that's been put up. Orthopedics, physical  
13 therapy and pediatrics moved into those new spaces  
14 and now we're working through the renovations.  
15 They are only 19 percent complete and as we're  
16 opening up the walls we're finding that there is  
17 more to be fixed than we thought, so that's  
18 creating some schedule risk, but we're still on a  
19 timeline to make it through the end of the BRAC,  
20 so minimal construction risk, a little bit of  
21 schedule risk left on the Bethesda campus.

22 You can see the number of projects that

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1 are going on. Those things that are up in blue at  
2 the top are the new contracts on which  
3 construction just got started. The kind of green  
4 down at the bottom are the big Buildings A and B  
5 for RFP 1, and a 943 space parking garage which  
6 will be open in a couple of months we hope to  
7 start to alleviate the parking congestion that's  
8 going on here on campus.

9 A couple of other things that are going  
10 in, you see some things in yellow that have been  
11 proffered by outside agencies, the Intrepid Center  
12 of Excellence for Traumatic Brain Injury,  
13 Psychological Health going up over on the  
14 right-hand side of the campus with construction  
15 going along very well. Should be finished within  
16 the year. And then the Fisher Foundation has  
17 donated three new Fisher Houses on the site where  
18 we had an old officer's club and gymnasium and  
19 those are being torn down and those Fisher Houses  
20 will be let, and then this year we'll start  
21 construction on that red parking garage up there  
22 that you see as well. So there's a lot of

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1 construction going on all around the campus.

2 This is the Fort Belvoir Community  
3 Hospital. It will be the country's leading  
4 proponent of evidence-based design. It is well on  
5 schedule, actually ahead of schedule so that we'll  
6 have a significant amount of time for transition  
7 down to the Fort Belvoir Hospital. It's working  
8 from the outside in and so the clinic building is  
9 on the outside and the parking garages are more  
10 complete than the central inpatient ancillary  
11 services tower, so those will be going along  
12 perfectly well. There is still some cost risk  
13 here because of the contracting vehicle which is  
14 known as integrated design bid/build, IDBB, and so  
15 we're finalizing those prices now in terms of the  
16 contract.

17 For those of you who are familiar with  
18 Northern Virginia, this footprint is about the  
19 size of the Springfield Mall not very far from  
20 here and from one of the parking garages into the  
21 middle is about the length of an aircraft carrier  
22 for those of you who might be a little more

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1 nautical, so it's two aircraft carriers pointing  
2 toward the middle there in terms of size. It's an  
3 extraordinary campus. There are a couple of great  
4 features here. I know that the Subpanel knows a  
5 lot of the evidence-based design features that are  
6 going into this. But also you'll see that in back  
7 of those clinic buildings there is room to expand.  
8 This is all green space construction and so we  
9 were able to provide space in the back for future  
10 expansion if that's necessary, and our population  
11 is certainly drifting south within the National  
12 Capital Region along the 95 corridor here, so we  
13 anticipate that there will be even further growth  
14 of this part of the campus in the future.

15 That's a quick update on the  
16 construction projects that are going on. I'll  
17 tell you that construction is part of what we need  
18 to do. We're green on construction. You also  
19 have to put gear and outfit these buildings once  
20 they're completed, and we anticipate that we'll  
21 have a contract out for outfitting before the end  
22 of this months. It turns out that this is an area

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1 where there is tremendous private-sector  
2 competence and it's big business. This will be  
3 about a \$400 million contract, and what we've done  
4 is put together the outfitting contracts for both  
5 of these hospitals so we'll have standardized  
6 equipment, we'll gain economies of scale in their  
7 purchase, their maintenance contracts, we'll gain  
8 economies on those because we'll be able to do it  
9 across systems, and we're trying to standardize  
10 patient safety items so that as you move from one  
11 of the hospitals to the other you're able to know  
12 the equipment and work through the patient safety  
13 aspects of that without having to orient  
14 completely to a new hospital.

15 I'll move into the Department's review  
16 of the Defense Health Board's Subcommittee's  
17 report. This is an executive summary if you will  
18 of the findings maybe a little bit reordered, but  
19 we're pleased that the Board that we thought that  
20 we could continue with construction and  
21 renovations and correct those deficiencies which  
22 the Defense Health Board had identified, and we're

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1 certainly in the process of doing that.

2 Secondly, the Board identified an  
3 authorities issue as foundational. This primarily  
4 has to do with the relationships on the Bethesda  
5 campus. They recommended empowering a single  
6 official with complete organizational and budget  
7 authority in the NCR, and I'll come back to that  
8 with what the Department is doing.

9 Develop a comprehensive master plan.  
10 This has to do with both our vision for providing  
11 integrated delivery systems of care for our  
12 patients here within the NCR as well as what the  
13 facilities on particularly the Bethesda campus  
14 will look like in the future and how we'll be able  
15 to achieve world-class through that master plan.  
16 We need to engineer an integrated military health  
17 care culture, more fully incorporate clinician and  
18 end user input into plans, and then evaluate the  
19 design and build processes that we're using in  
20 these two hospitals for future use in the military  
21 health system. We didn't build any hospitals  
22 within the military health system for about 10

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1 years. These are the first two new hospitals that  
2 we've built, and we've got eight new ones coming  
3 on in the next 5 years. So it is critical that we  
4 evaluate these processes and apply them to future  
5 construction projects.

6 I'll start out with what the Department  
7 thinks is the right way to respond to each of  
8 these recommendations. The Defense Health Board  
9 Subcommittee defined world-class medical facility,  
10 and Section 27.14 of the FY 2010 NDAA codifies  
11 that definition. The Congress accepted that  
12 definition, codified it and it's now part of law  
13 in the FY 2010 NDAA. The DoD is pleased to see  
14 that the designs for both Walter Reed and Fort  
15 Belvoir are sufficiently close to the newly  
16 defined standards to recommend construction and  
17 renovation projects should be continued. Where  
18 there are identified deficiencies, the Department  
19 is committed to correcting design and  
20 construction, provide a way forward within a  
21 comprehensive master plan for future construction  
22 projects within the National Capital Region

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1 Integrated Delivery System, and on the Bethesda  
2 campus. I will tell you that there are some  
3 elements of the Defense Health Board  
4 recommendations that make it impossible to achieve  
5 the definition of world-class within the BRAC  
6 construction projects and within the BRAC  
7 timeline. It was never planned that way, and so  
8 now we have to adapt as things go. There has been  
9 an evolution of standards that the Department has  
10 used as we have gone through the BRAC process.  
11 First it was the BRAC and the BRAC was in 2005.  
12 The Department reviewed using its methodology with  
13 the Joint Cross-Service Working Groups to make the  
14 recommendations to close the inpatient facilities  
15 at Fort Belvoir and out at Malcolm Grow at Andrews  
16 Air Force Base and consolidate them into these two  
17 new facilities. Since then, in 2007 the  
18 Department's response to all of the  
19 recommendations of Dole-Shalala, the independent  
20 review group, resulted in what was known as  
21 enhance and accelerate on the Bethesda and Fort  
22 Belvoir campuses, primarily on the Bethesda

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1 campus. There is some acceleration to make these  
2 facilities available as early as we can get them  
3 and to enhance what the BRAC vision was, so we've  
4 incorporated those now into the schedule as well.  
5 Now we have a new standard. This is the standard  
6 for world-class which has been codified within the  
7 FY 2010 NDAA, so that's a new law, and now we will  
8 have to work forward to meet that definition.

9 This creates a tension between the old  
10 design and the new design and the Department in  
11 its master plan will have to decide how it is  
12 going to approach achieving those world-class  
13 definitions. In particular, there are two parts  
14 of the definition that are involved here. One is  
15 single-patient rooms as a standard, so on the  
16 Bethesda campus they're renovating a significant  
17 number of rooms and if you count the intensive  
18 care and other units, well over 150 of the rooms  
19 will be single-patient rooms after the renovation  
20 is complete. That still leaves 203 patients are  
21 in what are known as single double-patient rooms.  
22 There is no additional space on the campus and so

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1 to get to that standard of single-patient rooms,  
2 the Department would have to involve itself in new  
3 construction. Clearly that's not going to happen  
4 before the end of the BRAC. But in terms of the  
5 master plan, the Department will review the  
6 single- patient rooms and decide whether or not  
7 that is the standard and then if so how to get  
8 there. Operating rooms would be another example.  
9 Operating rooms are a matter of significant debate  
10 as we've discovered out in the community. We had  
11 a lot of surgeons out at UCLA Monday and Tuesday  
12 to meet with their future OR folks and we've  
13 discovered that there are a lot of commonalities.  
14 We've been working in the same direction on a lot  
15 of the ORs, but we will have to establish a  
16 definitive standard and then work toward achieving  
17 it on the campus. Once again, there's no new  
18 space that's on the campus within the current  
19 projects and you can't just add on to the projects  
20 as they're going. We are doing other backfill  
21 renovations at Bethesda. We're getting ready to  
22 review the renovations of the existing ORs at

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1       Bethesda today to see if the plans for the future  
2       can be incorporated into those plans for  
3       renovation as a transitional step.

4                   One official with organizational and  
5       budgetary authority within the Capital Region.  
6       This is one of the things that Congress is  
7       requiring us to report about. Secretary Lynn in  
8       his response to Congress directed the NCR OIPT,  
9       and for those of you who don't know, the NCR OIPT  
10      is really comprised of the former members of the  
11      NCR Senior Oversight Committee in the Department.  
12      So it's the Vice Chiefs of each of the Services,  
13      the Assistant Secretaries for MNRA, the Assistant  
14      Secretaries for Installations and the Environment,  
15      the Comptroller of the Joint Staff, you name it,  
16      everybody from the Department comes and they give  
17      me advice on my way to the Deputy Secretary with  
18      these decisions. Secretary Lynn has directed that  
19      the NCR OIPT take on this issue and that they  
20      define what is the Walter Reed National Military  
21      Medical Center and that they review this issue of  
22      how to achieve the organizational authorities we

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1 need to be able to get to a world-class vision.

2           Since the Subcommittee met in January of  
3 this year, the Deputy Secretary did establish  
4 enhanced command authority to the Commander of the  
5 Joint Task Force by deciding that each of these  
6 hospitals will be operated by the Joint Task  
7 Force, that is that the Joint Task Force will have  
8 OPCON over these two new joint hospitals so that  
9 that authority has been enhanced since the board  
10 met. Right now, Health Affairs, the JTF and the  
11 Services' SG are working to develop the funding  
12 flow equities. A large part of being able to  
13 achieve world-class is where does the money come  
14 from. The Department isn't much different than  
15 any other place in the world. Everybody wants to  
16 influence the funding flow, all good ideas have to  
17 be funded somewhere, so we're working through  
18 those authorities as well.

19           Develop a comprehensive master plan.  
20 The Department recognizes and endorses the  
21 importance of achieving a clear and common vision  
22 both for the Walter Reed campus and for the

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1 National Capital Region Integrated Delivery  
2 System. We're already working on each of those to  
3 be able to meet the Congressional mandate. That  
4 master plan will include both facilities and  
5 health care delivery in the region and we have to  
6 have it all put together by the end of March in  
7 order to get it back over to Congress. The master  
8 plan will as directed by the Subcommittee work  
9 toward a concept and a vision that extends beyond  
10 the BRAC. It's not BRAC limited. It's how do we  
11 get to world-class in the end state. As the  
12 Subcommittee reports to us, it is a journey.  
13 There is not a completed state of world-class and  
14 those institutions certainly used as models I  
15 think provide a good illustration that you just  
16 don't have one plan, you have to constantly be  
17 adapting that plan both in terms of facilities,  
18 the services that you're going to be using for  
19 patients and the whole synergies between the  
20 integrated delivery system and the facilities.

21 Engineer integrated military health  
22 care. It's an interesting thought. I tell you

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1 I've been involved in this now for 2 years and I  
2 think that everybody thinks that they know what  
3 they're talking about when they say military  
4 culture. I've become convinced that there is a  
5 large overlap between business processes and  
6 culture and that if culture is defined as the way  
7 we do things around here, then our heuristic  
8 devices for getting through the day are a part of  
9 the culture, and so our business processes at each  
10 of the hospitals are different. This is as much  
11 as it is about locality as it is about the service  
12 because all of our hospitals have different  
13 cultures in that respect. So we're working toward  
14 arriving at a place where we can work across those  
15 business processes, but we've got consultants  
16 working with us now on achieving the overarching  
17 cultural design for this new integrated delivery  
18 system. I'll tell you we've had within the  
19 Department a tremendous ability to reach out and  
20 have traveling fellowships that Health Affairs has  
21 put together out to Mayo, to the Cleveland Clinic,  
22 we've been to UCLA, we're going out to Inter-

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1 Mountain, Kaiser Permanente on both coasts. A lot  
2 of folks would like to help us. These models are  
3 all close, but I don't think that any of them  
4 achieve exactly what we're looking for within our  
5 culture and integrated delivery system. We have a  
6 little bit of a different mission and so we will  
7 make sure that we form our culture around those  
8 things that are necessary for us to achieve our  
9 mission.

10 Fully incorporate clinician and end user  
11 input. We've been able to modify design  
12 processes. We had over 160 working groups not  
13 just with clinicians but with administrative staff  
14 as well to take a look at the space designs for  
15 the new Walter Reed and we directed the redesign  
16 of some portions of the planned outpatient  
17 building particularly those that are working  
18 toward cancer care and the pharmacy that was going  
19 to be located in the outpatient building. We're  
20 moving toward a concept of integrated cancer care  
21 through a comprehensive cancer center concept that  
22 I'm very excited about. We have world-class

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1 research and service capabilities for our  
2 beneficiaries within the Military Health System.  
3 We have no organized comprehensive cancer center  
4 and so we are working toward the delivery of  
5 services both in Walter Reed, and then we've  
6 reached across the street to Dr. John Niederhuber  
7 at the National Cancer Institute to work with us  
8 toward achieving NCI Comprehensive Cancer Center  
9 designation as we go forward. Once again this  
10 won't happen coinciding with the end of the BRAC.  
11 It will take us some time to get there. We are  
12 committed to doing this for our beneficiaries.

13 Not everybody's suggestion gets  
14 incorporated by the way into design. We went back  
15 as part of our own review of how do you using  
16 these design-build processes, they're in use in  
17 the private sector a lot, but it used to be that  
18 in the Department we took about 2 years to 3 years  
19 to do the design and then the construction took  
20 about 3 years. Our timeframes don't allow us to  
21 that today, and even if you did, the design that  
22 you had would be outdated by the time that you

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1 really got it out into contract. So we've  
2 overlapped those two processes, design and  
3 construction, to achieve speed and it's necessary  
4 but it's also very hard to manage. The sweet spot  
5 for inflecting the cost curve on the Bethesda  
6 campus for RFP 1 was January 2007. JTF wasn't in  
7 existence until September 2007. This Subcommittee  
8 didn't meet until late in 2008. So all of the  
9 things that we were doing were way past the most  
10 efficient time to inflect the cost curve. You  
11 have to understand the requirements early, and the  
12 Department has some risk here I think in the eight  
13 new hospitals that it's building over the next 5  
14 years if we don't manage these processes  
15 efficiently and effectively, so you can't wait  
16 forever for local clinician input would be I think  
17 one of the lessons that I've learned. You need to  
18 take as much of it as you can and kind of get  
19 there. In fact, how many clinicians does it take  
20 to tell you what kind of an OR you need? Every  
21 surgeon I've talked to has a different idea. I'm  
22 not kidding, literally, every surgeon I talk to

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1 has a different idea. They tend to approximate  
2 around a central theme, but the particulars are  
3 different. So within the Department as we arrive  
4 at what do these ORs look like, what does an ICU  
5 room look like, what is evidence-based design on a  
6 patient room, then moving toward a single standard  
7 may help us so that we don't reinvent this at each  
8 locality where there's a new hospital as we go.  
9 So this is a challenge I think not just for us.  
10 We do want to take the hard lessons that we've  
11 learned and put them into effect throughout the  
12 system for the benefit of our patients and for  
13 getting these projects done on time.

14 Further recommendations. We're  
15 continuing to work with those clinicians and we  
16 will be incorporating their concepts into the  
17 planning as we go forward from here. This is what  
18 I was talking about. This is to evaluate those  
19 construction processes for future MHS projects.  
20 In addition, we're going to use the Fort Belvoir  
21 Hospital as a design testing ground for  
22 evidence-based design. I told you that it's the

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1 leading exponent of evidence-based design in the  
2 country, and so we'll be able to test out some of  
3 those concepts I think through metrics in a way  
4 that you can't do in theory. We'll see how they  
5 work in practice.

6 In conclusion, the Department is  
7 appreciative of the Defense Health Board's  
8 invaluable support and guidance. I see Dr. Kizer  
9 and Dr. O'Leary, and I know members of the Panel  
10 and some others, thank you so much for all of the  
11 help in putting this together. It was a very  
12 short timeline to try to define something that had  
13 never been defined before. It's now codified into  
14 law. Think of that. The Department is committed  
15 to providing world-class health care in the NCR.  
16 We will achieve the Panel's newly established  
17 definition of a world-class medical facility and  
18 we are preparing that comprehensive master plan  
19 for the integrated delivery system to include both  
20 facility and installation services.

21 I want to show you a couple of pictures.  
22 These are where we're accelerating the projects.

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1 This is what the new RFP 2 will look like. You  
2 see on the left-hand side of the slide is that  
3 administrative building. The façade of that  
4 building is the old Naval Medical Research Center  
5 where all of the dive tables, if any of you are  
6 SCUBA divers or saturation divers, that's where  
7 all the dive tables in America were developed. In  
8 fact, there's a long history on this campus of  
9 cancer collaboration as well, so almost all of the  
10 lung protocols that are used today were developed  
11 in collaboration with the National Cancer  
12 Institute on this campus.

13 Over on the right-hand side you'll see  
14 the new towers that we're building for the wounded  
15 warriors. Those are 300 rooms/suites that exceed  
16 the ADA requirements, and an administrative  
17 building there in the middle with a dining  
18 facility for those wounded warriors and the ill  
19 and injured who will be residing on the campus.

20 This is a picture of those towers on the  
21 left- and the right-hand side in that medium  
22 building. The façade is over on the right-hand

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1 side. It will all be gutted and then this new  
2 construction will go on in the back. It actually  
3 goes down five stories. There's a hill there.  
4 This was originally three different construction  
5 projects, a gymnasium and parking garage complex  
6 now incorporated within that admin building  
7 complex.

8 That's the end of the slides. I'm  
9 available for any questions.

10 DR. LEDNAR: Thank you, Admiral  
11 Mateczun. The design of this morning's session  
12 includes a presentation by Dr. Kizer on achieving  
13 world-class, and since that's so central to the  
14 discussion as Admiral Mateczun mentioned, my  
15 suggestion is that we ask Dr. Kizer to make his  
16 remarks and then both Admiral Mateczun and Dr.  
17 Kizer together can take questions. I think some  
18 of the thoughts that might be in some people's  
19 minds might be addressed by some of the comments  
20 that Dr. Kizer will include.

21 DR. KIZER: Good morning. Thank you.  
22 Thank you, Admiral Mateczun, for those comments.

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1 I think that a number of your comments echoed  
2 things that I was going to say, so that should  
3 help catch up on some of the time.

4 Just to note a few milestones, since I  
5 believe the last time that we talked or had a  
6 conversation on this subject in this group was at  
7 the May meeting, early or mid- May, when the  
8 Subcommittee presented its penultimate report and  
9 then based on feedback from the board at that time  
10 made a few changes and reoriented or reformatted  
11 some things and then passed it on officially to  
12 the Defense Health Board at the end of May or  
13 first couple says in June. Whatever transpired  
14 took about a month. Then it was formally  
15 delivered to the Department. I should probably  
16 note that the findings of our report have  
17 essentially remained unchanged since they were  
18 first presented to this group in I think December  
19 2008, so in essence the findings have been  
20 substantially out there for much longer than might  
21 appear from the official timeline.

22 As was noted, the Department formally

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1        responded to the Subcommittee report in  
2        mid-October and briefed Congress a few days later.  
3        I should acknowledge that the Subcommittee  
4        recognizes the inherent challenge in compiling a  
5        composite report that so many different  
6        individuals contributed to as reflected in the  
7        report that John described which was quite  
8        lengthy. I think the Committee also appreciates  
9        and recognizes the varying levels of understanding  
10       and perhaps acceptance of the fact that the future  
11       is not what it used to be.

12                    The President signed the National  
13        Defense Authorization Act at the end of October  
14        and notably a section as has already been noted in  
15        that extensive bill codified the Committee's  
16        definition of world-class and specified that a  
17        number of other things occur. On an editorial  
18        basis, I believe this is the first time ever that  
19        a standard of this type has ever been put into  
20        law, or at least into federal law, and I have  
21        observed that everyone has been focused on health  
22        care reform and perhaps some other issues, and

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1 this completely went under the radar and many of  
2 the folks who I would have expected to have picked  
3 up on or commented on this legislation and this  
4 issue remain unaware of what I think is probably  
5 notable and ultimately will turn out to be fairly  
6 far-reaching that the standard has been put into  
7 federal law.

8 A bullet that probably should be on  
9 there but wasn't when I prepared these is that the  
10 Subcommittee after carefully reviewing the  
11 Department's response felt compelled to comment on  
12 the Department's plan of action and express some  
13 of its concerns to the Defense Health Board, and  
14 while the Admiral was speaking a memo was passed  
15 around that notes some of the Committee's concerns  
16 about the plan of action. I should note that  
17 actually that when our memo was prepared was  
18 formatted a little better than what is reflected  
19 in the copy that you have. Something happened in  
20 the electronic transmission and we'll clean that  
21 up for perhaps the formal for those who are  
22 concerned about how things appear.

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1           Just a couple of other points in the way  
2 of background worth noting. The Committee was  
3 convened last summer. It officially met for the  
4 first time in September. Although the purpose of  
5 convening the Subcommittee was not necessarily to  
6 do this independent review, when the Subcommittee  
7 was convened it was to provide advice on the  
8 creation of the integrated delivery network here  
9 in the National Capital Region and subsequently  
10 the Committee was additionally charged to do this  
11 independent review. Notably, all but I think Dr.  
12 O'Leary who is a member of the Core Board, all of  
13 the member appointments have expired so the  
14 Subcommittee technically does not exist and I have  
15 done my best to reassure the Committee members,  
16 many of whom who are very anxious to continue in  
17 the role, that the delay in reappointment is not  
18 due to the findings of the report or the  
19 recommendations that were put forth.

20           Just a couple of other things that may  
21 be relevant to context or philosophy in thinking  
22 about the definition and the recommendations. We

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1 certainly understood the Congressional charge of  
2 being a world-class medical facility to be a  
3 journey and not necessarily a specific designation  
4 which Admiral Mateczun has commented on, although  
5 I think the Committee may have a somewhat  
6 different take on this than what was expressed and  
7 we did comment in that in our memo. The Committee  
8 also took the view that world-class means the best  
9 of the best. This is the context or the way that  
10 the term is used in other settings. Ironically,  
11 if you go and do a Google search of world-class  
12 medical facility, you will quickly come to over  
13 100 institutions in this country that list  
14 themselves without that, notably without any  
15 specification of what that means or how they  
16 self-determined that they were world-class. But  
17 the Committee felt that as is detailed in our  
18 report that much of what would constitute that can  
19 be objectively measured and specified, some of it  
20 cannot at least with current measurement  
21 perspectives or measures that are used. There has  
22 been some, or at least I have heard feedback and

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1 have directly conversations that there are some  
2 varying interpretations of what world-class is  
3 taken to mean or what it should be taken to mean.  
4 I played football in college and many of my  
5 teammates were very good athletes and went on to  
6 play professional football, but only a few of them  
7 were ever all pro or would achieve that level of  
8 world-class, and I think in the athletic arena  
9 that are lots of very good, excellent athletes out  
10 there who never make it to the Olympics or perform  
11 at the level that would be considered world-class  
12 and I think you can use that analogy in other  
13 settings, and that is somewhat the context that  
14 the committee viewed what world-class should be  
15 taken to mean, that it's not for everybody,  
16 indeed, it's for a very select few who demonstrate  
17 a level of performance excellence that is truly  
18 the best in the world.

19 As I noted, the Committee also felt that  
20 the specifications should be objective and  
21 measurable whenever possible but acknowledges that  
22 a significant part, indeed, perhaps even the

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1 majority of what constitutes a world-class  
2 facility or a world-class anything if we think of  
3 a health care facility, that probably the majority  
4 of what constitutes that is what we could consider  
5 invisible architecture, the culture, the emotional  
6 state of the folks working there, the values,  
7 things that are harder to perhaps specify and lay  
8 out as may be design standards for how a facility  
9 is constructed.

10           With that, I don't know that we need to  
11 necessarily spend time going through this.  
12 Admiral Mateczun and at previous forums I think  
13 we've covered many of the key findings of the  
14 Subcommittee. I would underscore that the  
15 Committee I thought was quite clear in its  
16 recommendation about continuing construction that  
17 that was a contingent recommendation. It was  
18 contingent upon a number of corrective actions  
19 being taken, course corrections being made and  
20 other things, that it was not a blanket  
21 recommendation which perhaps some have taken it to  
22 mean.

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1           Let me focus perhaps on the response or  
2           the Committee's response to the report and make a  
3           few points. You can read what was said. I would  
4           note that what is included in this memo should not  
5           be taken to be an exhaustive list of the  
6           Committee's concerns about the plan of action that  
7           was espoused. It should be viewed more as an  
8           illustrative list of a number of issues.

9           First, I think the Committee certainly  
10          appreciates what seemed to be the Department's  
11          general agreement with the findings of the  
12          Committee, and frankly, while couched in  
13          Washington verbiage, the Department's candor that  
14          the current plans will not produce a world-class  
15          facility at Walter Reed, or at least certainly not  
16          by 2011. I think the Committee certainly would  
17          like to also commend the department for beginning  
18          to transition the military health care system from  
19          its historical service-specific, facility-centric  
20          of care delivery to a more modern  
21          integrated-service delivery model which is  
22          certainly the norm today in the VA and

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1        increasingly the norm in the private sector as  
2        well.

