UNITED STATES DEPARTMENT OF DEFENSE

DEFENSE HEALTH BOARD

CORE BOARD MEETING

Washington, D.C.

Thursday, May 7, 2009

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 PARTICIPANTS:

2 GAIL WILENSKY, Ph.D.

3 ALLEN W. MIDDLETON

4 COMMANDER EDMOND FEEKS

5 LIEUTENANT COLONEL CHRISTOPHER COKE

6 SHAKIR JAWAD, M.D.

7 JEAN LANGLOIS, Sc.D.

8 CHARLES FOGELMAN, Ph.D.

9 KENNETH W. KIZER, M.D.

10 COLONEL (RET) ROBERT G. CERTAIN

11 JOHN D. CLEMENTS, Ph.D.

12 GENERAL (RET) RICHARD A. CODY

13 WILLIAM E. HALPERIN, M.D.

14 COMMAND SERGEANT MAJOR (RET) LAWRENCE W. HOLLAND

15 EDWARD L. KAPLAN, M.D.

16 WAYNE M. LEDNAR, M.D.

17 MARK A. MILLER, M.D.

18 GENERAL (RET) RICHARD B. MYERS

19 DENNIS O'LEARY, M.D.

20 MICHAEL N. OXMAN, M.D.

21 JOSEPH E. PARISI, M.D.

22 MICHAEL D. PARKINSON, M.D.

1 PARTICIPANTS (CONT'D):

2 GREGORY A. POLAND, M.D.

3 CHARLES A. SANDERS, M.D.

4 ADIL E. SHAMOO, M.D.

5 JOSEPH SILVA JR., M.D.

6 HONORABLE CHASE UNTERMEYER

7 WILLIAM BLAZEK, M.D.

8 RICK ERDTMANN, M.D.

9 PIERCE GARDNER, M.D.

10 GROUP CAPTAIN ALAN COWAN

11 WALTER DOWDLE, M.D.

12 ALI S. KHAN, M.D.

13 H. CLIFFORD LANE, M.D.

14 ANNE MOESSNER, MSN

15 COLONEL ROBERT L. MOTT

16 COLONEL (RET) JOHN HOLCOMB, M.D.

17 COMMANDER CATHERINE SLAUNWHITE

18 PHILLIP TOBEY

19 BONNIE BENETATO, Ph.D.

20 BRIGADIER GENERAL LOREE K. SUTTON

21 RAYMOND F. DUBOIS

22

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

2 (8:00 a.m.)

3 DR. WILENSKY: I'd like to welcome
4 everyone to this meeting of the Defense Health
5 Board, and to extend a special welcome to our new
6 Board members. We have several important topics
7 on our agenda today, so let's get started. Mr.
8 Middleton, would you please call the meeting to
9 order?

10 MR. MIDDLETON: Thank you, Dr. Wilensky.
11 As the Alternate Designated Federal Official for
12 the Defense Health Board, a Federal Advisory
13 Committee and a Continuing Independent Scientific
14 Advisory Board to the Secretary of Defense via the
15 Assistant Secretary of Defense for Health Affairs
16 and the Surgeons General of the Military
17 Departments, I hereby call this meeting of the
18 Defense Health Board to order.

19 DR. WILENSKY: Thank you, Mr. Middleton.
20 And now in carrying on the tradition of our
21 Boards, I ask that we stand for a minute of
22 silence to honor those we are here to serve, the

1 men and women who serve our country.

2 (Moment of silence.)

3 DR. WILENSKY: Thank you. Since this is

4 an open session, before we begin I'd like to go

5 around the table and have the Board and

6 distinguished guests introduce themselves, and the

7 new Core Board Members and Subcommittee Members,

8 please tell us a little about yourselves. Let me

9 start. My name is Gail Wilensky. I am President

10 of the Defense Health Board and also chair the

11 Health Care Delivery Subcommittee.

12 COMMANDER FEEKS: Good morning.

13 Commander Ed Feeks, Executive Secretary of the

14 Executive Health Board.

15 MR. MIDDLETON: Good morning. I'm Allen

16 Middleton. I'm the Acting Principal Deputy

17 Assistant Secretary of Defense for Health Affairs,

18 sitting in for Ms. Embrey today as the Alternate

19 Designated Federal Official.

20 DR. LUDWIG: My name is George Ludwig,

21 and I'm the Civilian Deputy Principal Assistant

22 for Research and Technology at the Medical

1 Research and Materiel Command, and I'm here
2 representing the Director, Dr. Frazier Glenn.
3 DR. LONGACRE: Good morning, Dr.
4 Longacre here representing Dr. Rice at the
5 Uniformed Services University.
6 GENERAL MYERS: Dick Myers, Core Board
7 Member.
8 DR. KAPLAN: Good morning, Ed Kaplan,
9 Professor of Pediatrics, University of Minnesota,
10 Core Board Member.
11 DR. CLEMENTS: John Clements. I'm the
12 Chairman of Microbiology and Immunology at Tulane
13 University School in New Orleans and a Core Board
14 Member.
15 DR. CERTAIN: Robert Certain, retired
16 Air Force Chaplain, Core Board.
17 MR. UNTERMEYER: I'm Chase Untermeyer.
18 I'm in private business in Houston, and a member
19 of the Core Board.
20 COMMAND SERGEANT MAJOR HOLLAND: I am
21 Larry Holland from Houston, Texas, retired Command
22 Sergeant Major, Core Board Member.

1 DR. SILVA: Good morning, Joe Silva,
2 Professor of Internal Medicine, University of
3 California, Davis, Dean Emeritus, School of
4 Medicine, and Core Board Member.
5 DR. MILLER: I am Mark Miller. I am
6 Director for Research in the Division of
7 International Epidemiology Population Studies at
8 the NIH and Core Board Member.
9 DR. SHAMOO: Adil Shamoo, University of
10 Maryland School of Medicine, Core Board Member,
11 and the Chair of the Medical Ethics Subcommittee.
12 COLONEL HOLCOMB: John Holcomb. I'm
13 Chair of the Trauma Injury Subcommittee, just
14 recently retired from the U.S. Army where I was a
15 trauma critical care surgeon and ran a research
16 laboratory and now a Professor of Surgery at the
17 University of Texas in Houston.
18 DR. OXMAN: Mike Oxman, Professor of
19 Medicine and Pathology at the University of
20 California, San Diego, and a Core Board Member.
21 DR. SANDERS: I'm Charlie Sanders. I'm
22 the Chair of Project HOPE, Chair of the University

1 of North Carolina Health System, and Core Board
2 Member.
3 BRIGADIER GENERAL LEE: Good morning.
4 I'm Carol Lee. I'm the Deputy Joint Staff
5 Surgeon, and I'm here representing Admiral Smith.
6 COLONEL NOAH: I'm Colonel Don Noah, the
7 Acting Deputy Assistant Secretary of Defense for
8 Force Health Protection and Readiness and another
9 alternate DFO.
10 DR. POLAND: I'm Greg Poland, Professor
11 of Medicine and Infectious Diseases at Mayo
12 Clinic, the immediate past DHB President, now Vice
13 President, and Chair of the Infectious Disease
14 Control Subcommittee.
15 DR. WILENSKY: You've already gotten a
16 chance to experience what happens if too many of
17 us have our mikes on at the same time, so be sure
18 and put them on when you speak, but after you
19 speak just shut them off so we don't pick up the
20 vibrations. Commander Feeks has some
21 administrative remarks before we begin the morning
22 session.

1 COMMANDER FEEKS: Thank you, Madam
2 President. Good morning and welcome. First,
3 there is an empty seat at our table. Dr. William
4 Halperin is not with us this morning. His wife
5 passed away a couple of weeks ago, and let's keep
6 that family in our thoughts and prayers.
7 I want to thank the staff of the
8 Sheraton Crystal City Hotel for helping with the
9 arrangements for this meeting, and I want to thank
10 all the speakers who have worked hard to prepare
11 briefings for the Board. I want to thank my
12 staff, Jen Klevenow, Lisa Jarrett, Elizabeth
13 Graham, Olivera Jovanovic, and our newest staff
14 member, Kim Lundberg, for arranging this meeting
15 of the DHB. Finally, I also want to thank Ms.
16 Jean Ward for her invaluable assistance in putting
17 this meeting together.
18 In keeping with the rules of Federal
19 Advisory Committees, please do sign the general
20 attendance roster on the table outside if you have
21 not already done so. For those who are not seated
22 at the tables, handouts are provided on the table

1 in the back of the room. Rest rooms are located
2 down the corridor on the left-hand side. For
3 telephone, fax, copies or message services, please
4 see Lisa Jarrett or Elizabeth Graham. Because
5 this open session is being transcribed, please
6 make sure you state your name before speaking. If
7 your name is difficult to spell, please spell it
8 the first time you say it. And please use the
9 microphones so our transcriber can accurately
10 report your questions.
11 Refreshments will be available for both
12 morning and afternoon sessions. We will have a
13 catered working lunch here at the Crystal City
14 Sheraton for the Board Members and speakers and
15 liaison officers, and there are a number of
16 restaurants nearby.
17 Finally, the next meeting of the Core
18 Board will be held on August 17 and 18 of this
19 year in Colorado Springs, Colorado, at the Air
20 Force Academy. The Board will then receive a
21 series of updates on subcommittee activities and
22 draft recommendations. Before we move on, I'd

1 like to ask if anyone is on the phone with us
2 today. That concludes my remarks, Madam
3 President.
4 DR. WILENSKY: Before we start, I would
5 like to be sure that the people here at the table,
6 the Core Board members and Subcommittee
7 chairs, know that the working lunch is truly a
8 working lunch and we will count on your presence
9 here between 12:30 and 2:00, similar to the
10 arrangement that we did in Key West. So we'll
11 give you some time to attend to other matters
12 including grabbing your lunch, but please regard
13 that as a working session.
14 Our first speaker this morning is
15 Lieutenant Colonel Christopher Coke from the Joint
16 Staff in Washington who will present an update on
17 U.S. military operations worldwide. I've been
18 reminded that there's a tradition of having people
19 in the audience also indicate who they are for
20 purposes of the public record, so while we're
21 getting ready for Colonel Coke, maybe just go and
22 say your name and who you represent.

1 COMMANDER MCMILLAN: Dave McMillan,
2 Occupational Medicine for the Navy Surgeon
3 General's Office.
4 COLONEL KRUKAR: Good morning. Colonel
5 Michael Krukar, Director of the Military Vaccine
6 Agency.
7 GROUP CAPTAIN ALAN COWEN: I'm Group
8 Captain Alan Cowen. I'm the British Liaison
9 Officer in the Department of Defense. I'm also in
10 the Veterans Agency.
11 COLONEL MOTT: Colonel Bob Mott,
12 Preventive Medicine in the Army Surgeon General's
13 Office.
14 MS. LUDWIG: Sharon Ludwig, I'm
15 representing the U.S. Coast Guard Surgeon General.
16 MS. BENETATO: Bonnie Benetato,
17 Department of Veterans Affairs War Related Illness
18 and Injury Study Center.
19 MR. ERDTMANN: Good morning, Rick
20 Erdtmann from the Institute of Medicine.
21 COMMANDER SLAUNWHITE: Good morning, I'm
22 Commander Kathy Slaunwhite. I'm a Canadian Forces

1 Medical Officer stationed at the Canadian Embassy
2 in a liaison role here in Washington, D.C.
3 DR. FOGELMAN: I'm Charlie Fogelman.
4 I'm Chair of the Psychological Health Subcommittee
5 of the Board.
6 MS. MOESSNER: Good morning, Ann Moessner
7 from Mayo Clinic and chairing the TBI Family
8 Caregiver Subcommittee.
9 DR. LANGLOIS: Good morning, I'm Jean
10 Langlois, and I'm a member of the TBI Advisory
11 Subcommittee.
12 MR. RAYBOLD: Ridge Raybold, Office of
13 the Director, Armed Forces Institute of Pathology.
14 MS. COLADA: Sandy Colada, Defense and
15 Veterans Brain Injury Center.
16 DR. GARDNER: Good morning, I'm Pierce
17 Gardner. I'm a Professor of Medicine and Public
18 Health at Stony Brook University School of
19 Medicine and a member of the Infectious Disease
20 Subcommittee.
21 MR. DONELAN: Good morning, I'm Walter
22 Donelan with the Task Force for Global Health and

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

1 a member of the Infectious Disease Subcommittee.
2 MS. KITCHEN: Lynn Kitchen, Military
3 Infectious Disease Research Program.
4 MS. CARTY: Jill Carty, Force Health
5 Protection and Readiness, Psychological Health,
6 Strategic Operations.
7 MR. TOBY: Good morning, Phil Toby,
8 member of the BRAC Subcommittee.
9 MS. JEFFS: Barb Jeffs, J-3, JTF CapMed.
10 DR. BLAZEK: Good morning, I'm Dr. Bill
11 Blazek. I'm from the Center for Clinical
12 Bioethics at Georgetown University.
13 MS. COATES: Good morning, Marianne
14 Coates, Public Relations Communicator and Adviser
15 to the Defense Health Board.
16 Major OBAMWONYI: Good morning. My name
17 is Major Obamwonyi from the Department of Occupational and
18 Environmental Health at the USAF School of Aerospace Medicine.
19 MR. LANE: Cliff Lane, National
20 Institute of Allergy and Infectious Diseases and
21 the Infectious Diseases Subcommittee.
22 DR. SHAKIR: Good morning, Shakir Jawad

1 from the International Health Division of the
2 Office of the Assistant Secretary of Defense for
3 Health Affairs.
4 CAPTAIN MATOS: Captain Peter Matos,
5 Preventive Medicine, Occupational Medicine
6 Resident, Walter Reed.
7 CAPTAIN SHERRY: Captain Scott Sherry,
8 Preventive Medicine Resident, Walter Reed Army
9 Institute of Research.
10 LIEUTENANT COLONEL STONE: Lieutenant
11 Colonel Jay Stone, Defense Centers of Excellence
12 for Psychological Health and Traumatic Brain
13 Injury.
14 COLONEL JOHNSON: Colonel George
15 Johnson. I work for Ms. Embrey, Force Health
16 Protection and Readiness, currently working for
17 Colonel Noah.
18 DR. WILENSKY: Thank you very much.
19 Colonel Coke?
20 LIEUTENANT COLONEL COKE: Good morning.
21 If everybody can hear me, I tend to wander away
22 from the mike, so please keep me on it.

1 Like I said, Chris Coke. I'm a Marine
2 aviator. I fly CH-46s, our medium-lift
3 helicopter, and I'm a former Squadron Commander
4 and have served in Iraq, Afghanistan and over in
5 Africa and in the Europe theater, particularly in
6 the Balkans. I currently work on the Joint Staff
7 in the Joint Operations Directorate. We deal with
8 current operations, and my area of specialty is
9 Europe.
10 It's a pleasure to be with you this
11 morning. Thank you for the opportunity to get out
12 of the Pentagon and see some light. One thing
13 I'll preface with is just like most professions,
14 we are riddled with acronyms, so if there's
15 something that I say that doesn't make sense,
16 please stop me. And I hope this is a discussion
17 as well as a presentation, so at any point please
18 feel free to stop and discuss a particular issue
19 that we may touch on.
20 Because I'm not a very good joke teller,
21 the other course of action I have is to present a
22 short video, so we'll do that.

1 (Video played.)
2 LIEUTENANT COLONEL COKE: Now, why that?
3 A couple of reasons. It's always cool to talk
4 about yourself, so that's actually one
5 of the first landings I did in Iraq and it was
6 taken by DASH-2, the second aircraft, and as you
7 saw, you could see some of the dust being pulled
8 up and away aside from where this helicopter was
9 and that was DASH-2 figuring out that it probably
10 wasn't a good idea to land at that particular
11 time, so they took it around and decided to land
12 when the dust had settled. It kind of exemplifies
13 the conditions, and if you imagine at nighttime it
14 complicates issues. Particularly when you talk
15 about MEDEVAC and you talk about pulling people
16 out, you don't get to choose where you land. So
17 quite often this is what the pilots are dealing
18 with, as well as also you don't get to choose
19 where you fight. So we may employ Marines or
20 other servicemen and women, it is inherently
21 dangerous just trying to get them there, never
22 mind the actual fight that takes place or ensues

1 afterwards.
2 I always have to start off with a thank
3 you too. I recognize as we all do that your
4 effort leads to many good things for our service
5 folks, and I just use this example of Brad
6 Mellinger, a Lieutenant in the Army who was
7 injured in Iraq and very quickly was taken to
8 Germany for follow-on care and is today with this
9 family and multiple tours in Iraq and Afghanistan.
10 This alludes to a very pleasing statistic that we
11 like exemplifying, and that is right now about a 7
12 to 1 ratio of mortality when you talk about people
13 who have been injured. It's much better I am to
14 understand than 3 to 1 in the Korean War and 2 to
15 1 in previous wars. What has allowed that to
16 happen? I think there are two areas which you
17 have been a part of, and again thank you. One is
18 the equipment, whether we're talking about flak
19 jackets or protection or the new MRAP vehicle
20 with the V-shaped hull that the engineers have
21 figured out that allow the explosion to the taken
22 to the side of the vehicle instead of up through

1 it is certainly a contributor.

2 The second contributor is just in

3 medicine alone. I'll use the example of QuikClot

4 that I've seen personally work so very, very well

5 at arresting bleeding and allowing people to not

6 bleed out and get to the appropriate care that

7 they need to get fixed. So again your efforts are

8 truly appreciated. Thank you.

9 Where are we at? I'm going to go around

10 the world and just kind of touch on a couple of

11 things in each theater. As you can see, we've got

12 service folks deployed around the world. As one

13 would expect, in Central Command which I'll

14 abbreviate as CENTCOM but it really encompasses

15 the area around the old Persian Gulf and those

16 countries around there, and of course we've got

17 about 22,000 folks deployed there. But it's

18 important to remember also EUCOM has almost about

19 90,000, the Pacific has 150,000, Africa which is a

20 new command is growing with 3,300, and of course

21 our friends to the south, Southern Command, about

22 5,300. So this is where your servicemen and women

1 are around the world. Of course, they're broken
2 out into geographic commands which own those
3 particular regions and employ them as required in
4 the national security interests of the United
5 States.
6 In the national security discussion we
7 talked about the belt around the world that
8 happens to coincide with the equator, but it's
9 basically the hot points or the flash points. As
10 you can see, it's pretty much true to form around
11 the world this is where we are engaged, whether it
12 be off Haiti and humanitarian efforts, and we'll
13 go into some detail about a few of these, all the
14 way around to the Philippines and everything in
15 between.
16 We'll start with Africa which is a newly
17 shaped command as of 1 October of last year. A
18 little bit different. It's just not military, and
19 we recognize and have recognized that the solution
20 to national issues as far as foreign strategy is
21 just not a military solution. The second in
22 command is broken into two parts. One, you have

1 an ambassador that looks at the diplomatic aspects
2 and building partnerships within those individual
3 countries, and then you have the military aspect
4 that looks at all things military. But what are
5 they involved in? They're involved in partnership
6 development, theater security, involved in the old
7 contingency operations dealing with extremists,
8 but the Task Force Horn of Africa, they're in
9 Djibouti is still much alive and well, and then of
10 course Enduring Freedom which is alluding to
11 counterterrorism operations there in the
12 Trans-Sahara.
13 Central Command, again the area around
14 the Persian Gulf is really our focus right now.
15 There are really three areas, and I'm going to
16 touch on each of these. One is Afghanistan, Iraq,
17 and then maritime, and tied in there to a great
18 extent is counterpiracy which has taken the
19 headlines recently. It's relatively small in
20 space as far as geography goes with only 20
21 countries as opposed to 90 plus in Europe and
22 other commands, but nonetheless has our attention.

1 The other aspect as we all know is there's a lot
2 of energy out of this area.
3 Let's talk about Iraqi Freedom. There's
4 a lot of success there. It's not absolute, we
5 continue to have setbacks, but we are at that
6 point as you well know where we're able to start
7 drawing down and moving forces over to
8 Afghanistan. I think it's important to recognize
9 that there are very many positive indicators
10 starting with the provincial elections that have
11 taken place and the transition of the military and
12 our assistance to the Iraqi people, to the Iraq
13 government and to their military and police
14 systems. We're down now to about 14 brigade
15 combat teams as opposed to over 20 a year ago.
16 Violence is down about 60 percent from last summer
17 and that continues to go that way. Like I say,
18 there are always setbacks that we hear in the
19 news, but violence continues to go down. We still
20 view the area around Mosul up in the north as
21 being an area that we still need to pay particular
22 attention to. The fight hasn't ended there, but

1 we're at a point where we can start refocusing,
2 and if you've heard the news and words that have
3 come out of the Secretary and the Chairman is of
4 reorientation, certainly the President, and focus
5 into Afghanistan but certainly not allowing any
6 backwards movement of progress or success in Iraq.
7 I'd like to talk about Sergeant
8 Martinette, another hero who received the Bronze
9 Star With Valor. Again when we talk about IEDs
10 and we talk about the favorite weapon of choice
11 for the insurgents, countering IEDs is an issue
12 and who was responding to an IED that have gone
13 off. One of the most injured in the quick triage
14 of the scene was an Iraqi civilian and so he
15 attempted to move him, and in the process of
16 moving him, a second blast went off.
17 Miraculously, he was injured but no one was killed
18 that day, but as soon as he got up and shook off
19 the dust, he turned to and started doing his
20 practice, and like I said, no one was killed that
21 day. So he's a local hero from Virginia Beach.
22 Moving over to Afghanistan, there's a

1 lot of work here. As you've heard in the news,
2 deploying an additional 17,700 folks there, 4,500
3 to 4,800 additional to help with rebuilding and
4 reconstruction and other things than military
5 operations. There's a lot of emphasis in this
6 area in the south in what we call RC South where
7 we're going to be assisting. The Canadians have
8 it now and then it will be going to the British,
9 and then we'll eventually have a two-star
10 headquarters there. So this is our new focus of
11 effort. Certainly I've seen some setbacks, but
12 when you look at the successes, this is truly a
13 coalition effort. There are 35 contributing
14 nations and they're growing. And they're just not
15 NATO nations, being that this is ISAF, Security
16 Assistance Force Afghanistan which comes under
17 NATO, it also has many non-NATO contributors, for
18 example, Australia, and Jordon is thinking about
19 playing, and other countries.
20 Two concentrations that we're focused on
21 right now are obviously the elections coming up in
22 August and making sure that we have the forces

1 there to be able to support those elections. Then
2 afterwards to continue counterinsurgency
3 operations within Afghanistan, particularly the
4 south and the east. We're in the poppy growing
5 season so there's a lot of counternarcotic
6 operations taking place as well. Lastly, I'll say
7 we recognize, as we all have been hearing in the
8 news, that this just isn't an Afghanistan issue.
9 Our success is tied to the success within
10 Pakistan, so they really are interlinked.
11 The forces continue to develop there as
12 far as our Afghan partners, and to be honest, we
13 still have a ways to go there both in the security
14 and the policing. Again I'd just like to talk
15 about Petty Officer Chandler. He was deployed out
16 in one of the remote areas. He's a Petty Officer,
17 a Navy type, and he's a hull mechanic or hull
18 engineer, and was deployed on a PRT, provincial
19 reconstruction team, as a mechanic for their
20 vehicles. While he was in his area where they
21 were staged, his outpost, they came under mortar
22 attack and one hit directly in the motor pool. He

1 put together a quick team and went out and was
2 able to counter the attack, and for his efforts he
3 received the Bronze Star as well. He was a Navy
4 engineer who works on hulls is in Iraq doing
5 something very different than his trade, a good
6 example of what's going on.
7 Maritime operations. Obviously there's
8 a lot of focus on counterpiracy and efforts to
9 that extent. We'll talk about what took place in
10 the "Maersk Alabama" in a second. There are
11 several task forces, 150 which deals
12 counterterrorism activity within and around the
13 Horn of Africa region, and then there's 151 which
14 focuses on counterpiracy. It's important to note
15 that this is an international effort. The U.N.
16 has passed several Security Council resolutions
17 which allow ships to operate with consent of
18 Somalia within their costal waters, and actually
19 to go ashore. No one has really gone to that
20 point, but the authorities are building in
21 recognition that this piracy is a real issue
22 particularly when you talk about what we call

1 lines of communications, but the ability to move
2 freely at sea, and then counterpiracy which is a
3 new Task Force 151, focused specifically on that.
4 I have a couple of pictures here. You'll see the
5 big cargo ship. I don't know if you can see from
6 where you're at, but there are some small skiffs
7 or small vessels right next to it. Those are
8 pirates attempting to board. These are pretty
9 audacious folks when you consider the sizes of the
10 ships that they're capturing, and they're actually
11 successful. Prevention may be as simple as
12 bringing in our ladders and ropes and things that
13 dangle off your ship so that folks can't climb
14 them, so there is some education is going on here.
15 But this is how they're doing it, these large
16 cargo ships, these large tankers, they're doing it
17 from small platforms with certainly no
18 sophistication, AK-47s, RPGs, very simplistic
19 tactics, but it works.
20 In the case of the "Maersk Alabama" and
21 what was in the news recently where Captain
22 Phillips was a hostage for several days, the

1 commander of the "Bainbridge" which is the ship
2 where the snipers shot off from is depicted there
3 on the left welcoming him aboard his ship once
4 they were able to effect that rescue, graduated
5 from the Naval Academy, went to the Naval War
6 College, many years at sea, many years on shore,
7 and was at the right place at the right time and
8 did exactly what was right and made the call when
9 there was an opportunity and Captain Phillips's
10 life was at risk and made that call to eliminate
11 the pirates and was able to effect the rescue, so
12 good success there. It's important to note that
13 the French had similar success albeit I think one
14 fatality a few days earlier, so it's an
15 international effort and first and foremost in
16 everybody's mind. The main effort is still
17 Afghanistan.
18 Moving over to the European Command,
19 EUCOM. This encompasses NATO as well. The
20 Commander holds both hats. We still have
21 activities there to the extent of about 90,000
22 Service members still employed in the EUCOM area

1 of responsibility. Kosovo is still alive and
2 well. We still have about 1,600 folks there.
3 There's a lot of emphasis to the north when we
4 talk about Mitrovica and Serbian dissent and
5 influence within Kosovo. It's not all quiet yet.
6 The good news is all things Bosnia continue to go
7 in a very positive direction, and our presence
8 there in Sarajevo is about down to 28 folks, so
9 it's good there. We still have an enduring
10 mission, the USSC, which is a mission to train
11 Palestinians in the West Bank to provide for their
12 own security. Lieutenant General Dayton still has
13 that, then as well to the main effort, the
14 European Command provides forces and equipment to
15 help the fight.
16 The Pacific Command. There's a lot
17 going on there and I'll highlight just a couple of
18 things. The Philippines is a tremendous success
19 with operations countering terrorism, and it's
20 important to realize that it trained the trainers
21 and trained the Filipinos to be able to conduct
22 operations themselves, and they've been able to

1 counter much. The PRC and what appears to be an
2 expansionist or at least certainly on the economic
3 front when we look at China and Taiwan, but when
4 the election last year about this time of Ma in
5 Taiwan things are looking better, but it's still
6 a focus. As to Korea, obviously the Teapodong-2
7 launch continues to be worrisome, the departure
8 from the Six-Party Talks and bringing everybody
9 back to the table with the idea of how do you
10 denuclearize North Korea or the Korean Peninsula.
11 Then two, dealing with what we thought may be
12 rather imminent, the departure or death of Kim
13 Jong-il and the rapid assimilation potentially of
14 North Korea into South Korea and bringing the
15 Koreas back together, or how do we deal with that
16 crisis that may be there. Of course, the Pacific
17 Command also has India with the India-Pakistan
18 Mumbai incident which continues to be troublesome.
19 Looking at Southern Command which is
20 pretty much south of Mexico and includes Cuba and
21 Haiti, I'll talk about two real efforts. One is
22 counternarcotics. The slide on the left shows the

1 distribution of narcotics. Certainly you have a
2 supply and demand issue there and the demand
3 generates, frankly, from the northern part of the
4 Americas, so you see many arrows pointing in that
5 direction. The other picture there is dealing
6 with humanitarian assistance and theater security
7 cooperation. Recently one of the hospital ships
8 deployed down, and this is Commander Andy Malley
9 who used to be, coincidentally, a former flight
10 surgeon within one of my squadrons years back, but
11 she's off the coast of Haiti doing preventative
12 medicine. I think that's a mosquito trap that
13 she's inspecting in Haiti, so there's good stuff
14 there.
15 Then our back yard. It's kind of
16 interesting how it focuses on Mexico, one, talking
17 about counternarcotics and the drug trade. Again
18 to the top left, you probably can't see it, it's
19 in your slides, where the cartels are and the
20 issues that are being brought up to the front
21 dealing with the trafficking of drugs north and of
22 course weapons south. Calderon, the President of

1 Mexico, certainly has been engaging, and one could
2 argue that the wrath of violence may be
3 contributed because of Mexico's engagement now as
4 well as perhaps Colombia and we see successes
5 in Southern America forcing distribution up
6 north.
7 Secondly, and certainly near and dear to
8 I think everybody is the swine flu, and this is
9 about a week old, the genesis from Mexico, but
10 again there is still much discussion within the
11 Joint Staff and within Northern Command as far as
12 protecting our borders and our folks and
13 contributing to what we can globally.
14 In closing, working on the Joint Staff
15 we're away from the front obviously but we're
16 supporting, and so we never forget where the
17 emphasis is. Like I said, there are many
18 organizations and many groups that contribute to
19 our overall collective success, just not of the
20 military, but of the United States, and so we
21 always try to keep in mind our place. With that,
22 that's my presentation. I have some backup

1 slides. I can get into strategy. I can get into
2 policy. A lot of times I talk at Joint Staff
3 talks and to visiting war colleges, and that's
4 where they like to lead to, but I open the floor
5 to any discussion or any questions that you may
6 have.
7 DR. WILENSKY: Thank you, Colonel Coke.
8 Are there any questions that people have? I
9 actually have one that had to do with your comment
10 about the maritime protection. I think all of us
11 were impressed with the chaos that the pirates are
12 able to create for shipping in the area around
13 Somalia and going up through Yemen and the Aden
14 Straits. Is there anything that you can share
15 with us about what is reasonable and feasible to
16 do either by the U.S. itself or in collaboration
17 with other countries?
18 LIEUTENANT COLONEL COKE: Yes, ma'am.
19 To begin with, it's readily recognized across the
20 international community that this is a problem, so
21 identifying the problem is one of the most
22 important things because it's such a major sea

1 lane for many nations. That's why we have the
2 U.N. involvement, we have NATO involvement, we
3 have E.U. involvement, European Union involvement,
4 as well as individual countries that are involved
5 either solely or in a bilateral relationship. So
6 there's recognition. Most spheres of strategy
7 when you talk piracy, really to solve piracy you
8 have to go ashore. Unfortunately Somalia is at
9 best less than governed if not completely
10 ungoverned space, so where the safe havens are is
11 where you have to go to be able to really tackle
12 the problem. I don't think we're there yet.
13 That's really the ultimate solution, but it takes
14 a lot to get to that point. We already have
15 experienced Somalia in the recent past and that
16 was a tough one.
17 But there are things that we can do. I
18 talked a little bit about education and standards,
19 and the Navy brethren can certainly talk better to
20 this, as far as what you do to save your ship.
21 There are efforts right now within the 5th Fleet,
22 which is the naval component under Central Command,

1 to look at ships and to provide matrices as far as
2 risk factors and how you can mitigate that,
3 whether it you travel at night, the speed of your
4 travel, the location of your travel, what
5 protective measures you have taken. These are all
6 defensive things. Obviously organizations like
7 Blackwater and the military have looked at putting
8 armed folks aboard ships. That's one course of
9 action. Then the other course of action is simply
10 escorting ships. Unfortunately that's very
11 inefficient from the logistics aspect of moving
12 cargo through that area. So those are some of the
13 things that are being discussed and being done,
14 but I think there is general recognition that if
15 you really want to attack this problem we got to
16 go ashore, but we're not quite there yet.
17 DR. WILENSKY: Does anyone else have any
18 questions? Thank you very much for your
19 presentation. Our second speaker this morning is
20 Dr. Shakir Jawad. He currently serves as an
21 international health analyst at the International
22 Health Division, Office of the Assistant Secretary

1 of Defense for Health Affairs. He is also an
2 Assistant Professor at the Uniformed Services
3 University of the Health Sciences, Department of
4 Military and Emergency Medicine. Before coming to
5 the United States, Dr. Jawad worked for the Iraq
6 government where he held senior leadership
7 positions at the Iraqi Ministry of Health. Prior
8 to the liberation of Iraq, he served as a
9 Brigadier in the Iraqi Ministry of Defense and
10 spent most of his career as an orthopedic surgeon
11 in various Iraqi hospitals. Dr. Jawad will
12 provide the Board with an overview of the Iraqi
13 health sector. His presentation slides may be
14 found under Tab 3 of your meeting book. Dr.
15 Jawad?
16 DR. SHAKIR: Good morning. Thank you
17 very much for inviting me to talk here. I'm
18 really privileged. Through the background I have,
19 I think I can confidently speak about health in
20 Iraq. I have the experience of 26 years working
21 inside the country, inside Iraq as a health care
22 provider extending across the private health care

1 sector, the government health care sector, the
2 military health care system and in a senior
3 position I was the Assistant Secretary for the
4 Ministry of Health for Operations and Technical
5 Affairs for some time. So I would like to deliver
6 the experience that I have to you.
7 This is just to start with to
8 demonstrate to you self-service. I have a lot of
9 photographs in the presentation. Before you
10 faint, you can still help. That's the principle
11 of this guy holding his fluid bottle. If we talk
12 about history in Iraq, I'm sorry to go back like
13 5,000 years. It's a long history. Iraq was for
14 some time the best in the world in health. That
15 was in 2200 B.C., and in 900 -- that's during the
16 Abbasid Empire and then it went down and never
17 regained the top level again. If you look at the
18 Hammurabi Code, and in the year 2200, medical
19 malpractice and the concept of civil and criminal
20 liability for improper and negligent medical care
21 and fees were fixed, those were all written in
22 Hammurabi's Code, so you can see how much

1 developed the thinking of the principles of health
2 and health as a human right. During the Abbasid
3 Empire -- hospital of Baghdad in 1978 was
4 tremendous. If you read details, I've read a lot
5 about the details of this hospital, patients were
6 admitted and given a uniform in this hospital, a
7 white gown and white sheets and there was music
8 played in the halls to entertain patients in the
9 afternoons and food was provided. It's
10 unbelievable. And they had a patient records
11 system and they were having and keeping the
12 disciplines of surgery, ophthalmology, orthopedics
13 and general medicine at that time.
14 This is Almustansiryeah School in
15 Baghdad. I hope some of you were able to go and
16 see it. It's inside Baghdad. This is still
17 there. There was a 10-year medical program for
18 this school and the graduates were working at that
19 hospital, the one I just mentioned. So that's
20 going back to history. But in the year 1258,
21 Baghdad was occupied by the Mongol invasion. By
22 the way, the Mongol Empire was the second largest

1 empire in history after the British Empire. Iraq
2 kept on going down until the year 1917. That's a
3 picture of British troops getting into Baghdad in
4 1917. That's General Stanley Maude on the first
5 horse, and he was leading. This is how Baghdad
6 was looking at that time. Of course, they were
7 shocked. They were thinking of the 1,000 nights
8 and palaces and dancers and all those things, and
9 they found ruins of a city.
10 But in 1917, the Iraq infrastructure
11 started to develop tremendously and electricity
12 was introduced to Baghdad, clean water, the
13 modernization of Al-Majidi Hospital that was built
14 on ruins of that hospital, the lovely hospital,
15 the one I spoke about. And in 1921, military
16 medicine started in Iraq to support the Iraqi
17 troops that were just being established, and in
18 1927 Baghdad's Royal School of Medicine started,
19 and that's before any country in the region Iraq
20 started doing those things. This is in 1939.
21 That's in Kut. This is still being used to
22 control the water of the Tigris, and the Baghdad

1 Railway Station in 1948 was built, and
2 infrastructure was built in a proper way, with
3 communications, airports, water, electricity,
4 dams. The most interesting thing is the
5 construction -- this was the idea of the Iraqi
6 politicians at that time. They thought if
7 they set aside 70 percent of oil revenues on a
8 special account that's going to be outside the
9 ministries because the ministries need to go to
10 the Parliament and you need to approve things, and
11 that was a board created by experts from inside
12 Iraq. I know of the Board members. He was my
13 father's friend. He was a graduate of Johns
14 Hopkins in 1931. He was engineering agricultural
15 projects. Dr. Ahmed Susa is a famous name in
16 Iraq. There were also Americans and Brits on that
17 Board. They were helping the government of Iraq
18 to identify what's required to develop
19 infrastructure in the whole country without going
20 into politics. It was purely scientific and a
21 very proper approach I think at that time. All of
22 Iraq's modern infrastructure which is still being

1 used right now, and some of the projects are still
2 waiting to be implemented were designed by that
3 Board.
4 Concerning health, the Board's aims or
5 goals was to complete the number of hospitals in
6 Iraq. There were not many hospitals in Iraq, very
7 few, to 143 hospitals. They just evaluated how
8 much is required, and they wanted to build 1,000
9 public health care clinics to go through primary
10 health care, 29 military hospitals to support the
11 Iraqi growing military, and they sent thousands of
12 government funded scholarships for specialty
13 degrees and training in the West and Iraq became
14 the world model for a Third World country that's
15 developing. After that, only 14 hospitals were
16 added to the system. Nothing was added to the
17 Iraqi health care system. So the glorious history
18 of Iraq in medicine everybody speaks about in fact
19 was designed and built in the 1950s and 1960s.
20 The plan took 10 to 15 years. They were supposed to
21 be achieved by 1965. But unfortunately the Iraqi
22 kingdom was toppled in 1958 by a revolution by

1 some adventure offices in the Army and Iraq became
2 a republic ruled by generals from the Iraqi Army
3 all the time. The project was delayed until 1975,
4 but Iraq started very early and it's now still
5 working using this infrastructure.
6 This is how Baghdad was looking in 1918.
7 There's nothing on the horizon. Like 40 years
8 later Baghdad was looking like this. This is
9 downtown Baghdad -- if anybody has been to
10 Baghdad. It became like a modern city in the
11 Middle East, a country that's progressing. This
12 is the University of Baghdad that was built in
13 1957, although the School of Law was even started
14 before the Brits were in Iraq in 1908. And there
15 was a project for a university in Iraq in 1931 --
16 but funding was not there. But in 1957 without
17 the project of -- the Construction Board it was
18 one of the important things. This is a model of
19 the 400 bed hospitals that were built by Saddam
20 later on, the 14 hospitals.
21 Because of this development of
22 infrastructure, although it took a model of more

1 clinical medicine, not a preventive primary health
2 care model, but because the oil revenues were very
3 high and Iraq's population was low at that time
4 and very small, it was like 6 million in 1957, you
5 can see the development. I chose the two health
6 indicators, the under 5 mortality and infant
7 mortality just to demonstrate to you the
8 development in health in Iraq. These are the
9 health measures. It's not what kind of bypass
10 surgery you do, this is how we measure health care
11 as health indicators.
12 So in 1960s, 1970s, and 1980s, Iraq's
13 ambition was to go to one third or to one half of
14 its health indicators in 40 years. That was the
15 plan, and they really achieved it. Until 1980,
16 Saddam took over in 1979 as President of Iraq and
17 Iraq went into the war with Iran, 8 years of
18 devastating war with 1 million casualties,
19 chemical weapons used and 1 million dead from both
20 sides and a lot of casualties, this is the year
21 1980. If you look, this is the war on the curve
22 started. Iraq was going up and was progressing.

