

UNITED STATES DEPARTMENT OF DEFENSE

DEFENSE HEALTH BOARD

CORE BOARD MEETING

Fairfax, Virginia

Thursday, November 12, 2009

ANDERSON COURT REPORTING

706 Duke Street, Suite 100

Alexandria, VA 22314

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

- 1 PARTICIPANTS:
- 2 WARNER ANDERSON
- 3 PETER G. BLAIN
- 4 LIEUTENANT COLONEL CHRISTOPHER COKE
- 5 COMMANDER EDMOND FEEKS
- 6 CHARLES J. FOGELMAN
- 7 CAPTAIN MARTHA GIRZ
- 8 COLONEL WAYNE HACHEY
- 9 LYNN LAWRY
- 10 WAYNE LEDNAR
- 11 ANNE MOESSNER
- 12 GREGORY A. POLAND

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

2 (9:08 a.m.)

3 DR. LEDNAR: Okay, if everyone please  
4 would take your seats. Good morning, everyone.  
5 This is the opening of the meeting of the Defense  
6 Health Board, the Core Board meeting. I would  
7 like to extend our appreciation to all the Core  
8 Board members, guests, and briefers who have  
9 joined us today for this meeting.

10 I want to extend a special welcome to  
11 new board members and any new Subcommittee members  
12 and Task Force leaders that are here with us. We  
13 have a very ambitious agenda in the next day and a  
14 half. But what we would like to do is to  
15 officially open the meeting and ask Colonel  
16 Christine Bader who is our alternate Designated  
17 Federal Official for this board activity if she  
18 would please open the meeting. Colonel Bader?

19 Col BADER: Thank you, Dr. Lednar. As  
20 the alternate Designated Federal Officer for the  
21 Defense Health Board, a federal advisory  
22 committee, and a continuing independent scientific

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1 advisory body to the Secretary of Defense via the  
2 Assistant Secretary of Defense for Health Affairs  
3 and the Surgeon General of the military  
4 departments, I hereby call this meeting of the  
5 Defense Health Board to order.

6 DR. LEDNAR: Thank you, Colonel Bader.  
7 In keeping with the tradition of the board, we'd  
8 like everyone please to stand for a moment of  
9 silence. Let's remember to honor those that we  
10 are privileged to come and serve. This particular  
11 past week has been a very difficult one with the  
12 killings at Ft. Hood and the impacts on their  
13 family members, fellow soldiers, the community  
14 around them, and the entire military community  
15 worldwide. So let's please keep all of them in  
16 our thoughts and prayers.

17 (Moment of silence)

18 DR. LEDNAR: Thank you. Please be  
19 seated. We'd like to first start by doing  
20 introductions.

21 So we'd ask, starting with the board,  
22 and then we will go throughout the room, if you

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1 would please identify your name, your affiliation  
2 of where your day job is, and for those who have  
3 responsibilities with the Defense Health Board,  
4 perhaps as a Subcommittee member, Task Force  
5 leader, if they would identify and share that  
6 information as well.

7 So, can we begin with Major Fea?

8 MAJ FEA: Good morning. I'm Major Mike  
9 Fea. I work over at the Joint Staff. My boss is  
10 the Joint Staff Surgeon Rear Admiral David Smith.

11 CDR SLAUNWHITE: Hello. I'm Commander  
12 Cathy Slaunwhite. I'm a Canadian Forces Medical  
13 Officer in a liaison role at the Embassy in  
14 Washington, D.C.

15 CAPT NAITO: Captain Neal Naito,  
16 Director of Clinical Care and Public Health for  
17 Navy Medicine here in Washington, D.C.

18 DR. BLAIN: Professor Peter Blain. I'm  
19 a Professor of Environmental Medicine at Newcastle  
20 University in the UK and a physician there, but  
21 I'm here as a Chairman on the Advisory Group on  
22 Military Medicine for our Ministry of Defense.

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1 DR. LEDNAR: Dr. Blain, thank you for  
2 joining us.

3 CDR FEEKS: We'll be hearing from  
4 Professor Blain later this morning and we'll hear  
5 more about him, too, but I just want to say, it's  
6 a great honor to have you here, sir. Thank you  
7 for coming.

8 CAPT COWAN: Group Captain Alan Cowan.  
9 I'm the former British Liaison Officer to the U.S.  
10 Department of Defense and the Department of  
11 Veterans Affairs.

12 DR. BENETATO: Good morning. I'm Bonnie  
13 Benetato, the Acting Director of the War-Related  
14 Illness and Injury Study Center in Washington,  
15 D.C., for the Department of Veterans Affairs, and  
16 I'm the liaison member to the board.

17 MS. CARROLL: Bonnie Carroll, the  
18 Director of the Tragedy Assistance Program for  
19 Survivors and the Co-Chair of the Department of  
20 Defense Task Force on the Prevention of Suicide  
21 by Members of the Armed Forces.

22 DR. BUTLER: Morning. Frank Butler,

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1 Chairman of the Committee on Tactical Combat  
2 Casualty Care, and this morning sitting in for Dr.  
3 John Holcomb, the Chairman of the Trauma and  
4 Injury Subcommittee.