3                        Again the Committee after spending a  
4        considerable amount of time reviewing the  
5        Department's plan of action has some concerns that  
6        it feels should be brought to the attention of the  
7        full board and these are identified, or at least  
8        illustrative ones are identified in the memo as  
9        I've noted. I think first and foremost though the  
10       sense that the Committee got is that the  
11       Department may not have fully understood some of  
12       the recommendations or the essentiality of taking  
13       timely corrective action, and in viewing the plan  
14       of action, perhaps the most striking observation  
15       that was made essentially independently by all of  
16       the Committee members was the lack of detail and  
17       specific timelines, milestones, things laid out in  
18       the corrective-action plan. I think the Committee  
19       didn't feel particularly reassured that the needed  
20       course corrections would be accomplished based on  
21       reviewing the plan of action in view of the number  
22       of matters that were under review or under

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1 development or under study or similarly in some  
2 sort of under mode or unresolved status.

3 I think the Committee was troubled by  
4 this given the amount of time that our findings  
5 have been out there. As I said, they've been  
6 essentially unchanged since December 2008, or  
7 certainly the most important ones. I think the  
8 Committee was also concerned about the OIPT that  
9 was identified as at least one of the primary  
10 vehicles to resolve some of these issues  
11 recognizing that this is an entity that has  
12 existing for a long time and has had a number of  
13 these issues before it and today it has not  
14 seemingly brought resolution to some of these  
15 matters.

16 I think I'm going to digress a bit from  
17 the slide, and I'm mindful of the clock. I think  
18 the Committee philosophically certainly agreed  
19 with the idea that development of world-class is  
20 not a destination but a journey, but I think the  
21 Committee's expectations as I suspect are those of  
22 the Congress were that it would be less of a work

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1 in progress at this point than it is and would  
2 certainly appear to be by September 15, 2011 under  
3 the current course unless some changes are noted.  
4 I think the Committee was also somewhat dismayed  
5 by the seeming assertion that the Committee had  
6 concluded that the design plans were sufficiently  
7 close to the newly defined standard that  
8 construction projects should continue because I  
9 think that taken as stated and as reflected in the  
10 plan of action does misrepresent the Committee's  
11 findings and its position. To be clear, the  
12 Committee in its report I think was quite clear  
13 that neither the new construction nor the totality  
14 of what is apparently laid out at this point would  
15 result in a world-class medical facility and I  
16 think it was clearly stated that the current  
17 design plans were not those of a world-class  
18 medical facility and the recommendation to  
19 continue or not to call for a halt in construction  
20 was clearly contingent on a number corrective  
21 actions being taken, and I think I've already  
22 said, it was a very continent recommendation.

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1 Quite candidly, the Committee is much less  
2 confident in its conclusion and its recommendation  
3 in that regard after seeing the Department's plan  
4 of action than it was perhaps a month ago.

5 The last point is I think the second  
6 most important recommendation of the Subcommittee  
7 in its report was the need to consolidate  
8 organizational and budgetary authority in a single  
9 entity, and where perhaps there have been some  
10 steps in that direction, the Committee certainly  
11 felt that this needed to happen quickly and needed  
12 to get on with things, and it does not see that  
13 reflected or that decisiveness reflected in that  
14 Department's response and frankly feels that  
15 failure to resolve this authority issue doesn't  
16 portend well for further progress and indeed is  
17 likely to be the cause of significant negative  
18 impact going forward.

19 We've detailed illustrative concerns in  
20 the memo. You can look at them. I'm mindful of  
21 the clock so I'm not going to go through those.  
22 Some things maybe just to highlight two or three,

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1 the single-patient rooms that was commented upon,  
2 I think the Committee was rather surprised to see  
3 that characterized in the response as a newly  
4 defined department I believe was the verbiage that  
5 was used. Certainly the members of the Committee  
6 who have been working elsewhere have viewed this  
7 as a design standard that has existed for a long  
8 time. Dennis, as Chairman of the Joint Commission,  
9 can comment on it perhaps further. But this is  
10 hardly a new standard for world-class. This is a  
11 basic design standard for any new hospital being  
12 constructed anywhere. It's a minimal standard and  
13 not a stretch standard by any means. The  
14 Committee does recognize that there may be  
15 military-specific needs to maintain a few double  
16 rooms or two-patient rooms but feels quite  
17 strongly that the vast majority of rooms should be  
18 single-patient rooms and that would be necessary  
19 to meet minimal hospital construction standard in  
20 2008 or 2009.

21 As for the operating rooms, I think that  
22 the Committee was pleased that the three new

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1 operating rooms are likely to meet the size and  
2 infrastructure requirements, but the Committee is  
3 quite concerned about the 17 other operating rooms  
4 that would appear to remain substandard in various  
5 ways. The Committee was particularly also  
6 concerned about the apparent decision to locate  
7 frozen sections and surgical pathology  
8 substantially remote from the operating rooms  
9 which means at least if we understand things  
10 correct that the surgeon is going to have to break  
11 scrub, take the tissue sample, go down two floors,  
12 go through public areas, get the sample and then  
13 come back, all of which raises a number of  
14 infection and control concerns. It raises patent  
15 safety issues because as the surgeon is doing that  
16 as he or she is rescrubbing to come back into the  
17 sterile environment, the patient is going to have  
18 to be maintained under anesthesia for longer than  
19 would otherwise be necessary, and the Committee  
20 while we didn't to the surgeons who were involved,  
21 and I suppose it's possible, but the Committee has  
22 a hard time understanding or believing that the

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1 surgeons who will be affected by this decision  
2 would be pleased by what's envisioned. If this is  
3 the decision that goes forward, there clearly will  
4 be a need for some very rigorous infection control  
5 and patient safety policies and procedures that  
6 would have to be developed, but I would underscore  
7 that the Committee continues to not understand the  
8 logic for this design decision and well as some  
9 other things.

10 Perhaps the last thing I would note in  
11 this regard, I'm happy to address other things  
12 that I've stated here or that aren't stated,  
13 having to do with example information management  
14 and information technology. We've spent a lot of  
15 time and have had some significant concerns about  
16 that particularly the funding for it, because  
17 during our deliberations we heard consistently  
18 that funds hadn't been allocated for the IT  
19 infrastructure needs. The plan of action talks  
20 about a \$50 million procurement package for  
21 infrastructure that has been prepared and this is  
22 one of a number of examples where what's not said

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1 is of more concern I think to the Committee than  
2 what was said, because what wasn't said was that  
3 the procurement package has been prepared but  
4 whether it is going to be operationalized or when  
5 it's going to be operationalized and whether the  
6 \$50 million is actually set aside, the plan of  
7 action was silent and provided no information in  
8 that regard. Again, this is just illustrative of  
9 a number of other concerns where that type of  
10 detail which one would have I think expected to  
11 see in a corrective action plan was not available.

12 With all of these comments I think the  
13 Committee feels that this is an extremely  
14 important project not just for the Department of  
15 Defense but there are much larger implications as  
16 well. The Committee wants to be a constructive  
17 partner and help achieve the best possible  
18 outcome. We think perhaps one of the luxuries  
19 that we have is that we are independent and  
20 outside can put forth views that may not  
21 necessarily be popular in other settings, and  
22 whether it results in not being reappointed I

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1 guess time will tell. With that let me stop.

2 What's the format here for going forward?

3 DR. LEDNAR: Thank you, Dr. Kizer, and  
4 thanks to the Subcommittee for the very, very  
5 thoughtful work in reviewing the Department's  
6 position and then offering some additional  
7 feedback. I've asked Admiral Mateczun if he  
8 wishes to make a few comments initially to be in  
9 response to the Subcommittee's report, and after  
10 Admiral Mateczun has finished some comments, then  
11 we will open up the floor for questions to both  
12 Admiral Mateczun and to Dr. Kizer. Sir?

13 VADM MATECZUN: Thanks, Dr.  
14 Lednar. I'm not sure if I'm in rebuttal or  
15 surrebuttal at this point, but I'll keep an eye on  
16 the time and move ahead with some quick comments  
17 in how the Department works and what happens in an  
18 administration. Then the Department says it's  
19 committed to correcting deficiencies, that's a  
20 pretty big comment. In terms of a corrective  
21 action plan, that is a timeline which includes  
22 funding by the way. It's just not something that

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1 happens in government that quickly. As you move  
2 ahead, and I frequently tell the folks who I work  
3 with as we go up to the Hill and they ask  
4 questions, we're in the Executive Branch of the  
5 government and our answer is we support the  
6 President's budget when we're up on the Hill.  
7 When the President hasn't submitted a budget yet  
8 which includes major portions of the program, then  
9 we cannot comment, so I'm not going to comment on  
10 the funding piece. I think the message here is  
11 that the Department is committed to moving ahead.

12 I will say that I don't know that we  
13 misunderstood the intent of the report. I think  
14 that there is new construction and there were  
15 deficiencies identified in that new construction  
16 and it's our response that we're committed to  
17 correcting those deficiencies. We may not agree  
18 completely with all of the recommendations. By  
19 far the substantial majority of the  
20 recommendations about deficiencies I think are  
21 accepted here you'll see in the Department's  
22 response. That doesn't mean that we agree with

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1 everything that everybody said on the  
2 Subcommittee. So we'll be glad to work through  
3 those in whatever forum we need to because we are  
4 committed to getting to world-class.

5 The other part of it is that there's  
6 clearly new construction and achieving new world  
7 class in that new construction, and as the  
8 Committee pointed out, there is a substantial part  
9 of the infrastructure chassis at Bethesda that was  
10 built in the 1950s and the 1980s. Renovation was  
11 hot part of the BRAC process, and getting to world  
12 class and this new standard I think is separable  
13 from that. So as we take a look at achieving the  
14 rest of getting to world-class on the campus,  
15 those two things come together in the Department's  
16 approach, not trying to avoid or evade getting to  
17 world-class, but the BRAC portions of the  
18 construction are not the same as achieving world  
19 class in the parts of the chassis that are much  
20 older. I'll stop there and will glad to debate or  
21 answer any questions that you like.

22 DR. LEDNAR: Thank you, Admiral

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1 Mateczun. I'd invite Admiral Mateczun and Dr.  
2 Kizer, why don't you comfortably return to the  
3 seats. I'll act as the facilitator to keep the  
4 questions in order. I would ask if first the  
5 Board and then we can open it up to the floor  
6 generally if you've got questions. If the  
7 question is worded to either Admiral Mateczun more  
8 specifically or to Dr. Kizer, if you'd please  
9 indicate that in your question. So I'll take the  
10 first question from Dr. Silva.

11 DR. SILVA: I don't know who's going to  
12 answer this. The overheads and the printouts  
13 don't give me any wisdom as to what is an RFP 1  
14 and RFP 2. And each one, one is listed as 60  
15 percent complete, 70 percent complete. What is  
16 the status of the ORs? Are they in RFP 1 or RFP 2  
17 and are they done, do you have to make  
18 renovations, we have to go in there with a  
19 jackhammer to pull down hard construction?

20 VADM MATECZUN: There are three  
21 new operating rooms which all meet the definition  
22 of world-class within RFP 1 in the building that's

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1 adjacent to the current operating rooms. So the  
2 new construction operating rooms are certainly  
3 going to meet that world-class standard. There  
4 are 17 existing operating rooms at Bethesda today.  
5 Those were not part of any BRAC project. There is  
6 currently a Navy planned renovation project.  
7 We're working with them about the 17 ORs and how  
8 we may work to start to move toward world-class  
9 with the renovations that are planned there, and  
10 since that's predecisional and is subject to  
11 contracting, I will stop there.

12 DR. LEDNAR: Dr. Parkinson?

13 DR. PARKINSON: Thank you both, Admiral  
14 Mateczun and Dr. Kizer. As I've been listening to  
15 this and thinking, to quote old Steve Covey among  
16 other people, begin with the end in mind. I think  
17 what the Defense Health Board and what Congress  
18 wants and what all of us in the Department is the  
19 functionality of a world-class health care system  
20 with a world-class facility as outlined in the  
21 subcommittee's work. To Admiral Mateczun's point,  
22 Congress works in fits and starts and does not use

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1 3, 5, 10, 20 year strategic plans. So what we've  
2 got is a hodgepodge of legislative authority going  
3 back to the BRAC process of 2005 that has created  
4 a fits and starts planning cycle which frankly a  
5 leading health system would never do.

6 Having said that, if the goal in the  
7 wake of everything that's happened since 2002 and  
8 2005 about the awareness that the DoD and VA that  
9 frankly were not measuring up to the needs of our  
10 beneficiaries, I think the Defense Health Board  
11 has clearly the responsibility to continue to  
12 highlight the gap between what is a world-class  
13 functional integrated delivery system with a  
14 facility and where the Department is. It may  
15 sound confrontational, but it's factual, so I  
16 would just offer that as we go into this extended  
17 dialogue and talk about next steps because this  
18 facility should represent the best of the best of  
19 world-class health care and if it's not there it  
20 really doesn't matter how Congress got us into  
21 this mess because they're not at the table, but  
22 they are at the table. So we just need to be on

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1 as brokers in an evidence-based way for what is  
2 the delta and what is the Committee's and the  
3 Defense Health Board's confidence that given the  
4 current plans that we can bridge that gap.

5 DR. LEDNAR: Dr. Oxman?

6 DR. OXMAN: I had the privilege of  
7 attending the last meeting of the Subcommittee and  
8 was very impressed at the seriousness with which  
9 all of the members took their charge and the  
10 expertise that was brought to bear.

11 I have a concern because world-class is  
12 heavily dependent on the behavior of individual  
13 human beings. Physical plants don't make world  
14 class, but physical plans can limit world-class,  
15 and my concern with more than 20 to 30 years of  
16 experience as mostly Chair of an infection control  
17 committee at both a university hospital and a VA  
18 hospital is that some of the points that were  
19 brought forward by the Subcommittee address issues  
20 which would prevent not the practice of  
21 world-class medicine but which would be subpar in  
22 terms of the community standards. Admiral

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1 Mateczun said that he had spoken to many surgeons  
2 all of whom had a different idea of what the ideal  
3 operating room should be, but I would vouch for  
4 the fact or I would bet that none of them thought  
5 that it should be 450 square feet and they were  
6 concerned whether the lights would be purple or  
7 green or the walls would be yellow, but I don't  
8 think any of them would view the 17 existing  
9 operation rooms as satisfactory in a new  
10 construction hospital whether it's the private  
11 sector or the VA or anywhere else.

12           The second thing is the issue of  
13 surgical pathology. I think that the idea of a  
14 surgeon either not participating in the evaluation  
15 of surgical pathology particularly with difficult  
16 cases and cancer cases or having to delay surgery  
17 significantly is not acceptable to me. We have a  
18 situation where we require signoff by the  
19 infection control committee on all new and revised  
20 construction on the final plans. I wouldn't sign  
21 off on plans like that because I think either way  
22 you try to solve it without physical continuity

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1 will result in increased risk to the patient. So  
2 those are just two examples.

3 I guess the third example is the issue  
4 of command and control which is crucial and I  
5 think that my sense of the Committee's report and  
6 also, for what it's worth, my own opinion, is that  
7 it's crucial that with respect to the Walter Reed  
8 facility, an individual have both responsibility  
9 and authority and fiscal authority to do the best  
10 thing possible. I was particularly interested to  
11 hear Admiral Mateczun show us or tell us that  
12 construction is ahead of schedule and management,  
13 these are my terms, management seems to be behind  
14 schedule, and I think that's not a good thing.

15 VADM MATECZUN: In order, the  
16 operating room question within the current  
17 operating rooms, I don't think anybody would  
18 disagree that 450 feet is not an optimal OR. The  
19 question is how many do you need, 700, 800, 900  
20 square feet and beyond? What does the space need  
21 to be? Can it be more rectangular than square?  
22 What we have are definitions of attributes.

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1       When we take those attributes and we place them up  
2       against practice I will say that there are going  
3       to be differences of opinion and we need to  
4       accommodate. We will look again at the frozen  
5       section in your question, but once again I believe  
6       this is a practice and not necessarily a standard  
7       of care of which there are differences, and I've  
8       gotten in all honesty completely different  
9       opinions on how to accommodate that piece of what  
10      goes on.

11                 There are only I think two things that  
12      we disagreed about with the report and that was  
13      one of them. The other was the replacement of the  
14      dialysis unit. You try to get as many adjacencies  
15      as you can. I don't disagree with that. There is  
16      no perfect plan. If there were a perfect plan  
17      then all hospitals would have looked that way and  
18      we would have discovered it. So you're I think  
19      constantly in the process of trying to adapt the  
20      plans that you can or the plans that you've got to  
21      the practice that you've got in a location. We  
22      are facility-centric when it comes to the

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1 infrastructure in a lot of ways. I don't  
2 disagree. We'll go back and once again take a  
3 look at the frozen section problem, but I'm not  
4 sure what we're going to come to on that. We  
5 didn't disagree with very many things that the  
6 Subcommittee recommended.

7 In terms of authorities, I will  
8 challenge you that within the Department it would  
9 be nice to achieve unity of effort through  
10 somebody who has complete budgetary and  
11 operational authority. In the Department of  
12 Defense, that's the Secretary of Defense in all  
13 honesty and everything below the Secretary of  
14 Defense is fragmented to some degree in how we  
15 align those things. So we work to achieve an  
16 alignment of those authorities that will allow us  
17 to get to world-class. I am certainly committed  
18 to that and I'm as frustrated as anybody because  
19 I'm the guy who has to work through those  
20 authorities' questions.

21 DR. LEDNAR: Dr. Walker?

22 DR. WALKER: I'm a pathologist and have

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1       been responsible for providing interoperative  
2       pathologist consultation for 40 years and this is  
3       an activity that should occur adjacent to the  
4       operating room and not to do so delays proceeding  
5       with taking care of the patient in the operating  
6       room.

7                   DR. LEDNAR:  Are there additional  
8       questions from the Board?  Are there any questions  
9       from the floor?

10                   DR. MCCLOUD:  Dr. McCloud.  Dr. Kizer,  
11       Admiral Mateczun, a lot has gone on today just as  
12       to the definition of world-class and it reminds me  
13       of Justice Potter Stewart ruling on an obscenity  
14       case.  He says pornography is hard to define, but  
15       you know it when you see it.  I think we would  
16       know world-class when we see it.  Operating rooms  
17       at Memorial Sloan Kettering do that.  It's  
18       everywhere.  And so you're going out to UCLA and  
19       look at it, but right now it's not world-class.

20                   The other thing, Admiral Mateczun has  
21       done a great job here.  I've said this to you  
22       jokingly, sir, I wish he were an SES who could

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1 stay on because the military treats these jobs  
2 sometimes as ephemeral ones, and I'm going to  
3 bring out the fact that Monday his Principal  
4 Deputy, General Volpe, has just gotten orders to  
5 go to Madigan, so you got to start over again, but  
6 that's the way we did it in the 1960s and that's  
7 the we're doing it now.

8 DR. KIZER: If I just make two comments.  
9 The Committee had early on an extensive discussion  
10 and used the pornography analogy in a number of  
11 others in thinking through whether you could  
12 define world-class, and the only thing I would  
13 perhaps and disagree on is that many elements as  
14 reflected in our definition of what would be world  
15 class can in fact be objectively specified and  
16 measured. The current performance metrics do not  
17 allow all of those things to be measured. As I  
18 noted, a substantial if not majority of what would  
19 qualify as world-class in those entities that at  
20 least appear to have, to use the statistical term,  
21 face validity for being world-class, much of that  
22 is brought out by the invisible architecture. It

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1 is the culture. It is how people relate to each  
2 other and the values and other sorts of things  
3 along those lines.

4 In a different vein, I would note that  
5 the Committee is I think very respectful and  
6 appreciative of Admiral Mateczun's work here and  
7 his efforts and is also cognizant of the often  
8 difficult position that he finds himself in in  
9 trying to move forward working within both the  
10 military architecture as well as the government  
11 architecture, it's kind of a double-whammy. A  
12 number of the members of the Subcommittee  
13 certainly are not naive about government and have  
14 spent prolonged periods of time both wearing a  
15 uniform and working in the government, so I think  
16 the lens through which the Subcommittee viewed  
17 things was very cognizant of the limitations and  
18 constraints that are imposed upon some of the  
19 folks who have to manage and deliver the product.  
20 But as we say in the toxicology world, you can't  
21 let risk management guide your risk assessment  
22 decisions and you have to call things the way they

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1 are and point out as was said the gaps and the  
2 holes and then figure out how you fill those as  
3 best you can.

4 VADM MATECZUN: I would say that  
5 as well as the Department's response, you've got  
6 the Congressional response to the Subcommittee's  
7 report. They read it and enacted into legislation  
8 those pieces that they considered important to  
9 achieving what they think needs to be achieved on  
10 the Bethesda campus as well.

11 DR. COHOON: I'm Barbara Cohoon with the  
12 National Military Family Association and we've  
13 been very active, our association, as far as with  
14 both the new Walter Reed construction and design  
15 along with Fort Belvoir, and I had an opportunity  
16 when your Subcommittee first stood up to come and  
17 talk to you.

18 The first time that we had an  
19 opportunity as far as being part of the charette  
20 at Fort Belvoir, and then I attended the charette  
21 for the new Walter Reed, the design team, the  
22 contractor who was hired to do the design, there

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1 was a stark contrast immediately when you saw what  
2 products they had to choose from. The contractor  
3 for the new Walter Reed was only interested in  
4 getting the job done and moving on, and as you had  
5 different players from both Walter Reed and  
6 Bethesda sitting in the same room trying to  
7 explain to her issues that they were seeing trying  
8 to merge the two departments, they wouldn't hear  
9 of it. They wanted had a deadline, they wanted  
10 their money and they were moving on and whoever  
11 won the bid would then have to deal with what  
12 happened internally. So that drove a lot of  
13 issues. Even though voices were being raised,  
14 there were issues going on. The contractor would  
15 not listen.

16 On Fort Belvoir, it was the other way  
17 around because they were staying with the product  
18 the entire time, so they had what you would call  
19 skin in the game and a reason as far as wanting to  
20 compromise. So when you went to each charette, it  
21 was interesting to see the difference between the  
22 two. We brought this up, and DoD has tried very

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1 hard to make that situation work, but as the  
2 report was being developed, we have now had  
3 administrative change and also we have a lot of  
4 positions that have not been filled yet as far as  
5 appointees to help push and drive a lot of this  
6 change.

7           The report demonstrated that certain  
8 areas needed to be fixed, but Congress is saying  
9 I'm sorry, we're not going to allocate you one  
10 single dime to increase the space for ORs or to do  
11 the single bed patients. They're not going to do  
12 that. So then that falls back on DoD as far as  
13 how we try to make that work.

14           As far as the culture piece, the  
15 military is the military, but it's like merging  
16 Coke and Pepsi in putting the two together. So no  
17 wonder when you go out into the civilian sector it  
18 makes it a little bit hard to find lessons learned  
19 in incorporating it into our particular piece.

20           As I mentioned before, we're seeing  
21 tremendous progress as far as trying to make all  
22 this work together and I spent quite a bit of time

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1 at Bethesda and Walter Reed, and I'll tell you,  
2 when you're inside those facilities you have no  
3 idea that construction is going on around you.  
4 And people who are helping you, providers, they're  
5 making sure that you're being taken care of and  
6 are families are getting access even though the  
7 campus at Bethesda is under tremendous  
8 construction. And the same thing as far as Walter  
9 Reed. Even though they know they're closing, the  
10 providers there are very helpful, warm and  
11 friendly. When you drive by the new Fort Belvoir,  
12 that place is absolutely outstanding and patients  
13 are already starting to put in enrollment changes  
14 as far as to go down there because they see what  
15 that facility is going to be.

16 So I wanted to let you know that there  
17 are a lot of other factors going on and part of  
18 the reason why we are where we are is that there  
19 is a lot of different pieces involved. You've got  
20 Congress who dictates a lot of different things,  
21 you have DoD whose hands are basically tied and  
22 you have two different cultures working at the

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1 same time. But our families are being taken care  
2 of.

3 DR. LEDNAR: Thank you for those  
4 comments.

5 VADM MATECZUN: Thank you,  
6 Barbara. We're tremendously appreciative of the  
7 work that the National Military Family Association  
8 and all of the associations. We will need to  
9 incorporate those comments into the reviews that  
10 the Department is doing and health affairs is  
11 doing on how to use these construction processes  
12 in the future with these lessons that we've  
13 learned from these first efforts.

14 Let me take this as an opportunity to  
15 springboard into looking at the future in a  
16 speculative way and not in a response from the  
17 Department. If you take a look at these two  
18 issues of single-patient rooms and operating  
19 rooms, they come together in the sense of probable  
20 proposals for new construction. If we're going to  
21 achieve single-patient rooms, then we're going to  
22 need to build another 100-patient rooms some place

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1 on the campus. And the operating rooms need to be  
2 rethought. The concept on the campus needs to be  
3 looked at so that the operating rooms that are  
4 there right now and the new ones that are coming  
5 on board have to be complemented with a future  
6 look at the possibilities of moving outpatient  
7 surgery into an ambulatory surgery complex  
8 potentially to rethinking how we do the labor and  
9 delivery ORs and then to incorporate that into the  
10 master plan and new facility construction. I have  
11 found in my many, many trips to the Hill that they  
12 are tremendously supportive of making sure that we  
13 have what we need to provide world-class care.

14 DR. LEDNAR: Yes, sir. If you'd please  
15 introduce yourself.

16 COLONEL EDWARD: I'm Adolphe Edward  
17 again. I'm going to speak as both a pathologist  
18 and as a citizen. I live in Bethesda right across  
19 from the National Medical Center. I also serve on  
20 Montgomery County Advisory Board, so I'm familiar  
21 with all the discussions.

22 I want to address an issue that I think

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1 is critical and that is the idea of concepts and  
2 concept integration which seems to drive a lot of  
3 decisions involving BRAC and the objectives and  
4 goals. I'm very concerned about Vice Admiral  
5 Mateczun's distinction between a practice and a  
6 standard of care. We've dealt with this  
7 extensively at the State Department and at USAID  
8 as a public member of the performance review  
9 boards since 2007, because concepts gain meaning  
10 as they become operationalized and operation is  
11 performance which is practiced. You cannot define  
12 the practice of continuity of a surgical pathology  
13 frozen section suite close to the operating rooms  
14 in a vacuum because one distinction of health care  
15 as a market from the economics is that it's  
16 imperfect and one of the gaps that exists is in  
17 communication and the rapidity and the confidence  
18 of that exchange to make decisions which affect  
19 patient care. If the surgeon is not there and is  
20 convinced in the interaction with the surgical  
21 pathologist that this is the level of certainty  
22 upon which he can act and make definitive

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1 decisions, you are sacrificing quality of the  
2 standard of care. So it is very important that we  
3 distinguish when we talk about practice elements  
4 or concepts and standard of care a concept that  
5 they are not dealt with in a vacuum. They coexist  
6 because, again, concepts gain meaning in practice  
7 or in performance.