1 It was the best in the region. Iraq's health
2 indicators in 1990 were better than the two giant
3 countries in the region, Turkey and Iran. Iraq
4 was better than those in its health indicators.
5 In 1990 after 8 years of the war with
6 Iran, medical care in Iraq reached 97 percent of
7 the urban population and 71 percent of the rural
8 population, these are WHO figures, and Iraq was
9 very much praised for this, and below 5 infant
10 mortality rates were definitely going down. There
11 was a 10-year plan to make Iraq emerge from a
12 Third World country into a developed country.
13 They were aiming to drop this to more than 50
14 percent that's reaching European levels of health
15 indicators, and that was the aim. That was
16 supposed to be achieved in the year 2000. But on
17 August 2, 1990, the Kuwait invasion took place and
18 that was the turning point in the history of Iraq.
19 That's what really Iraq is suffering from now.
20 It's not the U.S. Invasion or anything else.
21 This point is really the most important.
22 If you look at this half a mile road

1 between Iraq and Kuwait and you can see how much
2 money is wasted. All these are cars used for
3 transportation by Iraqis. Can you see the damage?
4 This is just a simple example of how much money
5 was lost in that war. That's after the withdrawal
6 of the Iraqi forces and these are all the cars
7 damaged. This is the Ministry of Planning which
8 was not working after that. Saddam took over
9 planning for the country and he said I don't need
10 the Ministry of Planning. That was announced many
11 times by him. These are the countries that stood
12 against Iraq because of the invasion.
13 Let's see what happened in 1990 after
14 the invasion. The systemic air strikes destroyed
15 92 percent of the electric capacity of the
16 country, 31 municipal water and sewage facilities,
17 all major industrial capability, almost all the
18 country's highways and bridges, very few left.
19 Communications, oil refineries, central gas and
20 oil pumping stations, research centers, sports,
21 airports, railway stations, TV and radio stations.
22 I remember. I was still there in Iraq. For 5

1 months continuously we were without electricity.
2 We were living like sleeping at 7:00 or 6:00 when
3 it gets dark. That was really the turning point
4 because Iraq lost all the infrastructure that was
5 built by the Construction Board, the work of
6 years.
7 That was followed by 13 years of severe
8 trade sanctions and economic embargo. The oil for
9 food started practically in 1997 and it was abused
10 by the Iraqi government. It was to raise funds
11 for the government to still continue doing the
12 silly things. These are the same health
13 indicators I showed you before, and let's see what
14 happened after 1990. Iraq in 5 years lost the 20
15 years' achievements and we went back to figures of
16 the 1960s. The health percentage per capita went
17 down to .8 percent because there was no income to
18 the country. 1997 is the most severe year. The
19 country was about to collapse, and this is when
20 the oil for food program started.
21 Still in 2005, these were the last
22 figures before I left the Ministry of Health, they

1 were like this, although the Ministry of Health is
2 claiming now they were able to drop it to less
3 than 1990 which is impossible because it took the
4 Iraqi government 40 years to drop that much and
5 now in 1 year they claim they improved 70 percent.
6 Iraqi hospitals were looking like this with two
7 children on the same bed because there were not
8 enough beds and the hospitals are empty. If we
9 calculate by two health indicators and calculate
10 from the percentages of what the infant and below
11 5 mortality rates came down and up, it seems that
12 Iraq lost 380,000 deaths in infant mortality
13 between 1990 and 2003, and 480,000 below 5
14 mortality rate. These were figures provided by
15 the WHO. The Iraqi government gave this figure of
16 course. That's the reference for the Iraqi
17 government. I think it's quite inflated for
18 political reasons. They gave the figure of
19 1,700,000 died because of the embargo. This is a
20 unique situation that Iraq went through. It's
21 called the double burden of disease, Iraq as a
22 country developing emerged from infectious

1 diseases as the main cause of morbidity and
2 mortality to chronic diseases and degenerative
3 illnesses which are the main causes of morbidity
4 and mortality in developed countries. Iraq was
5 emerging in 1990, but because of the embargo, it
6 went back to the infectious diseases again. So it
7 had both chronic diseases and degenerative
8 illnesses and infectious diseases both as the main
9 causes of morbidity and mortality. This is double
10 burden of disease. It's a unique condition not so
11 many countries have.
12 Let's see what happened after the
13 liberation and occupation of Iraq in 2003. Iraqis
14 were so happy. If you look at their faces how
15 they were hitting Saddam's statue, they were so
16 angry and so happy that this took place. In fact,
17 if you ask public opinion inside Iraq what do you
18 think of the United States, in spite of all the
19 propaganda that Saddam was using against the
20 United States before 2003, Iraqis loved the United
21 States at that time. They were waiting for the
22 United States to come and help. But unfortunately

1 after 2003 they were exposed face to face and
2 worked together with the United States, this
3 public opinion went down greatly.
4 That was Baghdad during the war. The
5 problem, number one, was looting. The Iraqi
6 health care system was looted. If you look at the
7 hospital bed on the left side, the upper picture,
8 that's a hospital bed used to carry things, to
9 steal things, to loot things from the hospital.
10 This was equipment; that's an echocardiogram. They
11 don't know what this device is. They just break
12 it. They want to get rid of it. They don't want
13 to keep it. So there was some kind of a systemic
14 destruction. Hospitals were empty like this and
15 looting was a big deal. This is a clinic burned
16 in Basra in the south of Iraq. This is the
17 general condition outside because of the
18 infrastructure damage. Health is not the duty of
19 the Ministry of Health alone. This is what the
20 Ministry of Health is suffering from. The outcome
21 of this condition is disease, infection, diarrhea
22 and then and the Ministry of Health will try to

1 fix this. This also is a unique thing, that we
2 had 11 Ministers of Health in 5 years and there
3 was no strategic plan at the Ministry of Health so
4 they were working according to what they think is
5 right. So every 6, 7, or 8 months we changed the
6 minister and everything has to change and start
7 rethinking again, and that's not the way to work
8 or to develop something. Iraqis started becoming
9 angry. This is the Operations Center at the Iraqi
10 Ministry of Health. That's not working. It's
11 been locked because of $100 payment that has to be
12 done for a bandwidth contract and the ministry is
13 refusing to pay, and they just locked it and they
14 are using cell phones to collect information. The
15 disastrous thing was that the Ministry of Health
16 was given to Muqtada al-Sadr, and between April
17 2005, I left the end of May 2005, this is the year
18 I left the Ministry of Health after 1 month of
19 Muqtada al-Sadr being in power at the ministry.
20 Until December 2007, this person was in charge of
21 the Ministry of Health and you can see the guys in
22 the pictures on the right side inside the ministry

1 walking like this with weapons in their hands. If
2 you ask who these guys are, they will tell you
3 these are the facility protection forces. They
4 were dressed as civilians, and it was a militia
5 inside the ministry. Iraq went into the turmoil
6 of civil war, civil strife, civil unrest, whatever
7 you want to call it. And the double burden of
8 disease, in fact in Iraq is the only country in
9 the world that had the triple burden. It's the
10 only country when trauma became the leading cause
11 of morbidity and mortality in the year 2006 and
12 that's a historic event in any country in the
13 world. That's what the Iraqis used to believe in
14 after that, that the seculars who were prosecuting
15 the fundamentalists, the condition was only
16 trading places, that nothing happened in Iraq
17 really. It was just the other side who took over
18 power and started prosecuting the other side.
19 This is what's in the minds of the people. The
20 direction was so gloomy, we think it's going
21 nowhere.
22 But, fortunately, the war troop surge in

1 January 2007, and the Iraqi Minister of Health, we
2 were so happy that this minister took place
3 because I know him personally and I know how good
4 he is, and he really proved that he was good.
5 There was dramatic improvement, and yet with
6 cautious optimism. The Minister of Health is the
7 only person who has been changed. He could not
8 change a single person from inside the ministry,
9 all his directors, all his staff are still Muqtada
10 al-Sadr, and they are waiting for Muqtada al-Sadr
11 to come back to restart again. That's
12 unfortunate. He just couldn't do anything. He
13 personally told me that in Chicago when he came to
14 the United States, that I couldn't change this
15 person and this person, although I know they are
16 criminals and they are in charge of a lot of
17 crimes, but I couldn't and I was told not to touch
18 them.
19 The provisional elections in 2009, it
20 was promising yet still we don't know what's going
21 to happen in the next elections by the end of this
22 year. This is the Minister of Health visiting the

1 National Children's Hospital in Washington, D.C.
2 The last Iraqi official from the Ministry of
3 Health who came to the United States was me in
4 August 2004. I visited the United States. No one
5 else came to the United States after I did until
6 May 2008. Imagine Iraq and the United States
7 working together, and for 4 years, almost 4 years,
8 no one is visiting. So there like a cut when
9 Muqtada al-Sadr was in charge.
10 WHO always emphasized that health care
11 systems are to be looked at in a different way.
12 The next slide will tell that in the mid-20th
13 century there were two major models for health
14 care, medical care through hospitals and urban
15 centers with concentration of manpower and
16 resources, that's the provider-receiver model.
17 That's the hospital or clinical model. And the
18 other model was the comprehensive care that's
19 promotive, preventive, curative and
20 rehabilitative. That's the population based. In
21 1948 they started as equal systems. No one was
22 able to know which one is better. But in 1977 it

1 was proved by evidence that the second model is
2 the best for countries that are developing.
3 Unfortunately, Iraq and the United States took the
4 first model and is still using it. The first
5 model is not cost-effective and really is not
6 developing very much on promoting health while the
7 second model is. This is what's supposed to be
8 the people or factions who are working on health,
9 the country's Minister of Health, government,
10 local governorates, health care providers and
11 NGOs, and they should work the three disciplines,
12 clinical, population and community-based. The
13 target is the Iraqi citizen, or anywhere in the
14 world, the citizen. The problem is in Iraq right
15 now it's only the Ministry of Health developing
16 clinical services. That's the model that's being
17 used right now, and this is not going to work.
18 This is our anticipation. The RAND Corporation
19 named those factors as the main pillars for
20 successful reconstruction, economic stability
21 which is not there yet in Iraq because of oil
22 prices. And education. Iraq is one of the

1 highest countries in the region with illiteracy
2 for females. And security. All are so happy
3 including myself that Iraq is more secure, but
4 last month there were 400 deaths in Iraq because
5 of violence. If this happens anywhere in the
6 world it's going to be on the news all the time.
7 Basic infrastructure. I don't need to
8 say anything more about this. You just saw what
9 happened. And governance. The Iraqi government
10 is not yet really governing in the right way.
11 They are still doing this and that.
12 Our challenges are the national economic
13 and political structure of Iraq. It's not yet
14 settled or defined, and nationwide infrastructure
15 development requires a lot of money and time. So
16 if we are so optimistic and think that this is
17 going to be better in 10 years, no, it will need
18 like half a century until Iraq is back to where it
19 was for some time. It's very expensive. I don't
20 want to go through this financial debate of how
21 much Iraq would need to develop, but maybe the
22 last slide will show. If Iraq wanted to match any

1 of those countries on how much they spend on
2 health, you can see how much Iraq's health system
3 requires. Jordan spends $15 billion a year for
4 health, and Oman, Cuba, United Arab Emirates,
5 U.K., Sweden and USA, and the whole budget of the
6 Iraqi government is 59.9. That's the whole
7 government, and Iraq's health was supposed to get
8 $3.9 billion this year and its less because of the
9 oil prices and the economics.
10 The other challenge is Iraq is doubling
11 its population every 20 years. That's a big
12 challenge. How can you plan for a country that's
13 doubling its population every 20 years? This
14 picture is from Najaf Hospital. Someone was
15 trying to see whether the magnet is still working
16 or not, and of course this was ruined. There was
17 no way to bring this back to work. These are the
18 challenges and weaknesses. I don't want to go
19 through the details. I think you are quite aware
20 now that there are a lot of things like the
21 technology gap. It's in the slide show you have.
22 Politicization of the Ministry of Health and all

1 institutions in Iraq is a big problem, and these
2 are all maybe in your slides. I always like to
3 show this because I still remember the statement,
4 we broke it, we fix it. I think this is how it's
5 being fixed now. It's not very well fixed. Iraq
6 is still waiting for a lot to be done. Iraq is
7 not done. It's not okay, let's leave Iraq, that's
8 it. I think we need to invest on the improvements
9 that took place in Iraq and keep on pushing just
10 to demonstrate how Iraq could be a very good model
11 for our success there.
12 I just wanted to say this. There is now
13 the strategic framework for the status of forces
14 agreement between Iraq and the United States. The
15 Department of Defense is phasing out from Iraq and
16 Human and Health Services has been chosen to be
17 the agency inside the United States to take over
18 and look for Iraq's health, and no one is really
19 looking into this in detail. Up to my
20 understanding, we tried. We talked to USAID and
21 they said we are not, and the Department of State
22 is not really very much on this. Health and

and

1 Human Services has a small global office which is
2 not really very functional, and I think it's very
3 important because the Department of Defense is
4 going to leave without anybody taking over and
5 this is something to be addressed and maybe looked
6 at. Our office in fact tried to do very much. We
7 talked to CENTCOM, we talked to other partners,
8 and we are still hoping that someone is going to
9 listen to us, and I think that this is a policy
10 thing that has to be addressed right now. Thank
11 you very much.
12 DR. WILENSKY: Thank you very much. Are
13 there any questions that people would like to ask?
14 Do you know who in HHS, and it is a very small
15 office of Global health, that had previously been
16 in the Office of the Secretary when Bill Steiger
17 was the individual who was responsible, but he has
18 left, is there somebody who's identified in HHS to
19 head that Office of Global Health?
20 DR. SHAKIR: To my understanding there is
21 no one yet, and I think we are way behind the
22 timetable, and the Deputy Prime Minister of Iraq

1 in fact is visiting in May the United States, the
2 Deputy Prime Minister for Services is visiting.
3 He had three meetings in Iraq with senior U.S.
4 officials trying to develop on this project and
5 he's coming to the States in May to discuss with
6 someone the handout, the process of delivering. I
7 don't know to who he is going to talk about
8 health. It's not yet clear. It is still the job
9 of the Department of Defense and I think he has to
10 talk with the two sides, the phasing in and
11 phasing out sides so that he can understand what's
12 going on. That's why I'm trying to bring this in
13 front of you. I think it's very important.
14 DR. WILENSKY: Are the basic decisions
15 that you raised in terms of what the future health
16 care system in Iraq looks like, have those been
17 decided by the current government or is that still
18 under some question as to what kind of model they
19 will use?
20 DR. SHAKIR: The Iraq government, if you
21 listen to what everybody is talking about, they
22 are talking about the primary health care

1 preventive model. But if you look to practices,
2 there is not a single dollar for research, and how
3 can you know facts without doing research and
4 understanding the situation in your country? And
5 all the money is going toward building hospitals,
6 bringing modern very high-tech equipment to the
7 country, so they say something but they do the
8 other thing. They are not going in the right
9 line. They need a lot of money to reconstruct the
10 system as it was a very high-tech system and the
11 1970s technology was cheap and is still being used
12 and it's there, and it's very expensive to go
13 through that model and impossible to go -- there
14 is no strategic plan yet in the Iraqi Ministry of
15 Health. They don't have goals, they don't have
16 timetables, timeframes or implementation plans on
17 how much money is required or where money is put,
18 priorities, and there is nothing like this. It's
19 just like go to work every day and do whatever is
20 in front of your desk. This is what is really
21 going on.
22 DR. WILENSKY: Are the training

1 programs, particularly beyond the physicians, up
2 and running in terms of nurses and primary health
3 care workers of various types? Are those in
4 existence now?
5 DR. SHAKIR: They are still using the
6 same models and programs that were there in the
7 ministry since the 1970s and 1980s, and we always
8 talk about capacity building, but this is not
9 taking place. HHS brought 28 physicians to Iraq
10 on an observation program. They went to different
11 hospitals. They were enjoying shopping. A lot of
12 them were my friends and they were telling me we
13 enjoyed shopping and seeing sites. Like we do
14 surgery there. We do more advanced surgery like
15 than we were shown or we were allowed to look at.
16 I think the capacity for management, financing all
17 those things are so important in Iraq and they
18 have not yet been looked at. The Minister of
19 Health is a clinician, all his assistants and top
20 board of the ministry are clinicians, and none of
21 them has an MBA, none of them has an MPH at the
22 Ministry of Health. They are all clinical degrees

1 including myself. I'm an orthopedic surgeon. I
2 was trying to learn or do something.
3 DR. WILENSKY: Are there any other
4 comments or questions? Thank you very much for
5 sharing your information with us.
6 Our third speaker this morning is Dr.
7 Jean Langlois. She is currently the senior
8 scientist, an epidemiologist, at the National
9 Center for Injury Prevention and Control at the
10 Centers for Disease Control. Dr. Langlois will
11 discuss the recent activities of the Defense
12 Health Board's Traumatic Brain Injury External Advisory
13 Subommittee, including a summary of the
14 Subcommittee's last meeting held on March 24,
15 topics for future meetings, and the questions
16 formally tasked to the Psychological Health
17 External Advisory Subcommittee. Her presentation
18 slides may be found under Tab 4 in your meeting
19 book.
20 DR. LANGLOIS: Thank you very much for
21 the opportunity to present on behalf of the TBI
22 Advisory Subcommittee. I would just clarify that

1 since the last time I participated in one of the
2 Board Meetings, I've since moved to the Department
3 of Veterans Affairs where I am the Scientific
4 Program Manager for the research portfolio in
5 brain injury which includes traumatic brain
6 injury.
7 As Dr. Wilensky mentioned, these are the
8 topics that I'll address, membership, a summary of
9 our most recent meeting, review of the status of
10 the questions that were tasked by Ms. Embrey, and
11 a brief comment on future meetings and activities.
12 I'll just note that this subcommittee was stood up
13 last April, so we've been in operation for about a
14 year.
15 This is the Subcommittee membership. It
16 consists of 11 members with a variety of expertise
17 ranging from concussions, sports concussion
18 expertise, neurosurgery, trauma care and outcomes
19 research. We have had a decrease in membership,
20 and I'll talk about the Subcommittee changes next.
21 In January of this year, Dr. Jim Kelly who was our
22 chair was no longer officially the chair as he

1 accepted a position with the Defense Centers of
2 Excellence for Psychological Health and Traumatic
3 Brain Injury. He is now the Director of the
4 National Intrepid Center of Excellence for TBI and
5 Psychological Health which is located or soon to
6 be located in Bethesda. Dr. Kelly had neurology
7 and sports concussion expertise. Just recently in
8 April we received word that Dr. Ross Bullock, one
9 of the other Subcommittee members, has been
10 approved to be the new chair. Dr. Bullock is a
11 professor of neurosurgery and Director of the
12 Clinical Neurotrauma Program at the University of
13 Miami, a very well-respected traumatic brain
14 injury expert, and we look forward to his
15 leadership. Two other members have departed the
16 Subcommittee, Dr. Robert Cantu, a neurosurgery and
17 sports concussion expert left very soon after his
18 appointment, and Dr. Guy Clifton, more recently
19 neurosurgery and trauma care just to give you a
20 feel for the areas in which we have lost members.
21 We have talked with Commander Feeks about the
22 procedures for appointing new members, and I

1 believe that's under consideration.

2 Our most recent meeting was on March 24

3 and it was a joint meeting for the first time with

4 the Psychological Health Subcommittee. At that

5 time our goals were to establish a working

6 relationship between the Traumatic Brain Injury

7 and Psychological Health Subcommittees because of

8 the overlapping areas of expertise and interests

9 and also overlapping tasks. The details of that

10 session I believe will be reviewed to some extent

11 by Dr. Fogelman in his brief for the PH

12 Subcommittee which is coming up. Also at that

13 time the TBI Subcommittee convened a small working

14 group of concussion experts and epidemiology to

15 begin to address a specific question that we're

16 tasked with, and I'll talk about that question in

17 a moment, but it has to do with the automated

18 neurocognitive assessment matrices or ANAM. We

19 discussed the limitations through a presentation

20 by Colonel Bruce Crow who is the clinical

21 psychology consultant to the U.S. Army Surgeon

22 General.

1 Just to review the tasks that we've been
2 assigned by Ms. Embrey, we've been asked to review
3 the automated neurocognitive assessment matrices,
4 and I'll talk a little bit about that in a moment
5 to give you a bit more background. We were asked
6 specifically to determine whether it's an
7 effective pre-deployment tool and provide
8 recommendation for its use. The PH Subcommittee
9 was also tasked with this request which helped to
10 prompt our interest in working together. Also as
11 you may recall from the December Board meeting, we
12 have been asked to review the post-deployment TBI
13 screening tools. These are the post-deployment
14 health assessment, the PDHA, post- deployment
15 health reassessment, PDHRA, which includes
16 screening questions for concussion. I've been
17 asked to determine whether they are responsive to
18 the post- deployment needs of Service members.
19 A little bit of background to the work
20 that we've been doing to respond to the request
21 for a review of the ANAM, neurocognitive
22 assessment test. In general, our measures of

1 cognitive performance areas typically affected by
2 concussion include attention, judgment, memory
3 and thinking ability, and there is a range of
4 these types of measures that are in use in various
5 settings, not just in the military but in civilian
6 use, particularly for assessment in the sports
7 concussion area. The ANAM itself is a 15 to 20
8 minute computerized test that was the test
9 selected for pre-deployment assessment of Service
10 members' cognitive performance. This test was
11 selected in part because of the fact that
12 pre-deployment neurocognitive assessment testing,
13 or NCAT testing, was broadly recommended. I think
14 there were seven recommendations that we were
15 briefed on. Some examples of these are an Army
16 TBI Task Force report in May 2007. Probably the
17 most important was the National Defense
18 Authorization Act of 2008 which recommended
19 pre-deployment NCAT testing, and an Institute of
20 Medicine report that actually was December 2009.
21 I apologize for the error there. Despite all
22 these recommendations, it's still a fairly

1 controversial area and I believe that's why we
2 were asked to comment on it.
3 I'll also mention that although the
4 efforts now are focused on pre-deployment testing,
5 many of these recommendations also were for
6 post-deployment assessment, but that has not been
7 implemented. You have this in the back of your
8 handout. This is the Interim Guidance that was
9 given by Dr. Cassells, and I just wanted to point
10 out that it suggested that this was meant to be an
11 interim plan because it states that until ongoing
12 studies are completed that the ANAM would be
13 selected. So I guess we could consider perhaps
14 the implementation of the ANAM as a pilot effort.
15 This is from a briefing by Colonel Fortuin who
16 interpreted the guidance for us and explained it
17 as an effort to collect baseline neurocognitive
18 data on both active and Reserve forces prior to
19 their deployments, that this was put into effect
20 by July 20, 2008, each deploying Service member
21 was to have a baseline within 12 months of
22 deployment, that the ANAM was to be used as I

1 mentioned, that the guidance would be reviewed on
2 a quarterly basis, and that the Defense and
3 Veterans Brain Injury Center, or DVBIC, would be
4 the designated point of contact.
5 The status of our work in this area is
6 that we have received several briefings. The most
7 recent one by Colonel Crow was a detailed review of
8 the Army experience. We've assembled most of the
9 published ANAM literature and have begun reviewing
10 it, and I might just mention here that again this
11 is a small subgroup, working group, of interested
12 members that has been involved in this particular
13 task at this point. We have been awaiting
14 documents to be provided by DVBIC. These were
15 documents that were identified in March as being
16 important, and we have since received those, as of
17 Tuesday those have been sent to us, and to members
18 of the Psychological Health Subcommittee who have
19 joined our small work group so that we can provide
20 a combined response between the two subcommittees.
21 Then lastly, the other question that
22 we’re asked to address that the Board has some

1 experience with work in this area where we
2 received several briefings. As Dr. Kelly
3 mentioned, in December we had a small working
4 group which met at Fort Carson. Dr. Kelly then
5 presented to the full Board the interim
6 recommendation also last December. And most
7 recently, Dr. Kelly reported that he is preparing
8 a draft written response for submission to the
9 DHB. We haven't seen that in the subcommittee
10 yet, but it will be reviewed by the TBI and the
11 Psychological Health Subcommittees again taking
12 advantage of the expertise of the PH Subcommittee
13 as well.
14 Future meetings and activities. Our
15 current agenda consists of responding to those
16 requests that I've reviewed today and we await the
17 leadership of Dr. Bullock as the new chair to help
18 us reformulate the agenda for the future. Thank
19 you, and I'll take any questions.
20 DR. WILENSKY: I had two. Do you have a
21 schedule for your next meeting is one? Then the
22 second just as a piece of information, Dr. Guy

1 Clifton has indicated an interest in rejoining the
2 Subcommittee. He was unclear whatever formally
3 has to occur to make him no longer a Subcommittee
4 member had actually occurred or not, but in any
5 case he has indicated an interest in rejoining
6 either as a new Subcommittee member or as a
7 reactivated Subcommittee member. It's not quite
8 clear to me what the technical process is to
9 distinguish one from the other, but that will be
10 at least one less person who has left the
11 Subcommittee.
12 DR. LANGLOIS: I don't have any plans
13 for the next meeting. Dr. Bullock has just
14 received approval from his own department to
15 assume the role of chair. Commander Feeks, do you
16 have any information?
17 COMMANDER FEEKS: No, he has not gotten
18 that far yet, but we'll be working with him to get
19 set up for your next meeting.
20 DR. WILENSKY: Dr. Silva?
21 DR. SILVA: Thank you for this report.
22 To me and I think to this committee, the hairy dog

1 is mild TBI and how to define it, and it's quite
2 common. Has your committee made any progress in
3 establishing some criteria for TBI, because there
4 are a lot of compensatory issues that are
5 downstream once you establish a definition. And
6 of course, people within the military have written
7 about this, the "New England Journal of Medicine"
8 a few weeks ago, Dr. Hog and Dr. Castro, so I know
9 you're aware of those data, but that's the big
10 issue I believe. Thank you.
11 DR. LANGLOIS: There is VA and DOD
12 common definition of traumatic brain injury that's
13 being used in some circles, so your point is well
14 taken that this is an important issue and there
15 are still questions about which definition is
16 best.
17 DR. WILENSKY: Dr. Sutton, do you want
18 to comment?
19 BRIGADIER GENERAL SUTTON: Thanks so
20 much for that question. This certainly has been
21 an issue of considerable discussion. Most
22 recently the clinical practice guidelines both for

1 the non-deployed setting for mild TBI or concussion
2 has been revised from the 2006 version as well as
3 for the first time we've got a single clinical
4 practice guideline for the management of
5 concussion or mild TBI in the deployed setting.
6 In terms of the definition itself and the issues
7 raised in the recent "New England Journal"
8 article, these are precisely the questions that
9 Dr. Kelly and a group of us from DVBIC and
10 throughout the Defense Centers of Excellence is
11 working right now with the VA to come out with a
12 final set of recommendations and we'll certainly
13 work with both of the advisory committees to that
14 end. Thank you.
15 DR. WILENSKY: Command Sergeant Major?
16 COMMAND SERGEANT MAJOR HOLLAND: Ma'am,
17 have you done any work with Baylor School of
18 Medicine or UCLA Medical School? They've done
19 some real good work with actual wounded troops to
20 measure and evaluate and even use some
21 mathematical formulas to figure out the degrees of
22 traumatic brain injury. Have you touched base

1 with any of those entities?

2 BRIGADIER GENERAL SUTTON: Thanks,

3 Sergeant Major. Yes, in fact, Dr. Dave Hovda, who

4 is the Director of the UCLA Brain Injury Research

5 Center was just out here last month, and of course

6 we are very interested in his work which, along

7 with his colleagues, has really demonstrated that

8 in the post-acute period following concussion or

9 mild traumatic brain injury that the timing of

10 interventions is critical as the brain goes into a

11 hypometabolic state and where, for example, as we

12 have brought together our experts from the

13 consensus conference on hyperbaric oxygen as an

14 example, it's been very important for us to rely

15 on Dr. Hovda and his colleagues' judgment to guide

16 our actions and to understand that the logic that

17 some have applied to this issue, the brain needs

18 oxygen, the injured brain could benefit from

19 oxygen, is not quite as simple as it might first

20 appear. So, yes, we are working with Dr. Hovda at

21 UCLA as well as many others to address those

22 issues.

1 DR. LANGLOIS: I just wanted to add that
2 Dr. Hovda is a member of the TBI Advisory
3 Subcommittee, so we're aware of this work. And
4 also with regard to Houston, we are very aware of
5 the work of Dr. Harvey Levin at Baylor College of
6 Medicine. He is funded by the VA and I believe
7 also NIH, and perhaps DOD, I'm not sure, but very
8 excellent work and certainly work that we're
9 considering.
10 LIEUTENANT COLONEL JAFFEE: Just to add
11 to the comments and specifically address your
12 question again with Baylor and Dr. Levin, Baylor
13 and Dr. Levin and his team were actually selected
14 by your congressionally directed medical research
15 program to be the core of a hub of a TBI
16 consortium last year, so they are very much
17 engaged in coordinating research with the DoD.
18 There have been a lot of collaborative efforts not
19 just with UCLA and with Baylor, but with many,
20 many academic institutions throughout the country
21 through various research partnerships, it's our
22 civilian experts who come in and help contribute

1 to the practice guidelines that General Sutton and
2 Dr. Langlois were describing, some of the
3 screening tools that we use currently were
4 actually developed mostly from our civilian
5 experts around the country who we're drawing that
6 expertise from. And it was kind of with their
7 input as well getting back to the question of
8 definitions, the current definition we have is
9 consistent with that used by the CDC, with the
10 American Congress of Rehab Medicine and the
11 American Academy of Neurology. That being said, I
12 think the ideas most of the scientists will
13 be able to realize as we are gaining more
14 knowledge, perhaps our nomenclature does need to
15 be modified or adjusted. To that end, we actually
16 had a conference last year that was co-sponsored
17 between NIH and the Department of Defense
18 specifically addressing the question of TBI
19 nomenclature and a lot of those recommendations
20 are also currently being used to help guide and
21 drive various research agendas and the like. So
22 it is an evolving process that we're hoping to use

1 the knowledge as it comes in to continue to modify
2 and evolve the way that we are doing our things.
3 We've been fortunate to have the input
4 of such expert panels to include the Defense
5 Health Board and the Institute of Medicine who
6 recently evaluated the way we're doing screening
7 and actually had some very good inputs based on
8 current knowledge to endorse some of the screens
9 and tools that had been adapted by both the DOD
10 and the VA. So it's an iterative process which
11 very much relies on the input of our civilian and
12 academic experts.
13 BRIGADIER GENERAL SUTTON: Mike, maybe
14 you could also comment on the partnership we're
15 developing with NIH with respect to the
16 supercomputing analytic capability for both PH and
17 TBI.
18 LIEUTENANT COLONEL JAFFEE: Thank you
19 for bringing that up, General Sutton. And DCoE
20 has really facilitated this real partnership in
21 that we're able to provide really advanced types
22 of data and informational analysis through an

1 array of supercomputing things both in terms of
2 data archiving as well as more advanced IT
3 technologies in data analysis using a variety of
4 data to include not just information but
5 multimedia aspects, neuro- images, pathological
6 specimens and the like, and we're hoping, and the
7 plan is, that this will be a repository for a lot
8 of people throughout the DOD and other federal
9 agencies to kind of pool their information by
10 using more of these super-analyses being able to
11 gather more information. One of the models that
12 this is being based upon is the success that some
13 people are aware of with the National Database for
14 Autism Research, NDAR, which was developed by the
15 same people with whom we're in partnership. So I
16 think we are setting an infrastructure for
17 research and information gathering that will
18 further accelerate the knowledge that we're
19 gaining by instead of taking the pockets of
20 information, being able to correlate them and look
21 more for these overarching trends which may
22 accelerate our knowledge.