5 DR. FOGELMAN: I'm Charlie Fogelman.  
6 I'm Chair of the Psychological Health Subcommittee  
7 and I am an independent clinician and consultant.

8 DR. WALKER: David Walker, Pathologist,  
9 University of Texas Medical Branch at Galveston,  
10 member of the Core Board and Infectious Disease  
11 Subcommittee.

12 DR. PARISI: I'm Joseph Parisi,  
13 Professor of Pathology at Mayo Clinic in  
14 Rochester, Minnesota. I'm a member of the Core  
15 Board and Chair of the Subcommittee on Pathology.

16 DR. SILVA: Joe Silva, Professor of  
17 Internal Medicine and Infectious Diseases, Dean  
18 Emeritus, University of California School of  
19 Medicine at Davis, and I'm a Core Board member and  
20 a member of the Infectious Diseases Subcommittee.

21 DR. O'LEARY: Dennis O'Leary, President  
22 Emeritus of the Joint Commission, member of the

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1 Core Board and of the BRAC Subcommittee.

2 DR. MASON: I'm Tom Mason, Professor of  
3 Environmental and Occupational Health, College of  
4 Public Health, University of South Florida, Tampa,  
5 member of the Core Board and also a member of the  
6 Subcommittee on Occupational and Environmental  
7 Health and Medical Surveillance.

8 DR. LUEPKER: Yes, and I'm Russell  
9 Luepker, and I'm a Professor of Epidemiology and  
10 Medicine at University of Minnesota. I'm a member  
11 of the Core Board and of the Health Care Delivery  
12 Advisory Board.

13 DR. CLEMENTS: John Clements. I'm the  
14 Chair of Microbiology and Immunology at Tulane  
15 University School of Medicine in New Orleans, also  
16 the Director of the Tulane Center for Infectious  
17 Diseases and I'm on the Infectious Diseases  
18 Subcommittee.

19 CDR FEEKS: Commander Ed Feeks,  
20 Executive Secretary of the Defense Health Board.

21 DR. LEDNAR: Wayne Lednar, one of the  
22 two Vice Presidents of the Defense Health Board

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1 and Global Chief Medical Officer for the DuPont  
2 Company.

3 DR. POLAND: I'm Greg Poland, Professor  
4 of Medicine and Infectious Diseases at the Mayo  
5 Clinic in Rochester, Minnesota, VP of the Board,  
6 and Chair of the Infectious Diseases Control  
7 Subcommittee.

8 Col BADER: Good morning. Christine  
9 Bader. I am a Senior Advisor to the Assistant  
10 Secretary of Defense for Health Affairs, and I'm  
11 your alternate Designated Federal Officer for  
12 today's meeting.

13 Rev CERTAIN: I'm Robert Certain. I'm  
14 an Episcopal Church clergyman in Atlanta, retired  
15 Air Force chaplain, former combat aviator Vietnam,  
16 former POW, and served on the Core Board, the  
17 Subcommittee on Medical Ethics, psychological  
18 health, and the Task Force on Suicide Prevention.

19 DR. HALPERIN: Bill Halperin. I chair  
20 the Department of Preventive Medicine at the New  
21 Jersey Medical School and the Department of  
22 Quantitative Methods, Epidemiology by Statistics,

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1 at the School of Public Health. I am Chair of the  
2 Subcommittee on Military Occupational and  
3 Environmental Health and Medical Surveillance and  
4 a member of the Core Board. And I'm retired from  
5 the Centers for Disease Control.

6 DR. KAPLAN: Good morning. I'm Ed  
7 Kaplan, Professor of Pediatrics at the University  
8 of Minnesota Medical School in Minneapolis. I'm a  
9 Core Board member and a member of the Infectious  
10 Disease Subcommittee.

11 DR. OXMAN: Good morning. I'm Mike  
12 Oxman. I'm a Professor of Medicine and Pathology  
13 at the University of California in San Diego and a  
14 member of the Infectious Diseases and Pathology  
15 Subcommittees.

16 DR. PARKINSON: Good morning. I'm Mike  
17 Parkinson. I'm the Past President of the American  
18 College of Preventive Medicine. I currently work  
19 with health care, employer, and other  
20 organizations to improve prevention and  
21 productivity. I'm a member of the Core Board and  
22 also the Health Care Delivery Subcommittee.

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1 DR. SHAMOO: I'm Adil Shamoo, Professor  
2 and former Chair University of Maryland, School of  
3 Medicine, and a member of the Core Board and the  
4 Chairman of the Medical Ethics Subcommittee.

5 MS. MOESSNER: Good morning. Anne  
6 Moessner. I'm a TBI Clinical Specialist for the  
7 Mayo Clinic. I also do TBI research and currently  
8 the Chair of the TBI Family Caregiver Panel.

9 RADM KAHN: Good morning. Ali Kahn,  
10 Assistant Surgeon General, U.S. Public Health  
11 Service, and CDC liaison to the board.