8 DR. LEDNAR: Thank you. Dr. Oxman?

9 DR. OXMAN: I just have one comment,  
10 because one of the distressing things to me in  
11 attempting to read the DoD response to the  
12 Subcommittee's very specific report was the sense  
13 of being in a paper bag and not recognizing that  
14 there was no timeframe, there was no milestone, it  
15 was not at all concrete. Thinking about this as a  
16 naïve citizen and someone whose military  
17 experience is in the Public Health Service at the  
18 NIH and not in uniform in those days, the concept  
19 of the National Capital medical facility and  
20 practice is new. It's a new concept and it's  
21 different from the Air Force and the Navy and it  
22 requires not only new thinking and new

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1 construction and new practices on the part of the  
2 military personnel who are delivering medical  
3 care, but it also requires a revision of the way  
4 business is done in the Department of Defense so  
5 that it's matched. I think probably one of the  
6 Admiral's frustrations is how difficult it is and  
7 how many people have to weigh in before you can  
8 buy a new eraser. That culture also has to change  
9 if the BRAC program is going to be successful. I  
10 think that one of the things that this Committee  
11 should do, that the Defense Health Board should  
12 do, is try to point that out and in fact to the  
13 extent that we can demand, demand those kinds of  
14 changes. But the problem is that the construction  
15 continues to go on and as you continue to build if  
16 you then have to change later it becomes more  
17 difficult, more expensive and more disruptive. So  
18 this is a time-dependent process and I think the  
19 Subcommittee felt urgency with respect to time and  
20 that's not reflected in the DOD's response.

21 DR. LEDNAR: Dr. Silva?

22 DR. SILVA: I appreciate all the candor

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1 that's been expressed today. It's been bothersome  
2 for everyone. We all want to work toward the same  
3 goal. As I briefly mentioned yesterday, my  
4 opinion has not changed. If we're going to use  
5 the terminology of world-class, it's a misnomer  
6 where it sits right now. And if we're going to  
7 continue to use that term in the future, it may  
8 stall the appropriate processes to get to the  
9 place where it can be world-class. For active  
10 military, I would ask, and I'll bear to your  
11 personal conscience, that the coin of the realm in  
12 the military are medals. If you had a medal  
13 stating world-class, would you give it to this  
14 facility the way it is right now? Thank you.

15 DR. LEDNAR: Dr. Luepker?

16 DR. LUEPKER: There are attributes of  
17 world-class today at Walter Reed, there are  
18 attributes of world-class today at Bethesda.  
19 Those will be combined into something, we'll gain  
20 synergies and there will be more. When I look at  
21 "US News and World Report" 's reports on the best  
22 hospitals in the country, I find that they're

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1 ranked differently for different services. I  
2 don't think that there is one standard that you  
3 achieve for everything that you do that says this  
4 entity is now world-class. We've struggled with  
5 that to some degree. There is a world-class  
6 facility, then there's the world-class integrated  
7 delivery system. I am struggling with what an  
8 integrated delivery system that's world-class  
9 means. I've been to the best. We are  
10 extraordinarily facility-centric not just in the  
11 DOD but across this country. I challenge you to  
12 find a system that really does patient integrated  
13 delivery of care that's oriented around the  
14 patient and not our delivery system. It's  
15 extraordinarily difficult.

16 When I struggle with this integrated  
17 delivery system and world-class, those facility  
18 pieces of it, I'm still trying to struggle with  
19 how do you do the primary care piece of an  
20 integrated delivery system that we integrate with  
21 the specialty care. We've got some great models  
22 of specialty care. We've got the Cleveland

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1 Clinic, we've got Mayo. We've been out and we've  
2 looked at them. Their primary care systems aren't  
3 necessarily as integrated as I'd like to see for  
4 our patients within the delivery of care that we  
5 do. It's fragmented because of the way that we  
6 deliver care in America, that is that the  
7 continuing, the interface between primary care and  
8 specialty is a gap. And if we take a look at  
9 preventive services, there's a gap there too. How  
10 do we deliver those preventive services before  
11 they ever get to primary care? And on the far  
12 end, how do we integrate rehabilitation into that  
13 integrated delivery system?

14 I don't think we're naïve about this and  
15 I think that there are gaps that we have out there  
16 and certainly acknowledge those gaps. I'm not  
17 sure that it's not partly reflective of the  
18 American system of health care as well either.

19 DR. LUEPKER: I'm reluctant to get into  
20 the problems of the American health care "system,"  
21 but let me say I've been troubled by this  
22 discussion both yesterday and today and the

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1 responses by DoD. I think that our primary  
2 concern is patient care and safety, and at the  
3 minimum community standards. Let's not get into  
4 world-class quite yet. We have to do that. It  
5 concerns me that some of the things we're talking  
6 about are not community standards even.

7 I'm sympathetic, and with probably not  
8 enough sympathy because I live outside the  
9 Beltway, to the problems that confront us, but we  
10 seem to be hearing that the bureaucratic problems  
11 are so difficult that we just can't do this. I  
12 hear you talking about going and visiting other  
13 places to find out what they do. There's nothing  
14 inherently wrong with that, but you've had an  
15 expert committee look at this and give you advice.  
16 What I seem to be hearing and see in the reports  
17 is this advice isn't what you want to hear. It  
18 seems to me that this advice is to bring people to  
19 basic level of standard of care that I get in  
20 Minnesota and we expect around the country for all  
21 of our citizens and our service members.

22 VADM MATECZUN: There is no  
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1 question of standard of care. There is no metric  
2 on which the current way that we deliver care is  
3 measured that says that it's substandard or  
4 subpar. In terms of the Department's response to  
5 the committee's recommendations, we accept them  
6 wholeheartedly. That there is disagreement on two  
7 or maybe three very minor things I don't is  
8 reflective of the fact that we're headed toward  
9 adopting a solution that will get to those  
10 recommendations, and if I've in some way indicated  
11 that then I'm sorry.

12 As we work within the Department to be  
13 able to get there, I have to work within the  
14 constraints of government. That's quite true. So  
15 in terms of coming up and telling you we've  
16 identified the funding streams to do this, that  
17 and the other, you've identified them, we've  
18 identified what it takes to do that and the  
19 funding is coming and here is where it's coming  
20 from. Because of the way the government is  
21 structured and our yearly budget and our 5 year  
22 plans, it's impossible to do that. I can tell you

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1 that the Department is making every effort to fund  
2 those things for which corrective action is  
3 identified.

4 Now to the specific deficiencies that  
5 are identified in the report other than one or  
6 two, there is funding on the way to fix all of  
7 them. But I would take exception, I would take  
8 strong exception, to any inference that we somehow  
9 do not meet a standard of care for each and every  
10 patient that we see. We are in the process of  
11 going toward a new standard of world-class, we  
12 understand that we're there, but there is nothing  
13 about the care that we deliver to patients today  
14 that is subpar or substandard in any way.

15 DR. LEDNAR: Dr. Kizer?

16 DR. KIZER: I was going to respond to  
17 your comment before, John, or just amplify perhaps  
18 a small point, but it does have some important  
19 nuances. The definition that was put forth was  
20 for a world-class medical facility and in there  
21 facility is specifically defined as what that is  
22 taken to mean. The Committee spent a substantial

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1 amount of time on what might be perceived as an  
2 arcane issue of trying to segment this into a  
3 world-class system, a world-class facility,  
4 world-class care. There are a lot of ways you  
5 potentially could slice it and what was requested  
6 or mandated by the Congress and what was delivered  
7 was an operational definition of a world-class  
8 medical facility. I think much of that could be  
9 applied and has spillover if you want to look at  
10 individual services or systems or other things.  
11 It certainly provides a solid foundation to look  
12 at it, but the definition that was developed was  
13 for a facility as defined in the report.

14 DR. LEDNAR: I'm going to bring this  
15 session to a close. I think we've heard a lot of  
16 important input, reaction and comment. I really  
17 appreciate, Admiral Mateczun, your coming to be  
18 here with us yourself.

19 The sense I get is that this train is  
20 moving. The construction is underway and it's  
21 perhaps even ahead of schedule. The independent  
22 and very thoughtful review by the DHB Subcommittee

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1 has offered what really is an external sense of  
2 experience for what is out there in the world  
3 today as input to the Department. Dr. Kizer has  
4 prepared and distributed this morning a memo that  
5 I would ask each only the Board to review. I  
6 would suggest that the BRAC subcommittee organize  
7 its thoughts if there's anything else on the basis  
8 of this discussion, Dr. Kizer, that you'd like to  
9 incorporate as a thought, we can then communicate  
10 that to the department so that you get that input,  
11 sir. For the Board, we want to be constructive  
12 and partnering with you. We recognize that we are  
13 advisory, but we want to offer the best insight  
14 and help we can for a successful outcome with you  
15 for the beneficiaries of the department.

16 DR. KIZER: If I could make two brief  
17 points. One is that when and if there is a  
18 Committee to continue this, we will be happy to  
19 continue this, but that's pending official  
20 reconvening of the group. Secondly, and perhaps  
21 not emphasized enough, the Committee would be  
22 happy to engage in face-to-face discussion with

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1 appropriate and relevant individuals in the  
2 department if that were felt to be valuable. We'd  
3 specifically discuss this, and while no one on the  
4 Committee has an abundance free time, everyone  
5 felt that this was important enough that should a  
6 more direct communication be viewed as perhaps  
7 valuable and might facilitate resolution of some  
8 of these issues, either representatives or the  
9 Committee as a group would be willing to convent  
10 for that discussion at a mutually agreeable time.

11 DR. LEDNAR: Dr. Kaplan, and then we'll  
12 ask Admiral Mateczun to give us the final word as  
13 we close the session.

14 DR. KAPLAN: My question is to you,  
15 Wayne. Was this meant to be an informational  
16 session or is a formal action by the Board  
17 indicated after this discussion?

18 DR. LEDNAR: This was intended to be an  
19 exchange of information clearly to understand the  
20 communications back and forth and to identify a  
21 way ahead, so that there is no specific action per  
22 se other than to be sure that we're communicating

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1 in an understandable and constructive way to the  
2 department in terms of our recommendations.

3 DR. KAPLAN: So the Board will take no  
4 "official" action at this point?

5 DR. LEDNAR: The Board will take as an  
6 action a communication to really clarify any  
7 points that we think would be helpful for the  
8 Department to have and to have in writing and to  
9 do that in a timely way. As Dr. Kizer said, if it  
10 would be helpful to Admiral Mateczun in the  
11 process to have a more live interaction of members  
12 of the BRAC Subcommittee who have expertise, that  
13 remains an offer if Admiral Mateczun would find  
14 that helpful.

15 DR. KAPLAN: If that's the case then the  
16 revised report that Dr. Kizer has presented to us  
17 this morning will be circulated to members of the  
18 Board before it's sent forward for comment or  
19 suggestions or not?

20 DR. LEDNAR: Yes. The communication  
21 that Dr. Kizer for the BRAC Subcommittee of the  
22 Board has prepared which we just received this

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1 morning, we need as a Board to have a chance to  
2 review that, offer any comments back, but in a  
3 timely way to complete that so it can be  
4 communicated by the board to the department. Dr.  
5 Shamoo?

6 DR. SHAMOO: I think the only way the  
7 Board can weigh in is we have to adopt a report.  
8 I'm not saying the exact report. We can't just  
9 discuss it and it stays up in the air. So there  
10 has to be a plan of what we're going to do. The  
11 Subcommittee did their job. They have submitted a  
12 report for the Board for its deliberation. The  
13 deliberation has happened. There could be more  
14 deliberation. But then the Board has to act on  
15 it, either adopt it, modify it, put a covering  
16 letter on it or reject it.

17 DR. LEDNAR: One last comment by Dr.  
18 Oxman.

19 DR. OXMAN: Perhaps I'm mistaken, but my  
20 understanding was that the Subcommittee's big  
21 report to the DoD was endorsed by the Defense  
22 Health Board and it represents a Defense Health

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1 Board recommendation. Now we have a response to  
2 that recommendation and we haven't had a detailed  
3 analysis of that response, but we have our  
4 Subcommittee that had an analysis of that response  
5 and it's reflected in this document. I believe  
6 that our obligation is to read this document and  
7 at least consider endorsing its transmission to  
8 the Department of Defense from the Defense Health  
9 Board.

10 DR. LEDNAR: Yes. That's in fact a  
11 rewording of just exactly what I proposed. Dr.  
12 Kizer, did you have any other suggestion?

13 DR. KIZER: I was going to comment that  
14 the memo that was prepared other than reprinting  
15 it in the way it was actually written, the memo is  
16 the memo. It is now in the public domain. I  
17 would strongly encourage the Board to officially  
18 forward it to the Department, but it's hard for me  
19 to imagine that the Department will not be aware  
20 and have copies of this probably in a relatively  
21 short time period through channels other than the  
22 official DHB channel or it's at least conceivable

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1 that that might happen. I think the Committee  
2 would feel that an appropriation action of the  
3 Defense Health Board would be to forward it on to  
4 the Department with or without annotation  
5 according to how you choose, and if nothing else I  
6 think just transmitting it would be appropriate.

7 DR. LEDNAR: In fact, we will as a Board  
8 commit to review the Subcommittee memo, and as a  
9 Board if there are any additional comments, to  
10 make those and then to forward that officially to  
11 Admiral Mateczun. But I expect that the spirit of  
12 the comments were probably related in verbal  
13 discussion today in this morning's session.  
14 Admiral Mateczun, you've got the last word, sir.

15 VADM MATECZUN: Thank you. In  
16 summary, I would like to thank everybody again on  
17 the Committee and on the Subcommittee in  
18 particular for their work on this report. If you  
19 take a look at what happens to reports from  
20 Defense Health Board Subcommittees, this report  
21 has been extraordinarily successful. It's gotten  
22 a response out of the department, I think a very

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1 detailed response, not with the level of  
2 granularity you'd like, but the level of interest,  
3 and the commitment of the Department has been  
4 extraordinary. In fact, some of the  
5 recommendations of the Committee now are taken  
6 into next year's NDAA and so adopted into  
7 legislation with a codification of the attributes  
8 of world-class. Not many reports are going to end  
9 up that way, so I think it's been an  
10 extraordinarily successful and help report and I  
11 appreciate all of the efforts of the board.

12 DR. LEDNAR: Thank you, Admiral  
13 Mateczun, and thanks to all who participated in  
14 this discussion this morning. We will now take a  
15 15-minute break. Thank you.

16 (Recess)

17 DR. LEDNAR: I would like to call the  
18 session back to order. We've in a flexible and  
19 agile way elected to amend the agenda. As our  
20 first item of business in this reconvened session,  
21 we're going to have a discussion to follow-up on  
22 the morning panel in that discussion. Dr. Kizer

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1 has prepared for the BRAC Subcommittee of the  
2 Board a memo. We've asked everyone to read it.  
3 We will have a short discussion about the memo to  
4 understand it if there's any information that the  
5 Board would like some additional understanding.  
6 Then the intent will be to as a Board vote on this  
7 memo with the intention that there would be a  
8 formal written communication by the Board  
9 including the Subcommittee's memo communicated to  
10 the Department of Defense within the next 7 days  
11 or less. I said within; no later than.

12 I think it will be most helpful to the  
13 Department to get it sooner. It will be important  
14 for the Board with the amount of deliberation and  
15 expertise it's got to be respectfully but clear to  
16 the Department about where we stand. With that,  
17 I'll open up the floor to questions or comments.  
18 Dr. Poland?

19 DR. POLAND: The one thing I would  
20 suggest which I think we'd probably do anyway is  
21 whatever the changes in this that it be  
22 accompanied by a cover letter, and not that we're

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1 likely to get very far with it, but in part  
2 calling out the idea that Congress has created a  
3 sort of difficult situation here in terms of how  
4 one might have optimally planned and resourced  
5 something like this. In an attempt to in part  
6 make clear this isn't an issue of DoD not  
7 responding to Congress' intent or DHB making  
8 suggestions that aren't feasible, both are right  
9 and both are trying to work within the constraints  
10 of what Congress gave them and as Russ or somebody  
11 else said, it's not the way that a world-class  
12 integrated system would have approached this, but  
13 it is what it is and both sides are working within  
14 the constraints of what they have.

15 DR. LEDNAR: Dr. Oxman?

16 DR. OXMAN: I don't completely agree  
17 because I think that what's needed is a modicum of  
18 cultural change in the Department of Defense so  
19 that it's easier to delegate real authority and  
20 responsibility because that's one of the things  
21 that's missing.

22 The other thing if we're going to have a

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1 cover letter, I think it's very important to point  
2 out that construction is going on actually ahead  
3 of schedule, that as the construction goes on, the  
4 ease and cost of making changes that are necessary  
5 will increase and therefore time is critical, and  
6 what disappoints me about DoD's response is it  
7 appears to me to have ignored the critical issue  
8 of time.

9           The last thing is I think if you've ever  
10 been involved in any construction at all directly  
11 or indirectly, this is going as far as I know  
12 without a facility plan. I'm not talking about a  
13 plan for the delivery of care. I'm talking about  
14 a construction plan, an integrated facility plan,  
15 that integrates the BRAC construction with the  
16 future or concomitant construction with other  
17 funding. So I think that time is critical and I  
18 think that we need to make that clear and be  
19 demanding in a cover letter if we're going to  
20 fulfill our responsibility as an independent  
21 advisory group. The administration has changed,  
22 the advice is written down, and I think we need to

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1 try to get change occurring as quickly as  
2 possible.

3 DR. LEDNAR: Dr. Clements?

4 DR. CLEMENTS: One of the things that  
5 became apparent to me in reading all of this and  
6 listening this morning, and you probably all  
7 already knew this so it's kind of revealing to me,  
8 was that there are really two different things  
9 going on here, and this was pointed out by the  
10 Admiral as well. There was the BRAC and the  
11 consolidation of the two hospitals into one and  
12 Walter Reed, et cetera, and then there was the  
13 congressional mandate for a world-class medical  
14 facility which was an essentially unfunded mandate  
15 which was imposed on top of that. And rather than  
16 the DoD pushing back and saying we appreciate  
17 that, sir, but we can't do that with the resources  
18 you provided, they're trying to make this into  
19 what it can't become because rather than Congress  
20 saying what do you need and how long do you need,  
21 Congress said this is how long you have and this  
22 is what you have, and that's not the way to go

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1 about constructing a world-class medical facility  
2 or an environment.

3           So I don't see any way possible under  
4 the guidance and the resources that have been  
5 provided to DoD for them to accomplish the mission  
6 that Congress has given them on top of everything  
7 else. I think one thing that we could do in a  
8 cover letter is essentially point that out and say  
9 we appreciate Congress' intent here. We think  
10 it's vitally important. We don't see any way that  
11 it can be accomplished given the resources and the  
12 time constraints and here are the things that  
13 we've identified as deficiencies in the current  
14 plan. I really like the next- to-the-last  
15 paragraph that Ken has put in this which is the  
16 Committee concludes it will not be world-class if  
17 the needed corrections are not taken in a timely  
18 manner, but then to say but that does not appear  
19 to be possible given the constraints that have  
20 been imposed upon the Department. Because I don't  
21 think that anything we say is going to change the  
22 basic formula, that is, they're trying to respond

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1 to BRAC, they don't have the resources to build a  
2 new hospital or they don't have time to build a  
3 new hospital and put together those kinds of  
4 plans. I don't think you can reconstruct this in  
5 the existing facility.

6 DR. KIZER: Technically, the mandate for  
7 world-class was part of the appropriation bill  
8 that did authorize funding and to date about  
9 \$2-1/2 billion have been appropriated for Walter  
10 Reed and Fort Belvoir. I'm not sure whether the  
11 Committee would agree with the assertion that it  
12 is not achievable with currently authorized  
13 funding or that markedly more progress could be  
14 made in the timeline that's authorized.

15 DR. LEDNAR: Dr. Kaplan?

16 DR. KAPLAN: Yes, I agree with that  
17 next-to-the-last paragraph that the thing is that  
18 when that is worded, it has to be clearly worded,  
19 and at least my suggestion is so that when we say  
20 it can't be done that it doesn't come across as  
21 saying we're letting you off the hook. In other  
22 words, it can't be done, but it has to be worded

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1       some way so that somebody looking at that saying  
2       they caved in.

3                   DR. OXMAN:  I would like to comment  
4       related to what Ken Kizer just said, and that is  
5       we don't know anything about budgets and money and  
6       that's not our business.  What we can do is we can  
7       provide a document which the Department of Defense  
8       if it doesn't have the ability to find the  
9       necessary funds could use in going to Congress for  
10      that money.  I don't think we should comment.  For  
11      all I know, it would be very easy to change the  
12      appropriation and come up with funds from the Navy  
13      to do the renovation.  I have no idea and I don't  
14      think anyone on this Board either knows that or  
15      has any business trying to guess.

16                   DR. LEDNAR:  What I sensed in both the  
17      Subcommittee's recommendations and the discussion  
18      to them is there's an absence of clarity that  
19      there is a plan and there is a lack of signals  
20      that progress is being made.  The Subcommittee's  
21      recommendations have been out there for almost a  
22      year.  It will be in about 3 weeks, and December a

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1 year ago the Subcommittee made its recommendations  
2 without clear evidence of progress. There are  
3 some specific areas of concern like the ORs,  
4 single rooms, adequacy of the connect between  
5 surgical pathology and the operating rooms and  
6 items like that. I haven't said the word fund and  
7 funding and streams at all. I think that there  
8 are some substantive aspects to support  
9 good-quality care that have been identified by the  
10 Subcommittee that there's a lack of evidence that  
11 there is adequate progress particularly since at  
12 least the BRAC portion of the timetable is  
13 September 2011 and that will be here before we  
14 know it. So not having evidence for a year from  
15 the recommendations doesn't give confidence that  
16 the next year will see real progress unless some  
17 things change.

18 DR. LEDNAR: Dr. Parkinson?

19 DR. PARKINSON: I also want to draw  
20 attention to one of Ken's comments. I think there  
21 is embedded in the Committee's response to the  
22 response that there are actions that could be

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1 taken today to alleviate both the pace and  
2 direction of getting to world-class medical  
3 facility and that that is why there is an urgency,  
4 that the Committee believes that it doesn't  
5 require new legislation, it doesn't require new  
6 funding, it requires the Department's will to get  
7 on this even when the Committee has self-  
8 identified itself as being a resource to help to  
9 roll its sleeves and do this if it would be  
10 useful. So I think the other element of the cover  
11 letter is something to that effect, that this  
12 Committee feels that there are actions that are  
13 being taken, there are actions that could be  
14 taken, there are activities that could be underway  
15 today that could impact the delivery of a more  
16 likely to be world-class facility by time certain  
17 2011 if that's indeed the decided flow of the  
18 discussion that your Committee had, Ken. What was  
19 a little weird and disconcerting to me is that  
20 Congress comes back in this year's NDAA and says  
21 by the way, now we want to see the master plan by  
22 March 31, 2010, when really any forward-leaning

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1 integrated health system would have done this in  
2 2003 for where they wanted to be in 2011 or some  
3 timeline like that. So now we're going to do it  
4 after the facility is essentially open or 3 months  
5 before it opens to see the master plan for a  
6 world-class medical facility.

7 Again, this is not pointing fingers at  
8 the Department or at Admiral Mateczun or his  
9 Committee, it's the way government does work, but  
10 we've got to as the DHB/Subcommittee on this area  
11 say this is just nonsense, folks, and we can make  
12 it better today in a constructive way in that  
13 cover letter which would add to this if that's the  
14 sense of the body.

15 DR. KIZER: I might add that the  
16 essentiality for having a master plan was  
17 presented to this Committee last October. That  
18 was one of the first obvious things that jumped  
19 out that was missing. That's been a consistent  
20 and stable recommendations throughout our  
21 deliberations with the Department. Our  
22 deliberations were totally transparent and the

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1 Department is well aware of what our thinking has  
2 been. I think we're disappointed that having this  
3 as one of the prominent recommendations for such a  
4 long period of time that less progress has been  
5 made in developing the master plan, and I think in  
6 some ways that's reflected by the Congress in a  
7 relatively short timeline.

8           There are two or three things like the  
9 authority issue and the master plan issue that if  
10 rapid, substantial progress were made in that  
11 regard, it would change the whole complexion of  
12 how things are viewed. There are some critical  
13 decisions that have to be made that both  
14 facilitate forward progress that would be very  
15 consistent with the tone and the specificity of  
16 the Committee's recommendations, and absent those,  
17 I don't think the Committee at least is very  
18 enthusiastic that the end result will be achieved  
19 anytime soon if ever.

20           DR. LEDNAR: Admiral Mateczun shared  
21 that the Department has an expectation from  
22 Congress to respond by March 2010 and that's going

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1 to be a pretty important communication. The  
2 Department I'm sure will make that deadline. What  
3 I think is important and where the Board can be  
4 helpful is to give some input to the Department  
5 that can be reflected in the Department's  
6 communication back to the Congress around the  
7 master plan and other items in a way that can help  
8 the Department. Again that comes to the  
9 communication of the Subcommittee's findings to  
10 the Department in a timely way, and the more we  
11 can make the most-important issues clear and  
12 frontloaded especially to Dr. Parkinson's point  
13 that there are some actions that can be taken  
14 today, that will set the track record for what  
15 could really help the Department by March as it  
16 responds to Congress. Dr. Luepker?

17 DR. LUEPKER: I don't want to let them  
18 off the hook here, so that if we say at the end of  
19 this we realize you have lots of problems in doing  
20 this, that isn't helpful as an advisory committee.  
21 I think if there are some actionable items and  
22 there seem to be, and Mike is talking about it, we

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1 ought to hold their feet to the fire, and the  
2 larger plan. I see this as useful to DoD. When  
3 they go up to the Hill to describe what they need,  
4 they have an advisory board that says you need to  
5 do these things. I can't estimate the financial  
6 aspects of this. They haven't told us anything  
7 about this, and I certainly can't figure out all  
8 the convolutions of culture and things like this.  
9 I do think that the Committee has said this is  
10 what you need to do to make this the best facility  
11 you can for the people they take care of and we  
12 need to keep pushing in that direction. And  
13 blaming Congress, I'm sorry, we can do that. We  
14 do that every day, but it doesn't go anywhere.