1 COMMAND SERGEANT MAJOR HOLLAND: I'd
2 like to direct this to General Sutton. All you
3 great technical folks get way above a Sergeant
4 Major's head, but I'm down with a line unit way of
5 I've already seen UCLA medical and Baylor School
6 of Medicine take three or four of our great young
7 wounded who were having real struggles with things
8 that triggered events, et cetera, and helped them
9 through that. Now it has taken 3, 6, 9 months of
10 100 percent of care, but at least UCLA has just
11 taken two of the wounded that I deal with on a
12 daily basis, and now another one has just been
13 accepted into the program. I just hope that we're
14 collecting all of this data and making sure that
15 we're all sharing our great knowledge and we don't
16 just gather the data like we do AARs and put them
17 in a file cabinet and never use them again. So
18 I'd really like to make sure that we do this, and
19 I commend all the folks for what they're doing out
20 there and we have a lot of challenges. We just
21 had our first two family members finally break and
22 go into a traumatic brain issue and we found an

1 organization in Arizona to help these family
2 members. I'm pretty sure it's Arizona. So thank
3 you very much, but we just need to keep gathering
4 whatever we can, ma'am.
5 BRIGADIER GENERAL SUTTON: Thanks so
6 much, Sergeant Major. I'll count on you to keep
7 us on the road of reality and common sense, and I
8 couldn't agree with you more. Our collaborative
9 network goes far beyond the federal government and
10 extends to our civilian colleagues around the
11 country and, yes, throughout the world, and we'll
12 continue to reach out and maintain that learning,
13 that sharing, those collaborative relationships
14 that make us all able to reach out and serve
15 our troops better. Thank you.
16 DR. WILENSKY: Mike?
17 DR. PARKINSON: Yes, thank you, Dr.
18 Wilensky. One of the issues that continue to --
19 trouble is too strong a word, but we've got to pay
20 attention to is obviously what is our normative
21 data in an area that clearly will have a lot of
22 good information right now? I guess if you could

1 comment a little bit on not only within DoD, but
2 it seems to me as I listen to this that it's a
3 moving target in terms of what is the normative
4 value for the general population that come into
5 the military when we see increasingly lowered
6 attention spans as a result of technology at least
7 anecdotally. Have you had any exchange or could
8 you consider talking a little bit even to folks at
9 the National Health and Nutrition Examination
10 Survey to create a simple screening instrument or
11 something that could be a subset of the automated
12 DoD assessment that you could actually plug into
13 to begin to get true normative data from the
14 general population about this? Because
15 particularly for mild TBI, mild concussion, mild
16 cognitive effects, I'm very concerned about
17 labeling, case definitions and those types of
18 things. We have the opportunity here to really
19 define a new baseline I think, and maybe that's in
20 your work plan, just a reaction and comment to
21 that general approach.
22 DR. LANGLOIS: I think that's an

1 excellent idea and certainly we'll bring that idea
2 back to the small working group that's addressing
3 the issues. It certainly is of great concern that
4 the normative data be reflective of the general
5 population. There are issues though that were
6 raised with regard to what's the appropriate
7 normative example for our military population. Is
8 it other military personnel? So we're balancing
9 the various issues and trying to determine in
10 research as well as in testing which is the
11 appropriate normative example. But it hasn't been
12 suggested before and certainly we'll bring that
13 back into the small working group.
14 BRIGADIER GENERAL SUTTON: If I could
15 just add, this is such a critical point, and to
16 this end, this spring we are moving forward with a
17 15 year longitudinal study and Colonel Jaffee is
18 working close with both our TBI and our PH folks,
19 joining hands with the millennial cohort PIs to
20 make sure that we really do pose these critical
21 questions and then launch the rigorous scientific
22 scrutiny that will allow us increasingly over time

1 to answer them. Colonel Jaffee, is there anything
2 you'd like to add to that?
3 COLONEL JAFFEE: The way I understood
4 the question from Dr. Parkinson was can we advance
5 our understanding of how combat traumatic brain
6 injuries may be differing from our more
7 traditional civilian injuries in terms of
8 diagnosis, prognosis, treatments and the like, and
9 that is a very key aspect of information. So as
10 General Sutton mentioned with the congressionally
11 directed 15 year longitudinal study that the DoD
12 is doing, we've been working with the CDC and NIH
13 to make sure that there are civilian components to
14 that to provide that civilian comparison. Along
15 those same lines, we have a robust interaction and
16 collaboration with the VA, and the VA actually
17 just entered into an agreement with the Model
18 Systems part of the National Institute of
19 Disability, Rehabilitation and Research which is a
20 civilian network of hospitals that treat moderate
21 to severe injuries from civilian aspects. So
22 these relationships that are being formed I think

1 will lead to a much more robust comparison of our
2 combat injuries to our civilian injuries which I
3 think is very important for us to further advance
4 our knowledge. Some of the fruits of that
5 research are just now coming out. Some data was
6 released last week comparing civilian injuries to
7 combat injuries using various types of imaging
8 modalities that actually did illustrate that there
9 were significant differences in the patterns, so
10 we're beginning to learn more and more about these
11 differences and the next step is translating that
12 to prognosis and treatments.
13 DR. WILENSKY: Ed Kaplan?
14 DR. KAPLAN: This has been very
15 enlightening to hear. My question is more I guess
16 an organizational one. We have a Traumatic Brain
17 Injury Advisory Subcommittee and yet we've heard
18 in the last few minutes of numerous other
19 collaborations, organizations and so forth that
20 are addressing the same area. To what extent does
21 the Traumatic Brain Injury Subcommittee of this
22 Board fit into those, participate in those either

1 actively or passively? Because it seems like
2 there are many different parallel lines of
3 activity going ahead. I don't know who I should
4 ask that to.
5 DR. WILENSKY: I'll give you my limited
6 information, but maybe we can have participants
7 from the committee share more. There has been an
8 attempt to make sure we're crossing within our own
9 structure and we'll hear after the break from Dr.
10 Fogelman about a recent meeting that included a
11 joint meeting, for example, between Psychological
12 Health and the TBI Subcommittee. So we're trying
13 to make sure, and this will come up in a number of
14 other areas, that internally we cross
15 subcommittees where appropriate. Generally in the
16 subcommittees that I've seen, there have been
17 participants from some of these other activities
18 or at least reports on what they've been doing,
19 but if it's something, Dr. Langlois, that you want
20 to comment to more specifically with regard to the
21 VA and some of the university activities.
22 DR. LANGLOIS: The main way that we

1 learn about the activities of these other groups
2 as a subcommittee is through briefings, and I
3 think we'll be looking in the future to broaden
4 the base of information that we're getting because
5 we've become aware of the wide diversity of views
6 and the wide array of research that's done
7 throughout the Department of Defense, so I think
8 that's an important way. And certainly the
9 support that we've received has allowed us to have
10 quite a wide range of briefings already. There
11 are individual subcommittee members like myself
12 who are involved in a number of other activities
13 and other committees and receive briefings for
14 example on the millennium cohort study. I also
15 have consulted on the planning for the 15 year
16 follow-up study that was mentioned today. So in
17 that way certain subcommittee members bring
18 information from their outside activities that are
19 relevant to the subcommittee. Those are two ways.
20 DR. KAPLAN: Just a short follow-up.
21 This is exactly the point that I was trying to
22 make, that there are multiple activities going on

1 and it seems to me that the TBI Subcommittee of
2 the Board needs to be involved in those if it's to
3 make appropriate recommendations to this Board.
4 DR. WILENSKY: Are you suggesting formal
5 involvement, that we attempt to have a
6 subcommittee member actively participating in
7 these, or just to be aware of where they are so
8 that they can make sure that the work of these
9 other groups is reflected in the determinations of
10 the Subcommittee?
11 DR. KAPLAN: To the extent that it's
12 hopeful in drawing conclusions from the TBI Board,
13 I think this is almost essential to do so.
14 Whether it's our responsibility or the
15 responsibility of the Board to what extent they
16 should be involved, somebody else has to answer
17 that question. But it seems to me there are a lot
18 of parallel activities going forward and they
19 should be connected particularly if this is to
20 make recommendations to the Board.
21 DR. WILENSKY: Colonel Jaffee, did you
22 want to comment?

1 COLONEL JAFFEE: Again just to follow-up
2 on some of the ideas expressed by General Sutton
3 and Dr. Langlois, a lot of the major initiatives
4 that were described today including the clinical
5 practice guideline developments for the deployed
6 setting, the recent DOD-VA guidelines, a lot of
7 these research meetings and initiatives do involve
8 a lot of civilian experts and it so happens I
9 think back on each of these major initiatives that
10 some of the members who are currently on the TBI
11 External Advisory Committee have been invited and
12 are active participants in that, and if I think
13 back even longer before the TBI External Committee
14 was organized, a lot of the participation and
15 expertise of these civilians actually led to their
16 being nominated to serve on the Defense Health
17 Board panel and their participation has continued
18 in the context of their being on the DHB as well.
19 DR. WILENSKY: And I notice when people
20 were introducing themselves today and at previous
21 Core Board Meetings that we always have individual
22 from the VA who are involved with Institute of

1 Medicine representation. So the fact that
2 individuals representing these organizations are
3 present during our meetings as well as get
4 included in the briefs. I think it probably
5 occurs, but we can have discussions whether
6 there's anything more that needs to occur. Dr.
7 Holcomb?
8 DR. HOLCOMB: General Sutton, it's nice
9 to see you again, ma'am. We've discussed
10 diagnosis, definitions and touched on maybe a
11 little bit of treatment, but we haven't talked
12 about prevention especially for the more milder
13 form of TBI concussion. Can you discuss that
14 aspect a little bit for this group?
15 BRIGADIER GENERAL SUTTON: Thank you,
16 Dr. Holcomb. It's great to see you as well.
17 It's good to know there's life after retirement.
18 Before I get to your comment, let me just get back
19 to Dr. Kaplan's point for a moment because I
20 think, sir, that you raise a critical point. All
21 of what has been said in response to your point
22 certainly is true, but I think it still remains a

1 communications challenge, that we can continue to
2 foster that dialogue on a real-time basis. What I
3 would offer to that end would be perhaps if the
4 Board is interested, we could certainly share our
5 monthly summary that encompasses all of the work
6 that's been going on in all of our component
7 centers as well as headquarters. So, ma'am, I'd
8 be glad to share that with you and perhaps that
9 could give folks a more robust idea and avenue for
10 input. Thank you for raising that point.
11 Back to prevention. As you know, John,
12 our work I guess now over a year ago, first of all
13 working with the helmet community, and our work is
14 not done there, although that's not our immediate
15 domain of responsibility of authority, it
16 certainly has been a critical area. Dr. Holcomb
17 and former Surgeon General Carleton last year
18 brought to our attention some very interesting
19 data. First, it was a study that was performed by
20 the Riddell football helmet company comparing the
21 concussive protection provided by their helmet
22 pads versus the new Army combat helmet pads. That

1 of course was not sufficient to take it from the
2 company itself. Dr. Holcomb then had an
3 independent study that was done showing the same
4 results, and then the Army aviation community
5 conducted a third study showing similar results.
6 The upshot of it was that while there's been
7 tremendous advances made certainly in providing
8 ballistic protection perhaps on the concussive
9 protection front there could be some improvements
10 and I think that the material community over this
11 last year has proceeded down that road and we'll
12 need to follow-up with them and see what the
13 current status is, but it's a very important point
14 in terms of prevention.
15 Also I would say that the work that
16 DVBIC has been doing in terms of developing the
17 MACE, the Military Acute Concussion Evaluation, and
18 socializing that both within the medical community
19 as well as, importantly, the line community
20 because the real challenge here is to get as close
21 as we can to the actual point of exposure or
22 injury, document it, have the medical evaluation

1 and when indicated make sure that that troop takes
2 -- for a day or two, sometimes a week or more, to
3 prevent the long-term effects of concussion and
4 mild traumatic brain injury. That is continuing
5 in theater, the implementation of that program.
6 The awareness of the line leadership has certainly
7 been keen to this issue. For example, Lieutenant
8 General Clyde Vaughan who just yesterday retired
9 from the National Guard Bureau, but his work over
10 this last year partnering with the medical
11 community developed this personnel blast tracker
12 system that is an event reporting system that
13 links up with the medical reporting systems, that
14 we have not only real-time awareness and the
15 opportunity for intervention, but we also then
16 have a longitudinal and historical record, so as
17 individuals get into their communities and perhaps
18 may need further on intervention down the line
19 will have that visibility. All of these are works
20 in progress. We're not where we want to be at
21 this point, but I would welcome any thoughts that
22 you might have at this point that could really

1 augment our efforts at prevention. And of course,
2 it's not just on the battlefield. We know at home
3 with skateboard injuries, skiing, there are many
4 opportunities for us to heighten the awareness of
5 providing head and brain protection.
6 DR. HOLCOMB: I think that's a great
7 assessment and update. Thank you. I would just
8 comment that as a person who has taken care of a
9 lot of combat casualties and now works at a place
10 with about 6,000 trauma patients a year who come
11 in to one's hospital, there are I think many more
12 similarities than differences. My physiology now
13 as a civilian is remarkably similar to yours as a
14 military person and our body only reacts in a
15 number of ways to external injury. They look
16 remarkably similar when as a surgeon I open them
17 up or as a non-surgeon look at a CAT scan. I think
18 there are lots of lessons to be learned from the
19 great volume of injury that occurs in the United
20 States every day, and every time we've looked at
21 this whether it's a burn patient, military or
22 civilian, a hemorrhagic shock patient, military or

1 civilian, they are almost super-imposable
2 physiologic responses. I'm not an expert in TBI.
3 I've taken care of a lot brain injured people both
4 military and civilian and they strike me as
5 remarkably similar.
6 Most clinicians work on the treatment
7 side. Most folks as we heard from our Iraqi
8 colleague recognize that if you're going to make
9 big changes, it's on the prevention side. I would
10 suggest, and I know it's been discussed, but as
11 you said there are not many changes yet, that
12 prevention of TBI is something we really ought to
13 look at very carefully. I know people have done
14 this, I know it's been raised before, yet I'm not
15 sure any changes have occurred from a mild TBI
16 point of view from a prevention point of view in
17 theater. It's something that should be looked
18 at probably at very high levels and consciously
19 decide to move forward or not.
20 DR. WILENSKY: It would be helpful if
21 you would make sure you maintain; however, you want
22 to do some informal ties with the TBI

1 Subcommittee. Obviously your areas of expertise
2 have a lot of crossover, and however you want to
3 arrange it with Dr. Bullock would be fine. Dr.
4 Ludwig?
5 DR. LUDWIG: My comments have largely
6 been OBE'd at this point, but I would like just to
7 make a quick comment again about communication
8 because I think it's very critical and largely
9 addressed by the Colonel and General Sutton. The
10 Medical Research and Material Command has been
11 responsible for now executing almost a billion
12 dollars of money directed toward traumatic brain
13 injury and psychological health since 2007, and
14 again the use of not only a broad diversity of
15 expertise within the DoD, it has been very
16 responsible for pulling that together, but also
17 bringing in expertise from the private sector, and
18 again largely with some members who are already
19 closely associated with the Board, and we would
20 just like to continue that level of interaction to
21 ensure that we are addressing the most important
22 problems, identifying critical research gaps,

1 finding out what work is being done in those
2 particular areas, and then directing new research
3 to fill those gaps is a critical component to that
4 execution strategy for ensuring that that money is
5 actually put to the best use. We would just like
6 to continue to encourage the Board to take an
7 active role in that process to make sure that we
8 are in fact doing that.
9 DR. WILENSKY: Sergeant Major?
10 COMMAND SERGEANT MAJOR HOLLAND: Dr.
11 Holcomb, good to see you again, General Sutton.
12 All I would like to ask you to do is-- we've had
13 five different tests of helmets for my troops to
14 wear and we've tested those out but we've not
15 fielded very much of anything different than what
16 I was wearing in 2002 in Afghanistan. So sooner
17 or later we need to start moving forward before we
18 start having dollars cut because everyone thinks
19 the war is over, and to try to help protect these
20 young men and women or the numbers that everyone
21 keeps saying will be reduced, ma'am, I just do not
22 see that there will be a reduction. So the

1 concussive type issue that we've been talking
2 about and we've all talked about them in a working
3 group together, I would really like to see us try
4 to see how we can take some of those forward,
5 ma'am.
6 BRIGADIER GENERAL SUTTON: Thank you,
7 Sergeant Major. I absolutely agree and perhaps
8 could recommend at the next meeting to work with
9 the material combat development community to bring
10 a status report on helmet protection and where
11 things stand at this point. That might be very,
12 very useful.
13 Also, sir, to your point, I would just
14 like the offer the Board sort of save the date, I
15 guess I don't have an exact date yet, but a save
16 the month. February of next year we are planning
17 to hold a State of the Knowledge Summit which will
18 feature really all of the things that we've
19 learned over the last by then 3 years in terms of
20 PH and TBI and the tremendous investment that you
21 noted and would really invite the Board's
22 participation in pulling together that conference

1 and really making it count. Thank you.
2 DR. PARISI: Joe Parisi from the Mayo
3 Clinic. I'm glad to hear that you mentioned the
4 research component because I think this is a key
5 piece of this whole puzzle that's still very
6 elusive and really requires a lot more
7 coordination. I know there's a lot of research
8 being done, animal models by people in the
9 civilian sector as well as military, but who's
10 coordinating all of this? I guess I'm not sure
11 exactly who's in charge. I think this is a major
12 problem. We're hearing different pieces, but I'm
13 not sure who is actually coordinating everything
14 together.
15 BRIGADIER GENERAL SUTTON: That is a
16 work in progress. Right now I will tell you that
17 the investment that has been made has been
18 coordinated through sort of a joint team effort
19 led by the team at MRMC at Fort Detrick, but
20 pulling in the other services and their research
21 activities. Certainly as DCOE has stood up, we
22 are now in a position as Ms. Embrey has made very

1 clear that ours is the final approving authority
2 for research funds and to develop the strategy,
3 but clearly that is something that is not just
4 developed in a vacuum within the Services or DoD
5 or even within VA. We want to make sure that
6 that's a very broad coordination and organization
7 of efforts and that's where the project that
8 Colonel Jaffee mentioned a couple of minutes ago I
9 think is going to be very helpful as we make the
10 current data transparent in this sort of
11 supercomputing platform as in the autism community
12 as well as the cancer community has been able to
13 benefit from so that we can really advance and
14 catalyze knowledge as well as assess where are we
15 in terms of filling the knowledge gaps that were
16 identified in summer 2007 and then laying the
17 groundwork ahead, where does our strategy need to
18 take us. So I completely agree with you that this
19 is an area that we could certainly come to the
20 next Board and provide a lay down of where we are
21 at this point, but we'd want to invite your input
22 because we know that this is still a challenge for

1 us to pull all of this together and integrate and
2 coordinate in the way that you have mentioned.
3 DR. WILENSKY: Consider your offer
4 accepted.
5 DR. LANGLOIS: I'd like to add that the
6 Department of Defense through the DCOE has really
7 reached out to the VA to try and coordinate our
8 research efforts. Large sums of money have become
9 available very quickly and often those processes
10 happen so quickly that there is a need to reflect
11 and to be more thoughtful about how we put forward
12 future announcements for research. So I really
13 commend the DCOE for their efforts to work with
14 the VA on future coordination of our research. In
15 addition, there has been an effort over several
16 years to bring together in a voluntary effort
17 research organizers and funding representatives
18 from NIH, from HHS, from VA and from DoD in a
19 group called the Federal TBI Research Working
20 Group who meet on a regular basis to compare notes
21 on what research we're doing, what's needed to be
22 done, and that's led to a number of efforts to

1 help improve research to improve the
2 standardization across federal research efforts.
3 It's a huge animal and it's one that we haven't
4 conquered yet, but there are unprecedented efforts
5 I believe at this point to move in the direction
6 that you've indicated as important.
7 DR. WILENSKY: Are there any further
8 questions or comments? I think it was a very
9 informative discussion. Thank you, Dr. Langlois.
10 We are now going to take a break. We'll
11 reconvene at 10:15.
12 (Recess)
13 DR. WILENSKY: Our fourth speaker this
14 morning is Dr. Charles Fogelman who currently
15 serves as Executive Coach, Principal Leadership
16 Development and Management Consultant at Paladin
17 Coaching Services. Dr. Fogelman is also Chairman
18 of the Defense Health Board's Psychological Health
19 External Advisory Subcommittee and will provide a
20 summary of the Subcommittee's last meeting held
21 March 23 and 24 of this year, topics for future
22 meetings, and the questions formally tasked to the

1 Subcommittee. His presentation slides may be
2 found under Tab 5 in your meeting book and has
3 already been referenced. Part of the meeting was
4 the joint meeting with the TBI Subcommittee. Dr.
5 Fogelman?
6 DR. FOGELMAN: Thank you. It wasn't
7 just referenced. Jean gave me an assignment, but
8 she didn't tell me that she was going to give me
9 the assignment, so I'll pretend that I'm
10 responding to it.
11 Before we start I'd like you to imagine
12 this to be a blank slide for a second and
13 visualize a gear shift knob. Most of you in this
14 room are old enough to know what a gear shift knob
15 looks like. Right? It has the gears on it. You
16 may recall at the last couple of meetings I said
17 the first one was organization and then we were
18 trying to gather information and we're sort of
19 getting ourselves together. I think we're either
20 just in second gear or reengaging the clutch
21 between first and second gears. We're not in
22 third or fourth or heaven knows in fifth is

1 overdrive, but I do hope within the year we will
2 get there. So bear that in mind if you are
3 looking for substance and don't hear any. That's
4 what we're going to do today and I think that's
5 what Gail just said. You've seen this slide
6 before. That's the folks who are on the
7 committee.
8 We took a couple of steps to try to move
9 ourselves forward. I've told you before that I
10 and at least one of the other people on the
11 Subcommittee were going around interviewing folks
12 and having individual meetings and we continued
13 with that. But we have begun to focus a little
14 bit more in regard to what we want to know about
15 and what we want to talk about. In a few moments
16 you'll hear me talk about our skeletal, but
17 standard, agenda.
18 Among our ongoing agenda items would be
19 we'd like to learn about something new, about
20 something old. This is not about weddings. There
21 is nothing borrowed or blue here. Maybe there's
22 the borrowed part too. The psychological fitness

1 which is about resilience was something we had
2 begun to talk about and wanted to learn a little
3 bit more about. That's why we had that
4 presentation. Second, we met individually with
5 several of the folks from DCOE. Part of our
6 responsibility is to try to figure out the best way to
7 provide advice to DCOE and in order to do that we
8 wanted to learn as much about what's going on and
9 try to establish what the baseline and the
10 aspirations are, and we thought the best way to do
11 that was to have a series of individual
12 conversations, and those are the various folks
13 whom we met with at DCOE, and I'd like to thank
14 Dr. Sutton for allowing us to meet at her facility
15 in Silver Spring the last time. That was nice.
16 The two NCAT references, maybe that and
17 the combined TBI screening, are the assignment I
18 think that Jean gave me, but I actually think that
19 she summarized pretty well where we are. The
20 reason that we established an ad hoc working group
21 between our two committees was because of what
22 was to us obvious overlap between psychological

1 health issues and TBI issues. We had thought
2 first to have a joint meeting of the two
3 committees so we could talk about what we did
4 together. In order to do that, that's what Jim
5 Kelly came and talked to us about, and then ensued
6 a discussion about what we should do together and
7 adding that to the NCAT or as we were referring to
8 it, ANAM, and as Jean did, discussion, we decided
9 to have an ad hoc joint, I think there's a noun
10 and I don't know what the noun is that goes with
11 that, group, consisting of four people from our
12 committee and four people from the TBI committee
13 specifically to address the ANAM issue and to work
14 it through and then come back to our respective
15 committees either separately or perhaps in another
16 joint meeting so that finally we can get to some
17 recommendations and make formal recommendations to
18 the Board for it to go on to make formal
19 recommendations.
20 Starting with something new and then
21 something borrowed and I don't know what's in the
22 middle, and then the something new, we had Dr.

1 Michael Dineen come and talk to us about the
2 dashboard of metrics in the military health
3 system, and that was fun for us to see what hard
4 research is going on and what questions are being
5 asked and how they're being approached.
6 As I said before, we actually have moved
7 into another gear. Every time I've spoken to you
8 before I've said we're not quite there, but I'm
9 happy to report to you that we actually did some
10 things at our last meeting, and since I am an
11 inpatient sort, that makes me feel better. The
12 first thing is I got -- it's odd to say that we
13 took action when the second thing is that we
14 deferred an action. We had planned to finish up
15 the first part of dealing with the autism
16 question, but the person who was to brief us had
17 jury duty that day and therefore we couldn't do
18 that. We have a teleconference scheduled for
19 about a week and a half to 2 weeks from now to get
20 that accomplished, and I'm hopeful that by the
21 next time the whole Board meets that we will have
22 something to say to you about that as well. I

1 already talked about the ad hoc task force.
2 In the Executive Committee meeting
3 yesterday which was a kind of prefatory meeting,
4 among the things that we were talking about was
5 how do questions come before the Board to be
6 answered, do subcommittees only respond to
7 questions or do they generate areas on their own?
8 This is an unsettled question for the Board and
9 we're going to discuss it and discuss it in an
10 administrative session later. But in anticipation
11 of that, we began thinking about what we might do
12 in the future. One of the things we did was think
13 about how we could shape our relationship with
14 DCOE and we came up with some ideas about that
15 which we're going to put formally through the
16 Executive Committee and get their feedback and
17 then I'm going to talk to the DCOE folks and say
18 this is what we think, do you think this will
19 work, and we will proceed and that help us we
20 hope with our oversight. And that last item is-- we
21 thought a lot about what we would do if we were
22 given the freedom and the charge to decide what

1 areas we should really go into and look at in some
2 detail. That again is not a formal thing yet and
3 depends on what the Core Board as a whole decides.
4 And we have a schedule of meetings for the year.
5 Not listed here is the teleconference
6 we're going to have about autism which is as I
7 said in a few weeks, and I'm guessing that we will
8 have one or two other teleconferences in the
9 interim as well, and depending on what we may
10 attend to, we may have subgroups who actually go
11 out and meet in other places and visit. I drew up
12 an agenda template and circulated it to the
13 members of the committee and came up with a final
14 version. It's here as a supplemental slide just
15 as the questions we were asked before is as a
16 supplemental slide. I'll show you briefly what it
17 looks like. It looks like that. My anticipation
18 is that every meeting will look like this now, and
19 that brings us to the end. I have time for 15
20 minutes, but it took me 14. So I'm open to
21 questions.
22 DR. WILENSKY: Thank you. Are there any

1 questions that people would like to ask?
2 DR. LEDNAR: A thought I had offered to
3 the Subcommittee is in the area of metrics. There
4 may be an opportunity for another of the Board's
5 standing subcommittees to be a resource to this
6 discussion, and that's Dr. Halperin's
7 Subcommittee, which is the first on
8 occupational and environmental health and you
9 might ask what's the relevance, but it includes
10 medical surveillance. So a population health
11 monitoring of data to understand and then take
12 action is a competency with this subcommittee and
13 it may provide some insight to your discussions.
14 DR. FOGELMAN: That's a good idea. I'll
15 ask. I don't know how much psychological health
16 stuff they survey and gather, but I certainly will
17 ask them. Thank you.
18 DR. WILENSKY: Do you anticipate
19 continuing the jointness of some portion of future
20 meetings with TBI as you did in the last one?
21 DR. FOGELMAN: Where it stands now is
22 we're going to wait until our ad hoc group has

1 something to say, and then at that point I suspect
2 we will have, as we did this time, an overlapping
3 meeting with the TBI folks, since up until now
4 there was no named replacement chairman and I
5 didn't have anybody to talk to about it, but my
6 sense is once we have something to discuss with
7 the ad hoc people, we'll do what we did here which
8 is we had a Monday and Tuesday meeting, they had a
9 Tuesday and Wednesday meeting and overlapped for
10 part of Tuesday and I suspect that's what will
11 happen. We don't have it as a formal plan. It
12 may be that we wind up with joint meetings with
13 other subcommittees. Frankly, I liked doing it
14 and I think most of the members of the
15 Subcommittee liked doing that, so any of you who
16 is a subcommittee chair who thinks that there
17 maybe a useful overlap, I'm happy to talk to you
18 about that.
19 DR. WILENSKY: I'd also like to
20 encourage you to be in contact with Dr. Bullock
21 either as he develops his agenda now for the
22 subcommittee or whenever it's appropriate just so

1 that you're aware of what each is doing.

2 DR. FOGELMAN: Absolutely.

3 DR. LEDNAR: When I see the title of the

4 group is Psychological Health, I have a thought.

5 This may or may not be in scope for your

6 committee, but I thought I'd share it. In

7 thinking about the messages that Colonel Coke in

8 the global operations update, and I'm reflecting

9 on a discussion at the break that General Sutton

10 and Dr. Erdtmann and I had, it's the needs of our

11 senior leaders in the Department of Defense,

12 civilian or military in this very, very

13 challenging time, to keep up with all of the

14 inputs, to keep up with all the challenges, to

15 keep winning the war. There are more inputs than

16 there is time or bandwidth to process. This has

17 been going on for years and it's not likely to let

18 up. So the needs of our senior leaders in terms

19 of psychological health and system structure so

20 that they can be maximally effective for the long

21 term, this is a marathon and not a sprint, and if

22 this is something that is in scope to the

1 Subcommittee, I think there is special expertise
2 in your group that might be --
3 DR. FOGELMAN: Let me be certain that I
4 understand what you're asking. Is it the case
5 that you're asking about providing advice on
6 things like leadership development and
7 organizational structure and organizational
8 climate and strategic planning? Is that the
9 question you're asking?
10 DR. LEDNAR: Can you say that just a
11 little differently? I'm not sure I've caught your
12 --
13 DR. FOGELMAN: Is the question you're
14 asking should we be advising senior leadership
15 about the way they conduct their own jobs? Should
16 we be advising them on organizational questions,
17 on professional leadership development questions?
18 Or are you talking about should we find ways to
19 make sure that they are kept informed of what we
20 are doing? For example, should we meet with the
21 Surgeons General? Are you talking about both of
22 those things or one of the other?

1 DR. LEDNAR: We'll talk in the
2 administrative session about yesterday's
3 discussion, but thinking about that, I do not
4 think that we as an independent external board may
5 be the best source of advice on how to structure
6 and operate the business of the Department. I
7 don't think we are the people to advise on that.
8 But we do have experience in recognizing how work
9 can affect the effectiveness particularly in our
10 senior leaders that may become an insight, an
11 optic that is an input that can be offered to the
12 senior leaders. I'm not quite sure what the forum
13 for that is, the right way, but it's an expertise
14 that I feel is an expertise in the Board and
15 there's a reality in the Department, and if there
16 is some way to have those two come together in a
17 constructive way that the Department finds of
18 value, then let's not miss the opportunity.
19 DR. FOGELMAN: I think that most of the
20 folks on the Subcommittee who can assist with that
21 expertise or have that expertise would be more
22 than happy to do it, and if there are ways for the

1 committee to do it or the Subcommittee to do it as
2 a whole, then we will.
3 DR. WILENSKY: Dr. Silva?
4 DR. SILVA: You have a lot on your
5 agenda. I didn't hear anything about suicide and
6 suicide prevention. That's clearly in the news
7 all over the place.
8 DR. FOGELMAN: Actually, you didn't hear
9 anything about any of the specific items we have
10 on our agenda because as I said, we need to talk
11 in the administrative session and later about what
12 the committee or what subcommittees can initiative
13 and not. There is a list of things that we're
14 thinking about and among them is probably suicide,
15 but I would say that there is a very active
16 suicide task force and duplicating their work
17 probably doesn't make sense, but keeping informed
18 about it or assisting them if they ask might.
19 DR. WILENSKY: Our fifth speaker this
20 morning is Dr. Ken Kizer of the Medsphere Systems
21 Corporation, a leading commercial provider of open
22 source information technology. I don't know

1 whether that was provided by Ken as a definition.
2 Previously he served as the Under Secretary for
3 Health in the U.S. Department of Veterans Affairs.
4 He's also Chairman of the Defense Health Board's
5 National Capital Region Base Realignment and
6 Closure External Advisory Subcommittee. He will
7 provide an update on the Subcommittee's report
8 which was sent out earlier this week for your
9 review in preparation for the discussion. His
10 presentation slides and the Subcommittee draft
11 report may be found under Tab 6 in your meeting
12 book. Ken?
13 DR. KIZER: Thank you, Gail. Good
14 morning. Hopefully everyone has received the
15 report, everyone on the Board at least, and were
16 able to look at at least the relevant sections
17 that were called out in the transmittal e-note.
18 It at first blush might appear more daunting to
19 get through than it actually is. I do
20 apologize for the short time that the Board had to
21 review it, but hopefully in looking through it the
22 large amount of work that has been done to prepare

1 this or to come to these findings and
2 recommendations is apparent by what's included
3 there.
4 I would at the outset, and this is just
5 to give other Subcommittee members a heads up,
6 certainly invite comments from other members of
7 the Subcommittee who are here at the end of this
8 either to underscore things that they think are
9 important or to correct any lies that I've told.
10 And I would also note that the report that you've
11 received should not be viewed as the final report
12 in terms of formatting and some other issues.
13 It's a Word document that was set out, but it will
14 be formatted. There are several dozen additional
15 references to be added and a few miscellaneous
16 items, but basically the findings and
17 recommendations are as you see them and the report
18 as presented to the committee for action today. I
19 would also underscore that much of what I'm going
20 to say you've heard before at the presentations at
21 both the December and March meetings at least in
22 substantive part. The last introductory comment I

1 would make is that while our report focuses on
2 some deficiencies that have been identified and
3 some problems that need to be corrected, I want
4 to make sure that these don't obscure or make less
5 evident the very large amount of very good work
6 that's been done and the diligent efforts that
7 have been put forth by a large number of people to
8 make this a success, as is often in reports where
9 basically the job is to point out the problems, we
10 lose sight of the good things that have been done,
11 and there is a lot that the folks who have been
12 working on these projects can be proud of and feel
13 very good about.
14 So with all that as a preface, let me
15 quickly go through some materials again. You've
16 seen much of this, so I will go through this
17 relatively quickly. The Subcommittee was
18 originally convened just about a year ago, a
19 little less than a year ago, to advise the
20 Department on the efforts to have an integrated
21 service delivery network among the Services here
22 in the National Capital Region. There is a

1 parallel project going on down in San Antonio that
2 we are not involved with. A few months after that
3 we were additionally charged with conducting the
4 independent review of the design and construction
5 plans of the new Walter Reed National Military
6 Medical Center and the Fort Belvoir Hospital as
7 was required by the 2009 Defense Appropriations
8 Act.
9 As noted, the bill calls for this
10 independent review because of concerns that the
11 Congress had reflecting concerns of others I think
12 would be a fair way to characterize it, in that
13 they also posed a number of corollary questions
14 that I'll get to in a moment, but the fundamental
15 charge that we were given was to make an
16 assessment as to whether the design and
17 construction of these facilities would meet the
18 congressional standard that had been imposed, that
19 they be designed to be world-class medical
20 facilities, and if not what changes should be made
21 to ensure that they meet that standard. As is not
22 atypical, the Congress made its intent clear in

1 saying that they should be world-class medical
2 facilities and gave some rather superficial
3 verbiage as to what that might mean but provided
4 no meaningful or operational or functional
5 definitions of what world class meant or what
6 definition might be used to actually complete the
7 review that they required. So the first charge to
8 the group really was to define or come up with an
9 operational definition of what is a world-class
10 medical facility, and I would just note at the
11 outset that while that term is used widely now in
12 health care, no recognized body has established
13 any type of meaningful definition for what that
14 means. It's a marketing term that has taken off
15 without any truth in advertising if you will for
16 the consumer.
17 Corollary questions that were asked in
18 the report also are the Department's approach to
19 the design and construction of these facilities
20 which is different than what has been done in the
21 past, were those sound approaches, is there a
22 reason to halt the construction at this time if

1 the conclusion was that the design was not being
2 done to world-class standards, and were there
3 other things that should be dealt with, the
4 catch-all what else needs to be considered.
5 The process was straightforward,
6 Committee membership had been identified and the
7 Committee had been convened. When the additional
8 charge was given there was a need to add some
9 subject matter expertise that was not among the
10 original membership. That was done. The
11 Committee had a number of meetings both in person
12 and by conference call. A very large number of
13 documents were reviewed both in the general
14 literature and different documents about what
15 forward-looking hospitals might like, design
16 considerations, as well as the specific planning
17 and design documents for the facilities in
18 question.
19 There were a lot of presentations
20 presented at the various meetings from folks
21 involved in different aspects of the project.
22 Additionally, to I think gain some reassurance or

1 some validity of what the Committee was defining
2 as world class, I also invited several dozen other
3 health care luminaries or health care leaders,
4 folks like Denis Cortese at the Mayo Clinic and
5 George Halverson and others at Kaiser Permanente,
6 John Perlin at HCA and again a large number of
7 folks, to opine and to weigh in on the definition
8 that we had advanced, or at least the draft
9 definition that was advanced, at that time. They
10 provided helpful comments, many of which were
11 included in the definition after the Committee had
12 looked at them.
13 Further, this definition was presented
14 to a meeting of the American College of Physician
15 Executives a couple of months ago where at least
16 200 or more folks had the chance to review and
17 comment on it, and again those comments were
18 considered by the Committee and some of them were
19 incorporated. The bottom line is this wasn't just
20 the Committee's definition although the Committee
21 had quite ample expertise I think to opine in that
22 regard, but it was looked at by a lot of other

1 folks as well.