12 COL MOTT: Morning. Colonel Bob Mott.  
13 I'm a Preventive Medicine Staff Officer from the  
14 Army Surgeon General. I'm the Army liaison.

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

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

21 CDR SCHWARTZ: Commander Erica  
22 Schwartz. I'm the Preventive Medicine Liaison for

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1 the Coast Guard.

2 Lt Col GOULD: Lieutenant Colonel Philip  
3 Gould. I'm the Preventive Medicine alternate for  
4 the Defense Health Board from the Air Force.

5 CDR SPRINGS: Good morning. Julia  
6 Springs, the Preventive Medicine Officer for  
7 Health Services Headquarters, Marine Corps.

8 DR. COHOON: Barbara Cohoon. I work for  
9 the National Military Family Association. I  
10 handle health care for them, and I'm also a member  
11 of the TBI Family Caregiver Panel.

12 DR. ERDTMANN: Good morning. My name is  
13 Rick Erdtmann. I'm a staff member at the  
14 Institute of Medicine, direct the Board on the  
15 Select Population Health at the Institute of  
16 Medicine.

17 MR. RABOLD: Ridge Rabold, Office of the  
18 Director, Armed Forces Institute of Pathology.

19 LT DANIELSON: I'm Lieutenant Roxanne  
20 Landismann. I'm a Resident in Preventive Medicine  
21 at the Uniform Services University.

22 MS. WARD: I'm Claudine Ward. I'm also

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1 a resident at Uniformed Services University.

2 COL MACEDONIA: I'm Colonel Chris  
3 Macedonia. I work in the Office of the Chairman  
4 of the Joint Chiefs of Staff and I'm a Special  
5 Assistant to the Chairman for Warriors and  
6 Families.

7 MAJ JOSEPH: Tath Joseph, Joint Staff,  
8 Health Service Support Division.

9 CAPT LEE: Captain Roger Lee,  
10 Environmental Health, works on the Joint Staff  
11 Health Service Support Division.

12 MR. PERRY: Michael Perry, Director of  
13 Operations for the American Registry of Pathology.

14 Col McPHERSON: Colonel Joanne  
15 McPherson. I'm the new Executive Secretary for  
16 the DoD Task Force on the Prevention of Suicide.

17 LtCol COKE: Good morning. Lieutenant  
18 Colonel Chris Coke from the Joint Staff  
19 Operations.

20 MS. JARRETT: Lisa Jarrett. I'm the  
21 contractor for the Defense Health Board.

22 MS. CAIN: Christina Cain, DHB support

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1 staff.

2 MS. JOVANOVIC: Olivera Jovanovic, DHB  
3 support staff.

4 MS. KLEVENOW: Jen Klevenow, DHB support  
5 staff.

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

8 DR. LEDNAR: And on the telephone, can  
9 we please identify ourselves?

10 DR. MILLER: I'm Mark Miller, Director  
11 of Research at the Fogherty International Center  
12 at the NIH, and on the Infectious Disease  
13 Subcommittee.

14 MS. COATES: Marianne Coates. I'm a  
15 contracted consultant to the Defense Health Board  
16 for communications and public relations.

17 DR. LEDNAR: Thanks to everyone in the  
18 room for introducing yourself. Can I ask, is  
19 there anyone on the telephone? Okay. We'll just  
20 try to remind ourselves that we may have one or  
21 two Core Board members who join us on the  
22 telephone. And if that's the case, we'll just

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1 have to be sure that we use the microphones so  
2 they can hear. Did someone join us on the  
3 telephone?

4 Okay. With that, I would ask Commander  
5 Feeks, he has some administrative remarks before  
6 we begin our first briefing. Commander Feeks?

7 CDR FEEKS: This is Commander Feeks.  
8 Thanks, Dr. Lednar. Good morning everyone,  
9 welcome, thank you for being here.

10 I want to thank the Hyatt Fair Lakes  
11 Hotel for helping with the arrangements for this  
12 meeting. I want to thank all the speakers who  
13 have worked hard to prepare briefings for us. I  
14 want to thank my staff, Jen Klevenow, Lisa  
15 Jarrett, Elizabeth Graham, Olivera Jovanovic,  
16 Christina Cain and Jean Ward, back at the home  
17 office, for arranging this meeting of the Defense  
18 Health Board.

19 If you have not already done so, please  
20 be sure to sign one of the rosters at the table  
21 outside the room whether it be if you're an  
22 official attendee or a member of the public. The

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1 law requires us to keep a record of who attends  
2 our meetings.

3 For those of you who are not seated at  
4 this table, there are handouts provided on the  
5 table at the far end of the room. Restrooms are  
6 located down the hall and to the left. If you  
7 need fax, telephone, copier, or messaging service,  
8 please see a member of my support staff, in  
9 particular Jen Klevenow or Lisa Jarrett.

10 This open session is being transcribed  
11 -- actually, it's being recorded and if you look  
12 over your shoulder, Christine Allen is sitting at  
13 the table with the technicians. You'll notice  
14 that she's not typing, she's recording. Someone's  
15 going to type this later. So, each time you  
16 speak, please say your name because the person who  
17 does the typing will not recognize your voice at  
18 that time. Also, if you find that your name is  
19 easily misspelled, I suggest that you write it  
20 down on a piece of paper and give it to Christine  
21 at some point during the meeting so that we'd be  
22 sure to spell your name correctly in the

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1 transcript.