15 DR. LEDNAR: Dr. Oxman?

16 DR. OXMAN: I think there are two things  
17 to remember. When this Committee gave its report  
18 there was a tremendous sense of urgency because as  
19 we speak and by 2010, the construction will be  
20 finished and things will have been done which will  
21 interfere with -- I don't think world-class is  
22 even the appropriate term. I think standard of

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1 care. So that I think there is an enormous  
2 urgency and I don't think the fault is Congress'.  
3 I think the fault is the DoD. If the DoD is  
4 charged by Congress to do something that it can't  
5 do with what Congress provides, how is Congress  
6 going to provide adequate funding if DoD doesn't  
7 say it? We're in the position of being an  
8 independent board of experts. If you look at the  
9 composition of our Subcommittee. This is the most  
10 distinguished group that Congress could find to  
11 advise them. So that I think we have to both  
12 demand or request of the DoD that they pay  
13 attention to the time-critical aspect of this and  
14 provide them with ammunition if they need to go to  
15 Congress.

16 DR. LEDNAR: I see two actions or two  
17 documents. One is the document that Dr. Kizer and  
18 the Subcommittee prepared and shared with us, and  
19 I'm going to call in a moment for a vote of the  
20 board on this document. The second is building a  
21 DHB cover letter to go with this document which  
22 gets at some of these additional points in a clear

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1 and direct way. First, Dr. Shamoo?

2 DR. SHAMOO: Dr. Kizer, I know we are  
3 finished discussions so that's why I waited since  
4 my point is trivial. I think since we're going to  
5 attach this memo with a DHB formal letter, we  
6 should have it addressed correctly, saying Wayne  
7 Lednar, Vice President, rather than Acting  
8 President, because this is going to go way up and  
9 it may raise red flags.

10 DR. LEDNAR: I think that's why we'll  
11 ask for the staff's help. Obviously it's partly  
12 format and it's partly getting the words correct.  
13 But I think if we accept the content of the report  
14 as the Subcommittee is bringing it to us -- Ken,  
15 did you have something?

16 DR. KIZER: I was going to note that in  
17 the draft before the one you received, you were  
18 actually listed as Vice President and Acting  
19 President. Based on a query, I was advised that  
20 the appropriate term was Acting President. I am  
21 now advised that that is not the appropriate term.  
22 I would consider correction of that as a

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1 nonsubstantive change. Feel free to correct it as  
2 appropriate. I think I might not be quite as  
3 willing to accept other changes in the memo.

4 DR. LEDNAR: Do I hear a motion from the  
5 Board about the Subcommittee's report?

6 DR. SHAMOO: So moved.

7 DR. LEDNAR: Second?

8 DR. MASON: Second.

9 DR. LEDNAR: Is there any discussion?  
10 So moved. The Subcommittee's report is accepted.  
11 The Board appreciates the work of the Subcommittee  
12 and Dr. Kizer in particular. It is the unanimous  
13 position of the Board to accept the BRAC  
14 Subcommittee of the Defense Health Board's report.  
15 All in favor?

16 (Chorus of ayes.)

17 DR. LEDNAR: Any opposed? None. It is  
18 a unanimous vote on the Subcommittee's report.  
19 Dr. Kizer?

20 DR. KIZER: For clarification, does that  
21 acceptance also include the action item of  
22 forwarding it to the Deputy Secretary?

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1 DR. LEDNAR: Can you say that again?

2 DR. KIZER: The vote and the action  
3 taken was to accept the memo of the report, and  
4 for clarity I was asking whether implied in that  
5 was also forwarding the memo to the Deputy  
6 Secretary in the Defense Health Board.

7 DR. LEDNAR: We'll do this as a separate  
8 motion. With the report accepted, is there a  
9 motion?

10 DR. OXMAN: So moved, and it should be  
11 stated that it was unanimous.

12 REV CERTAIN: Are we going to write  
13 a cover letter to go over this?

14 DR. SHAMOO: You don't need that. The  
15 cover letter is we're going to vote on it. You  
16 said so yourself, even though to be very honest we  
17 don't need to.

18 DR. LEDNAR: There will be a  
19 communication of this report to the Department.  
20 There will be a prepared cover letter to accompany  
21 this report that will be communicated to the  
22 Department.

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1                   REV CERTAIN: In that cover letter  
2                   would it be wise for us to state very strongly  
3                   that any deficiencies not corrected that the  
4                   correction be included in the master plan? The  
5                   Admiral said to do that we'd have to build a whole  
6                   new patient care tower because you can't go to  
7                   single-bed rooms and still have enough beds to  
8                   meet the needs. It didn't look to me like there's  
9                   a whole lot of space left out here, but that's a  
10                  major deficiency that apparently has no solution  
11                  short of an additional construction piece. So  
12                  should we include that recommendation or urge or  
13                  insist that that additional bed facility be  
14                  included in the master plan when it is finally  
15                  prepared?

16                  DR. LEDNAR: Dr. Silva and then Dr.  
17                  Poland.

18                  DR. SILVA: Thank you. I don't know if  
19                  we need to state that. I like the way John framed  
20                  the comments because there are many other  
21                  important items that have to be addressed. The IT  
22                  is probably underfunded from where I sit without

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1 knowing anything about the facility. But if we  
2 send it up saying that there are multiple  
3 deficiencies and recognize them and work toward  
4 the future to repair them or correct them in order  
5 to get the world-class status, and I think that  
6 that was the spirit, John, that you were  
7 proposing. Just say we have problems. Don't  
8 sweep it under the rug. Let's move on to the  
9 future. You're doing what you're doing. I don't  
10 know if you could even turn off any pouring of  
11 concrete or anything at this point.

12 DR. SHAMOO: Obviously from all the  
13 comments there is a time constraint and urgency to  
14 the time constraint. Should we label the memo to  
15 attach to this called urgent on the top or  
16 somewhere in the subject matter? Otherwise they  
17 may just sleep on it for a few months.

18 DR. LEDNAR: We'll have to seek some  
19 wisdom on that. Dr. Poland, then Dr. Parkinson?

20 DR. POLAND: In part I think let's let  
21 our executive staff handle some of those details,  
22 but this is a memo or report back to us as the

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1 parent board. It needs to have a cover letter  
2 that is addressed to the Deputy Secretary but  
3 c.c.'ed to the ASD for Health Affairs so that it  
4 doesn't just go there and stay but yet both see  
5 it. The particulars about whether it has urgent  
6 or how those are listed I think we'll seek the  
7 appropriate advice of our executive staff, but I  
8 think the intent is let's get this to the Deputy  
9 Secretary and I would add to the ASD.

10 DR. LEDNAR: Given the interest we have  
11 to get this communication to the Deputy Secretary  
12 quickly and the need to prepare a cover letter,  
13 I'm going to ask if anyone would like to work with  
14 Dr. Poland I to draft those words knowing that  
15 we're going to sign up for getting a draft  
16 together in the next day or two, quickly, because  
17 we really want to get this communication next week  
18 to the Deputy Secretary? Dr. Oxman. Dr.  
19 Clements. Dr. Poland. Anyone else?

20 I think we have a plan. Thank you for  
21 the energy. This is an important item for the  
22 Department. This is an important item for the

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1 Board. We have said that the Defense Health Board  
2 is an independent advisory group of expertise who  
3 volunteer to provide the very best insight  
4 possible to the Department of Defense and this is  
5 a test of our walking the talk and I hope that  
6 those on the Board feel as though it's been a  
7 delivery and thorough consideration and feel proud  
8 of the product and the message that's being  
9 communicated. And especially to Dr. Kizer and the  
10 Subcommittee, this has been a very challenging  
11 task that they've taken on and a complex solution,  
12 but the Subcommittee is going to need all of our  
13 help on the Board to stay the course, and that's  
14 what we're here to do.

15 So that we will conclude our discussion  
16 of this agenda item, and returning back to the  
17 agenda as it was originally published, we'll go  
18 into our next agenda item which is a report by Dr.  
19 Shamoo of the Medical Ethics Subcommittee. Dr.  
20 Shamoo is the Chair of the Medical Ethics  
21 Subcommittee of the Defense Health Board. Dr.  
22 Shamoo is Founder and Editor-in-Chief of the

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1 journal "Accountability in Research" as well as  
2 Professor and past Chair of the department of  
3 biochemistry and molecular biology, Professor of  
4 Epidemiology and Preventive Medicine and a member  
5 of the graduate faculty of applied professional  
6 ethics affiliated with the Center for Biomedical  
7 Ethics at the University of Maryland. He also  
8 serves as guest faculty of the Applied Research  
9 Ethics Program at Sarah Lawrence College. Dr.  
10 Shamoo will provide a brief report on the  
11 Subcommittee's recent activities, and Dr. Shamoo's  
12 material may be founder tab 10 of your meeting  
13 book. Dr. Shamoo?

14 DR. SHAMOO: Thank you very much, Dr.  
15 Lednar. Ethics requires a lot of training, but  
16 this is the first time we've had an ethics  
17 presentation in 3 years of the Defense Health  
18 Board's existence, so maybe this is a good start  
19 to have more of them.

20 I'm just going to give you a quick  
21 overview of our activities of our inaugural  
22 meeting. Who are the members? The bylaws task

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1 force for the Committee. We had an August meeting  
2 and agenda topics. The most important part is the  
3 topics for future meetings. We spent most of the  
4 time, 2-1/2 hours, on that topic.

5           These are the members of the Committee.  
6 All of you know them. We have a person from the  
7 ASDH office, Ms. McCracken. Here are the tasks  
8 of the Subcommittee by the bylaws, to study the  
9 moral values as they apply to medicine and their  
10 practical applications in clinical settings. I  
11 won't review the rest of it.

12           We invited two leading bioethicists in  
13 the country who have experience with national  
14 security/defense issues. They have served on  
15 national commissions in both of these areas, Dr.  
16 George Annas from Boston University, and Jonathan  
17 Moreno who is currently at the University of  
18 Pennsylvania. Dr. Annas gave us a quick overview,  
19 but also he went over very large studies and  
20 ethical challenges of prevention in the U.S.  
21 military of suicide, how that study ought to be  
22 conducted and what are some of the pitfalls. Dr.

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1 Moreno is interested in the area of neuroethics.  
2 This includes the ethical challenges associated  
3 with psychophysiology and neuroscience-based  
4 technology where you read the mind. He has a book  
5 actually published 3 years, "Mind Wars." That  
6 includes lie detectors, functional magnetic  
7 resonance and infrared. You can actually image  
8 brain and/or some of the peripheral blood flow and  
9 some of these instruments are being used in the  
10 field with either little or no validated research  
11 studies.

12 I said the topics will be very  
13 important. What are the topics, how we prioritize  
14 them and how we're going to address them. The  
15 topics come from the ASDH office. Is there is a  
16 question, that will take top priority or from the  
17 Executive Director or the two Vice Presidents or  
18 from the Chairmen of all the Subcommittees, if  
19 they confront an ethical issue and they have  
20 written me about it, I have solicited their input.  
21 Other issues of course we came up with and these  
22 are the topics we prioritized and the reason we

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1 prioritized the first three is Dr. Smith from the  
2 ASDH office has an interest in this topic and he  
3 will need our input, and that is the treatment of  
4 the enemy to be addressed by Dr. Smith, force  
5 feeding of hunger strikers, detainees treatment  
6 and medical care of the wounded enemy. It may not  
7 be currently the highest priority, but this is one  
8 of the priorities that was brought to us.

9           The second one, research and controlled  
10 clinical trials. Commander Feeks recommended  
11 Lieutenant Maury to us. They want to do research  
12 in combat zones. Can you do a clinical trial in a  
13 combat zone? That's it in a nutshell. What are  
14 the ethical issues surrounding issues of informed  
15 content? How are institutional review boards  
16 going to act in combat settings? And evaluate the  
17 protocol. The whole issue of research with human  
18 subjects in the military requires maybe an  
19 overview also.

20           The third topic is ethics education for  
21 medical personnel within the medical health  
22 system. Currently there is no such program and we

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1 want to investigate it and we will ask Commander  
2 Feeks to have someone to brief us on the current  
3 status in the Military Health System whether there  
4 is any training in medical ethics within the  
5 system.

6 Most members of the Subcommittee felt  
7 this Board needs medical ethics training, and they  
8 really thought even for half a day to a full day,  
9 but I told them you guys are very important and  
10 very busy and you may never sit for half a day,  
11 let alone a full day. So we have narrowed it down  
12 maybe to a couple of hours, maybe an hour. But  
13 anyway, you need to be familiar even with the  
14 terminology and some of the implications of what  
15 we will be doing. That was everybody. There was  
16 no discussion on that issue.

17 The use of unscreened blood transfusion  
18 on the battlefield was the topic. As you know,  
19 there is currently some practice where we dealt  
20 with blood transfusion one time in one of the  
21 Subcommittees that you grab the nearest soldier  
22 and you give them fresh blood that has not been

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1 tested, that is, not within FDA compliance. If  
2 there is an emergency obviously and there is no  
3 blood which is FDA compliant, you will use that  
4 first. Then as some of the old DHB members  
5 remember that with the matter of providing just  
6 one additional military airplane they were able to  
7 reduce I think by over 50 percent -- Colonel  
8 Bader, do you remember by 50 or 70 percent? You  
9 don't remember that. Sorry. You may have not  
10 been involved in it too. Dr. Poland, weren't you  
11 on the teleconference? I'm going to keep going  
12 until I find someone.

13 REV CERTAIN: My memory is similar  
14 to yours, Dr. Shamoo.

15 DR. SHAMOO: Thank you. I knew I wasn't  
16 having some delusions.

17 So there are things you could do to get  
18 the compliant blood into the field if you do  
19 certain things without starting to consider heroic  
20 means to give them a blood transfusion. And it's  
21 of course safer in the long run.

22 I think the third topic we already

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1       talked about. No, we didn't. The ethics  
2       treatment of the wounded soldier that is the  
3       physician's dual loyalty, that is, to get him  
4       quickly back into the war zone versus keeping him  
5       in a hospital. This is no different than issues  
6       related to physicians for a football team or  
7       basketball team, how fast you are going to the  
8       solder back to the battlefield.

9                There are issues of research misconduct.  
10       For probably some of you that's not on your radar  
11       screen. There was a former military physician and  
12       researcher who was involved in a big scandal that  
13       was in the newspapers. Has any one of you heard  
14       of that? Amazing. It was on TV also. One. Mike  
15       Parkinson. A surgeon, and since it's my area, I'm  
16       aware of it. But there are others also in the  
17       military including research misconduct with a few  
18       cases here and there.

19               The ethics of performance-enhancing  
20       drugs and technology to soldiers. The other topic  
21       was something I'm not personally enthusiastic  
22       about because I think it's a deep hole that we go

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1 into and we will never come out of it. That is, a  
2 significant number of former high-ranking active  
3 military officers who retire to become lobbyists  
4 and project managers for the medical industry.  
5 That's a very big order and I don't know how we  
6 can put our arms around it to be very honest. You  
7 can see that it's low in priority.

8           These priorities will change as we see  
9 something much better and we could reprioritize  
10 them. So it's a fluid situation. We are not  
11 stuck with it. A colleague insisted that we have  
12 hand and face transplants conducted at AFIRM and  
13 there are a lot of ethical issues involved with  
14 that.

15           These are our topics. This is what the  
16 Medical Ethics Subcommittee became after we lost  
17 seven members because of renewal problems. Now  
18 you can understand why I was disturbed by it. We  
19 are really in suspension until we know about the  
20 renewal of board members.

21           This is what they decided for future  
22 meetings. Obviously in 2009 with only three

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1 members, we're not going to meet, and in 2010 we  
2 will meet quarterly. Thank you. I will be glad  
3 to answer any questions.

4 DR. LEDNAR: Thank you, Dr. Shamoo. Are  
5 there any questions for Dr. Shamoo?

6 DR. LUEPKER: Dr. Shamoo, when you  
7 address these issues, is the outcome a position  
8 piece or a report of some type? Is that where  
9 you're headed?

10 DR. SHAMOO: On each topic we will  
11 deliberate on it. First we will collect expert  
12 opinion and we will collect the literature, and  
13 then we will produce hopefully a one to three page  
14 white paper back to the board for their adoption,  
15 approval, changes or whatever they want.

16 DR. LEDNAR: Dr. Parkinson?

17 DR. PARKINSON: Dr. Shamoo, this is an  
18 excellent list. I would suggest when you get  
19 reconstituted that maybe the first thing that you  
20 might want to consider is a fundamental  
21 exploration. I remember we talked about the  
22 profession of arms and the profession of health

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1 and medicine to define at a high level, what are  
2 the guiding principles that are extant in our  
3 training curriculum materials, in our residency  
4 programs, because I think that review and asking  
5 the department to produce DoDIs, Service-specific  
6 policies so you can do a policy review of what's  
7 out. I don't think there is a consistent  
8 approach, yet there is a good body of knowledge  
9 that's taught at USUHA, it's taught at the  
10 academies, it's taught selectively at some of our  
11 officer training schools and our initial health  
12 profession schools, NMSO and some of these things  
13 that's out there but there is no inventory on  
14 this. I think a scrutiny from your fully composed  
15 body of what's out there, what's on target, where  
16 is our huge hole, would be the first step before  
17 we get into the individual hot-topic issues as  
18 opposed to ethical foundational work which I think  
19 will be most useful to do.

20 DR. SHAMOO: Mike, as usual you have  
21 very keen and important questions and that was  
22 discussed in detail. We wanted to know what

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1 medical schools, especially the Uniformed Services  
2 University and others, is currently being taught  
3 there.

4 DR. LEDNAR: I think in this area and is  
5 true of all the Subcommittees, as we identify  
6 areas of opportunity, in this case ethics, it will  
7 be important to have a conversation with the  
8 Department. Some of the questions may in fact  
9 come from the Department like from Dr. Smith.  
10 Others may be thoughts within the Committee of  
11 important areas for the Department to consider  
12 that might be proposed by the Subcommittee to the  
13 department. I think what's helpful in that kind  
14 of orienting discussion is to try to get the  
15 question as clearly framed as possible, the scope  
16 is understood as possible, that the priority of  
17 either the Department or the Subcommittee is  
18 understood by both so that the Department is  
19 getting useful product and it's ready to receive  
20 it and will assist in its implementation.

21 I'd encourage again with the help of our  
22 senior staff, who are the right people in the

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1 Department to have these conversations so that we  
2 get the very best traction of this independent  
3 advice. Are there other questions or comments for  
4 Dr. Shamoo? We look forward to the success of the  
5 senior staff in terms of appointments being acted  
6 upon so that Dr. Shamoo and the Medical Ethics  
7 Subcommittee is fully staffed with its complement  
8 of experts soon so that you can continue this  
9 important work.

10 DR. SHAMOO: Thank you.

11 DR. LEDNAR: Thank you. Our next agenda  
12 item is for Dr. William Halperin to share with us  
13 information regarding the Military  
14 Occupational/Environmental Health and Medical  
15 Surveillance Subcommittee as an update. Dr.  
16 Halperin is currently serving as Chair of the  
17 Department of Preventive Medicine at the New  
18 Jersey Medical School as well as Chair of the  
19 Department of Quantitative Methods for the School  
20 of Public Health at the University of Medicine and  
21 Dentistry in New Jersey. As Chair of the Defense  
22 Health Board's Military Occupational/Environmental

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1 Health and Medical Surveillance Subcommittee, he  
2 will share with us an update regarding the  
3 Subcommittee's recent activities. Dr. Halperin's  
4 slides may be found under tab 11 of the folders.  
5 Dr. Halperin?

6 DR. HALPERIN: Thank you very much. I'm  
7 going to aim for 5 minutes. Let's start with  
8 bastardizing a quote from Mark Twain who responded  
9 to an editor and was under deadline by saying,  
10 "With more time I could be briefer."

11 You're more familiar with the work of  
12 this Subcommittee in the area of occupational and  
13 environmental health. We've briefed you on  
14 chromate exposure in Iraq and dioxin exposure in  
15 Iraq and so forth. What we're going to focus on a  
16 bit today is the surveillance part of our charge.  
17 The members of the Subcommittee are very well-  
18 situated for dealing with acute exposure and acute  
19 turnaround reports having epidemiologists,  
20 industrial hygienists, occupational physicians,  
21 biostatisticians, et cetera.

22 Now we come to the charge to the

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1 Subcommittee that deals more with surveillance,  
2 and the origin of that charge if you go way back  
3 is from Dr. Winkenwerder in 2002 which said the  
4 AFEB which is now translated into our Subcommittee  
5 if you will, that we would meet with the DoD  
6 Centers for Deployment Health Research of which  
7 there are three to receive mission briefs and then  
8 we would develop in coordination with the  
9 directors of these centers an appropriate strategy  
10 to accomplish an ongoing program review, et  
11 cetera. Essentially the Subcommittee the way we  
12 interpret this is going to assess these three  
13 research centers and in a certain way become an  
14 ongoing standing review committee for these  
15 centers. This is a major undertaking to say the  
16 least.

17 To accommodate this task, we needed to  
18 do it within the capacity that we have, and I'll  
19 tell you how we're dealing with the first review.  
20 The first review was at the Naval Research Center  
21 that is responsible for the Millennium Cohort  
22 Study. The reason that we worked on that one

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1 first is because of the size and the importance of  
2 the Millennium Cohort Study. If you remember,  
3 they started accruing participants in this study  
4 in 2001. The goal is 170,000 participants, and  
5 they're up to about 140,000 participants by now.  
6 Each participant will be followed for 20 years.  
7 That's 3.4 million person years of observation  
8 time. I think it would be very hard to find  
9 another study anywhere that comes close to the  
10 magnitude and the capacity of the Millennium  
11 Cohort in the future to answer all sorts of  
12 questions.

13           Aside from accruing, that is registering  
14 and getting the participation of the members, they  
15 have sent questionnaires to 140,000 members every  
16 3 years so that when this is all said in done over  
17 20 years, then they have seven or eight rounds of  
18 questions amongst 170,000 people, and this is a  
19 huge volume of work. The way we chose to deal  
20 with this charge is a little bit novel which is  
21 that Ed Feeks and I after discussing in a  
22 telephone conference with the Subcommittee members

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1        what it is that was of interest to the  
2        Subcommittee members that Ed and I went out in a  
3        little reconnoitering to San Diego and spent time  
4        with the scientists out there trying to understand  
5        the issues that they were facing and the issues  
6        from our point of view that were most substantial.  
7        That report which essentially is drafted is going  
8        to the rest of the Subcommittee members, we will  
9        have another telephone conference to prioritize  
10       which are the major issues that they are most  
11       concerned about, and do we need a return visit to  
12       further debrief the scientists in San Diego. If  
13       we do, we will be headed back and we will then  
14       periodically be visiting with the Naval Research  
15       Center on the Millennium Cohort Study. Then we  
16       will turn our focus to the other two deployment  
17       research centers in turn.

18                    Essentially that is what I intended to  
19       tell you about this morning. If you have  
20       questions, I'd be happy to answer them briefly. I  
21       would like to reserve a minute for Tom Mason who  
22       accepted the challenge yesterday if you'll

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1 remember the discussion about should there be an  
2 electronic medical record that is functional and  
3 available, Tom has written a draft having to do  
4 with all sorts of exposure information and how it  
5 should be collected and be available. You have it  
6 in front of you. The goal is for you to look at  
7 this and then send comments to both of us that  
8 we'll look at and revise the recommendation, and  
9 then bring it to you as a vote either at the next  
10 meeting or perhaps electronically in between.

11 DR. LEDNAR: Thank you, Dr. Halperin.  
12 If I can ask, before Dr. Mason shares with us the  
13 wording of the draft to address an issue that came  
14 up yesterday, do we have questions for Dr.  
15 Halperin?

16 DR. KAPLAN: Bill, a few years ago there  
17 was a Committee that went out there. Was it last  
18 year?

19 DR. HALPERIN: It was the summer 2008.

20 DR. KAPLAN: There were a series of  
21 recommendations in the report. Where is that?  
22 Has that been taken into consideration and so

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1       forth?

2                   DR. HALPERIN:  Yes.  A large number of  
3       us went out and were briefed on some of the work  
4       of the Millennium Cohort, there were a series of  
5       presentations, wonderfully informative and  
6       entertaining, but it didn't quite get translated  
7       into action if you will.  Subsequently the charge  
8       has been given to our Subcommittee.  We looked at  
9       those recommendations.  We thought that some of  
10      them were not deep enough if you will, so we  
11      decided rather than to say something, that it was  
12      wiser to hold back and take a refreshed view of  
13      it, but those comments were used to inform us of  
14      what questions we should address out there.

15                   DR. LEDNAR:  Dr. Poland?

16                   DR. POLAND:  Bill, with the three  
17      centers then, is it the plan to do something like  
18      each one would be reviewed in depth every 3 years,  
19      for example, or how do you plan to approach that?

20                   DR. HALPERIN:  I think it depends on the  
21      state of the Centers.  My sense, and it's only  
22      mine, it's not the Committee's sense, is that with

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1 the Naval Research Center there are enough issues  
2 that we ought to be engaging with them every 3  
3 months until things are worked out, and then the  
4 frequency could become longer. So I think we have  
5 to frame the frequency of this to what we  
6 encounter. This is a major undertaking that  
7 they're engaged with out there.

8 DR. LEDNAR: What Dr. Halperin just said  
9 reminds me of what we mentioned yesterday for all  
10 of our Subcommittees, and that is for the  
11 Subcommittee Chairs to take a look at their  
12 membership in the Subcommittee hope that all will  
13 be reappointed but anticipating that some may not.  
14 And looking at are there critical skill gaps, are  
15 there volumes of work coming to the Subcommittee  
16 issues that suggest that we need to staff the  
17 Subcommittee in a way different than we do today?  
18 I think Dr. Halperin has put his finger on an  
19 understanding of a request to the Subcommittee  
20 which the current staffing may not be in a  
21 position to meet. Dr. Luepker?

22 DR. LUEPKER: Bill, as you know, I

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1       chaired a review committee for the Millennium  
2       Cohort in 2005 and then 2 weeks ago in Frederick  
3       they came out and presented to a group aside from  
4       me that does not represent this group under the  
5       aegis of AIBS. There are some serious worries  
6       about this program and I guess I'd like to be  
7       included if possible as we move forward.