2 The conclusion, and I don't intend to

3 get into the weeds on how the Committee defined

4 it--it is included in the report as Appendix B.

5 It is a fairly substantive document to wade

6 through particularly insofar as many of the

7 measurable attributes are by reference to other

8 documents and there is a certain amount of

9 expertise that is probably required to know what

10 is in those other documents and understand the

11 relevance to it and that probably goes beyond the

12 scope of this meeting. The attributes, or at least

13 the things that we felt could be measured at this

14 point in time, fell into a half a dozen domains and

15 a number of specific condition areas and then a

16 menu of things under those conditions, and again I

17 would refer you to Appendix B for the details in

18 that regard which we can certainly discuss as we

19 go forward, but I don't intend to present them.

20 I think it was also clear from our

21 discussions as well as outside input that there's

22 a lot of what goes into a "world-class" anything,

1 but certainly a world-class medical facility, that
2 can't be measured with current methods of
3 measurement and has some of the attributes as
4 noted on the slide about routinely going above and
5 beyond what's expected and that there's a synergy
6 among the different parts that's a little hard to
7 explain. And that I guess it really goes to the
8 last point there, that what makes a world-class
9 facility is their ability to make the
10 extraordinary ordinary and to make the exceptional
11 really routine. There is some significant
12 verbiage in there about these things, and I would
13 refer you to the document if you want to discuss
14 any of them in more detail, but I would again
15 emphasize that this has been looked at by a lot of
16 people and there seems to be a lot of agreement
17 that we've captured at least some of the main
18 points there.
19 This slide is intended for a couple
20 of purposes, but mainly to highlight some of the
21 key findings of the report, and really in a sense
22 at least the first five here. I think it's the

1 Committee's assessment that if these points aren't
2 addressed that simply it will not be possible for
3 the facility to achieve world-class status. There
4 are a lot of findings enumerated, a lot of
5 specific things, and I think it's important to
6 call out these more major issues that really are
7 threshold issues if indeed the goal is to be a
8 world-class facility and I think that that is a
9 goal that the Subcommittee was quite strong in its
10 feeling that it should be the Walter Reed National
11 Military Medical Center should be, indeed,
12 a world-class facility and should be the type of
13 facility that when people talk about how health
14 care should be delivered, they say as is done at
15 Walter Reed, that it really is the model or a
16 model for how to do it right in all respects, and
17 I think that's kind of the general tenor or the
18 flavor which the Subcommittee approached this.
19 I'm going to come back to many of these
20 things, but again I just want to call them out up
21 front and highlight them, that the BRAC funding
22 process has limitations and those limitations

1 fundamentally prevent the ability to make a
2 comprehensive design plan for a facility like what
3 is envisioned for Walter Reed which involves
4 extensive renovation of an existing facility, new
5 construction, merging them all together, and to do
6 that because of the limitations in BRAC funding,
7 funding has to come from multiple sources and at
8 the moment there is no way to integrate and bring
9 those different sources together so that there is
10 indeed a singular funding stream that supports a
11 comprehensive plan, renovation, new construction,
12 whatever else needs to be done, that ultimately
13 would lead to a design and construction of a
14 world-class facility.
15 The second point is that the vision and
16 mission, certainly it appeared to the Subcommittee
17 that these weren't clear, not that they haven't
18 been clearly articulated as Admiral Mateczun, I
19 think, has articulated a clear vision, but in some
20 ways this is just a corollary issue of the funding
21 problem in that there are multiple commands
22 involved, different commanders, different members

1 of those commands don't necessarily see it the
2 same way, and because the authority is fragmented
3 it results in people perceiving the end game
4 somewhat differently and that, at least in our
5 judgement, is a fundamental flaw. This leads into
6 the third point about the fact that both
7 organizational authority and funding authority are
8 fragmented. Some comes from BRAC some comes from
9 others. Some of the commands that bear on this
10 are under the joint command structure, some are
11 under service specific, and there isn't the
12 integrated and singular authority that is needed.
13 I think an example of that recent vintage is
14 the decision about how to define or redefine what
15 is the medical center at the Bethesda campus.
16 Again we can go into details as needed, but there
17 is some redefinition there that affects the
18 ability to bring all the pieces together.
19 There are clearly service specific
20 cultures, and the military health care culture,
21 much like the rest of health care culture, is very
22 facility centric and this is not necessarily

1 conducive to or supportive of an integrated
2 delivery system. Indeed, they fundamentally
3 conflict. Again, this is not a DoD or military
4 specific issue, and one of the reasons why I think
5 that I harp on this is having seen this played out
6 in the private sector in multiple instances is an
7 issue everywhere and that if there isn't a
8 concerted effort to engineer a culture that
9 supports an integrated delivery system, it's going
10 to fail and there is a long list of private sector
11 ventures in this regard which have failed because
12 they fundamentally didn't understand what it means
13 to be an integrated delivery system and bring all
14 the assets together. When one thinks about the
15 different assets, if you focus on where a health
16 care delivery system and hospital and clinics and
17 hospices and home care are just different tactics
18 by which one accomplishes that mission, that's a
19 different way of thinking about it than if you're
20 focused on the hospital and preserving the
21 hospital. Again, we could go into a long
22 discussion about this, but there is a fundamental

1 need to engineer a culture there that deals with
2 the different service specific cultures and the
3 facility centric mindset that prevails.
4 There is no comprehensive master plan
5 which is really an outgrowth of some of these
6 other things, not the least of which is the
7 funding, and as I think will become clear as we go
8 forward because we keep coming back to the funding
9 issue, if you can't decide up front what you're
10 going to fund to pay for and design, then it's
11 really hard to develop that master plan to do
12 other things that are ultimately contingent upon
13 that, so that it is a fundamental threshold issue.
14 Finally, because this was specifically
15 asked in the congressional language, is there a
16 need to halt construction, it is our conclusion
17 that there is a not a need to halt construction
18 if, and this is a qualified statement, a master
19 plan that addresses the deficiencies in the need
20 for renovation and that addresses the funding
21 issue and the authority issue can be completed in
22 a timely manner, then halting construction would

1 not only be very costly and demoralizing, but
2 would probably be the only thing worse than not
3 correcting the deficiencies going forward. Again,
4 there is much we can talk about on that, but it is
5 a really fundamental issue and our judgment at
6 this time is that we should not halt construction
7 if these other things can be addressed in an
8 appropriate timeframe which is, frankly, not very
9 long.
10 Just addressing a couple of the other
11 corollary questions, was the approach that was
12 used sound? Yes. I think that we can give that
13 an unequivocal endorsement. There were different
14 approaches used for the Fort Belvoir hospital
15 versus Walter Reed. Both of them appeared to be
16 improvements in the traditional process. One of
17 the deficiencies that we'll come to though is that
18 there isn't an identified plan and funding to
19 support an assessment of these things to inform
20 future military or other federal hospital or
21 health facility construction and these are
22 wonderful case studies that should be learned from

1 for future projects because I suspect this isn't
2 the last time that the federal government is going
3 to construct a medical facility, again going back
4 to the simple fact that some of the needed
5 renovations at the existing Bethesda site can't be
6 accomplished because of the funding issues and
7 that this is serious problem.
8 Other findings, and I'll quickly go
9 through these. Again a threshold question, is
10 this idea of constituting an integrated delivery
11 network in the National Capital Region a good
12 idea? Again the committee I think resoundingly
13 agrees that it is and that efforts should move
14 forward to in fact create an integrated delivery
15 network of the various military commands in the
16 area and that would be likely to better serve both
17 active duty and retired military personnel and
18 their families. Again, a lot of work has been
19 done, but despite best efforts, there are some
20 issues that are beyond the control of the folks
21 who are doing the work to effect it, things we've
22 already touched upon, the varying visions, the

1 unclear or fragmented and complicated chain of
2 command, the funding issues, really are root
3 problems that have to be addressed if in fact the
4 goal is to be achieved.
5 The Fort Belvoir hospital really
6 presented a different set of issues, and frankly
7 was much easier to assess, but it was done very
8 differently. It didn't involve the complexities
9 of the Walter Reed project. It didn't involve
10 large renovations. It was basically a green field
11 project, they started construction, and that's
12 quite a different scenario than what is occurring
13 at the Bethesda site and with the Walter Reed
14 facility.
15 Some of the other findings as noted
16 here, and again these are elaborated on in the
17 report about whether input particularly from
18 frontline clinicians and patients was incorporated
19 as much as it might have been, and the culture
20 issues I think I've already touched on
21 sufficiently. The need for what we believe is a
22 better demand analysis. The demand analysis that

1 was one is a static assessment that was based on
2 2004 utilization figures, and while I think it was
3 very commendable the efforts that were made to
4 address this issue, it really wasn't a forward
5 looking demand analysis that looked at future
6 service delivery needs based on population changes
7 and other sorts of things as well as where health
8 care is going to go and some of the likely changes
9 that are going to be seen in health care in the
10 next few years, to say nothing of the long term.
11 So we would suggest a more dynamic demand analysis
12 be made. The need for a master plan for both the
13 Walter Reed site as well as for the overall
14 National Capital Region. That is as I think I've
15 already said two or three times precluded because
16 of issues of funding authority and some other
17 things, but that clearly needs to be addressed.
18 Finally one more time, the inability to complete
19 renovations because of the BRAC problems.
20 As far as the specific plan or the plan
21 that has been put forward, a number of specific
22 deficiencies were noted, and again I don't know

1 that it would be a productive use of time to go
2 into all the nitty-gritty details. These are
3 detailed in the report. This lists a number of
4 them, and I may highlight a couple. But I would
5 also again couch this in terms of we shouldn't
6 lose sight of looking at these things, about the
7 large amount of good work that's been done, about
8 the changing nature of many of these requirements,
9 for example, nonconformance with joint commission
10 standards. Those standards are actually quite
11 different today than they were 4, 5 or 6 years ago
12 in a number of cases when the plans started to be
13 advanced and they were working on draft standards
14 and other sorts of things, and the key is not so
15 much I think the fact that it didn't meet these
16 because they can be addressed with appropriate
17 design changes, but that it's reflective of the
18 very dynamic nature of health care and the need in
19 any sort of plan to have flexibility and to
20 accommodate to changing circumstances and changing
21 technology, changing standards and other sorts of
22 things. That will continue to occur, and whatever

1 is designed today even if it's designed to meet
2 all the specifications for example that are in the
3 plan, are going to be different 2 or 3 years from
4 now because the world is changing very rapidly in
5 health care and so this has to be a very dynamic
6 and flexible process.
7 I would also note I think in fairness
8 that in some cases we identified issues that the
9 committee thought were of concern and didn't
10 necessarily understand the logic for, for example
11 the siting of the dialysis clinic above some of
12 the central supply and more sensitive areas of the
13 hospital where the plumbing to dialysis is always
14 a problem because of the corrosive materials that
15 are used and so you continually have to get in
16 there and change things and putting that above
17 central supply and some other things, the logic
18 wasn't necessarily clear, but there may be reasons
19 that that might be acceptable, it wasn't clear,
20 but that we maintain an open door to hearing
21 perhaps alternative explanations as this goes
22 forward.

1 The information technology plans, part
2 of the issue there is simply funding. A number of
3 things were identified that made sense, but then
4 on peeling back the skin, it was apparent that
5 there really wasn't the ability to execute those
6 plans because funding hadn't been approved. So it
7 sounds good, but is it actually going to happen?
8 And there were some other areas where we think
9 some additional things need to be looked at.
10 I anticipate that the issue of on-site
11 simulation labs is going to be controversial and I
12 think it's the Subcommittee's position that this
13 is just simply a must do today and that certainly
14 as is demonstrated in the aviation industry,
15 simulation is critical. Simulation has come into
16 its own in health care largely because of the
17 efforts of the military, the military has clearly
18 been the leader in this regard and in some ways
19 the Committee found this ironic that these weren't
20 on-site. While there may be plans for an offsite
21 location, just don't think that given the nature
22 of how busy health care practitioners are and

1 other things that that's going to be a workable
2 design in the future.
3 The need to go to essentially all single
4 patient rooms is clearly the norm in health care
5 today. Again, there are things that we could talk
6 about here, I think you get the flavor that there
7 are a number of things, but again the important
8 point, and what may appear incongruous at first, is
9 that when you look at this list, one might say how
10 can you on the one hand recommend that
11 construction not be halted when you've identified
12 these problems, and they actually do make sense.
13 We aren't totally schizophrenic, although maybe
14 Dr. Fogelman might want to weigh in on that, maybe
15 delusional, again if in fact design or a master
16 plan can be created and we can address some of the
17 other funding issues, we think that renovation and
18 changes can be made that would address these
19 things such that there would not be a need to halt
20 construction because we think that would be very
21 injurious to the process.
22 Some of the specific recommendations are

1 as noted here. We think bottom line a single
2 person has to be in charge and have the
3 commensurate organizational and budgetary
4 authority to bring all the pieces together. As
5 someone commented along the way, all you have to
6 do is count the number of stars on the shoulders
7 to figure out, or to see, that there's a problem
8 here because if everyone has the same number of
9 stars or someone in command has fewer stars than
10 others, it's not going to work and that somebody
11 on top has to have more stars than everybody else.
12 That may be somewhat simplistic, but I think
13 judging from the body language of the folks in the
14 audience that the point is made. There needs to
15 be a master plan and it needs to be developed as
16 quickly as possible, a culture change has to
17 embark on the engineering, and this isn't
18 something that is a 2-week course and you're done.
19 Certainly if you look at cultural change in
20 organizations or successful cultural change in
21 other organizations, people talk about 5 year or 7
22 year or 10 year timelines. This is going to be an

1 ongoing process. This raises a number of issues
2 as far as military and rotation of leaders and
3 other sorts of things, are some of those practices
4 compatible with the idea of having stability of
5 culture, stability of leadership that are
6 necessary if you're going to really create a world
7 class culture or world class facility. Obviously
8 these deficiencies need to be addressed. We need
9 to make sure that the folks who are most impacted,
10 i.e. the patients and their families and the
11 frontline clinicians, have their opportunity for
12 input and to be involved in the planning and
13 design process. Their issues need to be addressed
14 as much as possible, recognizing it often is
15 simply not possible to accommodate everybody's
16 interests. That's a balance that always has to be
17 achieved, but insofar as possible that that input
18 needs to be consciously addressed and if a
19 decision is made not to do something, it needs to
20 be understood why.
21 The processes need to be evaluated to
22 inform future federal construction projects. I

1 think this is really critically important if we're
2 going to invest hundreds of millions if not
3 billions of dollars that is being spent here,
4 there should be some assessment being done as to
5 how the lessons learned might be applied in the
6 future.
7 Finally, we think that the construction
8 can continue if the renovation issues are
9 addressed which requires that the funding issues
10 and authority issues be addressed and that there
11 be a master plan that addresses these things. So
12 while there are a few words there, there are some
13 qualifiers that need to go with that as well.
14 As far as further Subcommittee process
15 in this regard, the report is presented to the
16 Board for action today. Depending on that action,
17 it will be finalized, formatted, published, and
18 advanced after review and comment by the
19 Department, but advanced to the Congress. We do
20 expect that this isn't the last time we will hear
21 about these issues, that given the history and the
22 level of interest in these projects that this will

1 be a topic for further discussion on the Hill and
2 elsewhere and may be a fairly visible topic of
3 discussion. While the Committee has not been
4 charged with doing this, we do think that the
5 further design and construction efforts would
6 benefit from this type of outside review on an
7 ongoing basis. The Committee, after completing our
8 work in this regard, intends to go back and
9 continue working on the issues related to the
10 design and development of the integrated delivery
11 network in the Capital Region unless it's directed
12 to do otherwise, but that we think that with the
13 promulgation of this report, that at least
14 completes the assignment that it was specific
15 charged with to conduct this, at least, initial
16 independent review.
17 With that I will stop. I think there is
18 going to be a fair amount of time for discussion,
19 but before we do that I would invite, as I said at
20 the outset, Ray or Phil Tobey who participated in
21 the Subcommittee process to make comments as they
22 see fit. With that, Ray?

1 MR. DUBOIS: No doubt a number of you
2 are puzzled when we commented that no master plan
3 existed. As a matter of fact, I would ask Admiral
4 Mateczun perhaps to address this, multiple master
5 plans existed or exist, and what we found out was,
6 and this blends, if you will, to Ken's comment of
7 multiple funding sources, for those of you who
8 have dealt in the Department of Defense
9 authorization and appropriation process, often
10 times you have multiple funding sources to achieve
11 a singular mission at some point in the future on
12 purpose. In this case, and General Myers can back
13 me up because he was present when I presented the
14 BRAC recommendations to the Infrastructure
15 Executive Council of which he was a senior member,
16 and I made the comment at that time that of all
17 the BRAC recommendations in the United States in
18 all three military departments, the most complex
19 one and the most expensive one was going to be the
20 establishment of the new Walter Reed National
21 Military Medical Center at Bethesda.
22 We also understood then albeit we were

1 focused strictly on BRAC, base realignment and
2 closure recommendations to the BRAC Commission,
3 that there were already planned extensive
4 renovations and new construction for the National
5 Naval Medical Center at Bethesda. There is also,
6 as we heard from previous speakers, the new Fisher
7 family funded Defense Center of Excellence for TBI
8 at Bethesda. There were also plans to address the
9 Uniformed Services University of the Health
10 Sciences construction, technological upgrades, et
11 cetera, at Bethesda. Admiral Mateczun has in a
12 rather exemplary fashion, and I'm not trying to
13 suck up to him because I don't have to anymore,
14 the issue is he has a plan and he has I think
15 correctly suggested to his supervisor, the Deputy
16 Secretary of Defense, that these multiple funding
17 sources and these multiple plans which were
18 developed in the past need now to be pulled
19 together. It will also, I think, reveal not
20 surprisingly that there are some funding gaps when
21 one looks at a comprehensive, integrated master
22 plan for not just the new Walter Reed National

1 Military Medical Center- Bethesda, but as Ken was
2 suggesting, the integrated delivery network of the
3 National Capital Region which includes this new
4 community hospital at Fort Belvoir. So that slide
5 that shows the significant deficiencies, de novo
6 you could say, my God, time out. Let's start all
7 over again.
8 It's not that the military has gone too
9 far to stop. I think that the military hasn't
10 gone far enough to accomplish what the Congress in
11 its infinite wisdom has said is world class. No
12 medical institution today anywhere in the world
13 given our definition of world class would qualify,
14 and I suspect world class as has been indicated is
15 something that is not static but moveable,
16 expandable. World class 5 years ago certainly
17 won't be world class 5 years from now. So there
18 is a dynamic here that we tried to embrace and the
19 Congress demanded and the Defense Health Board
20 deserves to know what we in our respective
21 disciplines concluded as deficient, but also we
22 collectively recommended keep moving forward.

1 There are ways to do this.
2 I will conclude by saying we believe
3 that Admiral Mateczun should be given the
4 responsibility of pulling these multiple plans
5 together along with the multiple funding sources
6 that attach to the individual plans to in point of
7 fact create, and I believe, and I defer to Admiral
8 Mateczun, that he is already moving in this
9 direction because that in our view is our
10 collective judgment, and I want to emphasize I, as
11 a layman and not a doctor, not an architect, not
12 an engineer, although my son sometimes calls me a
13 political engineer, the fact is the people who
14 served on this Committee and the subject matter
15 experts, everybody from Phil Tobey, the country's
16 leading health care design architect, to Tammy
17 Duckworth of Illinois, a multiple amputee as you
18 know, soon to be hopefully Assistant Secretary of
19 Veterans Affairs, these people came to grips with
20 a lot of disparate and sometimes conflicting
21 information and synthesized it in my estimation
22 rather well. I would be happy to hear from

1 Admiral Mateczun in respect to the issue of
2 unifying the command and control if you will.
3 DR. WILENSKY: First, Phil, do you want
4 to comment and then Admiral Mateczun?
5 MR. TOBEY: Thank you. I'm Phil Tobey,
6 and as was noted, I am an architect and a health
7 care planner, so I'm going to wear that hat for
8 just a moment. I want to underscore a couple
9 points that Ken made, one of which is an emphasis
10 on urgency and focus a moment on the renovation
11 piece of the project where most of the
12 deficiencies that we noted actually occur.
13 I think as a committee we pretty much
14 decided that the new construction component of the
15 project which is well under construction, in fact
16 I believe is going to be topped out here in the
17 next week or two, was fine, and that the area that
18 was under greatest concern for us because of the
19 BRAC funding was the renovation piece which
20 obviously follows the new construction, and that's
21 why I say we have an opportunity here I think to
22 fix that piece of the project.

1 The BRAC constraints and limitations if
2 you will forced the planners to develop a
3 renovation plan that looks like Swiss cheese.
4 There are pockets of renovation all the way
5 through the existing complex that express the BRAC
6 constraint of addressing what has to move over to
7 the new facility, but there are no funds there to
8 fix the facility itself. So the Swiss cheese if
9 you will I don't believe is capable of being
10 constructed in a strategic way. For example, you
11 can draw a line around a department on a plan and
12 say we're going to renovate that department, but
13 all of you who have ever done any construction
14 know that you're probably going to have to tear
15 out the floor below because of all the plumbing
16 and so forth. Those kinds of things I think need
17 to be addressed.
18 What I want to reiterate one more time
19 is the critical nature of a master plan that steps
20 back and looks holistically if you will at the
21 planning for the renovation piece and then moving
22 out very quickly with the authority issue and the

1 funding issue in making that happen. We do have
2 an opportunity, but it has to happen quickly.
3 DR. WILENSKY: Are there any other
4 Subcommittee members who are here who want to
5 speak? Admiral Mateczun?
6 VICE ADMIRAL MATECZUN: Secretary Kizer,
7 Mr. DuBois, and Mr. Tobey, thank you for the
8 tremendous work that the Subcommittee did. I
9 think that when you originally accepted the jobs
10 on the Subcommittee you didn't know that you'd be
11 defining world class and doing all of the tasks
12 that Congress has requested you to do, but you've
13 done a great job pulling together all of that
14 information. In fact, these definitions will now
15 inform medical construction I believe not just
16 within the DOD but within the DVA and other
17 federal hospitals at the very least and will now
18 become terms of reference for construction and
19 projects that go well into the future.
20 It's been daunting working this project
21 and I appreciate you very much coming in and
22 taking a look at what was happening and providing

1 these recommendations. There were a number of the
2 recommendations, I guess a lot of things come
3 together when the Task Force on the Future of the
4 Military Health System which Dr. Wilensky
5 co-chaired and General Myers was on as well, had
6 an overarching recommendation of bringing an
7 integrated delivery system together with the
8 military health system's direct care system and
9 private sector care. So as we look at this
10 integrated delivery network and your
11 recommendations and findings about service
12 specific, facility centric cultures and
13 conflicting with the needs of an independent
14 delivery system, it goes beyond the Services and
15 really reaches into this question of how do we put
16 together the private sector care, the direct care
17 system for the benefit of our patients not just
18 now, but well into the future. So thank you for
19 recognizing those problems and challenges that we
20 have.
21 All of the things that are going on, I
22 will tell you part of this process is that we are

1 constantly moving. There are already things going
2 on. We have an independent architect now working
3 for the Joint Task Force that is diligently going
4 through around 150 joint commission standards
5 questions with the contractor and we'll be working
6 all those to completion. We're down to about 50
7 right now and so we're working ahead on that. The
8 on-site simulation labs, we're working with 5,000
9 square feet right now that will be incorporated.
10 So many of the things that you've brought up we
11 continue to work on. It's not a static process,
12 it is very dynamic, and we have incorporated most
13 of these things I think already into the process
14 and will be glad to come back and let you know
15 what's happening with each of those and appreciate
16 your continuing to look at them with us.
17 In terms of the process from here and
18 the recommendations and findings, it's been my
19 experience that there is a possibility of focusing
20 on the negative side of the recommendations and as
21 different people look at these recommendations
22 they'll see validation of their viewpoint or need

1 to do other things. A very helpful, I think, piece
2 to us is the executive summary of the reports as
3 they come forward so that in the department as we
4 review the recommendations, or the findings and the
5 recommendations, we sort of understand the
6 priorities that you have put into them so that we
7 can focus on those priorities. As I understand
8 them here, there is certainly this need for a
9 master plan in particular about the chassis at
10 Bethesda, but reaching out into the whole
11 integrated delivery system and how we view that,
12 the need for authorities to be aligned and the
13 need to identify funding streams. So if that's
14 true that that's in an executive summary some
15 place and then we're able to point to that and say
16 here are what the priorities we believe were that
17 the Subcommittee found, then we can work those
18 within the Department diligently and make sure
19 that we've responded to those findings. Dr.
20 Wilensky, thank you.
21 DR. KIZER: Just two comments I think to
22 underscore a couple of points. One that I think I

1 made before, but it's just the whole dynamic
2 nature of what's happening and that one shouldn't
3 view what's occurring in military health care as
4 all that separate and distinct from what's
5 happening in larger health care. Indeed, if you
6 look at the health care reform proposals, it is I
7 think undoubtedly the model that will be advanced
8 are integrated delivery networks because they work
9 better and it's a better model than having
10 facility based care, and that will be a part of
11 health care reform when and if that happens in the
12 next several months, next 2 or 3 years, or whatever
13 the timeline happens to be.
14 The second point is I think one of the
15 advantages to having an open and participatory
16 process such as we've had going back to last
17 October is that based on at least a review of the
18 documents and some of the things we hear now, it
19 would appear that some of the issues that the
20 Subcommittee has identified have been taken to
21 heart and indeed are being addressed. At least at
22 one point in time they were identified as issues

1 because it didn't appear that they were, it's
2 reassuring and comforting to know that a number of
3 these things are being addressed going forward,
4 and again I think that's part of the value in
5 doing this collaboratively and working together
6 with the common idea that we all want to arrive at
7 the same place where the National Military Medical
8 Center is a premier health care facility not just
9 in the United States, but indeed in the world.
10 Gail, with that I'm happy either to try to respond
11 to any questions or comments or avoid them if
12 that's the better part of valor.
13 DR. WILENSKY: General Myers?
14 GENERAL MYERS: I've got a question for
15 the Commander here in terms of one of these
16 recommendations which is to empower a single official
17 with complete organizational and budgetary
18 authority. As difficult as that is, what's your
19 view of that recommendation. Do you feel
20 empowered?
21 VICE ADMIRAL MATECZUN: I feel
22 accountable most days.

1 GENERAL MYERS: There's a difference
2 there.
3 VICE ADMIRAL MATECZUN: Yes, sir, I
4 think that that is a challenge, certainly, sir,
5 under your leadership in the Department and moving
6 ahead in the joint world the challenges in working
7 with the Services and the unified command plan and
8 crossing those, the technicalities of those we
9 need to address. I think that I believe I did
10 understand the intent of what's being asked for
11 here to bring together the authorities in the way
12 that we can legally to accomplish the mission,
13 yes, sir, I think that we can do that.
14 DR. WILENSKY: Can I try to just pursue
15 that as a nonmilitary person? Ken referenced the
16 flat structure of having you as a three star and
17 other three stars heading the Services. Is it
18 actually possible to have the unified accountable
19 responsible individual with that structure? I
20 thought that's what you were asking, but I somehow
21 don't feel comfortable that I see how that can
22 happen with a flat ranking, but if you tell me it

1 can, I will accept your word for it. It seems
2 problematic for a nonmilitary person when you have
3 that arrangement.
4 VICE ADMIRAL MATECZUN: Dr. Wilensky, I
5 don't want to speak for anybody else in the
6 Department, but as we're working through the
7 ultimate governance for the Joint Task Force,
8 where will the Joint Task Force ultimately reside,
9 it can't report to the deputy secretary forever
10 although it's a great way to get resolution to
11 issues that come up, but ultimately will need to
12 fit into the overall Unified Command Plan in some
13 way or fit into some other governance structure,
14 so I know that within the Department there are a
15 number of joint medical activities for which that
16 governance is still being worked out. There are
17 other fora where the question of what will happen
18 with the organization of military medicine is also
19 being considered and so those are sort of separate
20 lines of action if you will that will come
21 together I believe at some point.
22 MR. DUBOIS: Gail, may I just comment

1 briefly? The future of the management of health
2 care in the Department of Defense for all of its
3 constituencies, the active component, the Reserve
4 component, retirees, families, is certainly
5 something that the Joint Task Force, National
6 Capital Region, will have implications for, but
7 the step that was important was to put a third
8 star on Admiral Mateczun, number one. Number two
9 in my view, to have him remain reporting to the
10 Deputy Secretary of Defense not forever, but for
11 the purposes of creating this new Walter Reed
12 National Military Medical Center at Bethesda which
13 is a project that will be at least for the next
14 several years, and as long as he reports not to
15 any of the three Surgeons General and can in point
16 of fact can have budget authority over the project
17 and his supervisor being the Deputy Secretary, I
18 think the former chairman would agree that that's
19 enough clout to get things done.
20 DR. KIZER: I think the important caveat
21 there, Ray, is that that may be enough clout to
22 get things going. Whether it's enough clout to

1 sustain in the long term I think is another
2 question. As a former naval officer, it was
3 always my impression that in a hierarchical
4 organization, those with the same number of
5 stripes or stars on their shoulders had difficulty
6 being more equal amongst their peers and that
7 issues were usually best resolved when someone had
8 more stars or more stripes on their shoulder than
9 the folks who were debating the issue.
10 DR. WILENSKY: I understand that kind of
11 logic completely.
12 DR. KIZER: It's really not that hard.
13 DR. WILENSKY: The reason I had
14 elaborated on General Myers's question was the
15 fact that you raised it as the number one issue in
16 terms of your recommendations indicate that at
17 least as I would read it as a Subcommittee, you
18 don't believe that it has as yet occurred and is
19 the most important single step going forward. I
20 realize that this is still in process and there is
21 a mechanism as long as Admiral Mateczun is
22 reporting to the Deputy Secretary, that could be

1 invoked if it were necessary. I didn't know
2 whether it also meant that the budgetary authority
3 as it now exists does not grant -- I heard him say
4 he's accountable, but whether or not he has the
5 authority and budget control that goes with that
6 accountability was not clear, and I assumed by its
7 positioning you regarded that as a very
8 significant recommendation.
9 DR. KIZER: Just so there is no
10 confusion, I would make three points. One is the
11 Subcommittee does not feel that it has happened
12 yet despite good intentions. I've lost the second
13 one, but perhaps the most important aspect here is
14 that we don't believe that the goal or the
15 standard that Congress has set forth that it be a
16 world class medical facility can be achieved
17 unless that occurs.
18 GENERAL MYERS: I guess as you think
19 about this, I just hope the report is fairly
20 strong in this area and it sounds like it will be,
21 but accountability is kind of the last thing in
22 the chain. The first thing is you get somebody

1 with responsibility and authority and then you
2 hold them accountable, and I'm afraid the good
3 Admiral here, we might give him the responsibility
4 and not all the authority and then in the end say
5 you really screwed this up. That's not fair. The
6 corollary is that anything gets done well in this
7 life, there is somebody who is responsible that
8 has authority and then you can hold them
9 accountable. I have a very good feel for the
10 problems that you're up against.
11 DR. KIZER: That really was the second
12 point, that there is accountability without
13 empowerment which is a prescription for an
14 unsatisfactory result.
15 GENERAL MYERS: Right, and I guess my
16 point would be that this read well in the report
17 because I think it's an important part of that and
18 I think people will take notice and I think it
19 will help with the mission.
20 DR. WILENSKY: I think actually it is
21 stated clearly without ambiguity in the report and
22 is positioned number one in terms of the