2 Refreshments will be available for both  
3 morning and afternoon sessions. We'll have a  
4 catered working lunch here for our Board members,  
5 ex officio members, service liaisons, support  
6 staff, speakers, and distinguished guests. For  
7 others looking for lunch options, the hotel  
8 restaurant is open for lunch. There is also a  
9 Whole Foods located around the corner in the East  
10 Market Shopping Center that has some dining-in  
11 options. Also in East Market are a Starbucks, a  
12 Pei Wei Asian Diner, and in the shops at Fair  
13 Lakes, there are additional options including  
14 Logan's, Blue Iguana, McDonald's, Pizza Hut, Taco  
15 Bell, and Joe's Crab Shack. There are many other  
16 dining options all within a few miles radius. If  
17 you need further information, please see a staff  
18 member of mine or talk to someone at the hotel  
19 front desk.

20 Okay. The group dinner tonight is  
21 scheduled for 6:00 p.m. at Sakura Japanese Steak  
22 and Seafood House. Sakura is located about a mile

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1 from the hotel and shuttle service is being  
2 provided by the hotel. The shuttle will leave  
3 from the hotel at 6:00 p.m. with a second run  
4 likely to accommodate our group's size.

5 Return shuttle service to the hotel will  
6 also be provided. However, if you have not  
7 already RSVPed for this dinner, please see Jen  
8 Klevenow so that we have a good head count.

9 For those who need to take the Metro  
10 after this meeting, the hotel operates a  
11 complementary shuttle to the Vienna Metro Station  
12 every 30 minutes. Please see the shuttle schedule  
13 at the registration desk or visit the hotel front  
14 desk.

15 Finally, the next meeting of the core of  
16 the Defense Health Board will be at a date that  
17 has not been named and at a location that has not  
18 been decided at this point, but we will put that  
19 information out as soon as it's available.

20 DR. POLAND: Just be there.

21 CDR FEEKS: Right. You all come.

22 Okay. All right. And at that meeting we

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1 anticipate receiving updates from Subcommittees as  
2 well as information briefings, draft  
3 recommendations for vote, and so on.

4 This concludes my remarks. Dr. Lednar?

5 DR. LEDNAR: Thank you, Commander Feeks.  
6 We'll move to our first briefing.

7 And since a mission of the board is to  
8 serve the men and women who defend our country,  
9 our first speaker this morning is Lieutenant  
10 Colonel -- Promotable -- Chris Coke of the Joint  
11 Staff. He's assistant division chief from EUCOM  
12 of the Joint Staff Operations Directorate. The  
13 division is responsible for monitoring and  
14 coordinating of all Joint Staff actions for  
15 operational activities within NATO Headquarters in  
16 the U.S.-European Command. He is also a Marine  
17 Corps helicopter pilot. Among his many awards are  
18 the Bronze Star, Meritorious Service Medal, Ear  
19 Medal with the Third Strike Award, Navy and Marine  
20 Commendation Medal, and two Navy and Marine Corps  
21 Achievement Medals.

22 Lieutenant Colonel Coke has also been

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1 selected for promotion to colonel. That cannot  
2 come fast enough and we look forward to  
3 congratulating him when that happens, hopefully in  
4 the near future.

5 Lieutenant Colonel Coke will provide us with an  
6 overview of U.S. military operations worldwide and  
7 highlight one of the health issues of priority to  
8 the Department, that "keep up the line commanders  
9 at night." His presentation slides may be found  
10 under tab 1 of your meeting book. Lieutenant Colonel Coke?

11 LtCol COKE: Thank you and good morning.  
12 It's always a pleasure to be among you all. This  
13 is the third time and equally as so to be out of  
14 the Pentagon, out of the basement where there's  
15 actually more oxygen and light, so all good.

16 I'm honored and pleased to be joined by  
17 Colonel Macedonia, who was previously introduced  
18 to cover specific medical issues that have  
19 emerged. But what I'd like to talk to you about  
20 is similar to what we've talked about previously,  
21 but with a little bit more focus on engagements  
22 and concerns as well as operations that we're

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1 facing.

2 As somewhat fortuitous to Commander  
3 Feeks' comments, to one of the questions or  
4 concerns was really we are in a transition period  
5 and we feel this across the board. If you look,  
6 and not to provide a history lesson, but at every  
7 juncture of administrations, there's been a  
8 transition period, some rather dramatic, perhaps  
9 not so much, but we have an awful lot on our  
10 plate, as you all well know. And those things  
11 that we had no control over -- you know,  
12 economics, emergent Russia, China -- we'll talk  
13 about those things; and then perhaps those things  
14 that we do have control about that we're trying to  
15 effect change to: Those operations in the Middle  
16 East, one could say medical issues and health care  
17 and things like that. So, all makes for a very  
18 busy timeframe for all of us to include those in  
19 uniform and those within the building.