8                 DR. HALPERIN: Volunteers accepted with  
9       an A. Accepted.

10                DR. LUEPKER: I accept it.

11                DR. LEDNAR: Thank you. We will ask Dr.  
12       Mason to share his thoughts. Dr. Mason?

13                DR. MASON: I'll be very brief. What  
14       I've attempted to do is capture the essence of the  
15       discussion that we had yesterday, and since we in  
16       our Subcommittee have been tasked to do the  
17       impossible. Qarmat Ali. Sodium dichromate.  
18       Still classified. Those of us who have active  
19       clearances. Come to Washington. No read-ahead  
20       materials. Still classified. Sit in a room  
21       within a room. Get briefed. Get all the  
22       information that you have and 24 hours later have

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1 something we can go public with. There's a better  
2 way to run a railroad. Very simply where we are,  
3 very simply, is we need to systematically provide  
4 for the ability to assess exposures realized by  
5 persons in uniform for their lives and we can't do  
6 it because we're not set up to do it.

7           Yesterday there was this plaintive cry  
8 with regard to records being lost and disconnects,  
9 et cetera. We are sympathetic to that. We  
10 recommend that the electronic medical record plays  
11 a part, but will not by any stretch of anyone's  
12 imagination replace the hard work that is  
13 presently ongoing. Predeployment, postdeployment,  
14 postdeployment health reassessments, the nurturing  
15 of individuals. What we really are interested in  
16 is before the person, him or her, takes his or her  
17 oath that we have a really good sense of what's  
18 going on. Those of us who are interested in the  
19 epidemiology of suicide need to pay attention to  
20 family histories. We are a product of so many  
21 exposures that we realize before we ever take any  
22 oath, before we ever put on any uniform, and we

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1       need to pay attention to that. We need to be very  
2       holistic in our approach to military medicine.

3               What we're suggesting very simply is  
4       let's get serious. If we don't start as we said  
5       in West Philly when we fought the drug lords, we  
6       didn't get in this mess overnight and we're not  
7       going to dig out overnight, but if we don't start  
8       doing something today we're doomed to failure.  
9       What I'm suggesting very simply is read this  
10      whenever you have an opportunity and not while  
11      you're driving. Look at it. I'm an environmental  
12      epidemiologist. That's what I do. That's the  
13      what I think. That's the way I look at issues.

14             The sooner we can actually characterize  
15      these individuals and the sooner we can actually  
16      deal with the reality and we can actually improve  
17      on the assessment of information and use the tools  
18      that are available to us, body parts, biologic  
19      materials, sync/h that deal exposure. There is  
20      not a sync/h for every possible thing that our  
21      uniformed services might actually be exposed to,  
22      but we get asked and we will continue to be asked,

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1 and quite frankly, I'm very concerned. If we look  
2 at agent orange and we look at the Gulf War, we're  
3 staring down issues that are related to exposures  
4 realized by persons in uniform who are really  
5 going to make some of those activities pale  
6 because the magnitude is so much larger and the  
7 issues are even more complex. We need to get  
8 serious about ways in which to utilize techniques  
9 that have been used in our own occupational  
10 environment. Just because you got a uniform on is  
11 not different in any way in many respects from  
12 exposures that we realize at a work site. Use  
13 some of the respective tools. Use sampling  
14 methods. Be creative. When persons come to a  
15 clinic, get access to biologic materials. Update  
16 the information. Yes, electronic medical records  
17 can play a part. They're not going to answer  
18 everything at all. But it will push us we believe  
19 in the direction that we should be going.

20 So just consider it. I'm not the least  
21 bit protective of any of my words. I'm an  
22 academician periodically and I'm also from the

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1 Alsace, I come from a German/French background, so  
2 I write exceptionally long sentences. Break them  
3 up. Break them up into short, simple declarative  
4 sentences. That's what I tell my students. I  
5 don't do it. I tell them to do it. Thank you  
6 very much.

7 DR. LEDNAR: Are there any questions for  
8 Dr. Mason? Dr. Parkinson?

9 DR. PARKINSON: Très bien. It struck me  
10 that probably too many years ago there was a  
11 discussion which I think would be very useful for  
12 your Subcommittee or committee of a committee or  
13 whatever to create a useful, understandable  
14 framework for optimal individual exposure  
15 assessment and a codification. I go back to the  
16 experience with agent orange. Of these so-called  
17 I was in unit X during the day that the smoke came  
18 over turned out to be absolutely if not useless  
19 near useless until we got a biomarker of absolute  
20 exposure. But it seems to me what the Department  
21 could use unless some preventive and occupational  
22 colleagues can tell them you've got it today in

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1 Air Force manual X, in other words, what are the  
2 leading currently known exposures of interest,  
3 what are the emerging exposures of interest and  
4 what are the futures exposures of interest and  
5 what are the currently available biosensors a la  
6 the old radiation detector that we do in X- ray  
7 units in terms of acoustic shockwaves? What is  
8 the state of the technology that the Defense  
9 Health Board can push to say you need to get this  
10 embedded in a helmet next year? It would seem to  
11 me that that would be an action agenda on the  
12 sensor biological monitoring or whatever that  
13 would leapfrog the Department with an action  
14 agenda that right now is Brownian motion out  
15 there, it's the exposure de jure and what are we  
16 going to do about this without an assessment of  
17 what's currently capable or developmentally there  
18 and involves reaching into the research labs, it  
19 involves are that are not traditionally  
20 epidemiology at all. Maybe you guys are doing  
21 that, but I think it might be a good thing to do.

22 DR. MASON: I thank you very much for

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1 those comments. We play a role, but we play a  
2 minor role in comparison to all of the  
3 complementary sister disciplines, and until we  
4 start doing this which we are not, until we start  
5 doing this, we're going to wind up with addressing  
6 the concern right now and losing the sight of the  
7 fact that there are hundreds of thousands of  
8 individuals there who would actually benefit from  
9 a systematic review, analysis and promulgation and  
10 publication of findings that have an impact on  
11 preventive medicine.

12 DR. LEDNAR: I think what Dr.  
13 Parkinson's comments remind us of is the real  
14 benefit that the Defense Health Board can provide  
15 to the department by leaning forward,  
16 anticipating, seeing opportunities for connection  
17 within the department of technology expertise,  
18 with theater need and connecting those dots in a  
19 way that also allows us to understand the  
20 experience and to be able to be in a position to  
21 answer questions.

22 DR. MASON: Correct.

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1 DR. LEDNAR: Dr. Fogelman?

2 DR. FOGELMAN: Tom, can we have your  
3 email address?

4 DR. MASON: --

5 DR. LEDNAR: So the request is for  
6 comments on the draft that you've received, if you  
7 would email them to both Dr. Mason and Dr.  
8 Halperin for consideration by the Subcommittee.  
9 Is there anything else, Bill or Tom? Thank you  
10 for that report and that discussion.

11 Our next agenda item is going to be  
12 presented by Dr. Frank Butler. Dr. Butler is a  
13 retired captain and Chair of the Committee on  
14 Tactical Combat Casualty Care, as well as a member  
15 of the Trauma and Injury Subcommittee. An  
16 ophthalmologist and former Navy SEAL, he is  
17 currently serving as a medical consultant to the  
18 Navy Medical Lessons Learned Center as well as an  
19 Adjunct Professor of Military and Emergency  
20 Medicine at the Uniformed Services University of  
21 the Health Sciences. The Board believes trauma  
22 and injury treatment and prevention should be a

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1 Department of Defense core competency and is  
2 thrilled to have members of this Subcommittee  
3 participate in ensuring that such efforts  
4 optimally meet the needs of our Service members.  
5 On behalf of Dr. John Holcomb, Chair of the Trauma  
6 and Injury Subcommittee, Dr. Butler will provide  
7 an update on the subcommittee's recent activities.  
8 His presentation slides may be found under tab 12  
9 of the meeting binders. Dr. Butler?

10 DR. BUTLER: Thank you. It's a pleasure  
11 to be back. Commander Feeks has asked me to talk  
12 fast which is a tall order for us Georgia boys,  
13 but I'll give it my best shot.

14 I would like to bring the Board's  
15 attention to two proposed votes that we will go  
16 over as we proceed with the brief. The first has  
17 to do with battlefield trauma care research  
18 priorities. The second has to do with proposed  
19 TCCC burn management strategies.

20 First I would like to give the Board a  
21 little bit of feedback. I'm sorry that Dr. Oxman  
22 is not here.

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1 DR. OXMAN: I'm right here.

2 DR. BUTLER: I have some answers to the  
3 questions that you raised about what happens to  
4 our memos after we sign them and send them out. I  
5 think you'll be pleased with a couple of these  
6 actions.

7 You'll remember in Key West we talked  
8 about the fact that the literature right now says  
9 that among our total combat fatalities, about 20  
10 percent of this might have been prevented with  
11 optimal care, and there are now several units who  
12 have been using TCCC since the start of the war  
13 who have reported zero preventable fatalities  
14 despite sustaining about 800 casualties total  
15 including 60 deaths. That was translated into the  
16 Defense Health Board memo that was signed out by  
17 Dr. Holcomb and Dr. Wilensky on August 6 that said  
18 that's have everybody and their deploying  
19 combatants to do TCCC, let's teach the medical  
20 officers what their medics are learning so that  
21 they will know. They don't get this stuff in  
22 medical school and they don't get it in most

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1 residencies. Let's teach combat leaders to know  
2 what their medics are supposed to know. It's  
3 their responsibility to make sure it's done right.  
4 They have to know what it is. We need to better  
5 capture the point of injury data and we need to  
6 have a process improvement program that's ongoing.  
7 So that was the substance of the memo.

8           Interestingly, within a month it got  
9 picked up and was the feature article in "USA  
10 Today." For any of you who didn't see this, I'd  
11 be glad to email it to you. The thrust of the  
12 article was 20 percent indicates a problem.  
13 Second, the Defense Health Board has proposed some  
14 solutions. Third, Pentagon, what are you doing  
15 about it?

16           With respect to what are we doing, the  
17 memo found its way to Dr. Karen O'Brien who is the  
18 Command Surgeon for the U.S. Army Training and  
19 Doctrine Command. TRADOC trains everybody outside  
20 of medical in the Army. So Colonel O'Brien and I  
21 went and briefed her four-star commander about the  
22 contents of the memo and he agreed in August of

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1 this year to implement TCCC training for everybody  
2 who gets on to a battlefield and for all combat  
3 leaders. It was a huge success.

4 Your memo found its way to the Army  
5 Surgeon General's Working Group on Point of Care  
6 Injury Documentation and that group used the  
7 recommended card as the new standard of care for  
8 documenting care on the battlefield. The good  
9 news is that the Army has a form that does this.  
10 The bad news is of course that the Army has  
11 another form, so take that for what you will.  
12 This just came out. Your memo found its way to  
13 the Deputy Medical Officer of the Marine Corps,  
14 and on October 30 this message was released by the  
15 Commandant of the Marine Corps that said,  
16 "Effective now, this is our new standard of care  
17 in the Marines and we will train all combatants,  
18 all combat lifesavers and all medics in this." So  
19 thanks for the Board for their support and I hope  
20 you're pleased with some of the actions that have  
21 been taken in the interim.

22 I'd like to share this study with you.

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1 If traumatic brain injury is the signature injury  
2 of this war, tourniquets are the signature  
3 lifesaving intervention of this war. This came  
4 out in the "Journal of Emergency Medicine" a  
5 couple of months ago. It's the largest tourniquet  
6 paper as far as I know that's ever been published,  
7 499 casualties, tourniquets on 651 limbs, overall  
8 survival was 87 percent. Many of these casualties  
9 died of their polytrauma, they were injured in  
10 other places besides their extremities. The  
11 author noted that there was a very low survival if  
12 the tourniquets were applied aftershock had  
13 already set in. Complications include transient  
14 peripheral neuropathies at 1.5 percent, limbs lost  
15 due to tourniquet use, zero. That's a number we  
16 can live with. It's sad to note that there were  
17 10 fatalities who died of extremity hemorrhage  
18 with no tourniquet being placed. So the battle is  
19 being well fought but not completely won.

20 In the interests of time, what I will do  
21 is save the discussion of this fascinating Hextend  
22 study that's about to be published and come back

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1 to that with the Board's permission. This is  
2 complex. You will have questions about this and  
3 it's a great discussion, but it won't be short.

4 I think it's a reasonable question for  
5 this Board to say how are the things that you are  
6 recommending for trauma care being accepted by the  
7 civilian trauma sector. We had a panel session  
8 that was presented in early October at the  
9 American College of Surgeons' Clinical Congress.  
10 We had a panel session on trauma care advances in  
11 the military and TCCC was the prehospital segment  
12 of that discussion. In the Scudder Oration which  
13 is their named trauma oration each year, Dr. Brent  
14 Eastman who is the Chairman of the Board of the  
15 American College of Surgeons and a former chair of  
16 the Committee on Trauma said the military has got  
17 this right. They've got an incredibly  
18 well-functioning trauma system in theater. Every  
19 Thursday the trauma system as a group get together  
20 and discussion every patient who came into the  
21 system that week. We discuss every hospital that  
22 he or she was admitted to, what was done for them

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1       there and how they responded. And as a process  
2       improvement system, I've never seen anything like  
3       this. It is fantastic. They react to these  
4       conferences by publishing clinical practice  
5       guidelines that are implemented in CENTCOM. We  
6       all know the military can sometimes be a little  
7       sluggish in getting things done and committing to  
8       a specific course of action. This is an example  
9       of a system that works and these clinical practice  
10      guidelines, I really commend them for your  
11      perusal. They are posted on the internet and  
12      available for anybody to look at. Very positive  
13      comments from Dr. Eastman.

14                On to the new items. The first is  
15      battlefield trauma care research priorities, and  
16      the second is the treatment of burns. In trying  
17      to establish research priorities, we've discussed  
18      before that TCCC has had an historic focus on  
19      preventable deaths. There are so many great  
20      people in this room doing so many great things for  
21      our casualties, but the hospitals can't do  
22      anything, the rehab people can't do anything, the

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1 family advocates can do something but they can't  
2 help the casualties themselves unless we get them  
3 off the battlefield alive, and that's our focus.  
4 If you read this paper by Joe Kelly that was  
5 published in the "Journal of Trauma" last year,  
6 potentially survivable deaths, 232 out of a cohort  
7 of 982, 85 percent of the preventable deaths were  
8 hemorrhage. Using that, the Committee addressed  
9 the issue of let's provide some input to our  
10 leadership on what we think the priorities are if  
11 you are interested in getting your soldiers,  
12 sailors, airmen and Marines off the battlefield  
13 alive. This is what they were noncompressible  
14 hemorrhage control, damage control resuscitation  
15 which is the military's term for resuscitation  
16 that takes into account more than just fluid  
17 volume. You take into account the effects on  
18 coagulopathy, the effects on perhaps a forming  
19 clot at the site of the injury, the effects of  
20 immunomodulation with the fluid that you're using.  
21 It is a different way to look at fluid  
22 resuscitation.

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1                   Documentation of care and process  
2           improvement. Improved battlefield analgesia,  
3           better ways to train on TCCC, a truncal tourniquet  
4           for proximal injuries, better fluid resuscitation  
5           for casualties who have hemorrhage and TBI,  
6           monitor-driven fluid resuscitation, surgical  
7           airway kits and testing of new tourniquets and new  
8           hemostatic agents. We should probably stop here  
9           and address any concerns, issues or comments that  
10          the board has about that list or we can come back  
11          to it.

12                   The second vote item is treatment of  
13          burns and TCCC. I will say that we have not  
14          previously addressed this in our guidelines and  
15          you may be thinking it's 8 years into the war.  
16          Have these guys been sleeping? Burns have not  
17          historically been a leading cause of potentially  
18          preventable death nor are they now, however,  
19          they're becoming increasingly prevalent and both  
20          our leaders in theater and our medics are saying  
21          give us some guidance about what to do for burns  
22          on the battlefield. I would like to acknowledge

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1 the incredible input on this from the Army  
2 Institute of Surgical Research Burn Center. This  
3 is where all of our burn casualties go. It's one  
4 of the premiere burn centers in the world, and  
5 they helped us out immensely with this. We wrote  
6 12 chapters in the "Prehospital Trauma  
7 Life-Support Manual." They helped us out by  
8 writing one on burns this time, and they did both  
9 the chapter and the initial draft of the  
10 guidelines.

11 You'll recall that our phases of care  
12 are broken into care under fire, tactical field  
13 care and evacuation care. What do you do when  
14 you're still in the middle of a gunfight? You get  
15 your casualty out of the burning vehicle and you  
16 stop the burning process even in the middle of a  
17 gunfight. Once you are in a position of relative  
18 safety, it might just be behind a wall, it might  
19 be that the fighting has stopped, but now you  
20 really have a chance to focus on the patient, and  
21 this is burn care 101 in many respects, if it's  
22 old hat I apologize. Some of it will be new.

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1 First is to pay attention to whatever facial burns  
2 the casualty might have because those may indicate  
3 inhalation injuries and indicate the need for  
4 aggressive airway management. Estimate the total  
5 body surface of area of burn using the rule of 9s  
6 is pretty standard. Cover the burn area with dry,  
7 sterile dressings. This is going to disappoint  
8 the people who make millions of dollars selling  
9 antibiotic and silver-impregnated things to the  
10 military. The burn people said there's not much  
11 indication for that. Dry, sterile dressings; if  
12 you have somebody with extensive burns, we have a  
13 rescue wrap that will serve nicely both to cover  
14 their burns and to prevent hypothermia.

15 Third is that resuscitation is  
16 significantly changed. If you have wrestled with  
17 the Brooke and Parkland formulas, ISR has  
18 determined, A, they're too complicated for medics  
19 to calculate on the run out there on the  
20 battlefield; and B, they overresuscitate the  
21 casualties. There are significant numbers of  
22 abdominal compartment syndrome and ARDS in some of

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1       our burn patients and the burn surgeons feel that  
2       cutting back on the fluids might not be a bad  
3       thing.  If the burns are greater than 20 percent  
4       of the total body surface area, start fluid  
5       resuscitation early on.  Lactated ringers, normal  
6       saline or Hextend can all be used.  If you use  
7       Hextend, don't exceed a liter because of  
8       coagulopathy concerns.  The initial fluid rate is  
9       pretty simple.  You just take the percent total  
10      body surface area burned and multiply by 10, and  
11      that is your initial IV rate in milliliters per  
12      hour.  That works if you're up to 80 kilograms.  
13      If you're a big person then they increase that  
14      fluid a little bit to 100 milliliters an hour.  If  
15      you are in hemorrhagic shock it's a different  
16      story.  Bleeding shock takes precedence over burn  
17      shock.  There is no argument from the burn  
18      surgeons or the trauma surgeons that that was the  
19      case, in which case you would restrict fluids and  
20      not give more than a liter of Hextend.  Analgesia  
21      according to the guidelines is they worked  
22      previously.  The burn folks said absolutely do not

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1 start antibiotics prehospital for these severely  
2 burned patients. If you need to do that because  
3 they're also shot in the abdomen then do it, but  
4 don't do it just for burns. Then lastly, a  
5 question came up from the medics concerning, What  
6 can we do through burned skin? The answer is  
7 anything that you can do. You don't have to avoid  
8 doing intraosseous infusions or things like that  
9 or needle decompression if you have to do it  
10 through a burn. When you move into evacuation  
11 care, it is essentially the same as during  
12 tactical field care except that there was an  
13 emphasis on preventing hypothermia in these  
14 helicopter evacuation platforms because it's cold  
15 up there at 12,000 feet.

16 Those are the proposed two items. I  
17 will mention that both items were reviewed by the  
18 Trauma and Injury Subcommittee on November 4 and  
19 were approved unanimously by the 7 of the 10  
20 members who were present at the meeting. That's  
21 the lot. Questions?

22 DR. LEDNAR: Thank you, Dr. Butler. Dr.

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1 Poland?

2 DR. POLAND: Two questions from an  
3 internist so naïve to the surgical aspects. One  
4 is, is it possible that at least a controlled  
5 level of hypothermia might be desirable?

6 DR. BUTLER: This question has come up  
7 with TBI patients and so many of the patients that  
8 we have now are polytrauma. If somebody is in an  
9 IED explosion, the person is typically suffering  
10 from blast injury, penetrating trauma, burns and  
11 blunt trauma. The concern is when we think of  
12 hypothermia, as a diving medical officer we're  
13 concerned when people drop under 33 or 32. If you  
14 read the studies on hypothermia and coagulopathy,  
15 however, it's a different story and there are  
16 people who define hypothermia in trauma as  
17 anything below 36 C because that's when the  
18 clotting factors and the platelets functions start  
19 to be affected. We try to keep people so that  
20 they don't have this impaired coagulation that may  
21 contribute to their bleeding to death.

22 DR. POLAND: My second question relates

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1 to the observation that at least historically all  
2 the battlefield casualty care and algorithms that  
3 have been developed are probably very  
4 male-dominated. Just to give a simple example,  
5 we've shown that even in the thinnest women, their  
6 deltoid fat pad is thicker than heavier men, and  
7 so IM deltoid injections have to use different  
8 needles in women versus men. Is that an issue at  
9 all for some of the algorithms that you're talking  
10 about? After all, they have different percent  
11 body fat, different pharmacokinetic compartment  
12 sizes, et cetera.

13 DR. BUTLER: In theory, women would be a  
14 little bit protected from hypothermia, and there  
15 have been some studies in divers that show that  
16 there's a pretty direct correlation between your  
17 fat pad layer and how well you do in cold water,  
18 and since women do a little more body fat, they do  
19 a little bit better in cold water. But there are  
20 no differences in any of our algorithms based on  
21 gender. They're based on size.

22 DR. LEDNAR: Dr. Halperin?

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1 DR. HALPERIN: I avoid doing algebra and  
2 some other things in public, but if you go back to  
3 your tactical field care, is there a typo in the  
4 first line there?

5 DR. BUTLER: Probably.

6 DR. HALPERIN: It says, "The fluid rate  
7 is calculated as percent TBSA times 10 cc's per  
8 hour." Should it be times kilogram? No, that's  
9 not it. It's the top one. There's something  
10 funny.

11 DR. BUTLER: You're missing the  
12 kilograms.

13 DR. HALPERIN: So it should be times  
14 kilograms?

15 DR. BUTLER: No. The ISR took out the  
16 kilograms to simplify the math because we can't do  
17 algebra either. But they did put the restriction  
18 that this formula really is designed for the  
19 individual between 40 and 80 kilograms.

20 DR. HALPERIN: So it's 10 cc's per hour  
21 per kilogram?

22 DR. BUTLER: Ten cc's per hour times

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1 percent body surface area burned.

2 DR. MASON: Is percent an absolute  
3 number? Let's say someone was 50 percent burned,  
4 that would say 5 cc's an hour.

5 DR. BUTLER: 500 cc's an hour.

6 DR. MASON: It would be 50 times. It's  
7 an absolute and not a percent.

8 DR. LEDNAR: Bill, does that answer your  
9 question?

10 DR. HALPERIN: No, but maybe now is not  
11 the time.

12 DR. LEDNAR: Dr. Parkinson?

13 DR. PARKINSON: Dr. Butler, wonderful  
14 results and application. As a matter of fact, I  
15 think one of the things that the Board would  
16 benefit from is that we learn from our own  
17 best-practice examples as to how a Subcommittee  
18 using evidence focuses on a problem of major  
19 impact, does classic quality-improvement work such  
20 as supplying models that are out there, brings it  
21 to a rapid recommendation, brings it to the DHB  
22 for dissemination, and then where did it go

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1 subsequent to that? If we had a crisp  
2 description, case study, of this probably  
3 represents as far as I know a best practice to the  
4 early history of the DHB, not that the DHB did  
5 this, it was your Committee and it was good trauma  
6 surgeons who did it, but I think summarize this  
7 action step in the context of the DHB would be  
8 very informative, and if there is an orientation  
9 for DHB members it should be part of an  
10 orientation material in terms of a best-practice  
11 case study. What are we all about here? We're  
12 about this. We're about using the leverage of a  
13 multidisciplinary DHB with focused expertise  
14 around a problem that matters to improve outcomes.  
15 I think this needs to be distilled into a best  
16 practice in a short order, not a 20-page  
17 manuscript, but I think it would be very  
18 instructive for all of us because I think it's  
19 excellent.

20 DR. BUTLER: I think it has been a  
21 wonderful combination of both backgrounds and  
22 abilities. I'll be honest that the TCCC Committee

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1 was skeptical about being moved under the DHB  
2 because we weren't sure how an action- oriented  
3 group like that composed mostly of very forward-  
4 leaning operators and the medics who support them  
5 would integrate into the process here. However, I  
6 think the thing that is the redeeming quality is  
7 that we have always been committed to,  
8 understanding that we're not going to have RCTs on  
9 the battlefield, you use the absolute best  
10 evidence that you can find, and we look very for  
11 it. Second, the best answer in the world doesn't  
12 do you any good if you can't translate it into  
13 action. We have worked hard to try to figure out  
14 how to get people to pay attention to the things  
15 that we recommend, and absolutely we'd be glad to  
16 work with the board on some of the strategies that  
17 we've developed.

18 DR. LEDNAR: Dr. Oxman?

19 DR. OXMAN: I must say I would like to  
20 commend Dr. Butler and his colleagues for this  
21 fantastic job, and it certainly makes me very  
22 proud to be a nominal supporter.

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1 DR. LEDNAR: If I understand what Dr.  
2 Butler would also like is for us not to be only  
3 nominal but to be active in supporting the work of  
4 the Subcommittee because you have a request for a  
5 vote. Is that correct, Dr. Butler?

6 DR. BUTLER: Yes, sir.

7 DR. LEDNAR: Would you like to frame the  
8 question for vote to the Board, please?

9 DR. BUTLER: The first vote would be to  
10 endorse the battlefield trauma care research  
11 priorities with the understanding that they are  
12 blended into the context of the many other things  
13 that the military does research on. We understand  
14 that we only have a little piece of the picture to  
15 address, but there are a lot of people selling  
16 things to the military that should not be on the  
17 battlefield that may be on the battlefield that  
18 certainly a lot of research dollars will be spent  
19 on. I am mindful of the field surgical laser  
20 which is a carbon dioxide laser that was being  
21 actively marketed to the military that was going  
22 to be placed into the hands of the medics so that

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1 the staff to find out how best to address it as we  
2 did with the recommendations for the JTF Capital  
3 Region. We have had no much success in impacting  
4 the research priorities of the DoD in the past and  
5 whatever we were doing in that area was wrong, so  
6 I think we should re-explore that question and try  
7 to come up with a good answer.