1 recommendations, so I think both the language and
2 the positioning helps. But you ought to look at
3 the wording, and if you have any suggestions, any
4 of you, to try to get them back quickly to Ken so
5 that those comments can be incorporated.
6 COMMAND SERGEANT MAJOR HOLLAND: Dr.
7 Kizer, I guess my concern is as I go through the
8 Committee's review it seems like an effort was put
9 on Bethesda and the events and all that is going
10 on there, but you have Fort Belvoir that's going
11 to be a really important piece to this. Have we
12 looked to the missions that Fort Belvoir will get
13 that are different from what they have today and
14 the mission that we, the medical community, going
15 to ask them to do in the future?
16 DR. KIZER: I think the short answer is
17 that given what the Committee looked at and
18 reviewed, the situation at Fort Belvoir would be
19 perceived as much less problematic than at Walter
20 Reed and I think some of the issues that you
21 highlighted about mission and other things are
22 actually incorporated in or a part of the

1 statements having to do with the need for a master
2 plan and a clear vision for the Integrated
3 Delivery Network. Perhaps that's not clear
4 enough, but indeed you can't have that integrated
5 delivery network with these two pieces as well as
6 multiple others unless there is something that
7 ties it clearly and the mission is clearly stated
8 and other things. So actually your thoughts are
9 embedded in the recommendations having to do with
10 the need for some clarity about the Integrated
11 Delivery Network.
12 DR. WILENSKY: Admiral Mateczun, do you
13 want to respond?
14 VICE ADMIRAL MATECZUN: Sergeant Major,
15 this is a chance for me to talk a little bit about
16 the Fort Belvoir hospital, an extraordinary
17 facility that's going up. It's going to be the
18 country's leading example of evidence based
19 design. Today it's a pretty sleepy, small
20 hospital, about 10 beds. It's going to be 120
21 beds. There are a set of capabilities going
22 there, linear accelerators for radiation oncology,

1 cardiac catheterization. Half of the population
2 of the region lives in the south and so it's going
3 to be a truly extraordinary addition to that part
4 of the region.
5 DR. WILENSKY: Mike and then Ed.
6 DR. OXMAN: I had the privilege of
7 attending the last I think full Subcommittee
8 meeting in January and I'd like to say first of
9 all that I was enormously impressed by the efforts
10 and the breadth and the expertise that was present
11 around the table at that meeting and was applied
12 to the issue. The main focus in my mind was the
13 issue of the physical plant if you will and
14 subsequent operations in the Bethesda campus. I
15 have to tell you, my military service is confined
16 to 3 years in the Yellow Berets at the NIH. My
17 only war wound is lymphocytic choriomeningitis,
18 and I'm quite naive in that respect. I've always
19 been as a taxpayer troubled by the degree to which
20 the individual services are rivals, and I think
21 this is an area of great importance to medicine,
22 an example where we're creating a National

1 Military Medical Center, not an Army, not a Navy,
2 and there is where I think the importance of the
3 authority structure for both command and funding,
4 as well as obviously the responsibility for the
5 entire endeavor, is a crucial issue. I think it's
6 well covered in this report and I, as an
7 independent and more ignorant and naive observer,
8 feel that it's far and away the most important
9 issue because without it there is no possibility
10 of having an integrated physical plant and without
11 having an integrated physical plant it's
12 impossible to think of delivering world class
13 medical care. What we really care about is
14 delivering world class medical care. That doesn't
15 require that every piece of the machinery that's
16 used is the best in the world, but it requires a
17 level of all of it and it's integration that is at
18 least above a certain level, and unless there is
19 that authority over funding, I don't think that's
20 going to happen. I think that the last point in
21 the five of stopping construction is not something
22 that's recommended and is contingent upon rapidly

1 resolving the command and control of the plant and
2 the funding stream.
3 DR. KIZER: Could I just make one
4 comment in response before you go to the next?
5 Mike underscores a really important point that may
6 be resonating or moving around in people's heads
7 here in that the design and construction is only a
8 piece of creating world class and I think that we
9 addressed this well in the actual definition or
10 the statement about what is world class. It would
11 be very wrong to conclude that if you design it
12 and construct it to be the best that you're going
13 to end up with world class. Much more about world
14 class is about processes of care and how the
15 people come together and how they function as
16 teams and other sorts of things which can't be
17 necessarily designed and constructed in the sense
18 that the Congress was looking at. This goes to
19 culture and some of the more nebulous parts of
20 this, but it's absolutely paramount that people
21 understand that being world class isn't
22 necessarily about physical plant. It's partly

1 about physical plant, but largely about how people
2 and process come together.
3 DR. KAPLAN: It's quite clear that
4 people very strongly about how this is worded, and
5 General Myers has pointed out that it has to be
6 clearly stated. When this report is so stated and
7 is clear and reflects what we've heard here today,
8 what's its trail up on the line in the sense of
9 taking this message to heart?
10 DR. WILENSKY: Admiral Mateczun?
11 VICE ADMIRAL MATECZUN: Sir, generally
12 what happens within the Department with reports
13 that come from any number of places that the
14 Secretary is in charge of is that the report goes
15 back from the Defense Health Board endorsed to the
16 Secretary. The Secretary then takes some period
17 of time to review the findings and recommendations
18 and may or may not agree with them but lays out
19 then a way ahead, particularly if the report is
20 going over to Congress. So the Secretary would
21 then endorse the report back over to Congress with
22 what the Secretary is going to do or not do or his

1 agreement or disagreement with the findings and
2 recommendations.
3 Then separately those pieces start
4 working within the Department. For instance, the
5 master plan is a recommendation. We're already in
6 the process of starting to contract for a master
7 plan and get it constructed in the right way, and
8 the Secretary will say that as he sends it over to
9 the Congress. Congress then takes it and does
10 whatever they're going to do with it which is sort
11 of up to them.
12 DR. KIZER: Gail, if I might, and this
13 is really meant as a question, but it was my
14 understanding that the action that was requested
15 or that was sought from the Defense Health Board
16 was an acceptance of the report as opposed to
17 necessarily an endorsement. It might be difficult
18 to actually endorse something if you've not
19 conducted the review that the Subcommittee has,
20 but that's a point which may warrant further
21 discussion.
22 DR. WILENSKY: That's not correct. All

1 of the reports that are presented to the Defense
2 Health Board are done for the acceptance of the
3 Defense Health Board and it then forwards the
4 report to the Secretary or whoever in the line of
5 command has requested it, but is true of all. And
6 at some level your comment is true of all reports
7 that came in. The Task Force on the Future
8 Military Health Care that General Myers and
9 Admiral Mateczun and I participated in represented
10 15 months or 15 months of work. We presented it
11 twice to the Defense Health Board, once in May in
12 an interim form and a final report in December.
13 You could have easily have made the same statement
14 that spending an hour and a half listening to our
15 recommendations would not have put the Defense
16 Health Board in a position of accepting or not our
17 recommendations, but indeed that is what happened
18 and some suggestions about how wording was
19 presented or tone were made and reflected in the
20 final report, so that this is what the Defense
21 Health Board does with all of its reports.
22 GENERAL MYERS: Just one more comment in

1 conjunction with clarity and Dr. Kaplan's remarks.
2 In reading through the executive summary again,
3 the recommendation is pretty clear, but it's not
4 clear in the findings why we come to that
5 recommendation. We say this isn't right, this
6 isn't right, this isn't right, but we never say
7 it's not right because we got too many cooks and
8 not enough bottle washers working this thing.
9 DR. KIZER: Are you referring to the
10 findings in the executive summary or the findings
11 in the body of the report?
12 GENERAL MYERS: I didn't have time to go
13 through the second time through the findings in
14 the body of the report. They looked more robust.
15 But what people on the Hill are going to read and
16 what the Secretary is going to read is going to be
17 in the executive summary. This is just a
18 recommendation. I don't have to do the work. I'm
19 happy to help you. There ought to be some tie
20 there because this is such an important issue.
21 DR. WILENSKY: I actually would like to
22 continue on the same line. You've been around

1 this place long enough. You know this as well as
2 anyone, Ken. You need to have a stand alone
3 executive summary on the assumption that 99
4 percent of the Congress is going to at most look
5 at the executive summary and it needs to be
6 coherent in terms of both the message and the tone
7 that you want to have delivered, and I agree with
8 what General Myers just said in terms of the
9 findings need to support why it's such a critical
10 number one recommendation. The other two issues
11 that, one of which I'd shared with you earlier, is
12 I believe both in terms of the findings and in
13 terms of the recommendations, if the Subcommittee
14 believes this as it said it did, that the final
15 conclusion has to be clear which is that stopping
16 the construction or halting the construction would
17 present many difficulties and is not necessary or
18 desired provided that, and then your provisions.
19 That also needs to be very clear and very boldly
20 stated. Otherwise it is likely to get lost in the
21 shuffle with all of the deficiencies. So there is
22 either disagreement or you don't believe it,

1 that's one thing. If you believe what is said, I
2 don't think it is clearly and strongly enough
3 stated in a way that it can't get lost.
4 The other issue which I don't feel as
5 strongly about as the point I just made, and this
6 is offered merely as a suggestion, I think that
7 you have a large enough number of recommendations
8 that it would be helpful if you could prioritize
9 the recommendations in terms of the most critical
10 things to have happen. As people on the Task
11 Force used to hear me say ad nauseam, I learned
12 enormously from Donna Shalala that the power of
13 the Dole-Shalala Report, aside from all of its key
14 participants having good suggestions, was having
15 six recommendations and that unlike some reports
16 that had large numbers of recommendations, those
17 could be put in focus, they had some sub-bullets,
18 but it made it much easier to have the most
19 important issues, clearly the most important
20 issues. So I have taken it to heart. It was
21 something Donna insisted on. You might even want
22 to give her a call and talk to her about some of

1 this. I think it is a very effective way to make
2 sure that the most serious issues for you and your
3 Subcommittee are very clear to the Department and
4 the members of Congress going forward and if you
5 want to do less than the six that's fine, but it's
6 just a powerful way to make your message.
7 Let's do Mike Parkinson and then Mike
8 Oxman.
9 DR. PARKINSON: Ken, congratulations to
10 you and the Committee. I think you've done a
11 great service for health care generally, the whole
12 notion of world class more broadly. I'd like to
13 reflect on two things, and in the spirit of truly
14 trying to make the military health system if you
15 will to borrow from one of our
16 commanders-in-chief, the shining city on the hill,
17 that it should be. Some of you know that I left
18 the Air Force in 2000 and my parting conversation
19 was then with Dr. Ed Martin who was running the
20 Department after I had among other things worked
21 closely with then Colonel Middleton to put
22 together a 18- month to 2-year state-of-the-art

1 population health improvement plan for the entire
2 Department. It was reporting directly to Dr.
3 Martin with three of the senior most colonels, two
4 of which I think became surgeon generals after my
5 departure. The reason that I left the military
6 was in a frank conversation with Ed Martin, that
7 you're not organized to execute. I said as much
8 as I love the military and spent two decades in
9 it, you cannot execute this plan. Yet everybody
10 in the world from George Halverson to Dennis
11 Cortese is looking for something like we worked on
12 in 2000. So much so that we then had Dan Fox come
13 down from Milbank saying what you guys have done
14 here is as big as Eisenhower integrating the
15 Services. I'm not saying that for any personal
16 reason, but in a decade we have not advanced is
17 really what this case study says. I'm being a
18 little harsh around the edges here. But now we're
19 talking in a region within a military health
20 system which is a regional attempt which is really
21 where we were in 1996-1997 when we started talking
22 about regional comments in TRICARE when we had 12

1 and then we had six and now we have three.
2 So in the words of a great philosopher
3 who I now think is the Chief of Staff for this
4 particular President Obama, "Never let a crisis go
5 to waste," and I would never suggest to create a
6 crisis where there is not one, but sometimes you
7 do make hay where there is sun shining and I would
8 just ask if the notice layman or congress person
9 were to look at the deficiencies, how could we not
10 meet JCAHO standards? JCAHO standards are not world
11 class. They may be state of practice. I'm not
12 sure they're state of art with all due respect to
13 Dennis O'Leary. They're really not consumer
14 focused which is where the entire focus of the
15 world is going, they're really not electronically
16 enabled, so that I don't have to go to Walter
17 Reed, I can do it online, fill a new prescription,
18 many of the things that Dr. Wilensky's Task Force
19 brought to this same DHB a year ago. Is it time
20 to say stop the presses? Again I realize there's
21 a lot of downside and this is all about
22 collegiality here and trying to do this, but this

1 is just kind of a smoking gun again.
2 A provocative question, a sincere
3 motivation, been there, done that, 10 years or a
4 decade later to my parting constructive
5 colleagues, and I realize it's not about unified
6 command, it's about a unique way of doing this,
7 but I just wonder if we're not passing up on Rahm
8 Emanuel's word, a crisis, that there may be a
9 great opportunity, because we may not come this
10 way again just for probably happy hour
11 conversation.
12 DR. KIZER: I don't know whether that
13 falls under the category of those that you avoid
14 or actually try to respond to, but I will take
15 the latter tack in a couple of ways. One is that
16 much of the discussion that is occurring today is
17 quite déjà vu in the sense that more than 10 years
18 ago when Ed Martin and I chaired the Joint VA-DOD
19 Executive Council, these issues were being
20 discussed then. They're still being discussed,
21 and frankly not much has happened in the interim.
22 My only hope is that 10 years from now we won't

1 still be discussing them because the train will
2 have long left the station by then.
3 There is a great opportunity here and I
4 think that if these recommendations are actually
5 acted upon, there is a tremendous opportunity for
6 military medicine to be the shining light that I
7 think many of this room would like it to be. I
8 think to answer your specific question, the
9 Committee debated and extensively mulled over the
10 question is it time to stop the presses and our
11 conclusion was that it's not if the master plan
12 can be developed, if the authority issue can be
13 resolved, if the funding issue can be resolved.
14 So it's a conditional no and it really is
15 incumbent upon the Department to find the ways to
16 actualize the recommendations, but at some point
17 in time, and I think this goes back to Phil
18 Tobey's comments, that at some point down the
19 road, and it's probably not all that far down the
20 road, it will be too late and then we will have to
21 actually come back and ask the question again.
22 There is a window of opportunity now to continue

1 moving forward if these other things are done.
2 Just the last point, I would say one of
3 the reasons why the recommendations are as they
4 are because I frankly agree completely with Gail's
5 comments about narrowing it down, indeed I've
6 always had a standing rule that you should not
7 have more than five because at least most people
8 have that many fingers that they can count on and
9 then if you go above that it's too complicated,
10 but one of the reasons why there as many, because
11 the intent was to make them actionable, and I
12 think as Admiral Mateczun commented, that this
13 really does provide a bit of a template you can go
14 down or a checklist if you will, was this
15 addressed, was this addressed, was this addressed.
16 I don't think it's going to be hard to repackage
17 them in a way that that can be done to accomplish
18 both, but I think the Subcommittee was of the
19 mindset that it would really like to see its
20 recommendations acted upon and tried to make them
21 pretty clear as to what needed to be done but not
22 tell the Department or anyone else how that needed

1 to be done because I think that would exceed the
2 authority and responsibility of the Subcommittee
3 to actually say how it has to be done. And in
4 many ways that's a microcosm of the thinking of
5 integrated delivery networks. You can lay out
6 some goals and expectations that have to be clear
7 and actionable, but in the end it depends on the
8 pieces and how you make it happen, and how it
9 happens in the National Capital Region is likely
10 to be significantly different than how it happens
11 in San Antonio or in Southern California or
12 wherever else this may occur in the future, and
13 that's part of the adage that all health care is
14 local. That's true to a point, but if you're in a
15 national system, there is also a systemization
16 that needs to occur and so it's that balance of
17 what is laid out at the top and what occurs at the
18 bottom that I think always has to be strived for.
19 DR. WILENSKY: I have the following
20 three people, Mike Oxman, Jeff Longacre and John
21 Holcomb.
22 DR. OXMAN: First of all, I'd like to

1 really agree with and underline Gail's point that
2 most people are going to read an executive summary
3 which better be short and to the point, and I
4 would recommend that although there may be
5 flexibility in time for many of the aspects of the
6 capital plan, there is no flexibility in time for
7 the construction that's currently going on on the
8 Bethesda campus which I walked by yesterday. As
9 Phil Tobey made that point, I think that I would
10 recommend that you take slide number eight which has
11 your five critical points and then no need to halt
12 construction if a master plan addressing the need
13 for backfill can be completed in a timely manner,
14 and there I think as a member of the Board timely
15 needs to be defined with a timeline if the
16 construction that's going on now on the Bethesda
17 campus is continuing to go on. The other thing I
18 would recommend is that you turn these points of
19 criticism around by adding perhaps another phrase,
20 for example, the organization and funding
21 authority are fragmented but must be concentrated
22 in the hands of a single person with authority.

1 In other words, I think this is a great framework
2 which can be turned into more positive
3 recommendations, but I do think time is critical
4 when it comes to what's going on on the Bethesda
5 campus and I think there is really little to
6 spare.
7 DR. LONGACRE: We have the unique
8 opportunity to implement the original vision of a
9 world class medical center and a premier academic
10 health center collocated at the Walter Reed
11 National Military Medical Center, JTF CAPMED, the
12 Uniformed Services University, National Intrepid
13 Center of Excellence, NIH, with our ultimate goal
14 being to create the very best for our deserving
15 beneficiaries. We can do that by creating a
16 premier academic health center that emphasizes
17 quality clinical care, medical education and
18 clinical and basic science research. Several
19 members of the Board and Committee come from
20 highly esteemed institutions that exemplify how
21 it's excelled incorporating all three of these, so
22 I'd like to submit that we continue to emphasize

1 that the NCR World Class Medical Center be looked
2 at as a premier academic health center. One of
3 the comments earlier mentioned was that in order
4 to grow and evolve and be on the cutting edge, and
5 one of the best ways that we can continue to be on
6 the cutting edge is to make sure that we emphasize
7 all three of those, the clinical care that we
8 provide, the basic science and clinical research
9 as well as medical education. Thank you.
10 DR. WILENSKY: John?
11 DR. HOLCOMB: Thank you, Dr. Wilensky.
12 I'd just like to make a comment that this is a
13 very Washington, D.C.-centric presentation. I
14 know that was your task. The systems issues
15 you've identified are largely replicated in every
16 other BRAC site in the country. They're not
17 unique. There will be some idiosyncratic
18 differences at each site, but the system issues
19 especially command and control, responsibility and
20 authority are the same around the country, so your
21 report might serve as a template for many other
22 places.

1 Dr. Longacre, your comments on world
2 class are the ones that I was thinking of as well
3 that we've been mumbling over here a little bit.
4 You can have a great facility, but if you don't
5 have great education, great research and great
6 patient care, it's not world class, it's just a
7 great building. I didn't see that really
8 addressed in your slides very clearly. I don't
9 know if in your larger report you addressed those
10 three pillars of world class, the fourth one I
11 guess being the building.
12 DR. KIZER: Again the slides didn't
13 address a lot of things, and what I would
14 encourage you to do is actually read the statement
15 about what is world class and I think that you
16 will find that all of the thoughts and ideas that
17 have been addressed by the previous two speakers
18 are fully embedded there, and I see several people
19 who have read it seem to agree.
20 DR. WILENSKY: I agree, and I strongly
21 encourage you to go to Appendix B to read the
22 discussion. It's a two or three page discussion.

1 There is a lot of emphasis on all four of these
2 areas. Dr. Silva?
3 DR. SILVA: It's really a great report,
4 very disturbing, Ken. As you know, I've developed
5 a couple of large hospital wings, but just from
6 the bottom line, it's not too late to make these
7 corrections. A lot of these recommendations are
8 very important for a modern day facility. I guess
9 there's a whole in the ground. Right?
10 DR. KIZER: It's actually being rapidly
11 filled, if not largely already filled.
12 DR. SILVA: It's the renovation. Thank
13 you. So you have plenty of time. The master plan
14 would involve not only the integration, I agree
15 with Dr. Parkinson that's critical how to save
16 money. But also the budget. Do we have this
17 thing costed out? Do we have a bottom line yet?
18 Or is it so diffuse and in different ledgers that
19 no one has really been able to add it up?
20 DR. KIZER: That's a key issue and it's
21 impossible to cost out something that you don't
22 know what you're costing which is kind of the

1 essence of much of the discussion, until there's a
2 comprehensive master plan that addresses
3 renovation and new construction, you simply can't
4 put a dollar amount on it. So you got to do the
5 plan, figure out where all the pieces are and then
6 what the cost is going to be and then go back and
7 look at the multiple funding streams to see what
8 currently exists and what may be, as Ray said, the
9 gap between the multiple current funding streams
10 and what the price tag is. But that's something
11 that is not doable at the moment because the
12 necessary work hasn't been done.
13 DR. WILENSKY: Wayne and then Charley.
14 DR. LEDNAR: I have a question and then
15 a thought. The question just for my clarification
16 and education is we've used the term this report
17 will be given to the Secretary several times. As
18 a body, the Defense Health Board gets questions
19 from a variety of sources and many times the term
20 "the Secretary" means the Assistant Secretary of
21 Defense for Health Affairs, but is the Secretary
22 in this conversation the Deputy Secretary of

1 Defense? Is that person who will get this report?
2 DR. KIZER: I think that's actually up
3 to the Department. I think the Department would
4 be remiss if this didn't reach the level of the
5 Secretary or at least the Deputy Secretary because
6 it would seem based on the history of this event
7 or this project, if you will, and the level of
8 interest by multiple constituencies not the least
9 of which being the Congress that we're going to
10 hear a lot more about this in the future and
11 certainly having been around this town a bit, it
12 occurs to me that the Secretary would probably be
13 well served by being informed in some significant
14 degree about it, but that's a decision that the
15 Department has to make.
16 DR. WILENSKY: I don't think there's any
17 question but that this will go to the Deputy
18 Secretary and Secretary. This is much too
19 political an issue.
20 MR. DUBOIS: The issue is the Congress
21 directed the Secretary of Defense to stand up an
22 independent panel to assess and evaluate the

1 construction and design-build aspects of the new
2 Walter Reed. So technically speaking, this report
3 goes to the Secretary of Defense, it passes
4 through several hands to get there, and then he in
5 turn responds to his charge from the Congress in
6 the Defense Authorization Act.
7 DR. WILENSKY: Again this is precisely
8 the chain that went through with the Task Force on
9 the Future of Military Health Care which was
10 congressionally directed in the NDA of 2008 and
11 that is not that unusual in any congressionally
12 directed task force, commission, et cetera. But I
13 don't think you have to worry that this is going
14 to get lost somehow at a lower level than the
15 Secretary or the Secretary's office.
16 DR. LEDNAR: That's good to hear, but
17 now my thought, we've heard about the importance
18 of timing, the urgency for moving forward on the
19 conditionals that the Committee has identified,
20 this is important in answering the question about
21 the National Capital Region, but as the Committee
22 has put an awful lot of thought into the operation

1 of an integrated health system for the future, we
2 have probably as I understand it by early July in
3 the Congress proposals that will be presented,
4 will be drafted by early July for national health
5 care reform in the Senate. Congress is the one
6 that asked for this report and I don't know how
7 there's any interchange eventually of the insights
8 of this work, but it will miss an opportunity for
9 a much larger affect if it gets to the Congress to
10 late. So for lots of reasons I hear there's an
11 urgency to get this report completed, get it
12 submitted to the Department, work through all of
13 the hands that it has to, but it can serve a much
14 larger national benefit if it can also get to the
15 Congress in time for it to inform some of these
16 other larger discussions that are ongoing.
17 DR. WILENSKY: I suspect some of these
18 larger discussions are going to go on a little
19 later than July, but it's important for many
20 reasons that we not delay this report's moving
21 forward. Chase, did you have a comment?
22 MR. UNTERMEYER: Yes, Madam President.

1 It's a question for you. That is, what do you see
2 as the ongoing role of this Board in overseeing,
3 monitoring, getting further reports in the
4 implementation of these recommendations?
5 DR. WILENSKY: My hope is that this can
6 be an ongoing activity for the Subcommittee. I'll
7 need some advice from the Department, but because
8 there were so many directives or recommendations
9 of what needs to happen, there should be, in my
10 opinion, some kind of a follow-on. I'm not saying
11 this is necessarily a good guide, but again the
12 Task Force on the Future of Military Health Care
13 had its recommendations reviewed by the Department
14 and the Department chose to accept some, not
15 accept others. The Subcommittee that I chair is
16 going to be monitoring the implementation by the
17 Department of the recommendations that it has
18 chosen to accept and presumably opine on the ones
19 that it didn't choose to accept as to whether
20 those issues still exist. But it may also depend
21 on the results of this Subcommittee report going
22 up the chain as to whether or not there's a

1 specific direction as to what happens next.

2 MR. UNTERMEYER: What I might suggest is

3 we make this perhaps a semi-annual item to invite

4 Admiral Mateczun or Dr. Kizer or whoever is

5 continuing to look into this matter to report back

6 to us on progress.

7 DR. WILENSKY: That would make sense,

8 and if nothing else occurs in a more directive

9 capacity, that would be the least that we could

10 do.

11 GENERAL MYERS: Just to pick on what Dr.

12 Longacre commented on on the university up there

13 on the Bethesda campus for background and maybe

14 some of you know this, but there was a very strong

15 effort during BRAC to do away with USU and we

16 would do all our education at other universities.

17 We didn't call it world class at the time, but

18 that that was a real adjunct to the Bethesda

19 campus and it did make us provide better care. So

20 I took your advice. I read the appendix and back

21 there on K it has two lines that addresses this,

22 or three lines or five, make it 100. It's not

1 enough in my view. My view is you're never going
2 to drive a stake into the heart of bad ideas in
3 this town, but you could really help the cause if
4 you think that university is important to military
5 medical care, which I happen to believe as a
6 layman. I can tell you my personal story. I was
7 threatened by a couple of anesthesiologists on the
8 way into surgery who were graduates of USU and
9 they said we know you're on the BRAC Executive
10 Committee. They already had me under sedation and
11 they were extolling the virtues of their education
12 there and why it made sense, and I said anything
13 you guys want I want. I'm being facetious. I
14 already believed it and I've already made my
15 argument. I'm not sure we don't want to make that
16 tie just a little -- it would be very helpful to
17 those in Congress and maybe even to some in the
18 Department to understand this value of this
19 integrated facility.
20 DR. WILENSKY: That was only the latest
21 threat. As those of you who have had any
22 involvement know, there have been multiple times

1 when USU has almost died. This would be under the
2 same rubric of advice that you may want to look at
3 it and see whether there is any strengthening with
4 regard to the language that would be appropriate.
5 DR. FOGELMAN: I certainly want to
6 endorse the six or five headlines. It's certainly
7 something I'd recommend. But also when putting
8 things together, if you add a timeline, we heard
9 some talk about a timeline being attached to the
10 master plan which I think is absolutely correct,
11 but I think each of these ought to have some idea
12 of what the time beyond which it should not be
13 completed might be. And at the same time, each of
14 these can have attached to it a measure, empower a
15 single official, when that happens it's pretty
16 clear I think, or actually there may be some
17 disagreement about what that means, each of these
18 can have some measure. The one that it seems to
19 me the hardest to measure, speaking as an
20 occasional cultural change engineer, is to begin
21 engineering needed culture change. That's a big,
22 vague thing and it's unarguable that the cultures

1 don't necessarily fit now and they need to be
2 somehow made to fit better, but I'm not sure that
3 that's an easy item to put among these. So if you
4 have to take one out even though this one is dear
5 to my heart, I would take that out and embed it in
6 some of the others.
7 DR. MILLER: There was an allusion or
8 statement of world class and looking at the
9 immediate issues, but I wanted to bring up an
10 issue about long term strategies as well. What is
11 world class today is not necessarily what it is 5,
12 10 or 15 years from now. Look at Kennedy Airport
13 when it was built and now look at it today. So
14 the question is there actually a process to look
15 at not only the immediate with the BRAC closure
16 and the BRAC situation and the process that's
17 underpinning and funding it, but also
18 longitudinally to the future how will it be
19 ensured that this facility which will be a legacy
20 for the next 50 years perhaps that there is some
21 type of maintenance process to ensure that it is
22 still up to the standards that you have originally

1 envisioned.

2 DR. KIZER: If I could respond to both

3 that and a few of the other comments, for example,

4 Recommendation J is I think quite explicit in

5 recommending that there be an ongoing review

6 process or independent review. How that is done

7 and whether it's this Subcommittee or some other

8 body or whatever I think is an issue that could be

9 debated and opined upon by others, but clearly we

10 felt that it should. Another point is as I think

11 has been said three or four times this morning by

12 myself and others is the dynamic and changing

13 nature is what is state-of-the-art and what is

14 world class, and I think as I said quite clearly,

15 what it was 5 years ago is different than what it

16 is today and it's going to be different 5 years

17 hence, and embedded certainly in the definition or

18 the description of what is world class is that

19 understanding and the need for continual evolution

20 and adaptation as technology changes, as medical

21 science changes, processes, et cetera, that this

22 is a continually moving target.

1 Finally, I think the issue of the
2 university was discussed. Indeed, the board of
3 the university has contacted me on several
4 occasions how wanting input and I have no problem
5 in including verbiage about that, but I would also
6 note that in doing that we shouldn't overlook that
7 there are parallels, for example, the Joint
8 Pathology Center should probably be in the same
9 dialogue, the role of NIH should probably be in
10 the same dialogue, and there may well be other
11 facilities or institutions that would be in that
12 same level of detail if indeed we go that way.
13 Finally, just as a pragmatic matter,
14 several people have commented upon the urgency and
15 the need to move this forward which we fully
16 underscore, and I would just remind everyone that
17 the Committee is composed of volunteers who have
18 very busy daytime jobs and extensive other
19 commitments and an extraordinary amount of time
20 has already been committed and put into this and
21 the realities of how much further effort and not
22 to delay the process is something that we should

1 be mindful of.

2 DR. SHAMOO: I guess we have come to

3 almost the conclusion of this. My thinking is

4 that we approve it with a proviso of several

5 suggestions basically most of them are tweaking

6 such that Gail will ensure that the final copy

7 reflects some of the comments here rather than

8 bring it back. This way, we'll expedite it.

9 DR. WILENSKY: That was certainly my

10 intention, that before we break, which I hope we

11 will do shortly, that we approve it, but we

12 request that you incorporate the comments that

13 have been made to reflect the spirit of the

14 comments as they were given.

15 I don't think this is a huge rewrite. I

16 think it's some -- a little bit of repackaging and

17 something that the drafters of the report, which

18 -- who did an excellent job, could do in a day.

19 I mean, I don't think this is a

20 long-term effort. Mike?

21 DR. OXMAN: Just one thing that I think

22 is an important distinction when I talked about a

1 timeline, and it's a little potentially confusing
2 when you talk about a comprehensive design plan.
3 I think the timeline that's critical is
4 the design plan for the construction that's going
5 on on the current Bethesda site.
6 That's the timeline and the final plans
7 for that that have to be done quickly and
8 properly. And that's where the timeline is
9 critical.
10 The planning for how we evolve the
11 delivery of healthcare in the capital area doesn't
12 have to be accomplished in the next month or two,
13 but the former does.
14 DR. WILENSKY: Any further comments? Is
15 there an agreement that, subject to reflect the
16 discussion that we have had here today, that
17 people are comfortable that this report should go
18 forward?
19 Okay. Approved. Let me see a copy as
20 soon as it's possible to get some of these changes
21 reflected.
22 MR. KIZER: Sure. Let's talk offline a

1 little.

2 DR. WILENSKY: Thank you very much. An
3 awful lot of work has gone into this, and we
4 appreciate the effort that you and your
5 Subcommittee have ably done for the improvement of
6 this process.

7 (Applause)

8 DR. WILENSKY: Ed?

9 DR. KAPLAN: Short question: Will a
10 copy of the revised or added to with the remarks
11 be sent out to the Board members, too?

12 DR. WILENSKY: It will. We'll check
13 with the Department in terms of how and when they
14 would like that to happen.

15 But, yes, I'm just not sure exactly at
16 what point in the process they'll do that.

17 It is 12:30 p.m. We're running a half
18 hour behind our timeline.

19 If it would be possible for the Core
20 members (sic.) -- and -- Core Board members and
21 the Subcommittee chairs to take 20 minutes, make
22 phone calls, and get your lunch.

1 We're going to have a working session.
2 I want to bring all of you up to date with
3 previous discussions that we've had on some of our
4 organizational structure issues.
5 We do have some administrative -- yes,
6 here -- we do have some administrative time at the
7 end of the day, if we need to use it to conclude
8 those discussions or to at least continue them.
9 This is probably not -- this is going to be an
10 ongoing process.
11 But if we can reconvene as the group
12 I've indicated here in 20 minutes, and the open
13 meeting will reconvene at 2:15 p.m. Thank you.
14 (Recess)
15 DR. WILENSKY: We're going to reconvene
16 for this afternoon's meeting now, and our first
17 speaker this afternoon is Dr. John Holcomb.
18 He is currently Professor of Surgery and
19 Director of the Center for Translational Injury
20 Research at the University of Texas Health
21 Sciences Center at Houston.
22 Recently retired from the Army, his last

1 assignment was commander of the U.S. -- sorry --
2 U.S. Army Institute of Surgical Research at Fort
3 Sam Houston in San Antonio.
4 He is also the newly appointed chair of
5 the Trauma and Injury Subcommittee.
6 Dr. Holcomb will discuss the recent
7 activities of the Defense Health Board's Trauma
8 and Injury Subcommittee, including a summary of
9 the Subcommittee's meeting last week in San
10 Antonio.
11 His presentation slides may be found
12 under Tab 7 in your meeting book.
13 DR. HOLCOMB: Thank you, ma'am.
14 DR. WILENSKY: Mm-hmm.
15 DR. HOLCOMB: It's an honor to get up
16 and speak in front of you all, and we'll get right
17 into it.
18 So one of the first things -- I think
19 it's important just to reiterate, probably have
20 every time I brief this Committee is the Tactical
21 Combat Casualty Care Committee is a subpanel to
22 the Trauma and Injury Subcommittee, which is a

1 subcommittee to the Defense Health Board.
2 So while a new subcommittee, we actually
3 have a fair amount of structure. The Tactical
4 Combat Casualty Care Group has been meeting for at
5 least the last four or five years.
6 It publishes a book that is the military
7 companion to the civilian PHTLS. The PHTLS is the
8 bible for pre-hospital trauma care in the civilian
9 world.
10 Tactical Combat Casualty Care is the
11 bible for military pre-hospital combat casualty
12 care. Published in book form, signed off and
13 validated and approved the American College of
14 Surgeon's Committee on Trauma, and used in all of
15 the NATO countries to teach their medics and in
16 many non-NATO countries to teach their medics.
17 So this Tactical Combat Casualty Care
18 coming underneath this Trauma and Injury
19 Subcommittee, which comes underneath the DHB, is
20 actually a very good thing and provides that group
21 a fair amount of structure for an existing group
22 that's been meeting for a long time and has been

1 highly productive, and, frankly, fairly
2 influential in trauma care across many countries
3 in the world.
4 The Trauma and Injury Subcommittee
5 membership I'll show in just a second. We've had
6 two meetings.
7 The first meeting in 3 February was
8 really an organizational meeting, led by Commander
9 Feeks and Dr. Butler, who's been -- is the chair
10 of the Tactical Combat Casualty Care Group.
11 And then we met again on the 29th of
12 April, and I'll provide a meeting summary. And
13 this question is -- I'll state again at the end --
14 and we talked a lot about this yesterday in the
15 executive committee -- is what issues do you want
16 us to address.
17 This is the membership of the committee,
18 and I'll just briefly go through. We have
19 representatives -- an ex- astronaut and a VA
20 representative, an issues representative, a trauma
21 surgeon at the national- international level from
22 Tulane -- Don Jenkins, retired Air Force. He's

1 now up at Mayo.
2 Jay Johannigman is in the Air Force
3 Reserve in Cincinnati. John Gandy just retired.
4 I'm not sure where he's going yet. Ed Otten is
5 from Arizona. And Dave Callaway is from Boston.
6 Peter Rhee is from Arizona, and Brad Bennett is --
7 has a company.
8 So we have a variety of surgeons,
9 emergency medicine folks, who have really worked
10 for a long time in injury.
11 The 3 February meeting agenda, as I
12 said, was really just organizational in nature.
13 There is one little -- one little section I'd like
14 to highlight is that occasionally we will need
15 very rapid approval of the minutes and comments
16 that come out of the Tactical Combat Casualty Care
17 Group, because there are operational issues that
18 come up that are very time sensitive, and so for
19 the Defense Health Board core membership is they
20 vote to approve what we do in our subpanel and
21 Subcommittee.
22 If there is an operational issue

1 springing from the Tactical Combat Casualty Care
2 Committee, we may ask for rapid approval or
3 discussion.
4 I'm now going to go into the agenda
5 items, and with a lack of input on what our agenda
6 should be, we made an agenda and had eight
7 briefers that came and briefed us on the 29th of
8 April.
9 The first was, as you can read, the Life
10 Savings Benefits of Fresh Whole Blood. Dr.
11 Charles Wade is the DoD representative. He's a
12 senior scientist for combat casualty care. The
13 title carries a fair amount of influence in the
14 combat casualty care arena.
15 And what he presented was an abstract
16 with outcome data from over 2000 combat
17 casualties; about 400 that had received fresh
18 whole blood, case matched controlled to about 302
19 patients who hadn't.
20 And so, 302 patients had received all
21 component therapies, including platelets, and the
22 other 302 patients had received all of those

1 components plus fresh whole blood.
2 And despite the fresh whole blood group
3 being sick or by every measure that we currently
4 use -- with injury severity score, blood pressure,
5 heart rate, respiratory rate -- the survival was
6 significantly improved in the group that received
7 fresh whole blood; at a 15 versus 24 percent,
8 which was highly significant.
9 Those are long-term outcome data, all in
10 U.S. Casualties coming back through the United
11 States.
12 I bring this point up, because Dr.
13 (inaudible), this obviously would go against a
14 little bit of the Defense Health Board policy letter
15 that came out a year ago that really spoke to
16 fresh whole blood and untested blood transfusions
17 in theater; unfortunately, it didn't have any
18 outcome data associated with it.
19 So we will generate this data in a
20 little bit more standard format, bring them up to
21 the Board, and present the Board the outcome data
22 in the conventional format that you guys are used

1 to seeing.