20 Our vital national interests still  
21 remain the same and that is to secure our homeland  
22 and those Americans from a catastrophic attack.

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1       So, when we look at this and then we look at,  
2       though just as important, but other interests such  
3       as assuring access to strategic resources, you  
4       know, oil and water and such for our folks,  
5       flourishing in national global economics, trade --  
6       and this kind of ties into the last bullet --  
7       global influence and leadership, but access to the  
8       commons, the ability to be able to trade fairly  
9       across the world and of access to all those  
10       resources on a fair share basis across the  
11       international community.

12                 And then, of course, you know, being  
13       able to manage our military in such a manner that  
14       allows us to keep the edge. So, this is where our  
15       focus is.

16                 You'll notice that one could argue Iraq  
17       and Afghanistan interweaves throughout all of  
18       those, depending on where you sit, so -- and that  
19       obviously leads into the debate that we're having  
20       and we'll talk about that in a little bit. But,  
21       unarguably, I don't think, is certainly the  
22       implications of a Israeli-Iranian engagement or

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1 further deterioration of North Korea and the  
2 Korean peninsula or other type activities that  
3 would gain our attention very quickly and present  
4 a hit on us in the sense that we would be very  
5 heavily engaged.

6           Again the environment that we're sitting  
7 is still -- it's unique in the sense that there  
8 are emerging spheres or domains that haven't been  
9 traditional domains. I bring up cyberspace and  
10 space. We're seeing more issues and actually have  
11 stood up a Cyberspace Command, a 4-star general  
12 under a Strategic Command, to address these  
13 issues. But then we still do have our typical  
14 issues around the world, certainly much centered  
15 around the Middle East, Southern Asia, Africa,  
16 where we see much of the instability, perhaps,  
17 from ungoverned or less-than-governed spaces. And  
18 then, of course, other issues which we'll talk  
19 more specifically to such as natural disasters.  
20 So, this is what is keeping us busy.

21           Where our priorities rest. Of course,  
22 and like I alluded to, we are in a transition

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1 period, but without reading through this specific  
2 slide, we are trying to integrate and understand  
3 better how we integrate soft and hard power; hard  
4 power being military, soft being economic,  
5 political, information or other venues. And how  
6 do we do that across the interagency, and how we  
7 do that across the international community  
8 aligning them with everybody's priorities because  
9 they are different. So, as we move from the  
10 Presidential level to the Chairman's level,  
11 obviously, you know, our national interests, our  
12 vital national interest in the Middle East, you  
13 know, emerges as the number one concern right now  
14 and to this board and to the end of obviously the  
15 health of the force, just not in its ability to be  
16 able to fight today's wars, but also what's going  
17 to happen in 2020. And then lastly is to balance  
18 this risk. There's only so much resources that we  
19 have and to be able to balance it across the  
20 spectrum of the globe and the areas that we need  
21 to focus on.

22 We'll start by kind of going around the

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1 world. NORTHCOM, basically here at home, remains  
2 number one, homeland defense. Defend, provide the  
3 defense borders both north and south, and  
4 obviously from the oceans. Disaster response,  
5 ability to be able to respond to Katrina-type  
6 events -- earthquakes and forest fires and things  
7 like that -- and then to be able to deal with  
8 other type activity. Still a lot of counterdrug  
9 activity coming up through Mexico.

10 And to just segue a little bit into  
11 Mexico, because Mexico is part of Northern  
12 Command, the things that we've seen with Caldera  
13 and the reemphasis on counter-narcotic activity  
14 within Mexico as well as the success that we've  
15 seen in Southern America has actually, kind of,  
16 you know, squeezing of the balloon where we've  
17 seen, you know, increased activity within Mexico,  
18 within the borders. So, trying to curtail that.  
19 At the same time, we have a lot of weapons that  
20 are shipping south, so leads to a very busy  
21 border.

22 (Interruption)

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1                   LtCol COKE: As we look at SOUTHCOM, I  
2 talked about the counter-narcotic and counterdrug  
3 activity that's been going on. We've seen a fair  
4 amount of success in such countries as Colombia,  
5 and working with those governments, specifically  
6 those militaries, on how to train and how to  
7 conduct counter-narcotic activity. Somewhat  
8 different from counterinsurgency activity that  
9 we'll talk about in a little bit.

10                   Other areas of concern in SOUTHCOM,  
11 Guantanamo Bay. Consensus is we will not get to  
12 our deadline that we had made back in January as  
13 far as fully closing that facility. It continues  
14 to remain in the front of our senior leader's  
15 attention.

16                   The other sort of unknown, but really,  
17 the theater security engagement that we're having  
18 in South America has proved to be very successful  
19 when we look at such things as the U.S. Comfort  
20 sailing recently as last spring and looking at  
21 what it was able to do in preventative medicine  
22 such as in Haiti and other South American

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1 countries. A lot of success there. Again, not so  
2 much -- certainly providing a service to people,  
3 but also training the trainers and providing the  
4 leadership and the expertise so that you're  
5 building capacity within these individual  
6 countries.