8 CDR FEEKS: So that this would  
9 take the form of a memorandum to the Secretary of  
10 Defense recommending that those things be research  
11 priorities for the Department of Defense? Is that  
12 right?

13 DR. BUTLER: I think it would list all  
14 of these things but would have a special emphasis  
15 on the top two.

16 DR. LEDNAR: Dr. Shamoo?

17 DR. SHAMOO: I think it will be very  
18 appropriate that the Subcommittee give us one page  
19 or two pages in writing to see exactly what it is  
20 with some minimal paragraphs or two of logic  
21 behind it, approved unanimously by the  
22 Subcommittee or approved by a majority of the

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1 Subcommittee and come back here for our vote  
2 because we're voting on something not definitive  
3 to be very honest and I don't feel that I'm  
4 competent to vote on it now. Maybe everybody else  
5 is.

6 DR. LEDNAR: Dr. Parkinson?

7 DR. PARKINSON: I applaud the effort  
8 that you've had a demonstrated effort in the  
9 focused efforts on the TCCC training, but just as  
10 the DHB is just learning to walk, no less run, I  
11 think that probably the executive team or  
12 leadership needs to begin to say what are our  
13 primary quarters versus our desired future  
14 quarters versus whatever. Is for example  
15 reviewing DoD's allocation of research monies, to  
16 your point, Frank, there's a lot going on out  
17 there. Is the first shot across the bow that the  
18 DHB wants to make in this area as opposed to  
19 saying it's been brought to our attention that  
20 there has been perhaps a lack of sensitivity to  
21 the TCCC's research things and we'd like a  
22 briefing on how the DHB in its new constitution

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1       could be of more service to the department in  
2       allocation of research dollars? This is a  
3       strategy issue with staff and I think it should be  
4       thought about a little bit before we pass a  
5       resolution and send off a hotwire memo in any  
6       event. Again this is late at the end of the  
7       meeting and late in the day and we don't good  
8       decisions generally, so there might be a more  
9       deliberative process here which totally may move  
10      that way, Frank, but it may be a little premature  
11      right now for us as a body.

12                 DR. BUTLER: I understand the concerns.  
13      Dr. Shamoo, I absolutely understand that this  
14      would benefit from a line or two of explanation  
15      under each of these subject headings and I will  
16      send that to the staff and let them send it to the  
17      Core Board.

18                 DR. LEDNAR: I think that will help  
19      bring some clarity and focus to really make sure  
20      that not only we but as it goes further that the  
21      intention of the Subcommittee is well understood.  
22      I think that would be very helpful and we look

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1 forward to that additional document. Dr. Butler,  
2 there was a second aspect of action you were  
3 seeking?

4 DR. BUTLER: The second was as the Board  
5 knows I think, we maintain a set of TCCC  
6 guidelines that are published on the Health  
7 Affairs website. We don't publish the changes to  
8 the guidelines until we get Board approval and  
9 this information will not go out to our medics  
10 until we get Board approval. Does it need an  
11 action memo from Health Affairs? Do we need to  
12 send this up to Ms. Embrey again? I don't know.  
13 We could talk about that with the Board, but we do  
14 need Board approval before we can get this  
15 information out to our medics.

16 CDR FEEKS: What we have is  
17 Captain Butler's slides have bulleted points of  
18 recommended changes to the TCCC guidelines to  
19 address specifically the treatment of burns in the  
20 combat casualty care setting by medics in the  
21 field, and that's slides 18 through 25. These are  
22 the new guidelines that were recommended and that

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1 were unanimously adopted by the Trauma and Injury  
2 Subcommittee at their meeting and are brought  
3 forward now for Core Board approval.

4 DR. LEDNAR: Dr. Poland?

5 DR. POLAND: In looking through these,  
6 there are at face value I think are no  
7 difficulties medically with them at all. The one  
8 concern I was raising is this feels far down in  
9 the weeds to me for DHB to be involved in in the  
10 sense of we have not ever historically gotten  
11 involved at the level of saying an IV rate is  
12 going to be this, or a clinical algorithm, or the  
13 way something is going to be treated is X. There  
14 is nothing wrong them at all. It's just that this  
15 be somewhat precedent setting for us to be  
16 involved at this level.

17 CDR FEEKS: In fact, sir, you're  
18 exactly right that there is a new relationship  
19 between the people who write the guidelines for  
20 tactical combat casualty care and the Defense  
21 Health Board in that the Trauma and Injury  
22 Subcommittee effectively isn't now the scientific

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1 advisory board for that, and every recommendation  
2 that gets passed up requires Core Board approval  
3 so that this is new and it's correct.

4 DR. BUTLER: And it may be worth  
5 rethinking at some point because there are a lot  
6 of fine-tuning things that we do to the guidelines  
7 that may not rise to the level where they really  
8 absolutely have to be approved by the Core Board.  
9 Your time here is limited and I'm not sure  
10 everything needs a Core Board look. As we have  
11 been directed by Ms. Embrey and Commander Feeks to  
12 function at present, you are required to take a  
13 look at any change that we make.

14 DR. LEDNAR: Dr. Parkinson, Dr. Shamoo  
15 and then Dr. Kaplan.

16 DR. PARKINSON: I think it should be 8  
17 cc's instead of 10. I'm just kidding. It's late.  
18 I think it's fine, but clearly to my point  
19 earlier, we're just learning how to ride this bike  
20 and frankly that's okay, so we are now realizing  
21 as Core Board members the delegated authority that  
22 the Core Board has given to our Subcommittees of

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1 experts has a tremendous impact, and so if there's  
2 a timeliness to this, and I will you as  
3 nonsurgeon, nonburn expert primary care doc,  
4 simplification of practice guidelines can have a  
5 huge impact on outcomes. In other words, these  
6 old myths about burned skin and what about the  
7 infection risks versus the other, that alone could  
8 be very impactful by getting it out in the field  
9 and if it's our mission to do that and if it's our  
10 charge to do that, I would move that we adopt  
11 these guidelines as recommended by our  
12 Subcommittee Chair.

13 DR. LEDNAR: Dr. Shamoo?

14 DR. SHAMOO: Fifteen slides to me makes  
15 no sense. I would like to see it as a memo from  
16 the Subcommittee as to what are the guidelines,  
17 one, two, three and the changes, and we'll improve  
18 them and they could extract whatever portion they  
19 want and put it on the website rather than approve  
20 just a set of slides. I just don't see us doing  
21 that if this is precedent setting.

22 DR. LEDNAR: Dr. Kaplan?

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1 DR. KAPLAN: I think I would agree with  
2 Adil. I've been writing guidelines for many, many  
3 years and I agree that simplicity is important.  
4 On the other hand, if they come out as a  
5 guideline, I think they need to be formatted in  
6 which a way, and maybe they are, that they have  
7 appropriate references with them rather than just  
8 a series of slides. Perhaps that's what you  
9 already have, but I would rather than see them  
10 formatted before I would care to vote for them at  
11 this point in time, not that there is anything  
12 wrong with it. I'm not qualified to say so, but I  
13 think that I need to look at them a little bit  
14 more.

15 DR. LEDNAR: Dr. Silva?

16 DR. SILVA: This is an important area  
17 that we're all burrowing our way through and I  
18 like your term, Mike, riding the bike.

19 I have two comments, one about this set  
20 of guidelines and the previous one. I should have  
21 spoken up at that point. A lot of professional  
22 societies, all kinds of hospital systems, have

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1 guidelines, but I think the caveat here is it's  
2 just a guideline, it's not the standard of  
3 practice, we got to be careful here, and that's  
4 also been weighed in on by our civil courts in  
5 medical malpractice. In California I serve as a  
6 consultant to our prison system where we're now  
7 looking at the standard of practice of physicians  
8 and this keeps coming up. So I'm highlight the  
9 sunset here down the pike as we get into  
10 guidelines that it's just a guideline, that it's  
11 not a standard of care. If we cross the other way  
12 then all kinds of things will ripple out of this.  
13 This is a caveat.

14 In terms of the first slide on research  
15 priorities, I think a lot of these look good but I  
16 feel uncomfortable like anyone here because I  
17 don't know all the research going on. I think  
18 whatever we draft we send it up. We should have  
19 some feedback from DoD from whoever runs the  
20 research programs to say why they didn't fund this  
21 one or that one or why the priorities are  
22 different. We're not here to guide research I

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1 don't think. That's not within our mission.

2 DR. LEDNAR: I think on the last point  
3 that Dr. Silva brings up, what we can do is  
4 recommend to the Department that certain people  
5 talk to each other about research and together  
6 develop what's a rationalized for DoD set of  
7 priorities because we don't have all of the  
8 information, and until that discussion occurs with  
9 Dr. Butler's group and perhaps others who are  
10 much closer and much more expert in this, we won't  
11 get to the right set of priorities that should be  
12 going forward. Dr. Oxman?

13 DR. OXMAN: I'd like to respectfully  
14 disagree with Dr. Silva about guidelines, and that  
15 is when the CDC or any other body has guidelines,  
16 they have the force of law because if I do  
17 something other than the guidelines and I am sued  
18 for malpractice, for example, who is Mike Oxman to  
19 contradict guidelines from the CDC even if they're  
20 incorrect as they have been in the past? So I  
21 think guidelines often do have the force of law.  
22 But I think also that we have a new Subcommittee

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1 in a sense and they're doing work that's very  
2 time-dependent. Our troops are being wounded as  
3 we speak and so I think we have to balance our  
4 care and conservatism with the need to move  
5 quickly. I guess the Executive Committee will  
6 have to figure out how to do that, but I would  
7 urge us that if we have a Subcommittee that works  
8 hard and that has expertise that we don't have, we  
9 need to be able to support them, we need to be  
10 able to trust their judgment as much as possible,  
11 and in this particular area we need to move  
12 quickly.

13 DR. LEDNAR: Dr. O'Leary and then  
14 Commander Feeks?

15 DR. O'LEARY: On Mike's point actually I  
16 think in the world of medical malpractice, the  
17 issue is not guidelines, it is the standard of  
18 care which is different, and compliance with  
19 guidelines can be used as an affirmative defense  
20 in the case, but it is not the standard of care,  
21 that's different, and the reason for this  
22 distinction is because there are all sorts of

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1 guidelines, and as you know, some guidelines are  
2 in conflict with each other. Guidelines often  
3 reflect a certain unintended bias sometimes and  
4 intended bias. All that having been said doesn't  
5 mean that it's not important to pay careful  
6 attention to the guidelines, but I don't want them  
7 to be made out to be more than they are.

8 DR. SILVA: The standard is what a  
9 reasonable and prudent practitioner would apply.

10 DR. O'LEARY: That's right.

11 DR. SILVA: That's the standard. That's  
12 been laid out in courts of law in numerous state  
13 supreme court levels and our Supreme Court.

14 DR. LEDNAR: Commander Feeks?

15 CDR FEEKS: What you see happening  
16 today is going to happen more and more often as  
17 the Defense Health Board grows into its new  
18 identity. You have Subcommittees populated by  
19 subject-matter experts who forward recommendations  
20 to the core of the Defense Health Board which is a  
21 strategic decision-making body. Just like any  
22 other strategic decision maker, you don't have the

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1 luxury of only making decisions about stuff you  
2 know a lot about. There are people on this Board  
3 who know a lot of stuff that you don't much about,  
4 but we have a collection of very bright people who  
5 are not being asked to make strategic decisions  
6 based upon the recommendations of very bright o  
7 who know a lot about what they're talking about.

8 Historically our ancestor organizations  
9 didn't even have any trauma or surgery expertise  
10 at all. The Defense Health Board now covers the  
11 spectrum of all matters related to health  
12 including now one of our newest Subcommittees,  
13 trauma and injury, and they have looked very  
14 carefully at this and they think that this set of  
15 guidelines for burn care in the battlefield  
16 setting by battlefield medics is the right thing  
17 to do, and now they've presented it to a strategic  
18 decision-making body for action.

19 DR. BUTLER: If I could jump in here, I  
20 really appreciate the comments of the Board and I  
21 think based on the comments I need to take another  
22 minute and explain to you how these guidelines are

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1 developed and published.

2 If you look on the website, the website  
3 has the guideline.

4 CDR FEEKS: This is the MHS  
5 website. Right?

6 DR. BUTLER: This is the Military Health  
7 System website. It says here is what you do, and  
8 that's what we conveyed to the 21-year-old medic  
9 who has to learn everything about medicine that  
10 he's going to know in 16 weeks. It is here is  
11 what you do. As physicians, do we need to justify  
12 the things that we're recommending? Of course.  
13 So the way that we provide the scientific  
14 background is we work with the American College of  
15 Surgeons' Committee on Trauma, we have a huge  
16 section of the "Prehospital Hospital Trauma"  
17 manual that we own. I for better or worse am the  
18 editor of the military version of the "Prehospital  
19 Trauma" manual. If you wish to explore the  
20 scientific basis and the evidence that we have for  
21 the things that are in the 10 pages of guidelines,  
22 I would commend for your reading pleasure the 500

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1 pages that are in the "Prehospital Trauma Life  
2 Support" manual that does provide extensive  
3 documentation and available evidence for what  
4 we're recommending with the caveat, again, there  
5 are no RCTs on the battlefield so that we do the  
6 best we can with what we have.

7 DR. LEDNAR: Dr. Luepker, then Dr.  
8 Poland?

9 DR. LUEPKER: I am not an expert in  
10 this. I however understand the urgency of getting  
11 the state-of-the-art recommendations to the field  
12 and I'm not deterred by the slides. I think if  
13 it's a formatting issue, we can vote on it and let  
14 experts format it. I think this should come to a  
15 vote today. I don't think we're going to get  
16 more.

17 DR. LEDNAR: Dr. Poland?

18 DR. POLAND: Frank, I think you just  
19 said something to me. I think you implied that  
20 through the ACS that these are vetted through a  
21 professional organization.

22 DR. BUTLER: Through three professional

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1 organizations, the Committee on Trauma, the  
2 National Association of EMTs, and the Prehospital  
3 Trauma Life Support group.

4 DR. POLAND: That I think changes things  
5 considerably. I know that when we attempt to come  
6 up with guidelines at the Advisory Committee on  
7 Immunization Practices for just a vaccine if you  
8 will, we'll spend a half-day hearing the evidence  
9 base in order to vote. I think it's a very  
10 different thing if those guidelines are evidence  
11 based and have been vetted through professional  
12 organizations, in this case multiple ones. I  
13 think it becomes not quite this, but almost a  
14 little bit more pro forma than for us as a Board  
15 to have heard that, to hear from our own expert  
16 Subcommittee that they agree with these vetted  
17 guidelines through professional societies and I  
18 think makes our job and my conscience a little  
19 easier that I don't have to go and review all of  
20 those data before I vote on something like this.

21 DR. LEDNAR: Dr. Kaplan?

22 DR. KAPLAN: Can you interchange the

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1 word "vetted" and endorsed? If they've been  
2 endorsed by those groups, and I have no problem  
3 with it either.

4 DR. POLAND: That's what I meant.

5 DR. KAPLAN: You meant endorsed?

6 DR. POLAND: Endorsed.

7 DR. KAPLAN: Let the minutes show that  
8 you agreed with me.

9 DR. BUTLER: I would add to this already  
10 complex discussion the fact that while the  
11 Executive Committee of the Prehospital Life  
12 Support Group has looked at the chapter that is  
13 going to be included, the new manual is not coming  
14 out until September 2010, but all the chapters are  
15 in and we have the burn chapter.

16 CDR FEEKS: I was looking for the  
17 American College of Surgeons' page. Thank you,  
18 sir.

19 DR. BUTLER: For the prehospital trauma  
20 section, the American College of Surgeons endorses  
21 the guidelines that are developed by the  
22 Prehospital Life Support Executive Council which

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1 is a collaborative effort of the National  
2 Association of EMTs and the Committee on Trauma so  
3 that the entire American College of Surgeons  
4 hasn't see these, the entire Committee on Trauma  
5 has not see them, but the PHTLS group has seen  
6 them.

7 DR. KAPLAN: So the word is endorsed.  
8 Can you say that these guidelines as Greg pointed  
9 out have been not vetted bur endorsed by an august  
10 group like that before?

11 DR. BUTLER: We will be able to say that  
12 in September 2010 when it's published and there's  
13 the actual seal of endorsement from the American  
14 College of Surgeons.

15 DR. KAPLAN: But for all intents and  
16 purposes, it has been endorsed, we're just waiting  
17 for the printing presses to get rolling?

18 DR. BUTLER: That is correct.

19 DR. KAPLAN: If it's been endorsed then  
20 I have no problem with it.

21 DR. LEDNAR: Dr. Parkinson?

22 DR. PARKINSON: This is to my point that

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1        what we have is we have a charter and we have  
2        bylaws, we don't have an OPs manual for the  
3        Defense Health Board and we need to start creating  
4        that yesterday. I know you've got everything else  
5        on your plate Ed, but guidelines approval, how  
6        does it work from the Committees? Obviously the  
7        criteria is that it's important, it's neither  
8        necessary, it may not even be sufficient for it to  
9        be endorsed by an outside. There will be military  
10       unique things where they will not be able to go  
11       perhaps to the Prehospital Committee of the ACS  
12       because they've never seen these types of stuff  
13       from the military. So somewhere there needs to be  
14       for the five or six actions of the DHB which  
15       comprise 90 percent of our work, we need an OPs  
16       manual that is informative to our Committees and  
17       that is informative to our Board members both for  
18       orientation and for preliminary vetting with a  
19       minimal amount of bureaucracy and a minimal amount  
20       of codification so we facility this. This is not  
21       surprising, it's a healthy dialogue, but all the  
22       more reason that the OPs manual build has to

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1 start.

2 DR. LEDNAR: Dr. Shamoo?

3 DR. SHAMOO: Before something we were  
4 discussing on research, and I was going to ask the  
5 leadership is the research portfolio of DOD on  
6 health part of our own prerogative here to discuss  
7 and make decisions? My understanding was yes if I  
8 remember the charter and the bylaws, but if that  
9 is true, then we need to look at the mix of  
10 research rather than keeping those in one thing at  
11 a time and we don't know how this fits.

12 CDR FEEKS: This is a recommending  
13 body to the Secretary of Defense and there is no  
14 reason why it can't make recommendations on areas  
15 of research, but I think your point is well taken  
16 that it should be in the context or it should take  
17 the whole picture into account.

18 DR. LEDNAR: What I've heard is that  
19 there has been a lot of discussion before today by  
20 people who are very close to this issue of trauma  
21 care. It's been very thoroughly evaluated by our  
22 Subcommittee. It's been brought here for us to

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1 understand. I think that Dr. Shamoos raised a good  
2 point, and with Dr. Kaplan I heard a similar  
3 thought that it's a little hard to know what we're  
4 voting on without a little bit more packaging of  
5 the thought, and I expect that for Dr. Butler that  
6 all of this is already there, it's a matter of  
7 perhaps working with the staff to just pull this  
8 together into a document.

9 With that said, I come back to Dr.  
10 Luepker's thought and that is will there really be  
11 any additional value to delay a vote by the Board  
12 on the basis of what we've heard? Do I hear a  
13 motion.

14 DR. SILVA: So moved.

15 DR. SHAMOO: I want to hear what the  
16 motion is.

17 DR. LEDNAR: Can someone propose a  
18 motion? Dr. Silva?

19 DR. SILVA: I propose that we approve  
20 the publication as soon as possible since lives  
21 are on the line of the recommendations related to  
22 tourniquets and also fluid replacement in burn

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1 therapy. Does that help, Dr. Butler?

2 DR. BUTLER: It absolutely does. Thank  
3 you.

4 DR. LEDNAR: Second?

5 SPEAKER: Second.

6 DR. LEDNAR: Is there any discussion?

7 DR. KAPLAN: Yes. A question, now or in  
8 a new format?

9 CDR FEEKS: What's being proposed  
10 is that the new guidelines for treatment of burns  
11 in the battlefield setting by combat medics be  
12 adopted. That's what's being proposed.

13 DR. OXMAN: Now?

14 CDR FEEKS: Yes.

15 DR. OXMAN: Recognizing that with staff  
16 help it'll be put into a format that's a little  
17 more typical than a set of four slides?

18 DR. SHAMOO: I would like to see it in  
19 writing. I'm not going to vote on a set of slides  
20 on an oral discussion that I don't know what it is  
21 going to be. So I'm going to withhold my vote if  
22 I'm going to vote on something I don't know

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1 anything about. I need a document to be  
2 responsible for my vote on it.

3 DR. BUTLER: Can anybody pull down the  
4 TCCC guidelines from the website now? As I said,  
5 there's a 10-page set of guidelines. What we  
6 would do is take the text that's in those slides  
7 and incorporate those into the 10 pages of  
8 guidelines that are already there so that it would  
9 be a cut and paste into a 10-page existing  
10 document, and the document is available on the  
11 internet. Maybe we could get it up on the screen  
12 somehow.

13 DR. LEDNAR: Dr. Parkinson?

14 DR. PARKINSON: If I can propose that  
15 we're all well intentioned here but we're trying  
16 to put 5 pounds into a 2-pound bag here all of a  
17 sudden because we don't have our OPs manual  
18 processes right, and it's more important I think  
19 that we do this right the first time than we  
20 create a sturm and drang, if we could say rapid  
21 cycle, whether that's 24 hours or something, we  
22 know where it is on the website and we can print

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1       it off and put it in an email attachment to the  
2       Board members in an hour. We could give the  
3       Executive Committee the authority absent any  
4       strong objections, but I think Adil's point is  
5       absolutely right. It was there. I didn't know  
6       about it. Frankly, four slides with 10 bullets is  
7       good, but it's an intro. So I'd feel much more  
8       comfortable if we were true to a process and begin  
9       to develop that process using this as our first  
10      time out of the chute. There is no attribution  
11      here. It's just doing it better than we would if  
12      we just approved right now.

13                 DR. LEDNAR: Is there any further  
14      discussion? I'm going to need some help on  
15      Robert's Rules of Order.

16                 DR. SILVA: I'll withdraw the motion.

17                 DR. LEDNAR: So the motion that Dr.  
18      Silva is withdrawn. What I hear as a proposed  
19      path forward is, Dr. Butler, that you with the  
20      help of the staff pull together a document, you  
21      can link or direct us to useful reference  
22      materials, but to build a document then that can

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1 be shared with the Core Board, and the Core Board  
2 commits that we will have a prompt review and vote  
3 on that.

4 DR. BUTLER: I can do that.

5 DR. LEDNAR: Commander Feeks?

6 CDR FEEKS: I was going to say if  
7 it seems new to us, I think that this is a species  
8 of a recommendation and recommendations are what  
9 this Board has always been about. If this is a  
10 new-looking species, it will become more familiar  
11 the next time and the next time, so that that is  
12 one thing. The next thing I would say is you are  
13 not obliged to redo the work of the Subcommittee  
14 because they've already done that for you. That's  
15 all.

16 DR. LEDNAR: I think that's understood.  
17 To Dr. Parkinson's wise counsel to us, we want a  
18 streamlined, efficient, bureaucratically scrubbed  
19 process that we can use because this kind of issue  
20 will come up increasingly in the future. Dr.  
21 Kaplan?

22 DR. KAPLAN: I think what you've said is

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1 fine with me, to see a document. The other thing  
2 I was about to say was that if I get up a leave  
3 it's not because I'm mad, it's because we have to  
4 catch an airplane.

5 DR. LEDNAR: I think one other aspect as  
6 our operations practice is evolving that I would  
7 suggest is that we understand this approach that  
8 the DHB staff work with the briefers who are  
9 coming to the Board as much as possible to present  
10 at that time something that would be easy for us  
11 to vote on so that we don't add the extra step of  
12 leaving the Board meeting and needing to prepare a  
13 document after the fact.

14 DR. BUTLER: When I redo the guidelines  
15 and incorporate these five slides into five lines  
16 in the document, I will highlight those in red and  
17 I'll remind the Board that everything in the  
18 document except for those five lines has been  
19 approved by ASD Health Affairs previously so that  
20 it's not a vote on the entire set of guidelines  
21 because many of what's in there might be new to  
22 you.

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1 DR. LEDNAR: I think we have a plan  
2 going forward. Thank you, Dr. Butler, for this  
3 discussion and presentation, and we look forward  
4 to receiving your document to the Board just as  
5 soon as you're able to do that. I'm going to  
6 suggest that we do one additional brief and then  
7 we're going to break for lunch. I take that back.  
8 With the very wise of our preventive-health  
9 thinking for our health, Commander Feeks says in  
10 fact that the food has been laid out. The time  
11 and temperature considerations suggest that we not  
12 wait another hour before we consume what's there.  
13 So we're going to ask Commander Feeks to give us  
14 instructions and what we're going to do next.

15 CDR FEEKS: It's been a really  
16 full day and we still have some more work to do.  
17 I appreciate everyone's patience. Let's get our  
18 lunch and bring it in here and we'll continue. So  
19 let's resume our work in 15 minutes.

20 (Recess)

21 DR. LEDNAR: I'd ask if we can continue.  
22 Please feel comfortable to eat your lunch. I hope

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1 that's okay with Colonel McPherson. Let me  
2 introduce Colonel McPherson who is our next  
3 speaker. She is currently serving as the  
4 Executive Secretary of the DoD Task Force on the  
5 Prevention of Suicide by Members of the Armed  
6 Forces. Prior to this recent appointment, Colonel  
7 McPherson served as the Chief Financial Officer  
8 for the Air Force Medical Service. There she was  
9 responsible for the execution of \$5.1 billion  
10 annual budget serving 74 military treatment  
11 facilities and 2.6 million beneficiaries  
12 worldwide. Colonel McPherson was the key fiscal  
13 adviser to the Surgeon General, Headquarters AFMS  
14 Staff and the Major Command Medical Staffs on all  
15 Air Force Medical Service policy matters. She had  
16 specific responsibility for financial statement  
17 preparation and audit readiness for AFMS in  
18 support of the Defense Health Program's budget  
19 submissions and prepared the Air Force Surgeon and  
20 Deputy Surgeon General to represent AFMS positions  
21 on financial matters appearing before the Senior  
22 Military Medical Advisory Council, Congress, CSAF

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1 and CKAF. Her presentation slides may be found  
2 under Tab 13 of your meeting binders. Colonel  
3 McPherson?