2 And I think it'll be a topic for

3 discussion for the full Board to kind of readdress

4 with some new information.

5 Okay. Do you want to stop at each time

6 and get questions? Or how do you want to?

7 DR. WILENSKY: Why don't we stop at --

8 normally, the answer would be no.

9 DR. HOLCOMB: Right.

10 DR. WILENSKY: But because particularly

11 with regard to this issue represents a change in

12 position or a potential change in the position by

13 -- for the Defense Health Board.

14 Is there anything that people want to

15 address? Greg?

16 DR. POLAND: Yes. I don't -- I didn't

17 know any of the other individuals on the air, but

18 you've sort of implied that they were from a

19 variety of specialties. And I wanted to be

20 reassured that that was the case.

21 I think having -- well, let me say it a

22 different way. I think having people with some

1 study and methodologic expertise in designing and
2 presenting the results, particularly for this one,
3 is going to be critical. A case-matched approach
4 would not meet that definition, for example.
5 So I think particularly in contentious
6 issues like that where there is the opportunity to
7 probably even randomize people and collect data
8 that would be definitive and for which we could
9 claim causality would be critical.
10 DR. HOLCOMB: Right. So this is a great
11 lead-in to a comment that you'll see later where
12 we are going to ask our Ethics Subcommittee to
13 address the ethics of randomization without
14 individual consent in a theater of operations,
15 which would be the population that we're
16 speaking of, because these patients would be in
17 profound hemorrhagic shock, many of them with head
18 injuries, and not -- most people would feel -- not
19 be ethical or even possible to get individual
20 consent. Community consultation with CFR 50.24
21 has really been considered by the military not
22 doable in the theater of operations.

1 And so what you're left with is
2 something less than prospective -- the ability to
3 do prospective randomized data and should we then
4 not look at the retrospective data that is
5 collected in the best way we can.
6 Dr. Wade is really a world-famous
7 scientist in combat casualty care. That's why
8 he's named as the senior scientist in combat
9 casualty care for the Army; and is the first
10 author of the study that will be presented at the
11 American Association for the Surgery of Trauma.
12 So we can have Dr. Wade come and talk to
13 us in the future, or we can have these data
14 presented. But I think that the Board needs to
15 look at this pretty carefully, and think through
16 falling back on our standard recommendations for
17 prospective randomized data sounds good, but most
18 people feel can't be done in theater.
19 So then what you're left with is what
20 should we do? I think it's a great discussion to
21 cross committees.
22 All right. So next is the-

1 DR. WILENSKY: Steve, let me just be
2 clear now.
3 DR. HOLCOMB: Yeah.
4 DR. WILENSKY: What is the next step on
5 what will happen? Will this be a recommendation
6 coming out of your Committee?
7 DR. HOLCOMB: Yes. What we'll do is --
8 DR. WILENSKY: So we will have a chance
9 when you would present in a more fulsome way to --
10 DR. HOLCOMB: Right.
11 DR. WILENSKY: -- be able to address
12 these questions?
13 DR. HOLCOMB: I think right now is,
14 frankly, I'm learning how the process works. We
15 had our first meeting on, you know, just a couple
16 days ago and addressed to some topics that we have
17 had some previous information on -- were new or
18 fairly topical.
19 And I need to reformat this now in the
20 method that you guys, the core Board, is used to
21 seeing.
22 This was a fairly uniform

1 recommendation out of our Subcommittee that we
2 relook at the DHB recommendation from June of last
3 year based upon these outcome data. They are the
4 largest outcome data associated with fresh whole
5 blood in the trauma population that anybody is
6 aware of.
7 DR. WILENSKY: Mike?
8 DR. PARKINSON: Mike Parkinson. John,
9 first of all this is great but the whole process
10 has matured such that we're now talking about the
11 full scope of what is military medicine healthcare
12 in general, because this type of topic, except for
13 falling out of the sky in the traditional old day,
14 if you be -- you probably wouldn't be here.
15 So I'm glad that this is here, because
16 it's all about, you know, how do we learn better,
17 and give value to the troops, et cetera.
18 But it does bring up kind of another one
19 of these cross-cutting issues and that is where in
20 -- and it's not for an answer, but just to frame
21 this -- is where and how do we differentiate
22 ethically, epidemiologically things like what is

1 essentially INDs for therapy.

2 Now the therapy can be lifesaving. The

3 therapy can be for vaccines. The therapy can be

4 for -- but there's different cultures coming here,

5 which is exactly what DoD has to come up with

6 probably a value-added approach.

7 So while physicians -- I technically

8 have a license in Maryland -- I could do brain

9 surgery, technically -- no one's telling me I

10 can't, but I don't.

11 Likewise -- but I mean the broad scope

12 of life saving license that we're given as doctors

13 or surgeons or as combat casualty care specialists

14 in the field, where, and if, does that ever cross

15 over into experimental therapy and IND type of

16 thinking.

17 And that's where I think we're churning

18 here a little bit, which I think is a great

19 discussion. There is no other place in the world

20 that probably would have it in a constructive way

21 than the DHB.

22 So I think it's great. And so I think

1 it's wonderful that this dialogue may occur in the
2 future, not only for this, but for other issues.
3 And I think in classic fashion a rising
4 tide will lift all boats. There will be great
5 things that come out of this dialogue.
6 DR. HOLCOMB: Yeah. Just to continue
7 that for a second, whole blood actually is an
8 AABB-approved product. It's the American
9 Association of Blood Bankers.
10 So for whole blood, there's no need to
11 have an IND, which brings a whole different
12 discussion into play.
13 And so it's an approved product. It's
14 been a long-standing product; been in the policy
15 for the DoD since World War I.
16 If you look at any of the policy and
17 field manuals, et cetera, the walking blood bank
18 is in there.
19 In addition, one of the things that's
20 not widely appreciated or discussed is that the
21 amount of testing or not testing that's not done
22 on whole blood is equivalent to that for apheresis

1 platelets.

2 So the component therapies we use in

3 theater include apheresis platelets, which has the

4 same level or not of testing that whole blood has.

5 So many issues around this, and I think

6 it's worth discussing the depth and breadth of

7 these issues in an open fashion. And that's

8 really the reason to put that number one on that

9 agenda item.

10 Traumatic brain injury obviously

11 absolutely crossing the Subcommittee efforts here.

12 We looked at the impact of concussion and

13 potential prevention.

14 Again, Dr. Wade, representing the combat

15 casualty care scientific community from the Army

16 and Lieutenant General (retired) P.K. Carlton,

17 the Air Force Surgeon General, almost two times

18 ago now, and talked about a very simple prevention

19 measure that we discussed a little -- that we alluded

20 to this morning.

21 If we are just talking about concussion,

22 the pads that are in the helmets at least in three

1 independent studies that have been conducted
2 previously show up to 90 percent improvement in
3 concussion prevention using standard, testing
4 measures.
5 Just by taking the pads that are
6 currently in the Army combat -- or the ballistic
7 helmets and replacing them. So a fairly cheap, a
8 very simple thing that's begun in place in theater
9 could decrease concussion significantly.
10 And, ma'am, I do think this is -- you
11 know, General Sutton signed on to bring people to
12 this Committee and welcomed the opportunity to
13 bring folks in front of her to talk about why or
14 why not this hasn't happened.
15 And I think we ought to work with her
16 and let her lead those efforts to bring folks
17 together.
18 We would certainly welcome the
19 opportunity to help ordinate those I think from
20 our Committee and with General Sutton.
21 The Transition Military Care Guidelines,
22 the civilian sector Dr. Rick Hunt is an emergency

1 medicine physician at the CDC, who -- he and I
2 have been talking for some time in a different
3 forum, and I thought this was a great opportunity
4 to bring Rick and his group to this Committee.
5 As many of us have discussed, there are
6 lot of lessons learned in combat for military
7 medicine that should translate into the civilian
8 sector, and they have. The history is replete
9 with these examples going back as far as you can
10 document, back to the time of the Roman legions --
11 it's easily documented.
12 And I don't think this war is going to
13 be any different. I think that as opposed to
14 diffusing from the military into the civilian
15 sector, the civilians should pull, and the
16 military should push those lessons.
17 I think everybody expects future
18 terrorist activity to occur on her soil again.
19 Most people expect that to be remarkably similar
20 to what we're experiencing in Iraq and
21 Afghanistan.
22 The U.S. military has the world's

1 experience in those type of injuries right now,
2 and those -- that experience can be pushed and
3 pulled into the civilian sector and I think we
4 would like to see more of this effort come
5 forward. And again, we're not ready to put
6 forward the white papers yet, but we will present
7 that to the Committee.
8 Dr. Howard Champion, many of you all
9 know, who lives in this area, has presented on
10 data-driven changes in personal protective
11 equipment. For those of you all who have worn all
12 the body armor, all the PPE, it's heavy and it's
13 bulky, and for the area that it's on your body,
14 it's highly effective.
15 And so, people have been -- they may not
16 like it when they go into the first firefight, but
17 they certainly wear it on the second. All right.
18 And I'm sorry, Major, would you agree
19 with that?
20 MAJOR HOLLAND: Yes, sir.
21 DR. HOLCOMB: Unfortunately, it's not --
22 those things are designed with data. They are

1 really designed in an absence of medical data.
2 And with computers now and with our software
3 platforms, you can actually plot out on 3-D
4 diagrams of a body where the holes are.
5 And you can plot out -- you aren't going
6 to be able to cover all the holes on this body,
7 but you can take 3,000 or 4,000 casualties -- and
8 this has all been done -- and plot out where the
9 majority of the holes are.
10 And if they're right around where that
11 body armor is coming you would then go to the
12 material developers and the guys who have to wear
13 this and say, "Look. This area has one hole."
14 And they'll say, "No, don't cover that.
15 But this area has got 10 holes, and it's a truncal
16 area that is -- right underneath that is a big
17 blood vessel." And they might want to then cover
18 that area.
19 So you can drive developments in body
20 armor with data, and think this would be a great
21 topic for us to look at as well when we're ready
22 to bring that forward in the right format.

1 There is -- most people are surprised
2 that there's not prospective randomized human data
3 for hardly anything we do in the trauma world.
4 The ABC's that everybody's heard of -- airway,
5 breathing, circulation -- has essentially no data
6 associated with it.
7 And that's not changed by this war, as
8 we were just discussing. We have a lot of
9 retrospective data and no prospective randomized
10 data.
11 As an IND holder and they -- right
12 before the war started in all the countries
13 surrounding in Iraq, those -- that concept of
14 prospective randomized studies in a theater of
15 combat is extremely difficult and likely
16 ethically, I feel, not doable.
17 So where are going to do this? Well, I
18 think we should do this in the civilian community.
19 I think that the DHB will -- when we bring forward
20 the proposal -- hopefully will look at this very
21 clearly and we can then send soldiers into combat
22 and have their care driven by data in an

1 academically sound fashion so we can maximize
2 their outcomes.
3 The last two really deal with systems
4 and data as well -- institutionalizing the Joint
5 Theater System.
6 You know, in Vietnam, redeveloped trauma
7 systems and helicopters and moving folks rapidly
8 off the battlefield with a helicopter scooping and
9 running and bringing them to a hospital, and had
10 rapid surgery done within 30, 45 minutes -- from
11 those concepts bring the trauma centers that now
12 populate the United States and are the subject of
13 many reports from the Institute of Medicine
14 publications and the New England Journal, et
15 cetera, describing improved outcomes when trauma
16 centers are implemented in a region to take care
17 of trauma patients.
18 It's not just the surgeon turning his
19 wrist just right at 2:00 a.m. It's all the things
20 that go around that guy to bring the patient
21 laying on the table, so that the surgeon can turn
22 his wrist just right at 2:00 a.m. that really

1 improve outcomes.

2 So at the beginning of the war, we

3 didn't have a trauma system. We had a system to

4 develop in Vietnam. We gave it to the civilians,

5 and in the intervening 40 years, 50 years, forgot

6 how to do trauma systems in the DoD, which is the

7 conversation, Gail, as we were talking about I had

8 with General Peak.

9 When he was the Army Surgeon General, he

10 wasn't very happy about that. He asked us to

11 implement a trauma system, and we spent a lot of

12 time doing that or the DoD spent a lot of time

13 doing that over the last six or seven years.

14 The trauma system has clinical practice

15 guidelines. It has a registry. It has education.

16 It has research. It has performance improvement,

17 rapid feedback, and really all the elements of a

18 fairly mature system, as defined in the United

19 States and around the world.

20 Unfortunately, it's still operating in a

21 temporary structure within the DoD. And most

22 people -- the three Surgeon Generals, the

1 Department -- everybody kind of feels this is a
2 good idea. I think we need to help the DoD and
3 recommend to the DoD that this system be
4 institutionalized and made permanent.
5 And that is a memorandum that we did
6 send to you yesterday. So, we need to get it out
7 to the whole Board and ask the Board to look at.
8 I think this is a fairly easy thing for
9 us to recommend. The Departments are funding this
10 already. And we just need to help them
11 institutionalize it.
12 And hopefully, as the war gets smaller,
13 then this system will decrease, but still remain
14 the capability to expand when the next war comes
15 around the pike.
16 And then, Dr. Kaplan, this briefing
17 actually sprang from the discussions we were
18 having by e-mail. We -- there's not a really good
19 infection registry like there are in the
20 hospitals.
21 Now we are having folks who get injured
22 in multiple places in Iraq and Afghanistan or in

1 Africa or elsewhere move through a fairly
2 complicated three-or four- continent wide
3 evacuation system with multiple cultures and
4 multiple antibiotics being started and stopped and
5 taken at each level.
6 And that system doesn't communicate from
7 an ID point of view all into one central
8 repository. And we have lots of ID folks here.
9 You all know Colonel Clint Murray knows a little
10 bit about this at multiple levels.
11 And I think it will be a real
12 opportunity to take the leap forward in how best
13 to treat our combat casualties and what infections
14 they really do have and what infections really are
15 problematic as opposed to -- and this is my
16 personal bias -- what gets published in the
17 newspapers and the Washington Post and gets on
18 CNN; and try to do that in a data-driven fashion.
19 So those were our eight issues that we
20 went over. They're all -- will generate, you
21 know, one- or two-page executive summaries --
22 white papers -- that at the appropriate time when

1 they're ready we'll send forward.

2 We did discuss the major issues for --

3 our major issues on this is, as I said, we'll have

4 multiple white papers. We wondered how we would

5 interact with TBI, Ethics, and the ID Subcommittees.

6 I think we've answered that over the last day and

7 a half, and we'll affect those discussions.

8 We did discuss new agenda items. And I

9 don't think we are quite done with the old agenda

10 items. And before launching the new big ones, I

11 do want to finish those. I think they are

12 important.

13 But there are many things to do here --

14 many opportunities for discussion on prioritizing

15 research, you know, from our Trauma and Injury

16 Subcommittee point of view.

17 We really don't know what happens at the

18 medic level. So at that point of care, honestly,

19 there's not a lot of understanding of what happens

20 -- when it happens, what was done, what works

21 well, what doesn't work well.

22 And that needs to get integrated into

1 the joint theater trauma registry.
2 There's not an evaluation. Every trauma
3 center in the country evaluates every death as
4 being preventable, potentially preventable, or
5 non-preventable.
6 So every -- there's 1,200 trauma
7 centers, and they all do it the same way every
8 week and put it into their trauma registry.
9 We don't do that with every death. And
10 I think that we probably, as the DoD, the DoD
11 probably needs to do that because that really
12 drives performance improvement; it drives
13 research; it drives improvement to clinical
14 practice, because there are potentially
15 preventable deaths that occur pretty frequently.
16 In the Journal of Trauma last month was
17 a paper by Matt Martin that documented that 40
18 percent of the deaths that occurred in combat
19 support hospitals were likely potentially
20 preventable -- 40 percent.
21 That's a number that's replicated in
22 many trauma centers around the country. And then

1 we would like to go to hear issues from previous
2 level-three, -four, and -five commanders and see
3 what their issues are versus what we think the
4 issues are.
5 Dr. Butler I think can describe changes
6 in the Committee on Tactical Combat Casualty Care
7 process, after integrating it into the DHB and how
8 that's working.
9 There is lack of service compliance with
10 TC-3, and we can define those areas, and then we
11 do need to really merge this actual medical data
12 from an intervention point of view on research and
13 medical care in theater from the AFIP on the
14 deceased.
15 Our next meeting will be 5 August 2009.
16 Ma'am, you're invited, as any of the members of
17 the Core Board are.
18 We'll be meeting with the Tactical
19 Combat Casualty Care Committee -- that works out
20 pretty well for us -- sometime in November, and
21 then obviously tentative agenda items pending
22 feedback in both directions from our subpanel and

1 from the Core Board.

2 Any questions?

3 DR. WILENSKY: Any questions that anyone

4 has? Yes.

5 SGT MAJOR HOLLAND: Hey, sir. It always

6 amazed me that the care on the battlefield was

7 just always great and all, and then when we get in

8 our command tent and whatever and we have the

9 entire staff there, it seems like my JAG and my

10 medical folks if they're a little testy at one

11 another, they really get at one another.

12 And so, as much as we can about any of

13 these processes that we feel like need to be as

14 clear as possible, you know, when we need to try to

15 help there, because if not, we're going to

16 continue to always have this JAG- legal debate

17 with the medical guys.

18 DR. HOLCOMB: Yeah. Sir, I mean, I

19 think that most of these items need to be turned

20 -- we need to turn a lot of this -- the way the

21 line guys -- and the line guys, for those of you

22 all who haven't been in the military, really drive

1 everything. The medics are advisors on the
2 battlefield and recommenders.
3 They don't really drive much, and I
4 think, Sergeant Major, you're shaking your head
5 yes.
6 We got to put -- I think that
7 recommendations need to come in the words that the
8 line folks understand, and that would largely be
9 with a unit status report, the USR red, yellow,
10 and green.
11 And line folks understand that. General
12 Meyer, you know if your fighter airplanes weren't
13 up, you had a red. That was a big deal. And they
14 understand that.
15 Prevent potentially preventable deaths
16 might-- should be a yellow and preventable should be
17 red. And that will get some attention. Okay. We
18 just got to speak the right language.
19 DR. WILENSKY: Any other questions or
20 comments? Yes.
21 DR. PARISI: Joe Parisi. I think
22 there's some real -- first of all, thanks for your

1 report. That was very informative.
2 I think there's some real opportunities
3 here for cross-fertilization with other federal
4 agencies, and in particular the evolving JPC.
5 You've already mentioned the medical
6 examiner as part of this, but the JPC also has a
7 repository of infectious disease tissues that you
8 may or may not be aware of, but potentially can
9 provide some expertise in interpreting some of the
10 changes.
11 DR. HOLCOMB: Right.
12 DR. WILENSKY: Any other comments or
13 questions? Adil.
14 DR. SHAMOO: Maybe the DHB sometime
15 should consider the following question: What
16 quality data and what type of data one uses in
17 order to effectuate change in public policy versus
18 an individual case or group, small group case,
19 because public policy you have somewhere between
20 one million to a hundred million. People are
21 going to use that.
22 What quality data? Is it -- I'm just

1 going to throw this number -- things around type
2 I, which is randomized double control trial; okay
3 -- double blinded, I'm saying.
4 And sometimes, you cannot get that, so
5 you get lesser than that -- type two and type
6 three.
7 Type three is expert opinions, which, to
8 me, is worthless, but anyway, because who are
9 those experts and who chose them. Who chose them?
10 But for changing public policy, DHB, I
11 mean, public policy within DoD, what quality of
12 data DHB thinks ought to be used for changing
13 public policy?
14 Is a case study, for example, of 20
15 versus 26? I'm not saying either way. I'm
16 just saying this board can look at the literature
17 -- what's available -- and nobody has made that
18 linkage really between type of data versus public
19 policy.
20 DR. WILENSKY: I'm not sure this would
21 -- I mean, this will be if at all one of these
22 summer institute notions. I think it might be

1 better to have this discussed on an issue by issue
2 basis, because it really will depend on the
3 urgency of the issue and the amount of data
4 available and likely to be available.
5 It's also an area -- yesterday I was at
6 a meeting on pragmatic trials, and the whole issue
7 and debate going on between the Basians and the
8 Frequentists in terms of the type of tests that
9 ought appropriately be presented as part of the
10 FDA submissions.
11 So I don't -- and very interesting
12 debates going on about whether the type I, type
13 II, type III data is a worthless concept. A very
14 interesting lecture that was given is the Harvane
15 ratio by Sir Michael Rollins in October, which I
16 have a copy and can e-mail to you if you want that
17 looks at that whole hierarchy of evidence.
18 But the issue is a serious one, and it
19 was obviously at least part of the issue with
20 regard to the whole blood dispute. So I think we
21 ought to be mindful that the soundness of the data
22 is an issue we need to consider whenever we are

1 looking at a study or recommendation.
2 And if it is not in our opinion adequate
3 to answer the question that's being posed, then we
4 ought to be willing to say that it's not an
5 answerable question at present or the best
6 evidence suggests one course, but is of very
7 questionable scientific value -- so I -- rather
8 than doing a general one. Greg?
9 DR. POLAND: I would agree with that.
10 And, in fact, there are well-established, heavily
11 vetted, well accepted standards of evidence. And
12 I think that for -- I think the answer is actually
13 pretty easy: We make recommendations based on the
14 data we have, but we're honest enough and
15 transparent enough to say at what level of
16 evidence is this recommendation coming from.
17 And so, there are standards and matrices
18 of how to do that.
19 DR. SHAMOO: I don't want to argue the
20 point, but that's not really my question. She
21 addressed my question. Your comments are well
22 taken. I am -- what I'm saying is at what stage

1 it becomes a public policy.
2 Even if it's one clinical trial or two
3 or four or five or half or case study, whatever,
4 that's the question I'm asking.
5 Nobody -- and there is no paper has
6 addressed that issue. When do you transfer that
7 data into public policy?
8 DR. HOLCOMB: I'd just like one last
9 comment on that.
10 DR. WILENSKY: Again, I think that we --
11 this is an issue. It's a serious issue, but we
12 ought to take it up on a case-by-case basis.
13 Excuse me.
14 Any other questions?
15 DR. HOLCOMB: Yeah. Just one comment,
16 if I may. The data that drove massive
17 transfusion, which is what we are talking about --
18 and this is really getting down into the weeds a
19 little bit -- but the data that drove massive
20 transfusion at least in North America through ATLS
21 was a single paper from 1985 that had 21 patients
22 in it.

1 So a single paper from 1985 with 21
2 patients with no control -- not even an attempt to
3 make a retrospective control group, a case match,
4 and all the problems that that entails really
5 drove therapy for about 40 years.
6 And on the whole blood point of view and
7 it's interesting to go back and read these older
8 papers, you know, that are referenced that most of
9 us don't have time to do, and see how -- what --
10 how they're really designed and what the level --
11 the quality of the data really are.
12 It's hard to find in a surgical patient
13 a paper that says whole blood is bad. It's really
14 difficult to find a bad outcome associated with
15 whole blood. Thank you very much.
16 DR. LEDNAR: Thank you, Dr. Holcomb.
17 Our second speaker this afternoon is Dr. Greg
18 Poland.
19 Dr. Poland is Professor of Medicine,
20 Molecular Pharmacology, Experimental Therapeutics,
21 and Infectious Diseases, as well as Director of
22 the Mayo Vaccine Research Group.

1 Dr. Poland also serves as the Chairman
2 of the Defense Health Board Subcommittee on
3 Infectious Disease Control.
4 He will provide the Board with a
5 presentation on the findings and recommendations
6 of the Vaccine Safety and Effectiveness Work Group
7 from their initial meeting.
8 The Core Board has been sent a draft of
9 this report on April 29th for review in
10 preparation for discussion and vote today.
11 You may also find a copy of the draft
12 report in your meeting book. Dr. Poland's
13 presentation slides may be found on Tab Eight in
14 the binders.
15 DR. POLAND: Although there are some
16 changes to them. Thank you.
17 Let me just take you through this. We
18 were requested to form a workgroup that had, in
19 many ways, and impossibly broad set of objectives
20 associated with it.
21 One was to discuss post-licensure
22 vaccine safety, effectiveness, and surveillance

1 studies. There are whole federal agencies that
2 devote all they do to just that; review and
3 discussion of published and unpublished data from
4 DoD vaccine research; vaccine safety,
5 effectiveness, and surveillance studies, with a
6 focus on FDA-approved vaccines.
7 And we were to provide guidance and
8 advice on what studies should be done, what the
9 priorities were, identify research gaps, and areas
10 of research that should be further developed.
11 Myself, Ed Kaplan, Joe Silva, Mark
12 Miller, Dave Walker were in attendance there down
13 at USUHS in June of last year.
14 A couple of things that went into our
15 work understanding -- and I say this in the way of
16 context -- is that short of actual injuries due to
17 being on the battlefield, no other issue has
18 impacted force health and readiness more than
19 infectious diseases.
20 It is -- we are informed by history over
21 and over on this particular point. And from that
22 perspective, surveillance issues are important.

1 The other thing is that for some
2 vaccines only DoD can provide answers to issues
3 that sometimes immediately, oftentimes mid-or
4 longer-range, become critically important to the
5 public, for example, anthrax vaccine safety.
6 That is not a vaccine that's used in the
7 civilian population, with a few exceptions.
8 So understanding the safety of that is
9 only going to be done because of the fact that
10 that vaccine is administered in the military.
11 It was the military that picked up on
12 the myopericarditis issue and defined it for the
13 modern-day use of smallpox vaccines. The safety
14 studies being done with ACAM 2000 are only going
15 to be done in the military.
16 New vaccines that might result, like
17 vaccines against viral hemorrhagic fevers, as you
18 might imagine, are going to be done within the
19 military.
20 Similarly, the idea of multiple
21 simultaneous immunizations, while done outside the
22 military, has been an issue of particular concern

1 within the military and would inform public
2 policy.
3 Oops. Did I skip a slide there? We had
4 a number of briefings. I won't read them all, but
5 just in an attempt to show you that we got a wide
6 diversity of opinion and of expertise.
7 There were some specific issues that, I
8 think, brought about the charge to us. One was
9 enhanced interactions, coordination, and
10 collaborative efforts across DoD with respect to
11 vaccine surveillance; external validation of
12 vaccine research initiatives, which we get much
13 into; and particularly there were concerns that
14 DoD had been dealing with actually for some time
15 in regards to anthrax, smallpox, and influenza
16 vaccines.
17 Some of them were recipient concerns
18 regarding long-term safety, reproductive health
19 issues, hospitalization, et cetera.
20 Another issue was, to some degree, the
21 lack of cross-specialty interdisciplinary research
22 when it came to reproductive health studies and

1 vaccine recipients.

2 ACAM 2000 was coming on board, and

3 continuing issues with adenovirus vaccine.

4 So I'm going to take you -- the way we

5 organized our work -- and, again, a little bit of

6 background -- in 1999, the then AFEB spent about

7 two years -- I'm looking at Roger, who's just

8 joined us -- working on this issue. We had

9 outside contract support, and we did a mammoth

10 study of cross -- a deep and wide study -- across

11 DoD on vaccine issues.

12 So we went back to that '99 report and

13 used it as a checklist to begin our work.

14 The format for the report -- we just

15 sort of used green, yellow and red lights, with

16 green meaning significant progress; yellow meaning

17 there had been some notable progress; and red,

18 little or no progress.

19 That, by the way, was published as a

20 monograph and resulted in a series of 12 major

21 recommendations. I'm going to run through them

22 quickly with you.

1 So recommendation one was that policies
2 and practices that ensured the ready supply to the
3 military of vaccines essential to the mission be
4 developed with a watchdog organization within DoD,
5 funding of collaborative projects.
6 And the question had been raised about a
7 government-owned or maybe a government-operated
8 manufacturing facility. And we sort of rated that
9 as some notable progress had been made.
10 In particular, MILVAX had been in
11 operation by this time, and they were monitoring
12 the supply situation and engaging other DoD
13 entities.
14 Adenovirus vaccine project was funded,
15 but, as you all know, we -- that has just had
16 multiple delays.
17 And the one area that we did note here
18 was that new vaccine development was inadequately
19 funded and slow.
20 That's not a reflection on the quality
21 of the research. It's to say there are 30 agents
22 and enough money to do -- pick a number -- a third

1 of those well.

2 Recommendation two was to further
3 develop and expand efforts towards standardized
4 and computerized record-keeping and tracking,
5 including the ability to rapidly access
6 information -- standardize this across services
7 and facilities.

8 We thought substantial progress had been
9 made here, but there were still -- there was still
10 some significant work to be done, some included
11 shipboard systems, even for routine vaccines and
12 trying to understand what people had gotten and
13 not gotten; the ability to track family members
14 and retirees; to exchange electronic immunization
15 records, and the ability to give retirees and
16 separated personnel access to their immunization
17 records.

18 And at the end of this, I'm going to ask
19 Mike to make a comment or two on that.

20 Recommendation three was that services
21 should measure and report up-to-date immunization
22 rates as key indicators of medical care delivery

1 in force readiness. The particular issue of
2 immunization rates of the troops had been done.
3 There was some remaining work in terms
4 of immunization rates of communities based on age
5 or underlying risk factors; and some issues with
6 getting timely data on National Guard and Reserve
7 components.
8 Recommendation four was to consider some
9 sort of a vaccine or immuno-biologics oversight
10 board, and this had been achieved primarily
11 through MILVAX, who we thought had performed
12 really an outstanding job in synchronizing and
13 coordinating programs among the Services.
14 Recommendation five was developed and
15 disseminate a new joint instruction, and that was
16 also done. There was some issues about screening
17 for immunity, which we thought had been achieved
18 with great success in the Air Force and Army, but
19 there were some remaining issues for Navy, Marine
20 Corps, and Coast Guard.
21 Recommendation six was address whether
22 current procedures and resources were sufficient

1 to ensure personnel were aware of current official
2 vaccine policy. There were a number of issues
3 identified there over time and historically; and
4 again, substantial progress, primarily through
5 MILVAX.
6 This will never go away. It's an
7 ongoing effort to educate providers, medics,
8 troops, family members, et cetera.
9 Recommendation seven was committed to
10 informing every service member of the health
11 risks, personal and military benefits, and proper
12 use of vaccines and other medical countermeasures.
13 And again, we felt that there was substantial and
14 admirable progress here, primarily through MILVAX.
15 And we had some minor suggestions that
16 are not relevant to today's suggestions --
17 discussion.
18 Recommendation eight was address issues
19 of standardized training and proficiency of
20 immunization delivery practice.
21 And, again, substantial progress here,
22 in particular Immunization University and the

1 quality improvement tools, we thought, really were
2 precedent- setting; and, in fact, are now the
3 standard in the civilian world to try to match
4 that. So nobody actually was doing it better than
5 the military.
6 Again, this is always an issue, because
7 you've got people rotating in and out, so it's an
8 ongoing effort to try to get 100 percent of people
9 trained up towards standardization.
10 Nine was developed a policy statement
11 for how vaccines and other immuno-biologics might
12 be used in the specific case of humanitarian
13 missions. And that, by that point, had not been
14 achieved. I don't know if there's been further
15 progress on that.
16 Ten was maintained the current
17 centralized procurement system while at the same
18 time providing some flexibility at the local
19 level. And, again, we were quite pleased with the
20 progress that we have seen demonstrated there.
21 Eleven was continue to participate in
22 the development of a comprehensive pandemic

1 influenza planning document -- boy, were we right
2 in tune with what was going to happen just a year
3 or two later -- and devise, disseminate, and test
4 a DoD-wide plan. And this -- just huge progress
5 in this.
6 One sort of minor thing, but we still
7 gave it an A grade there, was for DoD to be very
8 visible and sort of have a seat in interagency
9 deliberations. That's actually a continuing
10 concern among the Pandemic Response Committee.
11 Number 12 was review faxing policy,
12 practice, and use recommendations every two to
13 three years instead of letting it get to four or
14 five just because everybody's busy with other
15 things.
16 So overall, we tried to assign a letter
17 grade, and the letter grade that we gave to DoD
18 was an A for the substantial progress in virtually
19 every area.
20 In fact, the only area where major
21 progress had not been officially made was in the
22 policy statement for use of vaccines in

1 humanitarian missions. Not that there were huge
2 issues there. It's just that there wasn't a
3 written policy.
4 We saw some opportunities and that's to
5 further enhance the electronic immunization
6 tracking system, the humanitarian policy I
7 mentioned, ensuring availability of all vaccines,
8 and adenovirus remains the poster child for that;
9 certification of vaccinators; and a larger one,
10 enhancing vaccine safety research capability.
11 So this is the background then to the
12 recommendations that we have made after spending a
13 day hearing the briefings and catching up on what
14 had happened within DoD.
15 So, we noted continuing delays in
16 adenovirus vaccine deployment; lack of vaccine
17 immuno-genetics research work done within DoD.
18 And this came about primarily one, my own
19 awareness of it, but, two, as personalized and
20 individualized medicine is pushing forward and
21 industry beginning to use this in the directed --
22 or some call it rational -- development of

1 vaccines.