7 Europe, still growing much active in the  
8 global picture, probably the most important aspect  
9 is NATO and really corralling the efforts with  
10 ISAF and all things Afghanistan, providing the  
11 senior leadership. The important thing that NATO  
12 is also involved in Kosovo continues, they're also  
13 involved in what we call two standard NATO  
14 maritime groups of ships that provide  
15 counter-piracy operations -- and we'll talk  
16 specifically about piracy in a little bit -- off  
17 the -- Amman and the coast of Somalia as well as  
18 being present within the Mediterranean.

19 Also, other elements, we have a NATO  
20 response force which is ready to basically provide  
21 reaction to any kind of Article V, protect the  
22 alliance requirements, and that's a NATO-wide

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1 group. And then, of course, Baltic Air Police and  
2 over flight within the Baltics as an enduring  
3 mission.

4 Other European issues, we continue to  
5 look at Israel and quite a bit of news recently  
6 with Abbas not stepping up for another term and  
7 how do we bring the West Bank and Gaza together  
8 between Fatah and Hamas and bring them to the  
9 table opposite Israel? Several efforts to that  
10 extent. We've had the Security Cooperation  
11 Mission there, which has taken West Bank and  
12 Palestinians through the help of Jordan and to  
13 train those and basically providing their own  
14 security for and within the West Bank. Small U.S.  
15 Contingent basically there to facilitate. Small  
16 success in pockets, is trying to expand that,  
17 that's the challenge.

18 And then a lot on missile defense as we  
19 go into this new architecture as far as missile  
20 defense, just not in Europe, but also around Japan  
21 and Korea; and how do we go forward with the  
22 decision to change course in what we were going to

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1 have under the previous administration and working  
2 with those countries, Poland and Czechoslovakia  
3 specifically.

4 Central Command, really three emphasis.  
5 And we'll talk specifically about Iraq and  
6 Afghanistan here in a minute, but also piracy and  
7 counter-piracy continue to have several  
8 international groups. You have Operation Atlanta,  
9 which is the operators -- it is the EU that  
10 provides 11, 12 ships from across the EU for  
11 counter-piracy operations. You still have Task  
12 Force 151, which is a cooperation among several  
13 nations for counter-piracy operations. And then  
14 you have SNGMs, the NATO groups that we've talked  
15 about, along with a lot of bilateral relationships  
16 and unilateral such as the Chinese and Iran, for  
17 that matter, as well.

18 Pacific Command, again everybody tends  
19 towards Korea and Kim Jong-Il, and last summer it  
20 was whether he was alive or dead, and now what are  
21 their intentions to return back to the Six Part  
22 Talks, to look at avenues that we can decrease our

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1 presence. We still maintain 25,000 people  
2 thereabouts in South Korea, still part of the  
3 armistice, so -- and then to that end, similar to  
4 Iran, counter- proliferation. Still have,  
5 although not as newsworthy, interdiction  
6 operations taking place around the Sea of Japan  
7 and Korean shores.

8 Tied into PACOM also is India, so when  
9 we look at the relationship between India and  
10 Pakistan, reflect back on Mumbai and how we're  
11 posturing ourselves in the event of hostilities  
12 breaking out, trying to work with those two  
13 governments and particularly those two militaries;  
14 to understand that for Pakistan, the threat really  
15 isn't India, it's more Pakistan Taliban; for India  
16 to understand that the threat is broader than just  
17 its neighbors. So, trying to work with those  
18 governments to look at things more holistic,  
19 perhaps more comprehensively.

20 Some success in different pockets,  
21 particularly in the Philippines, as we continue to  
22 work with them on counterterrorism activity and

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1 their own, as history has shown, emergence of  
2 different insurgence type activities.

3 AFRICOM, my newest COCOM a little over a  
4 year ago. Again, a couple of focuses. Trans  
5 Sahara still quite a bit of illicit activity that  
6 used to be part of the old GWOT terrorism, now  
7 kind of refocused on being a breeding ground, per  
8 se, of insurgent activity and illicit material.  
9 It ties into the old 150 operations within the Red  
10 Sea and moving what was basically being produced  
11 in Northern Africa over into the Arabian Gulf.

12 Still have a fairly strong standing  
13 there in Djibouti as far as the Horn of Africa in  
14 providing a response force, and then looking at  
15 theater security engagement and partnership within  
16 the various governments in Africa. The uniqueness  
17 of this is looking at it from more a comprehensive  
18 approach, certainly billeted under the combatant  
19 commander, second in charge, breaks out where you  
20 have a military type and then you have an  
21 ambassadorial level type, you know, looking at  
22 other things than just military.

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1           And then globally, obviously economics  
2           still. We're still on the recovery there. H1N1.  
3           And then as we talk to the lines that divide the  
4           various COCOMs in geography really are fading and  
5           thus our work on the Joint Staff in OSD has  
6           increased. We're working at seam issues, so when  
7           we deal with terrorism or al Qaeda or groups as  
8           such.

9           And then how do we source, and we'll  
10          talk a little bit about this, but basically  
11          balancing all these with the right forces at the  
12          right place at the right time.