4 Col MCPHERSON: Thank you. As you  
5 may have recalled from an earlier introduction, I  
6 began work at this job last week. I had my  
7 training on FACA Wednesday and Thursday. I met  
8 General Volpe on Friday. On Tuesday we had our  
9 first Task Force meeting, and since Wednesday  
10 evening I've been with this August group.  
11 Therefore, in my continuing quest to smash 3  
12 months of learning into 10 days, I am providing  
13 you your update this morning on the Suicide  
14 Prevention Task Force. I would ask your  
15 indulgence of my neophyte status. I would rather  
16 not be perceived as the gentleman on the screen.

17 A quick overview. Obviously, the Task  
18 Force membership questions, this will be the  
19 shortest briefing you have today, quick summaries  
20 from the October and November meetings and then  
21 where we're planning on going in the future.

22 Neither General Volpe nor Ms. Carroll

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1 were able to be here today. Ms. Carroll was here  
2 yesterday. She's flying off to Germany this  
3 morning and hopefully one of them will be  
4 available at the next update, otherwise I will be  
5 here with your next quarterly update.

6 The questions to be addressed by the  
7 Task Force are mandated in Section 733 of the 2009  
8 NDAA. They generally fall into three basic  
9 categories, trends, causal factors, effects of  
10 deployments, specialties affected or most affected  
11 by suicides in the military, then education and  
12 preventive programs, what's in place, what's  
13 working, suggestions for ways ahead on those. And  
14 then a plethora of questions related to  
15 investigations and how we do investigations and  
16 how investigations are standardized.

17 In August they had a very quick  
18 organizational meeting where they got their  
19 training and learned about special employees and  
20 regular employees, and their first public meeting  
21 was October 1 and there was a review by each of  
22 the services on the suicide prevention programs

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1 that they do have in place at this time. We also  
2 had information from Army Surveillance and  
3 Research, and of course the Armed Forces Institute  
4 of Pathology.

5 October 8 was a meeting in San Diego in  
6 conjunction with Ms. Bonnie Carroll's program, the  
7 Tragedy Assistance Program for Survivors which was  
8 founded by her in the early 1900s when her husband  
9 was killed in a C-12 airplane crash and has now  
10 taken on a specific focus for survivors of  
11 suicide. There were several briefings provided.  
12 The DODSR report was gone over, the DCoE folks  
13 were out there and then the rest of the day was  
14 spent with families who had lost a loved one to  
15 suicide. Then for several of the Board members  
16 who stayed, the Task Force members stayed and  
17 spent the weekend with a group of 350 family  
18 members who had lost their loved ones to suicide  
19 and experienced what Ms. Carroll's program is  
20 about.

21 November 10, Tuesday, we went had  
22 additional briefings from the DCoE and excellent

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1 briefings by General Sutton, Colleen McGuire and a  
2 superb briefing by Colonel Hoge. I think most of  
3 you are familiar with some his work which was  
4 interesting, CHPPM briefed, and in the Service  
5 panel discussion we had three young ladies who had  
6 both attempted and survived their suicide attempts  
7 talked to us. There were very striking  
8 similarities in their stories which rolled in with  
9 a lot of the information that Ms. Carroll is  
10 discovering in her work with suicide and the  
11 family members of suicide victims.

12 For the future, I think most of you have  
13 heard that General Volpe is moving out to Madigan  
14 Army Medical Center in the February-March  
15 timeframe. He will still continue to be a  
16 Co-Chair of the Task Force. We are though going  
17 to accelerate a lot of things prior to his  
18 departure. The game plan right now is there is a  
19 prep session just to get organized since I just  
20 came on board and look at our way ahead, do we  
21 want Subcommittees, what's our travel schedule  
22 going to be, what is the schedule working backward

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1 from August when our report is due to Congress,  
2 what else are we going to do and how are we going  
3 to run the Subcommittee. Then December 15 our  
4 focus is on the large number of questions related  
5 to investigations and how we investigate. Then in  
6 January there is also the DOD/VA Joint Conference  
7 on Suicide Prevention which rolls immediately into  
8 the next Task Force meeting. Pending your  
9 questions, that is the extent of the comments I  
10 was prepared to make today.

11 DR. LEDNAR: Colonel McPherson, you have  
12 in your usual way jumped right into the saddle and  
13 are galloping off on this. We are impressed by  
14 how much you've done in the last 2 weeks.

15 A thought for you. The meeting on  
16 December 15 is called to my mind. That's the  
17 thought of root cause understanding, and obviously  
18 one way to look at suicide attempts is it's a  
19 tremendously significant plea for help in someone  
20 who's feeling overwhelmed and without other  
21 options. The thought I'm having is not to  
22 overmedicalize this issue in how we go at it or

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1       how we would propose solutions. In some ways this  
2       issue of suicide may reflect how Service members  
3       are able or not to live and operate in the culture  
4       with the demands of being in the military these  
5       days, whether it's OPs tempo or other things. An  
6       analogous message from the civilian setting that  
7       we try to reinforce is that the health and safety  
8       of the work group is the responsibility of the  
9       line commander. We in the medical field advise,  
10      offer counsel, engage resources, but the  
11      responsibility for the health and well-being of  
12      the service members rests with the line. To the  
13      extent that they're not only involved but  
14      understanding what are all the levers that are  
15      involved in what could be this outcome of suicide  
16      beyond the medical, that I think will be very  
17      important to having a solution which is both  
18      sustainable and effective.

19                    Are there other questions or comments?

20      Dr. Silva?

21                    DR. SILVA: Thank you for assuming this  
22      important post. I think everyone knows here knows

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1 that suicide in the military is a big issue for  
2 the country. It's really touched all of our  
3 citizens. Have the rates gone up or down -- I  
4 know you're new to the post -- versus in the field  
5 versus in the United States on return from a  
6 mission?

7 Col MCPHERSON: The overall rate for  
8 the Army has just now matched the civilian rate of  
9 about 20 per 100,000. From the information I've  
10 briefly reviewed, we are seeing more of them at  
11 home than we are seeing in the field. The  
12 briefings from the first one reviewing the minutes  
13 were very clear that every single one of the  
14 Services briefed at that time that were not seeing  
15 a correlation with number or length of deployments  
16 with the suicide. I've learned a new term which  
17 is the confounding of data. Because so many of  
18 them are Reservists and Guards and once they move  
19 out we are not tracking to find out if they then  
20 later on commit suicide, so that's one of the  
21 things that we'll be looking at. There does not  
22 seem to be any tracking once you've departed

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1 active Service, but right now the data that we saw  
2 shows that there is not a correlation to number of  
3 deployments and that are much more still happening  
4 at home versus in the field.

5 MR. MIDDLETON: Dr. Silva, one of the  
6 things that might help as well is that as Colonel  
7 McPherson said, in the Guard and Reserve because  
8 of the vagaries with which some of these are  
9 reported by local coroners, there's not a really  
10 good tracking system for the Reserve and Guard to  
11 determine exactly if there is a correlation of a  
12 deployment and an actual suicide versus something  
13 that's reported as a different cause of death, and  
14 it's one of the confounders that we have in the  
15 Department and it's one of the things that I know  
16 the Task Force is going to wrestle with. We  
17 talked the Assistant Secretary of Reserve Affairs  
18 office about the same issue so that we will have  
19 an understanding on the reserve and guard side.  
20 The actives are a little clearer numbers, but on  
21 the Guard and Reserve side it's really a problem.

22 DR. SILVA: At U.C. Davis School of

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1 Medicine in the last 3 years we've had two  
2 suicides in men and all have had Iraqi experience.  
3 I don't know how to get my arms around that  
4 problem. I know the AAMC is worried about it, but  
5 that's only one cohort of people in the military  
6 who train. Maybe the Dean at USHUS could talk to  
7 the people in the AAMC about accumulating data  
8 because I hear about it grapevine and I haven't  
9 had time to confirm it, but a nearby school has  
10 had a similar experience with veterans returning.

11 MR. MIDDLETON: I'll pass that to  
12 Colonel McPherson. Maybe that's one of the  
13 considerations she could use with the Task Force  
14 to talk to Dr. Rice over at the university.

15 DR. HALPERIN: Again recognizing that  
16 you're new to the job, I see that Colonel Hoge  
17 has briefed your Panel, but are there  
18 epidemiologists and public health people on the  
19 panel?

20 Col MCPHERSON: Sir, I don't believe  
21 so. I'd have to go back. Their names are listed  
22 and I have their biographies. They're with me in

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1 a briefcase. I could take a quick look.

2 DR. HALPERIN: It's my obtuse way of  
3 making a suggestion that there ought to be.

4 Col MCPHERSON: Congress determined  
5 who was to be on the Task Force.

6 DR. HALPERIN: That's a problem. There  
7 might be a way to staff the Panel with some  
8 consultant public health -- then the next question  
9 I want to ask you again not expecting that you  
10 would know with being there for 5 working days.  
11 Is there a liaison between this Panel and the  
12 Millennium Cohort?

13 Col MCPHERSON: Not specifically,  
14 but we have learned about them and right now my  
15 Booz Allen staff is making contact with them  
16 because that became very apparent all through the  
17 briefings on Tuesday that we need to be talking to  
18 those folks out there. It's going to be very  
19 interesting to see what they come up. That's  
20 going to be an incredible source of information.

21 DR. LEDNAR: Dr. Shamoo?

22 DR. SHAMOO: I have extensive experience

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1 with the National Alliance for the Mentally Ill.  
2 I used to be on their board of directors as a  
3 matter of fact. They are very familiar and they  
4 deal with issues. They are the largest  
5 organization with issues of suicide. They have a  
6 committee on military personnel, issues of mental  
7 illness and suicide. So I would suggest if they  
8 could help you as well knock on the door  
9 and see if they could be helpful.

10 DR. LEDNAR: Are there any other  
11 comments for Colonel McPherson?

12 DR. COHOON: Barbara Cohoon of the  
13 National Military Family Association. I know  
14 you're chartered by Congress, but I think it would  
15 be very interesting to know as far as the impact  
16 on the family member and family members of those  
17 who were left behind especially since Bonnie  
18 Carroll is looking at that particular piece. We  
19 do hear that they are left with a lot of issues.

20 Also to you in looking at suicide as far  
21 as the family and are we looking at children or  
22 adolescents or the spouse themselves because of

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1 the frequent deployments? We are not really doing  
2 a very good job of tracking of that. I know that  
3 in the NDAA that just passed they're going to be  
4 looking at the impact of the war on children, but  
5 since you're looking at suicide, I think it would  
6 be important to know how many suicides we've seen  
7 within family members because of the frequently  
8 deployments.

9 DR. LEDNAR: Are there any other  
10 comments? Colonel McPherson, we look forward to  
11 work that your Task Force is doing and hearing  
12 updates, and obviously if there is any way that  
13 the Board can help connect resources within the  
14 board to the work of your Task Force, we are  
15 certainly eager to do that.

16 Col MCPHERSON: Thank you.

17 DR. LEDNAR: Thank you. Our next agenda  
18 item is a presentation by Commander Jim Hancock.  
19 Commander Hancock was deployed as the Joint Task  
20 Force Surgeon for multiple missions in support of  
21 Naval Special Warfare. Commander Hancock and his  
22 team developed and deployed the new concept of

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1 operations for resuscitative surgery aboard small  
2 combatant ships engaged in distributive operations  
3 which serve as the prototype for today's  
4 expeditionary resuscitative surgical system. In  
5 spring 2008, Commander Hancock deployed as Task  
6 Force Surgeon with the 2nd Battalion, 7th Marines,  
7 in support of Operation Enduring Freedom. Faced  
8 with extended casualty evacuations, Commander  
9 Hancock developed and deployed the Tactical Trauma  
10 Team concept with mobile trauma bays providing  
11 advanced resuscitative trauma far forward in  
12 support of expanded company operations. In  
13 February of this year, Commander Hancock was  
14 selected as the Navy and Marine Corps  
15 representative on the Chairman, Joint Chiefs of  
16 Staff's Grey Team which is tasked to evaluate and  
17 advise the Chairman on all facets of traumatic  
18 brain injury treatment. Subsequently, he deployed  
19 back to Iraq and Afghanistan in efforts to  
20 optimize the treatment of traumatic brain injury.  
21 Commander Hancock currently serves as Director,  
22 Medical Services, Naval Hospital, Camp Lejeune,

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1 and serves on the Navy's Trauma Advisory Council.  
2 His personal decorations include the Legion of  
3 Merit, Purple Heart, Meritorious Service Medal,  
4 Two Awards, Joint Meritorious Medal, Navy and  
5 Marine Corps Commendation Medal, Two Awards, and  
6 Navy and Marine Corps Achievement Medal, Three  
7 Awards. Commander Hancock, we appreciate your  
8 traveling up from Camp Lejeune to share your  
9 experiences with us.

10 CDR HANCOCK: That was a whole,  
11 big discussion to say that you have a simple  
12 emergency physician standing in front of you, and  
13 what I hope to do today is bring you the story of  
14 what your work is doing so as you go on these long  
15 days and you eat your meal as you go, why are you  
16 doing it? I hope to bring that to you today. So  
17 we'll talk a little bit about what's going on in  
18 Afghanistan and why it's different than what we  
19 saw in Iraq, why it's different than what I saw in  
20 Kosovo, why it's been different than other way  
21 that we've had. We'll talk a little bit about  
22 NATO because this board has to be cognizant of the

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1 fact that we work well within ourselves, but what  
2 happens when we go outside ourselves. Then we'll  
3 talk a little bit about my passion which is  
4 adaptive resuscitative medical efforts and combat  
5 training for medical assets and why that's  
6 important, and why the Board should understand  
7 what that means.

8 What you normally have sitting here at  
9 your Board is a 20,000 foot view. You really look  
10 from the very stratosphere to try to make these  
11 strategic decisions. What I hope to do is bring  
12 you to ground zero.

13 Ground zero in Afghanistan for me in  
14 March 2008 was the fact that I was supposed to  
15 deploy on a mission that involved the training and  
16 mentoring of Afghan police. We as a battalion  
17 were supposed to go through and replace Army unit  
18 and establish FOBs and replace them. The reality  
19 is as you may remember from the news that in 2008  
20 the Taliban didn't want to play our game. They  
21 changed the table. The reality was that General  
22 Cohen said to us, "Marines have to be Marines. I

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1       want you to go be Marines." What did that  
2       involve? That involved the nonsequential taking  
3       over, the simultaneously taking over of 10 FOBs  
4       over 11,000 square miles. So my AOR was to  
5       provide trauma support to the State of New  
6       Hampshire with a single shock trauma platoon which  
7       is 20 people, an emergency physician and a family  
8       physician, and our indigenous assets. That's why  
9       when Dr. Butler talked to you about having to have  
10      that pretraining why it's so important.

11               The reality is that that mission  
12      statement often goes unnoticed, that little red  
13      part there, the counterinsurgency operation,  
14      because we in the Marine Corps do not deploy  
15      without a special MAGFT. What does mean to you?  
16      It means that we don't normally deploy without our  
17      own support and logistics support, but this was  
18      supposed to be a training mission and it turned  
19      into something quite different.

20               The reality was that our AOR was 11,000  
21      square miles. When you compare that to what  
22      happened in Iraq, it was significantly different.

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1       What you see outlined is our AOR for each company  
2       versus what we had the year before in Iraq. The  
3       reality of Iraq is that we were very successful.  
4       We took a trauma support system and we made it the  
5       model that you saw attributed there. In fact, if  
6       you had -- in Iraq in those years, you probably  
7       could get it analyzed before it defused by  
8       helicopter. In other words, we had acute trauma  
9       support available.

10               That was very different than in  
11       Afghanistan. In Afghanistan, time and distance  
12       was of the essence. In Afghanistan, you had a  
13       population that was strung out. The Chairman  
14       likes to say that we are rebuilding in Iraq and  
15       we're building in Afghanistan. It is very  
16       different. You're talking about a population that  
17       has a life expectancy of 42 years of age, a  
18       population that understands and appreciates that  
19       one-third of their women will die in childbirth.  
20       One-third of their children will die before the  
21       age of 6 of disease or injury. It's a reality of  
22       their world. You're talking about a population

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1 who has been fighting since the beginning of time.

2           It's not built up at all. The reality  
3 is that there is one single road in all of  
4 Afghanistan. That road is called the Ring Road.  
5 It has the dubious distinction of being the most  
6 mined road in all of the world. Why is it  
7 important? It's important because as we try to  
8 provide medical care, as you make your decisions  
9 to provide medical care across the DoD, the  
10 reality is that there are times when our enemies  
11 understand it better than we do.

12           On a normal mission to a FOB, this was  
13 our mission, just trying to go visit the FOB to  
14 understand what was going on, what can happen to  
15 you on a daily basis?

16                           (Video played)

17           CDR HANCOCK: IED; one dead  
18 immediately. Both of my gunners were shot. Now  
19 come the RPGs. Understand this was not a combat  
20 mission. This was a mission for the resupply of  
21 medical assets to the FOB. This had nothing to do  
22 with combat. Understand that this was done at

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1       about 10,000 feet. Understand that you're on a  
2       mountainside. Ladies and gentlemen, I will submit  
3       to you that if we can provide trauma care at this  
4       edge, that we can provide trauma anywhere in the  
5       world in any conflict at any time.

6       The reality was that in his atmosphere that was  
7       brutal, in this atmosphere that I saw 140 degrees in  
8       July, minus 40 in February all in the same place, in  
9       an atmosphere where you've had a drought for 10 years,  
10      in an atmosphere when you have 120 days of wind in  
11      Southern Helmand Province. What does that cause?  
12      What you see here is a brownout. We had great  
13      resuscitative capability planned for that day until  
14      the brownout came and we lost of our helicopters  
15      because we couldn't fly in it. This stuff will get  
16      into everything. This sand is so fine that it is like  
17      confectioner's sugar.

18      The reality is that the Afghan people are affable,  
19      they're hard working, and most of them, at least the  
20      educated ones which is 98 percent of the population,  
21      they just want this war to be over. The reality is  
22      that in their culture they grow poppies like we grow

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1 corn. This is the village center. They're not trying  
2 to hide their poppies. It's not like growing  
3 marijuana in California. This is their culture and  
4 this is what they provide. The reality is that  
5 anywhere you find water in Afghanistan and green,  
6 that's where you're going to find families. You're  
7 going to find culture. The reality is that they live  
8 in these mud huts, and you wonder why disease and  
9 famine is there. The fact is that they live with  
10 their pets, they live with their livestock, they live  
11 in their culture without any heat, any running water  
12 or anything that goes with that.

13 The reality is that no matter where you look in  
14 Afghanistan you're going to see the ravages of war.  
15 These people have been fighting since the beginning of  
16 time. Several distinctive attempts have been made to  
17 occupy this country, whether it's the castle of  
18 Alexander the Great, or the modern warfare of you see  
19 with the Russians in the 1980s when they failed to  
20 succeed and take over this country.

21 The reality is that this harsh environment breeds  
22 things that you'd never imagine, whether it's the

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1 neurotoxic elaphids of the snakes that we currently  
2 don't have good antivenom for, all the way to the  
3 dogs. The Afghan people and Michael Vick have a lot  
4 in common. They enjoy dog fighting. It is part of  
5 their culture. This is Cujo. Cujo lived outside our  
6 FOB. He weighed about 180 pounds. It was interesting  
7 though, because every day we had a combat day, you  
8 could hear the dogs howling. Why was that? Because  
9 it was not unusual to drive out of the FOB and see  
10 Cujo feasting on human remains. That's how he  
11 survived.

12 All the way to the scorpions. I've been by scorpions  
13 in the deserts of Iraq. It hurt, it stung, it was  
14 bad. When I was stung by a scorpion in the fields of  
15 Afghanistan, what I can tell you is it felt like a  
16 ball bat. Furthermore, we've had 20 isolated cases of  
17 abdominal compartment syndrome without pancreatitis  
18 from this little bugger. We can't explain it, but  
19 it's there.

20 NATO medicine. I would ask you to close your eyes and  
21 think back to the "Star Wars" movie to the bar scene,  
22 and what you would see is NATO medicine. Why is that?

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1 Because you're going to see different uniforms,  
2 different languages, different ways of doing  
3 everything. All of them are right in some contexts.  
4 In some context to some degree all of them are right,  
5 but it's different.  
6 The reality is to understand NATO you have to  
7 understand the language. What is the language  
8 difference? We talk about levels within the U.S.  
9 construct about levels of care and how we provide  
10 that. The difference between levels of goals is  
11 because it's a financial difference (inaudible) it is  
12 a modern hospital. It has brick and mortar. It is  
13 funded by the British government absolutely. It has  
14 laboratory capabilities. It has X-ray capabilities  
15 that is portable and digital so that they can be read  
16 remotely. It has modern trauma bays or a trauma  
17 system -- wherever you go. But again, the funding  
18 for this comes from the British government. What is  
19 the problem with this hospital? Why am I bringing it  
20 to your attention? The problem is (inaudible) you saw  
21 was that there were five different countries' gears.  
22 Why is it a problem? It's not a problem until you try

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1 to provide power to it, you try to provide an adapter  
2 to it, you hook an oxygen supply up, it becomes a  
3 difference.  
4 This was prophetic. I dropped off some casualties at  
5 this Kandahar Role 3 and I got this picture here and  
6 it tells the story. What does it tell the story of?  
7 It tells us that there are different countries that  
8 take different care of their stretchers. Some clean  
9 them, some don't. What you really should see in this  
10 slide is that there are only two of those stretchers  
11 that will fit in my MRAPs, that will fit in my  
12 helicopters. That's the big issue.  
13 Then when you talk about purple, you hear purple, your  
14 tri-service, your DoD. We in the military have  
15 problems with that at times. I'm a Naval Academy  
16 graduate and I'm a USUHS graduate. I have a lot of  
17 reasons to hate the Army. So every time I've worked  
18 with them I've felt like there was a service issue, so  
19 we did our very best. In March 2008 up in Kulat and  
20 Zabul Provinces, the Army was doing one heck of a job.  
21 Unfortunately, they were taking massive casualties.  
22 When they were taking those casualties, they were

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1 having to over fly the FST, the forward surgical team.  
2 The reason they were having to do that is because they  
3 had no holding capability there. I had a shock trauma  
4 platoon that wasn't currently engaged. It only made  
5 common sense to put me there, provide them a triage  
6 capability and provide them a holding capability. I  
7 knew what I was going to do and my boss said go do it,  
8 get it done. Being a planner, I thought to myself I  
9 came up with about 4 hours of my life that I'll never  
10 get planning on how I was going to deal with the Army,  
11 how I wasn't going to end up with a price tag at the  
12 end of the day. That all went out the door when we  
13 landed because there were six dead bodies laying next  
14 to the LX and there were five they were working on  
15 inside. Ladies and gentlemen, we dropped our bags and  
16 we went to work. For 2 weeks we worked tirelessly and  
17 we worked seamlessly. We can do this. What you're  
18 doing works. It's just a matter of making it happen.  
19 And we do have an Air Force hospital. It is  
20 everything you would expect from the Air Force except  
21 for the golf course. Here you have a brick-and-mortar  
22 structure. In fact, it is very well staffed and very

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1 well thought out. The reality of the limitations of  
2 this hospital is the fact that it is covered up in  
3 Afghan nationals because we have no place to take  
4 them. If they are hurt in the ravages of the war we  
5 want to take care of them. This comes to the ethical  
6 question, what do we do with them at that point?  
7 It doesn't take you long in Afghanistan to understand  
8 that time and distance is the mode of all evil. If  
9 you have a severely injured patient in Afghanistan and  
10 you try to do a ground support, two things are going  
11 to happen. Your patient is going to die because of  
12 the length required, and you're going to blow up.  
13 It's not if. It's you're going to. So it becomes a  
14 necessity to fly most casualty evacuations. We have a  
15 premise about the Golden Hour which I'll get into, but  
16 if you look at those time distances, and those are  
17 one-ways which is the reality of 2008. This has been  
18 corrected and it is very much more robust at this  
19 point, but it is a problem.  
20 The reality of IEDs is that if you take August 2007  
21 and look at the number of IED injuries in Afghanistan  
22 and you compare it to August 2008, they went up

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1 sixteenfold. I don't have the numbers for this year,  
2 but I know they went up. The reality of an IED attack  
3 is that it's an asymmetric attack. It is the chosen  
4 limiting factor of our opponent and the reality is  
5 that we're going to get three surgical patients from  
6 that single IED attack. Armed with this information  
7 and the information that no matter what you think of  
8 when you close your eyes and you think of trauma, you  
9 think it's trauma, it's going to personnel and  
10 equipment intensive in order to do it right.  
11 I knew that going into this. I knew that I was going  
12 to get these three victims at least from an IED  
13 attack. I was familiar with Dr. Cowley's on the  
14 Golden Hour. The unfortunate part about the Golden  
15 Hour is it has been used as a moniker versus reality.  
16 The reality is that a trauma patient is a continuum.  
17 When you treat a trauma patient, they may not have an  
18 hour, they have minutes and we'll talk a little bit  
19 about that.  
20 The reality in combat is that 75 percent of people who  
21 die in combat, die almost immediately and there's  
22 almost nothing I can do. If I wound you in an

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1 operating room, if I shoot you through the head, there  
2 is not anything I can do to repair that. It's the  
3 other 25 percent that we're concerned about. Of that  
4 25 percent, there's about an 8 percent that I know me  
5 as an emergency physician cannot correct without a  
6 surgeon. But that leaves me 18 percent that I could,  
7 and I was put in a situation where my surgeons were  
8 going to be 2, 3 to 4 hours away at the time and we  
9 were trying to battle that. My first reality was that  
10 I had to take first of that first  
11 minutes, the Platinum 10 Minutes, if you will,  
12 catastrophic hemorrhage control, airway, tension  
13 pneumothorax. So I came up with a system to try to  
14 get my medical assets within 10 minutes of the line.  
15 My first reality was that we didn't have particular  
16 CASEVAC vehicles. We had the CAT2 MRAPs and I was  
17 very happy when the supply officer came to me and he  
18 said, "I have your ambulance package for the Cat 2  
19 MRAPs." I looked at him askance. I'm looking behind  
20 for a truck and he's carrying a box. In reality, back  
21 here in the States to somebody this made sense. This  
22 made sense to be able to turn that MRAP into an

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1 ambulance, that you would take the stanchions that you  
2 see and be able to put them up. The reality is, does  
3 anybody believe that you could provide trauma care in  
4 that space? No, you could not. We have fixed that.  
5 We have developed an ambulance version of this that is  
6 currently deployed in Afghanistan and Iraq that works  
7 very, very well.