2 DoD wasn't participating in that. It

3 was hard to find good examples of Guard and

4 Reserve components being included in safety

5 studies. Now, from a scientific point of view,

6 there's no pressing reason to include them.

7 The reasons to include them are really

8 sort of non-scientific, and that is to answer

9 concerns that that Guard and Reserve members

10 specifically have and feel sometimes outside of

11 the mainstream active duty types of studies that

12 were done.

13 There was no established -- it doesn't

14 mean it didn't happen de novo here and there --

15 but no overall established post-marketing entity

16 within DoD for vaccine safety research.

17 And some of them, ACAM is a good example

18 of where this is happening, but where it could

19 only happen in DoD, when you're going to enroll

20 whatever it might be -- in fact, for one study

21 with an avian influenza vaccine, 40,000 people are

22 going to be enrolled in a study. That's hard to

1 do, with the exception of Mike's study, outside of
2 the DoD.
3 And we wanted to say in writing and I'll
4 say it publicly today that MILVAX we thought was
5 just an outstanding asset to DoD.
6 So specific recommendations that came
7 from this first set of meetings that we had was
8 that prioritization of research, given the limited
9 time, personnel, and other resources was
10 necessary.
11 We saw this also -- and you'll recall
12 this from when we did the Bio Defense or Bio
13 Surety recommendations.
14 There's an overwhelming amount to do,
15 but a limited amount of resources. So it has to
16 prioritized.
17 Particularly in the issue of vaccine
18 safety, which is something DoD has had to spend a
19 lot of time, resources, and man hours on, we
20 thought it was time to really develop
21 cross-disciplinary approaches in teams, for
22 example, including a cultural anthropologist or a

1 psychologist in some of these teams -- people who
2 understand reproductive safety research, which is
3 not something we standardly get trained in.
4 Because of the importance of phase four
5 safety research, we thought this was best done
6 through some sort of central entity.
7 Our tentative recommendation was that
8 MILVAX would be an appropriate place for that, to
9 address long- term health concerns, and to carry
10 out or at least to provide oversight.
11 They may not be the ones actually doing
12 it, but provide the office for reproductive and
13 pregnancy studies.
14 Some of these are fertility questions,
15 for example, that people have. And then
16 particularly when it came to AVA, DoD was the
17 leader in anthrax vaccine absorbed research, but
18 that, we thought, despite that locus of expertise
19 needed to become diminished in intensity because
20 of new anthrax vaccines coming online.
21 So it's not to take away from the
22 research in anthrax, but not so focused on one

1 vaccine.

2 Next, develop the capability for

3 immuno-genetic vaccine research. We specifically

4 pointed out where we thought the -- and this

5 was a recommendation to consider. We didn't, in

6 the course of a day, have enough time to say, you

7 know, we've looked at this inside and out, and

8 MILVAX should be the one.

9 This is our impression that we're

10 wanting to put forward; that we thought the MILVAX

11 role should be considered for expansion.

12 They could be the coordinating office

13 for phase four research, the coordinating office

14 for vaccine safety studies and for Guard and

15 Reserve studies.

16 And in some ways, and I think both

17 formally and informally members of the group that

18 were involved in this have expressed this; it's a

19 little hard to understand, in part, because it's

20 evolutionary what the boundaries and roles are of

21 organizations that sometimes are playing in the

22 same arena -- NHRS, MILVAX, the Health

1 Surveillance Center, VHC, and others -- and how
2 might those be best integrated.
3 So to try to summarize that down using
4 Gail's rule of thumb, I'm going to use a Midwest
5 farmer's hand -- I think I got three or four here;
6 okay?
7 One is to put this sort of together
8 create an interdisciplinary, cross-specialty,
9 collaborative, joint effort to answer significant
10 questions. These include long-term safety
11 studies, reproductive studies, phase four studies,
12 and immuno-genetic research.
13 The second was we thought there were
14 significant opportunities for DoD to conduct
15 pre-licensure clinical studies and provide rapid
16 answers to important questions that are --
17 important not only to DoD, but to the public.
18 To do that, again, you'd need a
19 centralized office with authority and
20 accountability, and lest I not point this out,
21 it's in DoD's interest to materially assist with
22 moving vaccine candidates to FDA licensure,

1 because we want to use them in DoD, and we're not
2 going to use them short of some sort of an EUA
3 type situation.
4 So it also provides funding, provides
5 expertise and training opportunities, et cetera.
6 The third was an external advisory group
7 of some sort to help with prioritization. Often,
8 among their largest roles might be to provide
9 external validation and assessment of efforts.
10 It's hard sometimes -- I know this is
11 true in my own institution -- to say to my
12 colleagues, you know, this is really no longer a
13 productive area of inquiry. We need to sort of
14 sunset that area and build up a new area that's
15 coming.
16 That's hard to do internally. It's
17 easier to do with an external committee.
18 And opportunities to further involve
19 academia and pharma.
20 And then next steps, we thought there
21 were some further meetings that would be likely to
22 be productive, including agendas specific to

1 particular vaccines -- anthrax and smallpox in
2 particular; overall integration, coordination, and
3 management of vaccine surveillance efforts; and
4 then prioritization, as I mentioned, of research
5 efforts.
6 And I think that's it.
7 (Applause)
8 DR. WILENSKY: Are there any questions
9 for Dr. Poland?
10 DR. POLAND: Mike?
11 DR. OXMAN: Have you integrated plans to
12 involve the Millennium Cohort, the Millennium
13 Cohort in this for post -- you know, for phase
14 four studies? It's an ideal group to look at.
15 DR. POLAND: Well, it is and it isn't,
16 depending on what the research question is,
17 because that's not the actual intent of the
18 Millennium Cohort, and they are widely dispersed
19 after they're enrolled, as opposed to a group that
20 you're going to have available to you, for
21 example, for blood tests or something over a
22 six-month or a year or two-year time period.

1 So we didn't specifically address that.
2 The only place it came up was in the integration
3 of efforts with NHRC, who's sort of taking the
4 lead on that, as you know, on the Millennium
5 Cohort studies.
6 But yeah, you know, that would be a
7 potential opportunity.
8 DR. WILENSKY: Wayne?
9 DR. LEDNAR: Wayne Lednar. Greg, you
10 identified in your discussion that one of the
11 opportunities is developing a humanitarian vaccine
12 policy.
13 DR. POLAND: Yes.
14 DR. LEDNAR: I'm wondering, do you think
15 we are becoming adequately informed about what
16 some of the infectious threats might be? So I was
17 thinking about our first briefing this morning on
18 global operations.
19 It's becoming, you know, a fairly
20 substantial part of the operations of our military
21 around the world, and are we getting the right
22 kind of data to learn from that experience, to

1 inform potential vaccine policy?

2 DR. POLAND: We didn't look specifically

3 at that. I guess I would say outside of this

4 meeting from other meetings we've had that yes,

5 there's a lot of surveillance data available.

6 This really pertains more to -- how to

7 say it -- suspend the Western way you've been

8 taught to -- you've been taught to think; okay?

9 Of course, it's good to prevent disease; okay?

10 Well, we go to the Philippines, and we

11 provide vaccines. And what do they think? The

12 military is providing vaccines that have

13 reproductive control measures within them. It's

14 crazy. It's fantasy thinking.

15 But who would think of that? We

16 wouldn't think of that. I'm very heavily

17 influenced by the story my dad told me, where they

18 went through -- during Vietnam -- and immunized a

19 village of Hmong and shortly after that the NVA

20 came through and every child that had an

21 immunization mark on their arm, they held the

22 child down and amputated their arm. It sent a

1 strong message about cooperation with Americans.
2 Now that's not -- that's sort of
3 humanitarian in the intent of the Navy folks that
4 went in there to immunize them, but they're just
5 issues surrounding that.
6 Those are rather dramatic ones -- but
7 issues surrounding that -- record-keeping,
8 surveillance, et cetera -- where you need a
9 policy, because you're going to go in there once,
10 assist, and then you're leaving with no intent of
11 follow up.
12 DR. WILENSKY: Other questions or
13 comments? Yes, Chase.
14 MR. UNTEMEYER: I'm just curious to know
15 from an immunological point of view why are the
16 Guard and Reserve any different from the active
17 force?
18 DR. POLAND: They're really not, and
19 that's why I say it's not so much a scientific
20 issue, although you could argue sometimes that
21 they might be older or less active, et cetera.
22 But it was more sociologic in them

1 feeling that they were excluded from some of the
2 studies; them feeling that they are different,
3 and, you know, their concerns not being taken into
4 account.
5 So it was just to try to include that,
6 but not necessarily on a scientific or immunologic
7 basis.
8 DR. WILENSKY: Mike?
9 DR. PARKINSON: Yeah. Thank you, Greg.
10 Mike Parkinson.
11 There's -- as I think about the scope,
12 the charge of the Committee, and what's happening
13 in the external world, this whole area of risk
14 communication, not just around vaccines, but also
15 around all pharmaceuticals, is huge right now.
16 And I know pharma is dealing with it.
17 FDA certainly has got a mandate to deal with it.
18 So there may be, as your Committee moves
19 downstream, there may be an interface around not
20 just monitoring safety, but risk communication
21 in a way that could be very synergistic with
22 national need.

1 It's something you've always dealt with
2 with anthrax and vaccines, but now it's for
3 chemoprophylaxis; it's for antibiotics; it's for
4 antidepressants -- a huge issue. And I think we
5 can shed any light on that based on --
6 DR. POLAND: Great question. And I
7 think nowhere did we learn that more than with
8 anthrax, and AVIP and then subsequently MILVAX
9 were critical in addressing that. I did want to
10 just ask Mike if he wouldn't make a couple of
11 comments, and he may even want to give a few
12 examples, particularly about the immunization
13 tracking.
14 MR. KRUKAR: Yes. Thank you. Michael
15 Krukar from MILVAX.
16 That is probably one of our biggest
17 pressing needs is what we need is an effective
18 universal immunization tracking system. We feel
19 that this would be the basis for all future --
20 potential future resource.
21 Really there is not that type of
22 mechanism that we have effectively used in ALTA

1 right now.

2 I know that Dr. Holcomb, probably his
3 last talk as an active duty soldier last year,
4 very passionately explained the problems with ALTA
5 that we presently have. And our senior leadership
6 clearly heard that message, and they are trying to
7 work the issue now. But that is probably one of
8 the biggest hindrances that we have that's facing
9 us presently right now.

10 DR. WILENSKY: Other questions or
11 comments? Yeah. Oh, sorry. Dr. Ludwig?

12 DR. LUDWIG: Sure. Thank you. You
13 know, I look at your specific recommendation
14 regarding prioritization of research given the
15 limited time, personnel, and resources.

16 And I couldn't agree with you more that
17 prioritization is very critical. But I did notice
18 back and looking at the briefings that you got
19 that you actually didn't receive -- at least it
20 doesn't appear that you received any briefings
21 from the military infectious disease research
22 program.

1 And I would just point out that that
2 program is very highly prioritized and what
3 direction it works towards, mainly because of the
4 issues you pointed out -- lack of resources. And
5 that prioritization is very highly threat-based
6 and very thoroughly worked through.
7 I just wondered if you had visibility of
8 that, and, if not, to make sure that you looked in
9 that direction to make sure that you did get
10 visibility.
11 DR. POLAND: Fair point. No, they were
12 not -- we did not get briefed by them in that
13 particular arena, although we'd had interactions
14 with them prior to that.
15 And this was sort of focused on
16 vaccines, not pre-vaccine research work, and on
17 FDA-licensed vaccines. So we sort of viewed them
18 in the context of this set of briefings as we
19 before that period or that point.
20 DR. LUDWIG: Yeah, fair enough. Thanks.
21 DR. WILENSKY: Any other questions or
22 comments? Thank you very much, Greg.

1 DR. POLAND: So we're -- were we going
2 to vote on this, I think?
3 DR. WILENSKY: This.
4 DR. POLAND: On the -- this was --
5 DR. WILENSKY: On the assessment or the
6 action items?
7 DR. POLAND: -- on the action items,
8 because this was meant to be our report back to
9 the DHB for approval. Thanks, Mike.
10 DR. WILENSKY: Okay. You're asking then
11 for --
12 DR. POLAND: Am I right about that?
13 DR. WILENSKY: -- well, I didn't -- no,
14 I actually had asked Ed whether this was a vote,
15 and was told it was not.
16 DR. POLAND: Oh. Okay.
17 DR. WILENSKY: That it was just an
18 update, which is why I'm hesitant.
19 DR. POLAND: Okay. Well, members of the
20 Committee all had -- it was vetted with them, so I
21 guess it was to just get your all's approval
22 before this gets signed off on as a letter and

1 then forward it up the chain.
2 DR. WILENSKY: Is there -- well, in that
3 case, if it's going up the chain, then we need to
4 have the whole Board opine.
5 This is the specific recommendations, of
6 which there are the six specific recommendations
7 or --
8 DR. POLAND: There's -- well --
9 DR. WILENSKY: -- the comments? It's
10 not clear to me what you're asking us to approve?
11 DR. POLAND: To approve this report so
12 that it can then -- and the letter that
13 accompanies it, which had been circulated so that
14 it can be signed off on.
15 DR. WILENSKY: Okay. Everyone
16 comfortable? Okay.
17 DR. POLAND: Thank you. And again, the
18 Committee, I think, just wants to publicly give
19 its congratulations to MILVAX for a job well done.
20 So.
21 (Applause)
22 DR. WILENSKY: Our final speaker this

1 afternoon is Dr. Ed Kaplan. He is a Professor of
2 Pediatrics at the University of Minnesota Medical
3 School, and holds an appointment as adjunct
4 professor in the Division of Epidemiology at the
5 University of Minnesota School of Public Health in
6 Minneapolis.
7 Dr. Kaplan will brief the Board on the
8 Warren Air Force Base Cohort Serum Repository and
9 data assets. Dr. Kaplan's presentation slides
10 may be found under Tab Nine of the binder.
11 Actually, I think they were handed out separately.
12 MR KAPLAN: Thank you very much for the
13 opportunity to represent to the Board the current
14 status of a very unique collection of serum
15 (sic.).
16 I will present briefly the background of
17 this, and in the audience are Drs. Rick Erdtmann,
18 Roger Gibson, and Ed Feeks, who will help me to
19 answer questions at the end.
20 The purpose of this briefing is to seek
21 confirmation of an AFEB and ASD action from 2004
22 and 2005 to maintain this valuable Warren Air

1 Force Base Serum Repository, dating back to the
2 late 1940s and early 1950s.
3 This series of studies was carried out
4 under the auspices of the Armed Forces
5 Epidemiologic Board, and the information about
6 this is in some of the briefing material you have.
7 Just for background, here's a picture of
8 United States Air Force hospital at the Warren Air
9 Force Base, where these studies were carried out.
10 This slide I won't go through in detail
11 because you have this word for word in the
12 material that you were given. Briefly, these were
13 studies that were carried out for understanding
14 streptococcal infection and preventing rheumatic
15 fever, which was a major problem in the military
16 up to the Korean conflict.
17 These studies were delegated to Dr.
18 Charles Ramelkamp, and a streptococcal research
19 laboratory was started at Warren, and these
20 studies were carried out.
21 Shortly before his retirement, Dr.
22 Ramelkamp, in the late 1970s, asked me to act as

1 guardian for this collection, the details of which
2 will be presented in just a moment.
3 These samples were moved from Cleveland,
4 where he had them in a frozen state, to Minnesota,
5 where they've been since the late 1970s.
6 As far as can be determined, there's not
7 been any evidence of any significant deterioration
8 of antibody between these constantly frozen
9 samples.
10 You will see in pictures in just a
11 moment what the vials look like. There are 48,000
12 approximate serum vials.
13 The mean volume for 43,000 of those was
14 four milliliters. The mean number of sera per
15 individual was almost five, and approximately a
16 half of these subjects had six or fewer serum
17 samples available.
18 This bar graph shows you the total
19 samples available and the number of individuals.
20 As you can see there were acute and convalescent
21 sera for over 3,500 of these individuals. And
22 I'll go into who they were in just a moment.

1 Of interest at the far right side of
2 this graph, you'll notice that there were a few,
3 including one individual who had 107 serum samples
4 taken as far as we can tell during recruit
5 training.
6 And I hope Dr. Shamoo doesn't ask me any
7 question about the ethics of that.
8 This slide, I'm sorry it basically just
9 showed the number of individuals and the amount of
10 serum, and it didn't reproduce properly.
11 The brief recent history that I'd like
12 to bring to your attention is outlined here.
13 In December of 2004, before I became a
14 member of the Board, I was asked to brief the
15 Board and presented the collection at an AFEB
16 meeting, as I said, in December of 2004.
17 The Board favorably looked at this, and
18 agreed that this unique sample, at that time
19 almost 50 years, was too valuable to be discarded.
20 And in May of 19 -- sorry -- of 2005,
21 Greg Poland and Roger Gibson wrote a memorandum
22 stating this, and a copy of that is in your

1 briefing book, to Dr. Winkenwerder.

2 In September of 2005, Dr. Winkenwerder

3 wrote a letter acknowledging this, agreeing to it,

4 and at that time suggesting that the AFIP receive

5 and store these samples. Now this was before the

6 BRAC action took place.

7 From 2005 to 2008, we made some attempts

8 to find a home for these because of the fact that

9 the AFIP was going to be -- have a status change

10 in 2011, I believe.

11 And so this past November, Dr. Gibson

12 and I went to Wright Patterson where the Ranch

13 Hand Study samples are stored, and met with

14 Lieutenant Colonel Woodruff who has space

15 available, and basically agreed to act as the

16 storage site for these samples.

17 In April of this year, last month, there

18 was a telephone conference and a memo from Dr.

19 Erdtmann, and it was decided at that time that

20 this idea should be brought back to the Board for

21 confirmation of its earlier action -- the earlier

22 action of the AFEB -- and also at the request of

1 Ms. Embry, I'm here at this point.
2 I'll show you some quick run throughs.
3 Many of you have seen these when I did the
4 original briefing. These are the cards from each
5 of the individuals where you can see and I -- this
6 was before the days of HIPAA, so I apologize for
7 not blacking out the names.
8 Each person had a card with their
9 service number, these studies they participated
10 in, and the date the sera was obtained.
11 Nowadays, these are stored. The volumes
12 and the storage space have been computerized. And
13 these are stored into large freezers, which you
14 see here at, at minus 20.
15 And one serum specimen from each of the
16 9,500 individuals was aliquoted into one
17 milliliter aliquot in order that there would be a
18 repeated freeze and thaw cycle.
19 These are the original vials that the
20 majority of the samples currently are stored in.
21 And you can see the identify information on this
22 sample.

1 The aliquoted samples are stored also at
2 minus 20 in other freezers, and they are all
3 catalogued in order, as you can see on these
4 slides.
5 We believe that it is time that these be
6 transferred back to the custody of the DoD. It's
7 a very valuable collection of sera.
8 I have nightmares about breakdowns in
9 freezers and think that there is some reason to
10 expedite this action.
11 There have been a number of awards given
12 for the studies done at the Warren Air Force Base.
13 But studies are continuing to be done.
14 I'll just run through -- you can see some of the
15 papers that were published earlier on with this
16 collection.
17 More recently, a collaborative effort
18 between the NIH are rare, where a lot of the
19 funding for this came from, looked at the presence
20 -- looks for the presence of hepatitis C infection
21 in military recruits. This was published in the
22 Annals of Internal Medicine in 2000.

1 More recently, in collaboration with the
2 gastroenterologists at the Mayo Clinic, they have
3 looked for evidence using genomics of celiac
4 disease and that is another example of how these
5 samples might be used.
6 Our hope is there are several options as
7 to what might happen to these. The option which I
8 think almost is ready to go would be to store
9 these at Wright-Patterson, to have the supervision
10 of these samples looked at by the Institute of
11 Medicine, and particularly Dr. Erdtmann, who I'll
12 let explain in just a moment. And what is needed
13 now is a small amount of funding from DoD, and Ms.
14 Embry is seeking reconfirmation of this.
15 I don't think because -- I don't want to
16 put words in her mouth -- I don't think because
17 she has any doubts about it, but this has been
18 going on now for five years.
19 So, Rick, do you have anything to add in
20 terms of the role of the IOM and the medical
21 follow-up agency?
22 GENERAL CODY: Well, I don't have any

1 formal comments. But I do want to just make a
2 couple of things known to the group.
3 I think many of you may know that the
4 medical follow-up agency has been in existence
5 since 1946 in order to try to understand the
6 implications, the long-term health effects, of the
7 military experience.
8 Dr. Michael DuVage started this
9 agreement with the National Academy of Sciences to
10 study, using medical records and personnel records
11 of military personnel, study the effects of
12 tropical diseases, war trauma wounds, and other
13 kinds of conditions that soldiers were exposed to
14 during World War II.
15 And so we've been doing this for lots of
16 years, and this is just another opportunity to
17 take advantage of information on military
18 personnel and try to understand some of the
19 implications of military service.
20 One of the things that we have been able
21 to do in the past is to provide medical oversight
22 of studies that are actually being done by other

1 investigators.

2 And perhaps the quintessential example
3 of this is the large registry of twins that were
4 members of -- they were both members of the pair
5 were involved in military service in World War II.
6 We have 46,000 twins that were involved in this
7 registry, and a lot of information about the
8 inheritability of disease has been done using this
9 twin registry.

10 When an investigator wants to look at an
11 issue, they would come to the medical follow-up
12 agency, and we have an advisory board of experts
13 that can look at the scientific merit of various
14 studies that could -- that might be done, in this
15 case, in the Twins Registry.

16 So we could use that same kind of model
17 at the medical follow-up agency to provide
18 oversight, professional, medical, research,
19 scientific oversight, over any research that could
20 be done with this asset that Ed has just
21 described.

22 And I think that would be the principal

1 role that we would like to play in the future with
2 this.
3 There's a couple of other things you
4 might be interested to know. One is that one of
5 the things we've already done with the Warren
6 Cohort asset is that we have the morbidity and
7 mortality information on these 8,000 or 9,000
8 folks at least up through 1996.
9 And we have been asked by the Department
10 of Defense to update to currency. And we are in
11 the process of, in fact, doing that as we speak.
12 So we have -- he has the serum, and we
13 have the morbidity and mortality data; and,
14 therefore, we have a tremendous asset to do future
15 research.
16 I think one of the things that should be
17 done in the future is to actually try to track
18 down these 9,000 people and get them officially
19 integrated into the research program, get their
20 permission, because if we're going to do biomarker
21 research, we're going to need to do that for
22 future purposes and for ethical reasons.

1 So I think there's a lot of potential
2 here. And the medical follow-up agency
3 historically and currently has a great deal of
4 interest to participate in.
5 DR. KAPLAN: Thank you. Colonel Gibson
6 is here and probably has had more contact with
7 this collection than any of us, myself included.
8 So, Roger, would you please fill in the blanks?
9 COLONEL GIBSON: I just wanted to add a
10 bit to Dr. Kaplan's discussion of where we went
11 since 2005. As he mentioned, we -- the
12 recommendation was for AMIP to (inaudible) to
13 them, to there. Almost exactly after the
14 recommendation was signed, BRAC was published.
15 That created big-time problems with this.
16 We went to AFIP to discuss with them
17 where they were headed, and if there was a
18 possibility to integrate this with their specimen
19 collections, their histology collections as a --
20 in that entire program to make sure that they had
21 a home.
22 There were questions at that time, and,

1 to some degree, they still remain of who owns
2 these samples, and the involvement of the
3 University of Minnesota and a few other issues
4 that were worked through.
5 As Dr. Kaplan pointed out today, this
6 study was actually funded by the AFIP -- or excuse
7 me, by the Armed Forces Epidemiological Board. In
8 those days, back in the late '40s and '50s, the
9 Armed Forces Epidemiological Board has its own budget.
10 It was sort of a mini NIH.
11 They got their dollars through DoD, but,
12 they, in fact, went out and bid for work; usually
13 one of the Board members or what we can now call
14 Subcommittee members ended up running the study.
15 And those samples were collected, and
16 they (inaudible) and we can technically say
17 potentially these still belong to the AFEB, and
18 not (inaudible).
19 So, with that, when -- we also pursued
20 the DoD Serum Repository. Really, we were told
21 that really wasn't a good fit. Those samples are
22 part of a surveillance system rather than a

1 research system.
2 The big concern was that they get in a
3 place where they aren't forgotten, where we have
4 somebody to arbitrate how they're used, and that
5 they're properly stored and maintained.
6 It's -- when a (inaudible) hadn't
7 occurred, and Congress passed legislation moving
8 those Ranch Hand samples to the fiduciary care of
9 the Institute of Medicine, it seemed like that's a
10 segue. We would use the same sort of a model in
11 pursuing that. We're back to the Board today to
12 ask for confirmation of (inaudible). (Inaudible)
13 still agrees that these samples are worth saving
14 and DoD needs to move them into their care.
15 DR. KAPLAN: Commander Feeks has been
16 recently involved. Ed, do you have anything you'd
17 like to add?
18 COMMANDER FEEKS: I've been working a
19 couple of issues at once while the conversation
20 has been going on, so forgive me if I'm repeating
21 myself.
22 One of the issues is convincing

1 policymakers, who are not scientists, of the value
2 of the sample collection.
3 I don't know if that's been discussed
4 yet or not, but that's important. I think -- I
5 don't have any trouble imagining the value of this
6 collection. But my checkbook is no good to you.
7 The second thing is, speaking of money,
8 there are still some blanks on the sheet as to
9 what money will be required to do this. And I
10 don't know if it's been brought out if Wright-Pat
11 planned to -- if there was a cost associated with
12 storing the collection at Wright-Pat.
13 I have spoken to a couple of people
14 about costs, and don't have data back from them
15 yet. I do know, for instance, I've had this
16 conversation, though, with Rick Erdtmann about
17 what it would cost to have the IOM do the role
18 that was described by Dr. Gibson.
19 And I think, if I remember, sir,
20 initially it was rolled up with the Ranch Hand
21 custody funds, but depending on the demand for the
22 collection, there could be additional costs in the

1 out years. Is that a fair statement, sir?
2 DR. ERDTMANN: That's right.
3 COMMANDER FEEKS: Okay. And that's all
4 I have to add.
5 DR. WILENSKY: Greg?
6 DR. POLLAND: So this first came up
7 during my tenure, and so I want to speak to it.
8 We also at the time as a Board felt very
9 strongly that this has value. We subsequently had a
10 phone conversation with the then ASD, Bill
11 Winkenwerder, who felt the same.
12 It may be hard for some people that
13 maybe don't think of some of these diseases, but
14 just to use one example, the hepatitis C example.
15 It was thought that that was virtually a
16 death sentence, universally, if you were detected
17 to have hepatitis C; and it would require fairly
18 morbid treatment to try to treat it and not very
19 effectively at that.
20 This -- the results of that study
21 changed practice throughout the world and what we
22 do with it.

1 There are possibilities here that
2 intermittently come up. An example is smallpox,
3 where, because of what was assumed to be a threat,
4 it was not clear what the level of antibody or
5 immune memory would be five decades later in
6 people who had been immunized. Well, there wasn't
7 a cohort where we knew what their immunization
8 records were, and we had there sera.
9 This is one such. Just as one example
10 now, they're trying to find people who got
11 immunized with the 1976 swine flu vaccine; get
12 sera, and try to look at immune memory.
13 Well, they didn't have it -- that
14 vaccine, but it's just an example of how these
15 kinds of repositories are helpful. A variety of
16 toxicology studies that could be done in people
17 where you have phenotype over five decades and
18 sera.
19 With the availability now of biomarkers
20 research, including proteomics, and the way these,
21 undoubtedly the way these were spun and cared for
22 in the 1940s, they are "contaminated" with DNA.

1 And nowadays, you need such a little bit
2 to be able to do genomic studies, which would make
3 this an incredibly powerful and useful collection
4 and database.
5 So it's just to say through a handful of
6 examples I can think of quickly off the top of my
7 head of what the value of these would be, and let
8 me just add that often times that value is
9 unpredictable until a new threat or a new question
10 comes up; and everybody scrambles around trying to
11 say, well, where would we find sera from 50 years
12 ago.
13 Well, the number of databases where you
14 have sera and phenotype data over five decades I
15 think you can count on two or three fingers.
16 That's the value of this collection.
17 So I would hope that we would again
18 re-endorse strongly the value of this, and that
19 this is an asset for DoD.
20 DR. WILENSKY: Mike?
21 DR. OXMAN: Two issues. First of all,
22 although I'm not an expert on cost, if it's

1 already in a place where monitoring is done and
2 you're just talking about the cost of maintaining
3 them frozen with adequate safety backup, it's very
4 low.
5 And any studies that would be proposed
6 to be done with the serum could be self-supporting
7 in that if they were important enough to do and to
8 use this valuable serum, then it would be
9 important enough to get some funding for from the
10 NIH or from the DoD.
11 And thirdly, one other aspect that's
12 important to the military if people come back from
13 a tour of Afghanistan and there's some evidence of
14 a new disease, it can be very useful to know that
15 that disease existed in 1949 before anyone visited
16 Afghanistan.
17 So there's enormously valuable data in
18 these sera and in the medical records that go with
19 them.
20 And so I would be a strong advocate for
21 not only storing them, but keeping the DoD in the
22 driver's seat with respect to what happens to

1 them.

2 DR. WILENSKY: Mark?

3 DR. MILLER: Yeah. I'm just thinking of

4 an immediate study with four letters -- H1N1, and

5 that you have a wonderful specimen collection here

6 that people who haven't been exposed to, I mean the

7 H1N1 viruses at that time, a unique opportunity?

8 DR. WILENSKY: Joe?

9 DR. PARISI: I'd just like to second

10 everything that's been said. I think there is a

11 lot of parallels with this -- of this collection

12 with the tissue repository at AFIP.

13 I mean, it's an invaluable resource. We

14 ought to do everything possible to preserve and

15 maintain these. These are not only natural

16 resources. They're international resources.

17 And they're good for mankind. These are

18 kinds of resources we can't replace, and

19 potentially can answer lots of questions.

20 As Greg said, a lot of them we don't

21 even know what the questions are yet. And it's

22 just -- I think it's a no-brainer. We need to

1 support these.

2 DR. WILENSKY: Mike.

3 DR. PARKINSON: Mike Parkinson. Just to
4 be responsive to Ed's comment about declaring the
5 value, it seems to me in kind of the new value
6 proposition of the DHB that probably what we need
7 to do is to say, we'll give you the three most
8 prioritized studies, given the current threat to
9 DoD where these might be applicable, because,
10 absent something specific, in almost a prioritized
11 threat list potential use of this database, I
12 don't think it's -- because, again, it's the
13 dilemma of the comments.

14 I mean it might be good for the NIH. It
15 might be good for mankind. How is it good for the
16 Defense Health budget, you know, and the role of
17 DoD.

18 And today, we could probably sit down
19 and say here's five studies if you wanted to fund
20 that could be relevant to this threat list that
21 we're going to hear about tomorrow or something.
22 I don't know.

1 But we got to connect the dots so that
2 these people have an easier job of it.
3 DR. WILENSKY: Colonel Johnson?
4 COLONEL JOHNSON: Thank you. Ms. Embry
5 tasked me to look into that -- and to this issue
6 and to make a recommendation to her, and we're in
7 the process of doing that.
8 We're gathering information. There's
9 never been any question about the importance of
10 this information. I mean, this is clearly unique
11 and very important information.
12 The question has been is this
13 operationally significant to DoD? Is DoD the
14 right place for this? Maybe NIH is the better
15 place for it. Maybe this is a national asset
16 rather than a DoD asset.
17 We're trying to look at lots of
18 different options, and that's -- give us some
19 time. Clearly, we don't want to throw this out.
20 This is an asset that has been protected very
21 well. We appreciate that.
22 But we're not sure the best location for

1 it at this time.
2 DR. KAPLAN: Could you continue please
3 hear and tell us a little bit about what your
4 concerns are?
5 COLONEL JOHNSON: Concerns as far as?
6 DR. KAPLAN: The right place, the
7 relevance and so on.
8 COLONEL JOHNSON: We just -- there's no
9 question that it's scientifically valid and
10 important information. The question is where's
11 the right location for this to be.
12 I would think that just about any
13 university in the country would be thrilled to
14 have this to use with their own research at no
15 cost to DoD. And is it the proper use of DoD
16 funds to -- for us to hold this and control it.
17 We don't know.
18 We're looking at the different options,
19 and our plan is present that up the chain once we
20 get -- once we've developed the different options.
21 DR. WILENSKY: Well, I'd just like to --
22 as I read the statement of the purpose of this

1 briefing, it's agnostic as to where it's housed;
2 just that it should be maintained. Is that
3 correct? Is that a correct reading?
4 DR. KAPLAN: I'm sorry. I didn't.
5 DR. WILENSKY: As I read -- as I read
6 your statement about the purpose of the briefing,
7 the positive action is to maintain the valuable
8 serum repository.
9 I don't read it that you're saying it
10 necessarily needs to be at Warren Air Force Base.
11 DR. KAPLAN: Well, it won't -- excuse me
12 -- it won't be at Warren Air Force Base.
13 The purpose of the briefing was that we
14 went through this five years ago, and it went
15 through rather extensive investigation, which
16 resulted in the ASD confirming the recommendations
17 of the AFEB; and these sera do belong to DoD.
18 This was never given to the University
19 of Minnesota. It was given to me, the truth be
20 told.
21 So I -- the purpose of the briefing was
22 simply to say that the predecessor to this Board,

1 the AFEB, went through the assigned task,
2 discussed it, voted on it.
3 It was sent in a message to Dr.
4 Winkenwerder in the message in May of 2005. And
5 he subsequently basically agreed, if you read
6 that. So the issue was to reaffirm that this is
7 -- that we should go forward with this.
8 DR. POLAND: Could I jump in, Ed? I
9 think what we're really saying here is it's
10 confirmation of what the previous ASD's
11 determination was. And that determination was
12 that it be transferred to DoD.
13 He requested the Department of the Army
14 and AFIP. Other things have intervened there.
15 But the intent of his memo and what you're seeking
16 confirmation of is that DoD take possession --
17 DR. KAPLAN: Yes. Yes.
18 DR. POLAND: -- of these.
19 DR. KAPLAN: Yes. Thank you.
20 DR. WILENSKY: Okay. Well, I guess that
21 -- given what you've just said, it sounds like --
22 well we can make that as a recommendation or we

1 could make an alternative recommendation that DoD
2 needs to make a timely determination of where it
3 should reside and that we continue to support the
4 notion that it be maintained.
5 I mean, those are -- I mean, those are
6 two alternative ways to frame our support. I
7 haven't heard anybody suggesting anything other
8 than strong positive support for the serum being
9 maintained.
10 So it's only a question of do we say it
11 should be DoD or would we say DoD needs to make a
12 timely determination of whether it will be DoD or
13 somewhere else, and that somewhere else has to be
14 a credible place.
15 DR. OXMAN: I do think. Oh, sorry.
16 DR. WILENSKY: Dr. Ludwig and then Mike.
17 DR. LUDWIG: Yeah, I think -- you know,
18 I hate to complicate things, but in reality the
19 value of this serum sample -- this serum
20 repository is so great, and in many respects we
21 ought to be looking at where else in the DoD
22 similar repositories exist.