13          Afghanistan. Really, there's two things  
14          that press us and that is security and governance.  
15          And as we look at the great debate that's taking  
16          place on the resourcing of Afghanistan and how we  
17          bring to bear what it is we think to -- on this  
18          issue, we agree pretty much and principally across  
19          the globe that the strategy and the focus from  
20          General McChrystal's assessment, and what we've  
21          pretty much known is on the people, it's a  
22          population-centric, where we might say, the center

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1 of gravity needs to be focus.

2 This isn't new. We've had 3 Block War  
3 or counterinsurgency type operations all the way  
4 back in history. But what it entails is the  
5 ability -- and I'll use an example within the  
6 Helmand Province -- to be able to provide election  
7 support and to be able to provide the security so  
8 people can actually elect a government. At the  
9 same time or around -- you know, on the different  
10 block, be able to actually engage the enemy with  
11 kinetic activity. And then to hold that ground,  
12 to allow the population to be -- get out from  
13 being under the scrutiny and under the control and  
14 to allow that governance to develop.

15 And then lastly to teach, and to be a  
16 part of building that capacity within their own  
17 security, within the other elements of government.  
18 So, obviously, this is just not a military  
19 solution. This is a broad brush, a broad,  
20 comprehensive approach, and that pretty much forms  
21 the basis of the strategy.

22 Now, how we resource that is obviously

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1 the great debate that's going on today. You all  
2 may have heard in the news today that Ambassador  
3 Eikenberry has come out against increasing any  
4 troop levels. So that will go into the mix of the  
5 discussion. But I think the point is, is that  
6 when we look at Karzai and we look at the  
7 government, that we have to have an honest and a  
8 real partner there in order to make this thing  
9 work. The military is posed to do that, is posted  
10 to do that based on my next slide, which is Iran,  
11 that we have a responsible withdrawal -- I'm  
12 sorry, Iraq -- a responsible draw down from Iraq  
13 in order to provide those resources to  
14 Afghanistan. Specifically are the resources that  
15 deal with enabling: the logistics, the ability to  
16 be able to feed and care and provide support to  
17 the personnel that are providing the actual  
18 security and doing these operations. And again,  
19 this is just not military; it's international  
20 military and it's all forms of government.

21 It's probably good to just reflect and  
22 to reemphasize that this is an international

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1 effort. When you look at, by population, in those  
2 contributing countries, it is rather stark in the  
3 sense that we have 53 countries participating and  
4 24 of those countries have sustained killed in  
5 action. And of those, strangely enough, Estonia  
6 has .05 of a percent, 6 people to their population,  
7 so they rank number 2. And then everybody else  
8 kind of comes down, but we're number six. So,  
9 when you look at population and what various  
10 countries are giving, I mean, we're obviously in  
11 the top 10, but we're not the first.

12 Iraq. Again, being able to hold the  
13 success and allow the success to continue with  
14 those enforcing and assisting the Iraqis  
15 themselves tied to what we call a responsible  
16 withdrawal to the point -- or exit, to about  
17 50,000 next August, by the end of next August.  
18 We're seeing more and more of this where the  
19 Iraqis are actually taking responsibility for  
20 their own security to the point that we're able  
21 to, once we get past the elections here in the  
22 next couple of months, start sizably withdrawing

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1 those regiments.

2 Now what's keeping us up at night? Very  
3 much, if you were here last -- or when I gave this  
4 very much same thing, we sort of have near term  
5 and long term. In strategic balance, in the near  
6 term, is more aligned to being able to provide  
7 those resources for right now, to be able to  
8 provide those resources in Afghanistan, to arrest  
9 the continued success of the Taliban and al Qaeda;  
10 at the same time, be able to withdraw from Iraq.  
11 We can't do both at the levels that certainly Iraq  
12 has been and certainly we need to go in  
13 Afghanistan.

14 Pakistan and India -- let me back step  
15 one thing. We understand that success in  
16 Afghanistan is interlinkedly tied to success in  
17 Pakistan. So those two -- and how we deal with  
18 that, now throwing in India, is front and center  
19 on our minds.

20 Talked about the Middle East, you know.  
21 And it's just not the potential of red lines being  
22 crossed either on Iran or Israel principally, as

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1 far as whether they start shooting at each other,  
2 but also countering such things -- or interdicting  
3 arms shipments, particularly when we look at arms  
4 shipments to Hamas and Hezbollah and potentially  
5 Syria.

6 And then the threat to homeland defense  
7 as previously depicted on the slides was these  
8 ungoverned spaces and less than governed spaces.  
9 Somalia being an example where illicit material  
10 and people are allowed to breed and continue to  
11 fight.

12 Talk about North Korea and then talked  
13 about the links that exist between, you know,  
14 several groups, whether it be piracy, whether it  
15 be al Qaeda, whether it be Taliban, but sort of  
16 the link of the bad brotherhood.