8 My next reality was that I'm a Navy doctor. I go with  
9 the Marine Corps. We provide ourselves in  
10 resuscitative medicine. We put our tents and we go  
11 down range and we do it and we it fast, we drill to  
12 the point we need to be able to get it up in an hour  
13 to provide that surgical care. The Taliban did not  
14 like my tents. They shot in 107 rockets and they  
15 burnt me to the ground. I'm not an overly bright guy,  
16 but that was an experience that I wanted to live  
17 through again.

18 The reality was that if I were going to treat these  
19 victims in that first 10 minutes and I had to be  
20 provide that care and I had to be able to provide  
21 stabilization for that 2 to 3 hours that I know I was  
22 going to, I had to come up with a different system.

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1 That system was what's called a tactical trauma team  
2 because I had a paucity of assets so I had to be able  
3 to move that out. What was my least-common  
4 denominator to provide effective combat care? In my  
5 reality that was half of a shock trauma platoon. That  
6 was an ER physician, an ER critical-care nurse, a PA  
7 or an IDC and some highly trained corpsmen. How I was  
8 going to do that was I took a CONEX box off of a  
9 ton. I hooked up an air conditioning system to it. I  
10 gave it a generator. We traded 3 pounds of good  
11 American Starbucks coffee and got some welding done  
12 and we put up some stanchions. Why was this  
13 capability important? It was important because I had  
14 to be able to get to that first  
15 minutes, but I had to do it safely. We lined this  
16 with Kevlar blankets and off we went.  
17 The reality was that I could go with the Marines where  
18 they were going. I could set up immediately. I could  
19 treat that first trauma care immediately up on there,  
20 and I could do it safely in an austere environment.  
21 Why is that important? It's important because what  
22 you see there in the yellow dot is the first times the

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1 Marines have fixed bayonets since World War II and  
2 went to hand-to-hand combat and we're 300 yards away.  
3 Why was that important? That was important because  
4 this village was in the middle of an IED field. There  
5 was no way in and no way out. I had to provide it to  
6 the point of care. I was tucked behind a big wall to  
7 provide that care, but I was within 300 yards of the  
8 fight. The reality was it took about 2 seconds for me  
9 to get my first patient. My first patient was shot  
10 through the buttocks. He was awake, he was happy, he  
11 said, "Doc, this is going to be a bar story. Let me  
12 tell you where I was shot," and off we went. But the  
13 reality was that he was hurt a lot more gravely than  
14 he thought he was. In essence, the bullet had tumbled  
15 off of his acetabulum and it ended up in his liver and  
16 I was able to tell that because I was able to do that  
17 testing at the point of contact. That changed that  
18 young man's care drastically.  
19 The reality was that I was taking very young men with  
20 minimal training, 8 to 16 weeks of training, and  
21 putting them in a combat environment of a full trauma  
22 center. This is why TCCC is so important. This is

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1 why we have to get it right. The reality was that  
2 we're going to take care of these gravely injured  
3 patients. These are patients with trauma scores  
4 greater than 16. That doesn't mean anything to you.  
5 What it means is they should die. They should not  
6 survive their injuries. The reality means that we  
7 have to provide clinical essence of what to do. Do I  
8 put an airway in this guy or do I hold on to what I've  
9 got because he's maintaining his airway and I have to  
10 hypotensively resuscitate him because he's going to be  
11 prolonged from surgical care which was the right  
12 answer. But me as a trauma physician for 15 years, it  
13 took everything I had not to intubate this guy before  
14 I put him on a plane. The reality was is that what I  
15 had was a system that we had to be able to provide  
16 that up-close care. The reality was when I got an  
17 injury we would roll in an MRAP. That was the  
18 best-protected vehicle that I had. I would provide  
19 care as we moved all the way back to the mobile trauma  
20 bay that was within that 10 to 15 minutes. We would  
21 be able to provide that trauma support right from the  
22 point of injury out. When we got to the mobile trauma

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1 bay, that was in a safe location that was protected  
2 that allowed me to provide that continued emergent ICE  
3 resuscitative care at the point of contact.  
4 Case in point. This is Corporal Nickels. Corporal  
5 Nickels was shot on August 8 of last year. He was  
6 shot from zone 1 to zone 3 of his neck. It went into  
7 the base of his neck and came out the opposite side in  
8 his jaw. His trachea was severed, and I got to him  
9 within 2 minutes. In there we were able to use  
10 cutting-edge resuscitative care to provide a way of  
11 providing a tourniquet, if you will, i.e., an  
12 endotracheal tube, which was placed between the two  
13 ends of his trachea. How was that done? That was  
14 done because I had a video laryngoscope. I had a  
15 video laryngoscope that had just come out. It came  
16 out in March 2008. I saw it at a trade show. I  
17 called the owner of the company at home and said, sir,  
18 I want to buy one of these before I go to Afghanistan.  
19 I think it might be important. Let me write you a  
20 check and pick one up. He said, "Doc, God bless you.  
21 I'm a retired Marine. I'll meet you in the parking  
22 lot at Twenty-nine Palms in 10 minutes and I'm going to

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1 give you one," and he did, and it provided that care.  
2 Our system has to allow for resuscitative care to stay  
3 at the pointy end of the spear in advances.  
4 Corporal Nickels had a good outcome. We got him  
5 splinted him and we got him stabilized, and 3 hours  
6 later we were able to get him out in a helicopter.  
7 Within 48 hours, our system has advanced so much that  
8 he was back here at Bethesda and he got amazing care.  
9 He got care that was so good that he was able to  
10 speak, walk and talk, in fact, he did it well enough  
11 to start dating a Redskins cheerleader. It wasn't  
12 until Colonel North came to the FOB at Nalzac that I  
13 realized what we were in. This was my fifth combat  
14 tour, but I still didn't have a good appreciation for  
15 the 8-1/2 months we took fire every day. I was  
16 sitting there and a 107 rocket came over and exploded  
17 and it was nowhere near us, and Colonel North and  
18 looked at me and he said, "Doc, you know I was Cason,  
19 Vietnam. I was awarded the Silver Star and a Bronze  
20 Star. It was a horrible place." I said, yes, sir,  
21 I've read your book. Another one comes in and it  
22 lands and he says, "Doc, I was at Fallujah. For 11 it

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1 was living hell." I said, yes, sir, I lived through  
2 it. Another one came in and he said, "Doc, I've never  
3 seen a place like this." That put it into reality,  
4 ladies and gentlemen, about what we're doing in  
5 Afghanistan.  
6 Adaptive resuscitative medical efforts. When you look  
7 at what my jalopy was, and that's what they called it,  
8 they called it, and Oopty was the call sign for my  
9 mobile trauma bay. I took offense but I understood  
10 it. There had to be a better way. The reality was  
11 that before I left country we drew up plans and we  
12 provided a more armored capability. This was an  
13 armored personnel carrier that we put a top on and  
14 provided resuscitative care. It was better. But it  
15 wasn't good enough. I came back and I briefed the  
16 Commandant of the Marine Corps on this asset. I  
17 briefed and Admiral and the Joints Chiefs of Staff.  
18 Ladies and gentlemen, your DoD in 4 months' timeframe  
19 from the time I gave the brief, this was produced in 4  
20 months from start to finish. This I would submit to  
21 you is the most-advanced resuscitative care that is  
22 out there. This has everything that a trauma bay of

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1 modern-day 2009 can provide at the point of impact.  
2 In fact, on August 31 it went to combat and has done  
3 remarkably well. We have nine of these currently in  
4 combat. I would submit to you and submit to this  
5 board that if we can do it in 4 months for this, we  
6 can do a lot of things on this fast track that you  
7 discussed today so eloquently.  
8 The reality is that our combat training, whether it's  
9 TCCC, whether it's getting that effort of  
10 understanding what our people are seeing in what  
11 environment. Ladies and gentlemen, I had two  
12 confirmed kills protecting my patient the first month  
13 I was in Afghanistan in 2008. I'm not proud of that  
14 fact, but it's the reality of what we do. It has to  
15 be. We have to understand our training processes to  
16 the point that we cannot put our ladies and gentlemen  
17 that we train in harm's way where they're using their  
18 heart and not their head. It has to be engrained.  
19 That culture has to change. Case in point. On June  
20 23, I had 23 major casualties that I took care of that  
21 day. Unfortunately, I lost two of my corpsmen that  
22 day. The reason I lost my second corpsman was because

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1 I trained him for 2 years, I taught him better, but  
2 his heart took over. We had trained him that when he  
3 hears "call corpsman up" that he runs to the  
4 battlefield and he takes care of his buddy who is  
5 down. He takes care of the quad amputee Marine who  
6 was laying on the ground next to him. But  
7 unfortunately, a bomb blast blows up behind him as  
8 you'll see here and he loses situational awareness and  
9 goes around the sweeper that was leading him to his  
10 patients. This is very hard to watch. (Video  
11 played.) -- believes that this is important because he  
12 doesn't want this to happen to anybody else. He sees  
13 his patient. He's trying to get there. He's doing  
14 what he's supposed to do, staying behind the sweeper  
15 taking sniper fire. He's moving forward until they  
16 start screaming "corpsman up" and he takes off to go  
17 see the patient. He lost his legs. The guy behind  
18 him lost his life. It's not pretty to see, but it's  
19 the reality of the decisions you make a day-to-day  
20 basis are so important to us.  
21 I was appointed to the Grey Team which went in and  
22 looked at traumatic brain injury. It has been called

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1 the sentinel illness of his war. I'm the fat guy that  
2 got blown up and sustained a traumatic brain injury  
3 which is why folks like to hear my viewpoint on  
4 it. Folks, I will tell you that being blown up, I was  
5 a college football player, I was concussed. When I  
6 got blown up it is a very different event. It is a  
7 very different event. I can tell you that 95 percent  
8 of the patients that I treated in country were for  
9 traumatic brain injury are straight shooters. They  
10 understand exactly what happened to them, it was  
11 witnessed, they have a particular set of symptoms.  
12 Everybody wants to get up tight about the other 5  
13 percent because there are two sets of liars. The  
14 first set, about half of that 5 percent, is my First  
15 Sergeant who comes back with his 1st Lieutenant and he  
16 helped me put him in the body bag. He had been blown  
17 up and then the sniper had taken him down. The  
18 corpsman who was with him said, "Doc, the First  
19 Sergeant was out for about 5 to 8 minutes. He's been  
20 blowing chow. He can barely walk, but he's starting  
21 to clear and I think he's going to be good to go."  
22 The First Sergeant looked me dead in the eye and said,

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1 "Doc, I was not knocked out. I'm fine. I'm going to  
2 go kill the guy who killed my lieutenant." I want 100  
3 of him. I love that man. He's a hero. But I had to  
4 protect him from him. The other 2 percent are the  
5 ones who people want to talk about. They want to talk  
6 about the Lance Corporal who was sitting in a truck 50  
7 yards from a blast, I had five corpsmen between him  
8 and the blast, and he says, "I got knocked out."  
9 Folks, I don't care about him. I care very much about  
10 his medical care, but I don't care about figuring who  
11 he is. Let's just take care of him and move on. He's  
12 served his country. Let's just take care of him, move  
13 on and not get into what happened to him there because  
14 I can't explain it.  
15 What can I explain about traumatic brain injury? I  
16 can explain that our education levels have to go up.  
17 We found that across the FOBs. We have to be able to  
18 get away much like TCCC, much like a panel like this  
19 endorsing those guidelines, to get them out there, and  
20 get them out there with authority, so that that  
21 education process has to happen. The next thing is we  
22 have to symmetry. You're right, sir, whoever

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1 mentioned that earlier. The symmetry has to be there.  
2 I can tell you that DARPA is lit up on it, the Joint  
3 Chiefs of Staff, right from Admiral Mullens's mouth,  
4 this will happen and it will happen in the next 6  
5 months. What was that mean though? Then we have to  
6 figure out what the diagnosis is because quite frankly  
7 we don't understand the disease, so we're getting  
8 there. We have our best and we have our brightest,  
9 guys like Colonel Macedonia or Colonel Jaffe, they're  
10 all in it and they're in it heads up, Brigadier  
11 General Sutton. Then we have to figure out the  
12 treatment process, what do we do, when do we do it?  
13 Do we hypo resuscitate this particular population?  
14 What happens when it's cold? What happens when we're  
15 at 10,000 feet? Those are all things that we have to  
16 answer. A Board like this can govern what that  
17 research is going to look like not only ethically but  
18 finance it.  
19 Ladies and gentlemen, I would submit to you that no  
20 matter what we do, when you go to combat it's going to  
21 have a cost. It's going to have a cost whether you  
22 have post-traumatic stress disorder, you come home

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1 without your legs or you come home with problems from  
2 a traumatic brain injury. Somebody's going to pay the  
3 cost. Nobody ever comes back from a conflict the way  
4 they left. It's just a reality. But when it's the  
5 deepest, darkest day in D.C. And you're up into this  
6 quagmire of what you do on a day- to-day basis and you  
7 think I got to go through one more brief, what I would  
8 ask you is to remember this, these gentleman on June  
9 23 are fighting for their lives and through your  
10 efforts I stand humbly before you and submit that I  
11 think what your work does is these same two gentlemen  
12 on January 17 in Las Vegas standing on prostheses  
13 alive and well.

14 Thank you. I appreciate the honor of the podium. I  
15 hope it was instructional. I will take any questions  
16 you might have.

17 DR. LEDNAR: Commander Hancock, thank  
18 you very much for the presentation, the heroism  
19 and innovation that you bring to our Marines and  
20 to our soldiers in the field. We really stand in  
21 awe of you. Thank you. Are there any questions  
22 or comments for Commander Hancock?

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1                   CDR HANCOCK: Thank you. I know  
2                   it's late. I appreciate your attention.

3                   DR. LEDNAR: Thank you, Commander  
4                   Hancock. Our last agenda item, we appreciate Dr.  
5                   Scoville being patient with us. Dr. Charles  
6                   Scoville is a retired colonel and Chief, Amputee  
7                   Patient Care Service at the Military Advanced  
8                   Training Center at Walter Reed. He served for 29  
9                   years in the Army, with his most recent assignment  
10                  prior to retiring in October 2003 as Chief,  
11                  Physical Therapist Section, Army Medical  
12                  Specialist Corps, and Consultant to the Surgeon  
13                  General, U.S. Army. Dr. Scoville is a graduate of  
14                  the Army War College. His awards include the  
15                  Legion of Merit, Meritorious Service Medal and the  
16                  Army Commendation Medal. He has also been awarded  
17                  the "A" Proficiency Designator, military  
18                  recognition for outstanding qualifications in  
19                  physical therapy and continued demonstration of  
20                  exceptional professional ability, as well as the  
21                  "8Z" Proficiency Designator, the military  
22                  recognition for demonstration of exceptional

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1 professional achievement in the design, conduct  
2 and publication of clinically relevant medical  
3 research. Dr. Scoville's presentation slides may  
4 be found under Tab 15. Dr. Scoville, thank you  
5 for joining us.

6 DR. SCOVILLE: Thank you. I'm here  
7 representing General Franks and the Panel for the  
8 Care of Individuals With Amputations and  
9 Functional Limb Loss. I will briefly go over the  
10 Subcommittee membership, what we had covered in  
11 our June meeting and what we plan to look at in  
12 our next meeting.

13 Our membership has dropped off  
14 significantly because of individuals who have  
15 either been assigned into positions where there is  
16 a conflict with this or family members have been  
17 assigned into positions that conflict with our  
18 Committee. So we have dropped down currently to  
19 six active members and we have nominated a number  
20 of individuals to replace those who have left our  
21 Committee.

22 Our last meeting was held in San Diego

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1 Naval Medical Center. They have opened the C5  
2 which is the Comprehensive Combat Casualty Care  
3 Center. We provide care for individuals with limb  
4 loss and traumatic brain injury at that center.  
5 We discussed the VA DoD Center of Excellence  
6 requirement from NDAA 2009. We did an update of  
7 the amputee program looking at the numbers and the  
8 trends we have seen over the years with the  
9 program. Dr. Ficke discussed the Army's approach  
10 to hand transplantation as this has advanced and  
11 the capabilities are now available. We have  
12 several Service members who are interested in hand  
13 transplantation, so we looked at how we would be  
14 approaching that and making sure that the Service  
15 members were well educated as they entered into  
16 this process.

17 We looked at the Task Force sustainment  
18 of amputee patient care and what will we do to  
19 keep the skill sets that we've learned? In this  
20 current conflict it took us a year to get our  
21 staff really up to the level of performance with  
22 the tactical athlete population that we're dealing

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1 with. We were very skilled at taking care of the  
2 dysvascular tumors but not the high-end  
3 rehabilitation that our service members deserved.  
4 We looked at the clinical competencies and  
5 financial support as we looked toward the  
6 sustainment and discussed the need or the  
7 requirement to go forward and get CARF  
8 accreditation, the Committee for Accreditation of  
9 Rehab Facilities, for our facilities and also the  
10 accreditation of our prosthetic labs which is  
11 something that the VA has been doing.

12 We have a meeting scheduled for December  
13 1 which will take place at Walter Reed. Joe  
14 Miller who is our lead prosthetist will be talking  
15 about the latest advances in prosthetics and how  
16 we will look at the population distribution of the  
17 prosthetics. As we get new items and they first  
18 come on the market, they come on the market in  
19 very low quantities. So Power Knee which we are  
20 now using are producing about 10 every 2 months,  
21 so how do you select which are the patients who  
22 would get the latest technology? We're looking at

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1 the research advances, and what we've been doing  
2 at the Intrepid Center at Military Advanced  
3 Training Center at Walter Reed and out at the C5,  
4 and will again do an update on the numbers and  
5 distribution of the patients. We have recently  
6 received funding through a joint incentive fund to  
7 bring DCVA and Walter Reed together in amputee  
8 patient care. Dr. B.J. Randolph is a retired  
9 colonel who now works for the VA will be  
10 presenting that. I will look at the role of the  
11 military in coalition military missions as to  
12 whether there is a requirement for uniform  
13 prosthetists and then some of the DoD to VA  
14 transition timelines. We've been involved with  
15 missions with a number of countries' coalition  
16 forces. We've sent teams into Iraq, into Sri  
17 Lanka and we've gone to Colombia every year.  
18 We've been into Pakistan and we're preparing for  
19 another mission into Pakistan. I talked with our  
20 Surgeon General's foreign consultant the other day  
21 and China has asked for some assistance there so  
22 that there are a number of those missions coming

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1 up.

2 Currently we have used Joe Miller who is  
3 a reserve officer to assist in those missions.  
4 That's the one prosthetic military asset that we  
5 have.

6 DR. LEDNAR: Thank you, Dr. Scoville.  
7 Are there questions for Dr. Scoville? Dr. Silva?

8 DR. SILVA: Thank you. That's wonderful  
9 work. Of course, the war is moving on and the  
10 number of amputees I understand have diminished to  
11 what degree since a year ago?

12 DR. SCOVILLE: In the last 6 months we  
13 have the same number of amputees as we had had the  
14 similar 6 months a year ago. The shift has been  
15 in the last 6 months we have had no amputees from  
16 Iraq, so 1 year ago we had 24 amputees, 12 were  
17 from the Iraqi conflict and 12 were from the  
18 Afghan conflict. This year in the past 6 months  
19 we've had 26 individuals with major limb loss and  
20 all of them were from Afghanistan.

21 DR. LEDNAR: Are there other questions  
22 for Dr. Scoville? I know an issue that you've

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1       been thinking about, although what you've just  
2       said makes me change what I was going to say, and  
3       that is as we were watching the experience in Iraq  
4       over time, the number of soldiers experiencing  
5       traumatic limb loss was going down and that's  
6       wonderful. The question was how we maintain and  
7       retain in a sustainable way the skills and the  
8       rehabilitative effectiveness that's been developed  
9       around the need for care for soldiers in this war?  
10      Afghanistan is again unfortunately generating more  
11      amputee cases to take care of, but at some point  
12      we hope that there will be a reduction in the  
13      number of the new patients with limb loss. The  
14      challenge will be how do we hold onto, how do we  
15      retain that terrific capability that has been  
16      developed over the last 8 to 10 years going  
17      forward? I'm not looking for answer now, but  
18      clearly it's important.

19                   DR. SCOVILLE: We've looked at this.  
20      For a while following the end of hostilities we  
21      will continue to have a patient population. We've  
22      had over 110 individuals of the 938 who have had

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1 major limb loss who have had their amputations  
2 done up to 5 years after their initial injury.  
3 The average time is about 2 years. So they've had  
4 a limb salvage which has been successful, but the  
5 patient does not have the functional level they  
6 desire so they elect to have an amputation to be  
7 able to increase their functional activities.  
8 That will provide some.

9           If you look at the data prior to this  
10 conflict, we were averaging within the DoD over  
11 100 individuals a year through motor vehicle  
12 accidents, training accidents, tumors and other  
13 situations who had major limb loss. Prior to this  
14 conflict, we would provide initial care for those  
15 individuals and they would be discharged from the  
16 service. As a result of our successes with  
17 patient care, we've had over 130 individuals  
18 returned to active duty, over 40 of those have  
19 redeployed back into theater with prosthetic  
20 devices, and we are now maintaining people on  
21 active duty with limb loss, so that population  
22 with the motor vehicle accidents, training

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1 accidents and such would be engaged in care  
2 through the military for a longer period of time  
3 looking at their potential to return to service.

4 DR. LEDNAR: That's a great success  
5 story. Dr. Parkinson?

6 DR. PARKINSON: It dawns on me that we  
7 often times look internally as in Wayne's question  
8 about sustaining our internal capability in DoD.  
9 All of our activities like so many things that DoD  
10 develops have huge implications for the civilian  
11 population and I wonder with the global epidemic  
12 of landmines all of which will never be removed,  
13 the global epidemic of amputation injuries due to  
14 those landmines and a global epidemic of Type II  
15 diabetes which now be complication-related  
16 amputations, frankly, we're on the cusp of that,  
17 if there shouldn't be some exploration in your  
18 committee of international ties, alliances, fund  
19 raising, whatever? That's a little off scope  
20 maybe or maybe you've already talked about that.  
21 It's just a question.

22 DR. SCOVILLE: We have done that. As I

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1 say, we've been down to Colombia, into Bogota and  
2 Medellin every year for the past 5 years. We've  
3 gone in for anywhere from 4 days to 2 weeks. They  
4 are getting two new amputees a day between their  
5 fighting with the FARC and their fighting with the  
6 drug cartels down there. We've gone to Sri Lanka  
7 and worked with them. The potential is there. In  
8 our current situation we're relying all on  
9 civilian prosthetists to provide our prosthetic  
10 care. So without military assets, we are  
11 stretched on what we can accept as an additional  
12 mission and on capabilities.

13 DR. PARKINSON: Perhaps it's more over a  
14 cocktail conversation sometime than a formal  
15 mission, but there are national private voluntary  
16 organizations and humanitarian organizations that  
17 might be looking for a niche or a cause. While  
18 it's not in your mission, rather than going  
19 country to country it might be that the equivalent  
20 is the Eliminate Polio Rotary Club initiative or a  
21 thing like that. It's not DoD mission related,  
22 but it certainly is an application and it would be

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1 a tremendous application of what we've done.

2 DR. SCOVILLE: And we've also looked at  
3 using the Institute of Surgical Research in burn  
4 care and how we care for the civilian population  
5 in times where we're not at war to maintain our  
6 skill set. So we are looking. We have a task  
7 force looking at sustainment and figuring out what  
8 are the best ways to address this in the future.

9 DR. LEDNAR: Are there any other  
10 questions or comments or Dr. Scoville? If not,  
11 Dr. Scoville, thank you very much for that update  
12 and we look forward to hearing from you again.  
13 Thank you. Commander Feeks, if you would, please.  
14 What Commander Feeks and I are doing is huddling,  
15 and that is, Dr. Butler has been working hard  
16 since he left the podium to give us something to  
17 look at, and if Dr. Butler, you would explain to  
18 us and introduce this document that has just been  
19 given to us, please.

20 DR. BUTLER: The document that you just  
21 received the exact same document that's on the  
22 Health Affairs website except for the part in the

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1 box which is the new treatments recommended for  
2 burn therapy so that is the part in the box that  
3 is the subject of the vote. As you look through  
4 the guidelines, what we have there is here's what  
5 you do for training combat medics. There are  
6 1,000 slides that go along with this because it  
7 takes a little bit more than just giving them a  
8 document and saying do this to train them. This  
9 is in outline form what we recommend for  
10 battlefield trauma care supported by the PHTLS  
11 chapters in the military version of the  
12 "Prehospital Trauma Life Support" manual and by  
13 the training curriculum used by all the services  
14 that's also on the Health Affairs website.

15 DR. LEDNAR: So that the boxed material  
16 identifies the content that goes with the  
17 recommendation. Again to Dr. Shamoo's advice to  
18 us which is good, and that is if we can with the  
19 help of the staff pull this together into a  
20 document that should be fairly straightforward to  
21 prepare that includes this content material  
22 relative to the recommendation that is then

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1       circulated to the Core Board and we can rapidly  
2       turn it around and get it back and let you know.  
3       Dr. Silva?

4                   DR. SILVA: I know the hour is late and  
5       we're getting ready to leave, but quite frankly as  
6       an internist, it would take a month to have done  
7       what the surgeon has done here in about a  
8       half-hour.

9                   DR. LEDNAR: Our gratitude, Dr. Butler,  
10      to our heroics. We should be behaving more like  
11      surgeons and trauma specialists than some of us  
12      do. Thank you for that.

13                   At this point this concludes our  
14      business and I'd at this point turn to Mr.  
15      Middleton as our Designated Federal Official and  
16      ask if he would adjourn the meeting. Mr.  
17      Middleton?

18                   MR. MIDDLETON: Thank you, Dr. Lednar.  
19      This meeting of the Defense Health Board is  
20      adjourned.

21                   (Whereupon, at 1:00 p.m., the  
22                   PROCEEDINGS were adjourned.)

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