1 I know for a fact that there's a very
2 large repository of sequential serum samples that
3 were taken as part of the Operation White Coat
4 during the offensive biological days that
5 continue to today.
6 Long term serum repositories that are
7 part of the special immunization program at
8 USAMRIID. Similar repositories exist, and we ought
9 to try to find out where all of these exist, and
10 make use of all of those for similar types of
11 studies that we might be seeing. So.
12 DR. OXMAN: Since money is an issue, I
13 would think that Ed could come up with a
14 reasonable estimate of the incremental cost of
15 adding these to a pre-existing monitored facility.
16 And I would bet it would be in the thousand of
17 dollars, not any more, you know, in the thousands,
18 $10,000s, not $100,000 or a $1 million year.
19 It's basically -- if it's already
20 monitored, it's backup -- it's a couple of
21 freezers that are ballasted, kept frozen, and the
22 electricity.

1 DR. WILENSKY: I agree -- well, I think
2 it would be useful to have an estimate of what it
3 costs. It seems to me the cost of the maintenance
4 is trivial.
5 And I don't know whether the cost of the
6 access and monitoring and decision-making about
7 who can access it for various purposes. That
8 might not be trivial.
9 But the actual maintenance -- now I had
10 asked something earlier, and I don't know whether
11 this is related. I had asked, you know, Ellen
12 maybe or maybe Al Middleton about if DoD doesn't
13 want to maintain the cost of some of the
14 activities, why don't they charge for those
15 activities and was told that DoD does not have the
16 legislative authority to charge institutions. It
17 would have to set up -- or to charge for making
18 available something that it has.
19 It would need to do some other
20 administrative structure, maybe a foundation like
21 NIH has were something else, in order to be able
22 to accept monies.

1 But that was why the alternative, which
2 actually Wayne had mentioned, of having a timely
3 determination, if not held in DoD, where held
4 because of the importance of maintaining the
5 valuable serum.
6 So, as again, I haven't heard anybody
7 suggest anything other than support for
8 maintaining it.
9 But the question of is that only at DoD
10 or would it be other places? I mean, could it be,
11 you know, through NIH or the National Library of
12 Medicine or some other area as appropriate at NIH
13 because it has the NIH Foundation, which can
14 charge. Adil? Okay.
15 DR. KAPLAN: We have --
16 DR. WILENSKY: Go ahead.
17 DR. KAPLAN: -- if I might interrupt,
18 this didn't just come to DoD without investigating
19 other possibilities. Five or six years ago, we
20 had extensive talks with the National Cancer
21 Institute, for example. And the reason that it
22 settled on DoD is because I think -- and I think

1 most people would agree -- that this belongs to
2 DoD.
3 The important thing is -- and what I
4 think adds a little bit of urgency to this
5 decision -- is the fact that this -- I'm worried
6 about this collection. I caught some people in
7 the room, which is beside the point, but trying to
8 do some things with the collection recently.
9 It cannot stay at the University of
10 Minnesota indefinitely at this point.
11 And if there is -- if this Board does
12 reconfirm what the AFEB did five years ago, then
13 we have to work a way out. To say we're going to
14 start looking all over again, respectfully, I
15 would think is not a very realistic option.
16 DR. SHAMOO: This Board may want to
17 consider -- put some kind of boundaries; that is,
18 it should remain either in the public sector or
19 non-profit institutions, as well as that should be
20 done with the current ethical use of tissues from
21 human subjects, because some of these people may
22 be alive.

1 DR. WILENSKY: It may just be because I
2 didn't move through this experience you're talking
3 about five years ago, but I'm not at this point
4 comparable of saying it must be DoD. I'm much
5 more comfortable, particularly listening to what
6 we just heard from Colonel Johnson saying the DoD
7 is trying to decide where it thinks the best place
8 is.
9 I am comfortable of saying that the
10 decision needs to be made in a timely way. It
11 needs to be in a place that will be accessible --
12 either university or other portion of government.
13 But, I mean, I don't -- I guess today,
14 given what I've heard, I'm not comfortable saying
15 it has to be DoD.
16 I'm very comfortable saying the decision
17 needs to be made in a timely way and it must be
18 supported and maintained for use. Wayne?
19 DR. LEDNAR: I guess just a thought as
20 we're thinking about options leaving this
21 discussion.
22 I'm just reminded what Dr. Erdtmann

1 said. Dr. Erdtmann has aspects of information
2 about this cohort that complement the collection
3 of sera. The value to any use of this serum bank
4 is, in part, related to some of the value that the
5 medical follow-up agency manages.
6 So whoever would be the keeper of the
7 freezers, there's got to be an obligation and an
8 agreement comfortable to the medical follow-up
9 agency and IOM that this is acceptable to them.
10 So this is not just, you know, finding a
11 place to put some freezers. It really is a
12 management of the whole resource. I don't know if
13 Colonel Irvin has -- is in agreement with that or
14 differs.
15 DR. ERDTMANN: Yes, I think that's
16 exactly right, Wayne.
17 One of the options I think that Health
18 Affairs is considering is possibly locating the
19 bio-specimens out at Wright-Patterson Air Force
20 Base where we're going to -- where currently the
21 Ranch Hand materials were trans -- are located.
22 They were transported from Texas, where

1 the Air Force project office kept them for 25
2 years, and then last year moved them to Ohio.
3 They have the space. They have the
4 desire to keep these specimens, and, of course,
5 they don't have whatever marginal funding it
6 would require, but they seem to be in a position
7 immediately to take these specimens.
8 And if there was some urgency or if a
9 need to take care of this quickly, they would be,
10 I think, the ideal spot to move them.
11 DR. WILENSKY: Roger, did you have a
12 comment you wanted to make?
13 COLONEL GIBSON: Yeah. I just wanted to
14 echo a comment that as usual the Board comes up
15 with very good, insightful things.
16 I would argue that there's probably
17 among the vaccinology community within the United
18 States, there's probably two or three or five who
19 know that DoD has Operation White Coat, et cetera.
20 It's -- I think it's important that we
21 use these things. I think it's important that the
22 public and the academic public be aware that they

1 exist and that they can be used in important
2 research.
3 One of the draft questions that I've
4 never quite got to the Board was having the Board
5 review the repositories and registries within the
6 Department of Defense -- just to find out where
7 everything is and make recommendations on whether
8 we need a central agency or a central look at
9 those things.
10 The issue is that these things get put
11 away and forgot and then 10 years from now,
12 somebody throws them out. Well, overall
13 coordination. So.
14 DR. WILENSKY: Yeah. We had discussed
15 -- Wayne reminded me -- yesterday talking about
16 the potential of having coordination of overall
17 biomedical research in DoD be an issue that the
18 Board take on.
19 So I -- I mean, this would clearly fall
20 within that category -- your suggestion. Oh, yes.
21 Mike?
22 DR. OXMAN: Just one point. I do think

1 that there are almost predictably going to be
2 issues in the future where having these will be of
3 direct benefit to the DoD. And so I wouldn't want
4 to see the DoD lose a significant element of
5 control and find that they were used up for other
6 interesting and scientifically important matters,
7 but which weren't important uniquely to the DoD.
8 And that's an important point to bring
9 up.
10 DR. WILENSKY: I don't disagree, but I'm
11 hesitant when somebody in Ready Force Protection
12 tells me they're trying to make a determination
13 now as to what they're going to recommend in terms
14 of whether DoD keep it or put it in what would
15 presumably be a safe and accessible place that we
16 jump in this moment to say do it this way.
17 So I would either like to hear what
18 they're going to do in a timely way or tell them
19 they need to make a determination in a timely way
20 that either they keep it or they put it someplace
21 where it will be safe, protected, and available
22 for DoD and other users at future times.

1 DR. KAPLAN: But does that -- I'm sorry.
2 Go ahead.
3 DR. WILENSKY: No, and I'm.
4 DR. KAPLAN: No. But that I can
5 understand. What I have brought before the Board
6 is to say does the Board confirm the fact that
7 this is a valuable -- well, basically does the
8 Board confirm the previous deliberations and the
9 memorandum by Secretary Winkenwerder or not.
10 If the Board does not support keeping
11 these, then I've got to start someplace else. I'm
12 hearing that the Board thinks these are valuable.
13 If the Board goes on record as
14 confirming this, then I think that would be
15 valuable advice to give to Force Health Protection
16 and Ms. Embry's office.
17 DR. WILENSKY: Again, for my purpose, if
18 we're confirming the statements that's there,
19 which indicates its value and is silent on where,
20 I'm fine.
21 If what you're saying we should
22 reconfirm an earlier document that goes further

1 than that and says not only that, but that it
2 should be in DoD, I'm personally not quite ready
3 to do that.
4 I am ready to direct DoD to make a
5 decision in a timely way as to whether it will be
6 in DoD or elsewhere that will make it available.
7 So, I just -- if you're asking -- I
8 don't have any problem with this statement that's
9 up there on the Board now, but you have each time
10 sounded as though what was referenced is much more
11 specific --
12 DR. KAPLAN: It is.
13 DR. WILENSKY: -- than what we see up
14 there.
15 DR. KAPLAN: If you read it, it's in
16 front of you. If you read what it says, it's
17 there.
18 DR. WILENSKY: Okay. Well, then, I
19 guess I'm not sure exactly what it is you're
20 asking us to reconfirm.
21 DR. KAPLAN: Well, it's -- it's to
22 confirm --

1 DR. WILENSKY: Okay. It says to the
2 DoD.
3 DR. KAPLAN: -- the letter written by --
4 DR. WILENSKY: Well, we can't -- but
5 we're (inaudible) we can't transfer it to AFIP,
6 because that's no longer a relevant.
7 DR. KAPLAN: No, but he recognized the
8 value of it and as did the Board. So if I've
9 asked for the Board -- forgive me, and I don't
10 want to sound insubordinate, I guess, but I've
11 asked the Board for confirmation.
12 The Board has spoken out, at least those
13 that have spoken, have spoken in favor of what
14 I've said, as I understood it.
15 Is there a difference of opinion and how
16 is it to be resolved?
17 DR. POLAND: Perhaps the way forward
18 here would be to say this as one option: That the
19 Board reconfirms the importance -- as per the
20 September 2005 memo, the Board reconfirms the
21 importance of the Warren collection and believes
22 that it should be owned by or maintained by DoD.

1 If DoD in the next -- fill in the time
2 blank -- feels that that's not appropriate, they
3 need to notify DHB and Dr. Kaplan so that another
4 disposition can be made.
5 So it reconfirms this, but if they
6 decide they don't want it, then they tell us so in
7 a reasonable timeframe so that you can make
8 another disposition of the collection.
9 DR. KAPLAN: Does your suggestion
10 include both letters -- the letter from you --
11 DR. POLAND: Yes.
12 DR. KAPLAN: -- and Roger --
13 DR. POLAND: So it's the two.
14 DR. KAPLAN: -- and as well as the one
15 by Secretary Winkenwerder?
16 DR. POLAND: Yes. It's what you have up
17 there, so the motion would be that we confirm the
18 intent and direction of the AFEB and ASD letters
19 for the Warren Serum Repository -- given the
20 importance of the Warren Serum Repository and the
21 intent that DoD own and maintain it.
22 On the other hand, if Health Affairs

1 decides they don't want it, or don't want to
2 maintain or own it, they need to let us know that
3 in whatever we think an appropriate time period
4 is.
5 Five years is not an appropriate time
6 period. Sixty days is.
7 DR. WILENSKY: As a suggest -- I was
8 hearing a suggestion that perhaps we can use the
9 term under DoD oversight, because the reference
10 that's in the letter is no longer relevant. The
11 reference in the letter is an AFIP reference.
12 DR. POLAND: Well, it's a bifid
13 reference. It's Department of Army and AFAP work
14 to transfer the samples.
15 So AFAP isn't here, but the Department
16 of the Army still is.
17 DR. KAPLAN: That's correct.
18 DR. WILENSKY: But I -- okay, I would --
19 I prefer the notion again. Given that we are
20 hearing that the Department is in the process of
21 trying to determine exactly what -- having --
22 exactly where they want to recommend it, having it

1 be under the oversight of the Department of
2 Defense, either directly located in or in
3 someplace that they would have oversight and
4 control seems a reasonable way to resolve the
5 issue of that. Does it literally have to be in
6 the Department of Defense?
7 DR. KAPLAN: Okay. But would that
8 eliminate the Board's reaffirming, as Greg
9 suggested? I mean I think if the -- if Ms.
10 Embry's office is considering this, the purpose of
11 this Board is to advise that office, and we are,
12 by voting or by reaffirming this, we would be
13 advising them that this Board thinks this is
14 important and this is what ought to be done.
15 They can decide whatever they want to as
16 far as that's concerned, as I think Greg indicated
17 in his suggestion.
18 DR. WILENSKY: Well, if this were to be
19 at the National Library of Medicine or at the
20 Institute of Medicine under the oversight of the
21 Department of Defense, is that objectionable to
22 people in this room?

1 I mean, that would be consistent with
2 the alternative language that was suggested. I
3 mean, that's why having a little more latitude as
4 to what it is we want, which is to reaffirm the
5 importance and to have the oversight of the
6 Department of Defense, it seems to be more
7 operative than literally whether it has to be at
8 the Department of Defense or another government
9 agency.
10 I mean, I could -- it seems to me you
11 could make at least as good an argument that
12 having this be at the National Library of Medicine
13 or the Institute of Health is every bit as
14 important and relevant as having it in DoD.
15 DR. KAPLAN: The --
16 DR. WILENSKY: But you would like to
17 have oversight at DoD?
18 DR. OXMAN: Yeah. I think it's not
19 oversight. It's control by the Department of
20 Defense. It's an asset for the Department of
21 Defense. A lot of deliberation by the AFEB went
22 into this before, and we're supposed to provide,

1 with good conscience, our best advice.
2 Now that doesn't mean that everyone
3 agrees, Gail.
4 DR. WILENSKY: And I understand.
5 DR. OXMAN: But we should be able to
6 vote or provide our best advice even if we don't
7 all agree.
8 DR. WILENSKY: I absolutely support that
9 notion. Joe?
10 DR. PARISI: Could we say something like
11 the most logical place words isn't -- or isn't for
12 it to reside in DoD since DoD already is a
13 stakeholder in the collection. But if DoD decides
14 that it should go elsewhere, then that's their
15 prerogative.
16 DR. POLAND: I think that's what I'm
17 saying basically.
18 DR. WILENSKY: Yeah.
19 DR. POLAND: I mean, in some ways, these
20 belong to DoD. They've been stored somewhere
21 else. But they are -- they belong to DoD and DoD
22 needs to make a decision. The advice of the Board

1 was to take control of these.
2 If you deem that that isn't what you
3 want to do, there are other options available to
4 you, but let us know in a timely manner.
5 DR. WILENSKY: Well, taking -- I'm less
6 troubled by the taking of control than I am by
7 saying it's got to be physically at DoD,
8 personally. Again, for me, I could make as good a
9 case it should be at NIH or a lot of other places.
10 Yeah, it could be a contract. So, I
11 mean, the notion, what I'm troubled by is that
12 it's got to be at DoD per se. So I would rather
13 --
14 DR. KAPLAN: With respect --
15 DR. WILENSKY: -- have it -- well.
16 DR. KAPLAN: -- we have investigated
17 those other areas, and it means five more years.
18 We have found a place that will accept them, and
19 I'm very much afraid, because I consider myself
20 responsible for this, that someday something is
21 going to happen -- a freezer is going to blow up
22 or what have you.

1 And I think that the -- the sense that I
2 hear from here is that the Board supports the type
3 of statement that Greg Poland just offered. If
4 that's not the case, then I'm sorry --
5 DR. WILENSKY: I'm not sure.
6 DR. KAPLAN: -- I misunderstood.
7 DR. WILENSKY: I'm not sure I hear that
8 consensus yet. Dr. Clements?
9 DR. CLEMENTS: Well, it seemed to me,
10 though, that there are two problems here, and is
11 the urgency of Ed's problem with what if something
12 happens to this and I'm not confident about the
13 security of the material.
14 And that's something that has some
15 urgency and immediacy that needs to be dealt with
16 by the Department of Defense, and whether that's
17 moving it to Wright-Patterson or pulling a backup
18 generator and a what ever that is that's really a
19 separate question than who ultimately controls,
20 but not necessarily houses this material.
21 And I agree with Gail. I think it's
22 less important where it resides but that the DoD

1 have some opportunity to control at least the
2 level of access so that they know in the back of
3 their minds that a certain portion is reserved for
4 their use, even if the rest of the use is
5 determined by someone else.
6 So can we -- I mean, if that's correct,
7 maybe we could deal with the question of
8 recommending that the DoD do something immediately
9 to secure this material however they choose to do
10 so, and then, as quickly as possible, how they
11 want to handle the controlled material.
12 DR. WILENSKY: I am completely
13 comfortable with that statement.
14 DR. POLAND: Can I offer a motion? The
15 motion I put forward would be along these lines:
16 The Board recommends that -- that the Board
17 reaffirms the intent of the AFEB and ASD actions
18 of 2005.
19 The Board recommends that DoD assume
20 control of the Warren Serum Repository or
21 indicate other options in a timely manner.
22 DR. WILENSKY: That's right. Again, I'm

1 -- as long as the control --
2 DR. POLAND: So, I'm looking for a
3 second --
4 DR. WILENSKY: -- yeah. Well, we're not
5 doing the vote. Is there -- I mean, with --
6 that's relevant if you're doing a vote. Since
7 we're not -- as they are -- is this the consensus
8 unless you want to have a vote. Wayne?
9 DR. LEDNAR: I guess just listening to
10 the words, I -- in listening to what John
11 proposed, I'm not so sure that those words exactly
12 achieve John's thought.
13 I think that the DoD needs to take
14 control of the serum repository. Period.
15 Next step is to identify options at
16 where it may be housed and rules of access. But
17 even in step two, DoD maintains control.
18 DR. POLAND: I'm happy with that
19 amendment.
20 DR. WILENSKY: Yeah. I -- if we can --
21 I agree. I think that is what John said and in
22 the right order and the immediacy is clear.

1 DR. KAPLAN: So, excuse me, does that
2 mean that Colonel Johnson can then go back to Ms.
3 Embry's office and say that the Board supports
4 basically what Greg has said?
5 DR. WILENSKY: I think the --
6 DR. KAPLAN: And that will go in the
7 record as supporting by the DHB.
8 DR. WILENSKY: -- what is -- what should
9 go back is the immediacy of taking control and the
10 near need to make a near-term decision as to where
11 it will be housed. That is the two action step I
12 think we just affirmed as a group; is that
13 correct? John, would you -- was that -- is that a
14 correct way to characterize your statement? And
15 I'm not trying to put words in your mouth.
16 DR. CLEMENTS: No, I think that the --
17 yes, that's correct in what it says. But I think
18 the urgency has to do with securing the material
19 quickly so that that relieves Ed of the
20 responsibility. As to how it's controlled, it may
21 ultimately DoD can decide they don't want to
22 control it.

1 DR. POLAND: Right. Right.
2 DR. CLEMENTS: I don't think that that's
3 the way to go.
4 DR. POLAND: The only thing I think
5 missing is the antecedent of reaffirming the
6 importance of the collection.
7 DR. CLEMENTS: Right. So we reaffirm
8 the importance of this material, and recommend
9 that they DoD take immediate control, and in a
10 reasonable time period make a determination about
11 how it ultimately will be.
12 DR. POLAND: Where it's housed.
13 DR. WILENSKY: I would strongly prefer
14 those three statements be made as an independent
15 statement rather than with reference to an
16 exchange that occurred when parts of those -- that
17 exchange are institutionally not relevant.
18 This is a very clear three-step
19 directive of what we think should happen. But I
20 would -- my suggestion is that's what this Board
21 delivers to the office. Mike?
22 DR. OXMAN: Gail, you're going to throw

1 me off the Board. But I think there are two
2 phrases that are important. One is the immediacy;
3 the other is that my recommendation is that the
4 DoD, however they do it, maintain control. And
5 those are the words -- maintain control of the
6 collection.
7 For example, there could be lots of
8 reasons that have no benefit directly to the DoD,
9 which would use up all those sera. And that would
10 be -- that could conceivably be a tragedy to the
11 DoD five years from now.
12 And so I think it's important, and from
13 my responsibility as providing independent expert
14 advice, it would be for the DoD to take control
15 now and to maintain control. They don't have to
16 listen to that advice, but we're supposed to give
17 them the best advice we can. And that's my
18 recommendation, which I think is Greg's, and I
19 would make that motion.
20 DR. WILENSKY: Sorry. What I would like
21 to see is the two alternative statements
22 side-by-side, because we're -- and they were --

1 they're similar in spirit, but they are -- but I
2 thought initially other than perhaps you might --
3 I thought people had nodded to the statements that
4 John had suggested.
5 So I want to put those up, and we can
6 put up what you would like to see and then just
7 see the -- where people felt comfortable.
8 I thought we had already reached that,
9 but, if not, then we need to -- I'm not sure now
10 how what you're saying differed from what John had
11 said. I'd like to see that. I know that I was
12 comfortable with that.
13 DR. CLEMENTS: I don't think it does
14 differ. I think that it's just the wording of the
15 last third. And that is the first is to
16 immediately secure or take control -- immediately
17 secure and then take control; and then you could
18 say the Defense Health Board recommends that the
19 Department of Defense maintain control of that
20 material, but, in any event, determine in a
21 relatively short time period what the fate will
22 be.

1 And that we've made a recommendation
2 that we think the DoD should maintain control, but
3 they are free to not. But at least, we're on
4 record as saying we think that's the best
5 alternative.
6 DR. POLAND: But I think you do -- you
7 want to include the antecedent statement stating
8 that the Board believes the collection is
9 valuable.
10 DR. CLEMENTS: The antecedent statement
11 is that the Board believes that this material has
12 inherent scientific value --
13 DR. POLAND: To DoD.
14 DR. CLEMENTS: -- and should be -- to
15 the Department of Defense and should be
16 maintained.
17 DR. POLAND: Right.
18 DR. WILENSKY: Okay. Here's a -- we may
19 need to circulate, unless we're just -- we can do
20 this now. The finding is that the serum are at
21 risk and that they are valuable. And the
22 recommendation is that the DoD immediately take

1 control of the serum and make a determination in
2 the short term about its future.
3 DR. POLAND: About where it's housed.
4 DR. WILENSKY: About its future housing.
5 DR. KAPLAN: Gail, does your statement
6 include the reaffirm the correspondence of 2005?
7 DR. WILENSKY: No, it didn't, because I
8 don't find it relevant. What we are making is a
9 direct statement that we believe that the sera is
10 valuable and it's at risk.
11 I would prefer not to because there is
12 stuff in there that is I think no longer relevant.
13 We don't have to say we'll ignore the part that's
14 no longer relevant.
15 DR. KAPLAN: If I may again say, I think
16 that certainly the action of the AFEB in May of
17 2005 was the result of considerable liberation.
18 And I think that that could be
19 influential in the DoD's ultimate decision about
20 what they want to do with it.
21 So if it's appropriate, I would suggest
22 that that be included in the statement, because it

1 does reflect what happened.

2 DR. WILENSKY: And this, I guess, I will

3 respectfully disagree. I think the statement is

4 extremely strong to say this -- the finding -- we

5 -- this group is responding to an appropriate

6 request, which is that there is a concern that the

7 serum is now at risk, and that we need to do

8 something; and that our response to that is to

9 agree that this is a valuable asset and that it is

10 potentially at risk. We accept that -- and that

11 we, therefore, recommend that the DoD immediately

12 take control and that it make a deliberation about

13 where it is to be housed in the short -- in the

14 near-term; and that in a timely way; and that that

15 is what we have now done.

16 I just not -- I mean, we have not spent

17 any time -- I'm not trying to cast aspersions on

18 what you did. It's just -- we're not -- we

19 haven't gone through this activity. I don't see

20 that it in any way strengthens the statement of

21 this Board now.

22 This Board now is saying it's at risk.

1 It's a valuable asset. Take control immediately.
2 Make a determination immediately. I think that's
3 a very strong statement.
4 DR. POLAND: I think what you could do,
5 Ed, that maybe would be satisfying to you is just
6 as we do with every recommendation that comes from
7 (inaudible) Board, we attach relevant materials -- just
8 attach the background material to it.
9 DR. KAPLAN: I have no problem with --
10 DR. OXMAN: Gail, there's also -- excuse
11 me. There's also one subtlety that you left out,
12 and I think should be in.
13 It is valuable to the DoD, and that was
14 after a lot of deliberation by people before me
15 that it's not just valuable; it's valuable to the
16 DoD. And that's why I think that our
17 recommendation, whatever the DoD decides how they
18 will maintain control, even if it's to give it to
19 the NIH, with certain stipulations, we should
20 recommend in the long- term that the DoD also
21 maintain control.
22 DR. WILENSKY: Well, I thought we

1 already recommended that the DoD maintain control as
2 part of our statement.
3 DR. SHAMOO: No, no. Maintain control
4 -- the way he's saying it -- I'm not saying I
5 agree with -- maintain control for their own use.
6 DR. OXMAN: No, no. Just maintain
7 control, which means, for example, you ensure that
8 all of it doesn't get used for something else, and
9 none is left by (inaudible).
10 DR. SHAMOO: But they could have
11 somebody else use it 100 percent, and it's gone.
12 DR. WILENSKY: Mark? Did you -- are
13 you?
14 DR. MILLER: Well, I think the word
15 definition is to a matter of degree when you're
16 saying control, because you do have to provide
17 some incentives as well for someone to locally use
18 it. And I think the issue is control or oversight
19 and to what degree.
20 DR. WILENSKY: Yeah. I mean, I think
21 that it also includes that the DoD needs to make
22 decisions on who can access and under what

1 circumstances. I mean, that's what having under
2 its control means.
3 I guess I regarded that it is valuable
4 as being a stronger term than it is valuable to
5 the DoD. It is valuable to the DoD. It's
6 valuable to the DoD and to the rest of humanity.
7 So I think you're weakening it myself
8 with that.
9 DR. POLAND: Put both in.
10 DR. OXMAN: Put both in. Yeah. Put
11 both in. It's -- it has great scientific value
12 and including value specific to the DoD.
13 DR. WILENSKY: That's fine. John, the
14 scribe?
15 DR. CLEMENTS: That's right. Could we
16 say then that the Defense Health Board affirms the
17 value of this material to the Department of
18 Defense and the larger scientific community and
19 also believes that this material is at risk; that
20 the Defense Health Board recommends that the
21 Department of Defense secure this material
22 immediately and that the Department of Defense

1 take control of the material; and that the
2 Department of Defense determined the fate of the
3 material quickly or in a relatively short period
4 of time for the housing in a relatively short
5 period of time; yes.
6 DR. WILENSKY: Do we want to go more --
7 do we get more specific in terms of devising policies
8 regarding its use or shall we just stop there?
9 DR. POLAND: No, just stop there.
10 DR. WILENSKY: Okay.
11 DR. CLEMENTS: I would stop there.
12 DR. OXMAN: Stop there.
13 DR. WILENSKY: Okay?
14 DR. KAPLAN: Yes.
15 DR. WILENSKY: All right. I think we've
16 gotten through this and passed. Again, unless
17 somebody has a need for a vote, I don't see that
18 we've added. I think we've reached a consensus.
19 DR. KAPLAN: As long as it's in the
20 official transcript that can be taken back by
21 Colonel Johnson to Ms. Embry, I have no problem
22 with it.

1 DR. WILENSKY: It is the same mechanism
2 we have used to have something as
3 non-controversial as our views on the BRAC/NCR
4 Report.
5 I think it's okay.
6 DR. KAPLAN: I'm sorry. I didn't
7 understand the answer.
8 DR. WILENSKY: I said this was the same
9 mechanism we used this morning for Ken Kaiser's
10 report about the National Capital Region and its
11 building.
12 So, if it was clear enough there, I
13 think it's clear enough here.
14 DR. KAPLAN: With due respect, Gail, I
15 think this is an entirely different matter, and my
16 question is, will this be -- a simple question --
17 will this be in the transcript that he goes back
18 and refers to the previous documents? I'm fine
19 with the wording.
20 DR. WILENSKY: No, that was not what we
21 agreed to. What we agreed to, per Greg's
22 statement, which I'm comfortable with, is that we

1 have a short statement about the finding and the
2 recommendation, and that it will have attached to
3 it, without any further reference, the previous
4 information from 2005. That's what we agreed to.
5 SPEAKER: With John's wording?
6 DR. WILENSKY: With John's -- yes, with
7 John's wording.
8 DR. SHAMOO: Everything is in the
9 transcript. You don't have to worry. It is
10 everything we say. It's in the transcript. The
11 answer to your question is yes.
12 DR. WILENSKY: Of course. This is an
13 open meeting. It's been transcribed. You can't
14 get it out if you want it out. Yes, Joe?
15 DR. SILVA: Madam Chair, the hour's
16 getting late, if I could make one short comment
17 with a little levity.
18 Dr. Mark Miller and I have agreed to
19 take this collection, if no one wants it, and
20 we'll offer it up for sale on e-Bay and take a 10
21 percent commission.
22 (Laughter)

1 DR. SILVA: Thank you.
2 DR. KAPLAN: I get 10 percent agent's
3 fee.
4 DR. WILENSKY: Okay. I'm going to turn
5 this over to Commander Feeks for some
6 administrative comments.
7 COMMANDER FEEKS: Before I proceed,
8 could I ask the good Dr. Gibson to see if --
9 actually, let me ask Beth, instead. I'm sorry.
10 Colonel Gibson can relax.
11 Can you ask either Lisa or Jen to come
12 in, please?
13 Before I go on, thanks was given for Dr.
14 Kaiser and his Subcommittee's work for that
15 enormous undertaking of the report that they
16 prepared, and I also want to recognize the members
17 of my staff who participate in that -- not the
18 ladies who are coming in in just a minute, but
19 particularly Sheila Bowman and Merrily McGowan --
20 an enormous amount of work that those women put
21 into that report, and I just wanted to enter that
22 into the record.

1 (Applause)

2 COMMANDER FEEKS: Okay. Well, my next
3 item is that for Board members, ex officio
4 members, liaisons, and speakers, tomorrow's
5 briefing at the Industrial at the College of the
6 Armed Forces, at Fort McNair, will be preceded by
7 breakfast at Fort McNair.

8 I have maps of the post; that is to say
9 Fort McNair, in my hand, if anyone will need a map
10 to get there in the morning. Did the people at
11 Fort -- excuse me -- Fort McNair stipulate which
12 gate?

13 MS. GRAHAM: Second Street.

14 COMMANDER FEEKS: Second Street gate.
15 So enter by the Second Street gate. The map will
16 show you where ICAF is, and the parking lot behind
17 the ICAF building has a marina next to it. You'll
18 recognize it by the boats.

19 Okay. All right now. I beg your
20 pardon? Yeah, what time does the bus leave,
21 please, Jen, from the hotel?

22 MS. KLEVENOW: 7:30 in the morning.

1 COMMANDER FEEKS: The bus leaves the
2 hotel at 7:30 in the morning to go to Fort McNair.
3 Okay. For those who are joining us for
4 dinner tonight, please convene in the hotel lobby
5 at 6:15 p.m. so that we can walk to the
6 restaurant. If I have it understood right with
7 Dr. Poland, the pre-meeting that the Pan-Flu, the
8 Pandemic Influenza Group, wanted to have tonight,
9 they are going to have tonight, but at the
10 restaurant. They're just going to sit together.
11 DR. POLAND: So that's a change in plans
12 related to the reservations that we really
13 couldn't cancel it turns out at the last minute,
14 we're actually going to meet at -- with the rest
15 of the group, but I mean at the restaurant, but
16 we'll sort of sit a little bit away from you.
17 COMMANDER FEEKS: Yeah. And I think
18 that they'll find that they can have the
19 conversation that they want to have --
20 DR. POLAND: So 6:15 --
21 COMMANDER FEEKS: -- there's a long
22 enough table that will work.

1 DR. POLAND: -- will that be, you said?
2 COMMANDER FEEKS: Yes, sir. 6:15 in the
3 lobby. The regerate -- excuse me -- the
4 reservations are for 6:30 p.m. at McCormick
5 and Schmicks, here in Arlington.
6 And lastly, if you want to keep your --
7 if you want to keep your binder, please take it
8 with you tonight. We won't be coming back here
9 tomorrow.
10 If the binder is too bulky, please
11 remove the contents if you want to keep the
12 contents and take those home with you, and we'll
13 take the binders back to the office.
14 If necessary, we can send the binder to
15 you by FEDEX, for the members, that is. Of
16 course, it's expensive, and it involves some
17 labor, but we can do that.
18 We'd prefer not to, if you don't mind.
19 And with that, let me ask Dr. Wilensky to take
20 over.
21 DR. WILENSKY: This concludes the public
22 portion of our meeting. We are going to have a

1 short administrative session immediately
2 following, so if you would please stay. I've
3 promised Marianne some time.
4 And then, as you have heard, the Board
5 Members, liaison, ex officio members will be
6 meeting to board the bus by 7:30 to go to Fort
7 McNair.
8 Any of you who are leaving for the
9 airport directly after the meeting, you ought to
10 bring your luggage with you. Mr. Middleton, would
11 you adjourn the meeting?
12 MR. MIDDLETON: This meeting of the
13 Defense Health Board is adjourned. On behalf of
14 Ms. Embry, I want to thank all of you for
15 attending. And I also want to thank all of you
16 for the tremendous support we received to the
17 Defense Health Board and particularly to the
18 speakers, who did such outstanding presentations
19 today. Thank you.
20 (Whereupon, at 4:46 p.m., the
21 PROCEEDINGS were adjourned.)
22 * * * * *

1 CERTIFICATE OF NOTARY PUBLIC

2 I, Carleton J. Anderson, III do hereby
3 certify that the forgoing electronic file when
4 originally transmitted was reduced to text at my
5 direction; that said transcript is a true record
6 of the proceedings therein referenced; that I am
7 neither counsel for, related to, nor employed by
8 any of the parties to the action in which these
9 proceedings were taken; and, furthermore, that I
10 am neither a relative or employee of any attorney
11 or counsel employed by the parties hereto, nor
12 financially or otherwise interested in the outcome
13 of this action.

14 /s/Carleton J. Anderson, III

15

16

17 Notary Public in and for the
18 Commonwealth of Virginia
19 Commission No. 351998
20 Expires: November 30, 2012
21
22