17 And then in the long term is strategic  
18 balance as far as how we balance across the forces  
19 to be able to provide what it is we need in 2020,  
20 where we're going to be in 2020. Who is going to  
21 emerge as potential threats and are we going to  
22 have the right resources? Are we going to have

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1 the right people trained with the right strategies  
2 and the right doctrine to be able to deal with  
3 these emerging threats much, much further beyond  
4 than what we're facing today, understanding that  
5 we're kind of in a time period of diminishing  
6 resources?

7 We talked about the cyber and ungoverned  
8 spaces. Where we're going to go in the Middle  
9 East, particularly with Iran and Israel, this is a  
10 long term, but you have some very short-term  
11 implications. You know, there's a lot of  
12 strategies that still are being developed and get  
13 tested. A good example would be Georgia last year  
14 where we sort of have to reflect on what is our  
15 strategy with Russia? Is Russia really an  
16 emergent threat? Or is it an emerging partner  
17 within the global community? And how do we, you  
18 know, foster and assist in the latter?  
19 Understanding that they just whacked their  
20 neighbor pretty good, perhaps provoked, perhaps  
21 not. And then obviously we're all affected by the  
22 global crisis.

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1       need to be able to react to those threats, it is  
2       -- the prevention is becoming more and more to the  
3       forefront. The ability to build capacity within  
4       individual countries is really more of the mission  
5       than simply being ready, being in barracks ready  
6       to go when the conventional call cries.

7                   And then, just to bring it to closure,  
8       the idea that -- and I've said this several times  
9       -- that the COCOMs are part of an interagency and  
10      a global partnership, that it's just not a  
11      military solution. And that goes back to the  
12      slide that, you know, as we look at foreign policy  
13      and bringing to bear all the tools of government  
14      and all the tools we have on these various issues  
15      around the world, it's just not the U.S. military.  
16      It's part of a growing international community and  
17      interagency within our government.

18                   With that, I'm going to turn it over to  
19      Colonel Macedonia to talk specifically about  
20      medical issues. And I'll stand by afterwards to  
21      address any operational or way ahead questions you  
22      all may have.

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1 Thank you.

2 COL MACEDONIA: Is it possible to use  
3 this mic over here instead of standing up? Yeah,  
4 I saw these people over here craning their neck to  
5 see the briefer and I hate standing at the podium,  
6 so I'd rather look people in the eye as I'm giving  
7 the briefing.

8 I'm Chris Macedonia. I'm the Chairman's  
9 Special Assistant for Warriors and Families. And  
10 so this isn't exactly health briefing. In fact,  
11 when the chairman handed me the job he says,  
12 Chris, I need you to stop thinking like a doctor.  
13 Okay? Stop thinking like a doctor. Think about  
14 families, think about the more global issues of  
15 health of the force, and don't think just about  
16 disease. So I do want to clear that up.

17 We've already covered this, but I just  
18 want to say that the second strategic mission  
19 statement out of the Chairman actually has even  
20 been updated since that time, it's health of the  
21 force. So the second thing that -- I don't want  
22 to say keeps him up at night because everybody

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1 calls Admiral Mullen "Midnight Mike," and there's  
2 a reason for that: Because he's the hardest  
3 working man in the building, I have to say, and so  
4 I don't know when he sleeps, actually.

5 Chairman Mullen, if he said, if there  
6 was only one message to send to the Defense Health  
7 Board about his priorities it would be that we  
8 have to change the culture. And it's not just  
9 within the health fields, it's change the culture  
10 primarily in the building. We need to catch up  
11 with the culture change that has happened at the  
12 05 Level and below, the people that have been  
13 fighting the various wars on this plant, the  
14 people have deployed over and over and over again,  
15 they have all -- their culture has already  
16 changed. And that culture change involves not  
17 thinking about people as widgets, as replaceable  
18 parts. Sort of, you know, when I came into the  
19 military, all we thought about was fill the gap,  
20 all we thought about was fighting the Russians,  
21 and at that time a person was far less important  
22 than the M1 or whatever weapons system they

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1 occupied.

2 We now have a military where that's  
3 completely inverted on its head and vehicles are  
4 expendable. In fact, if anybody saw the report  
5 this morning on CNN talking about the new versions  
6 of the MRAPs, the vehicles are deliberately  
7 designed to fly apart when they get hit by an IED  
8 except for the crew compartment, so that the crew  
9 is the last thing to be hurt. The engine can fly  
10 away, the tires can fly off. We have to change  
11 the culture and the way we think about our  
12 individual people who wear the uniform, and their  
13 families and stop the -- you know, for instance,  
14 if I want a new solider into my unit, I still fill  
15 out, guess what? A personnel requisition, just  
16 like I'm ordering a part. We have to change the  
17 culture. And if we're going to improve the health  
18 of the force, we have to have the rest of the  
19 force, and that means the 06 and above, and the  
20 rest of the bureaucracy in D.C. to start thinking  
21 about people as people and not as replacement  
22 parts.

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1           The second objective is -- his second  
2           priority is develop objective measures of what  
3           we're doing. How are our programs working? I'm  
4           sure this group has been briefed on a million  
5           different programs: how to reduce suicide, how to  
6           help TBI, how to make people's teeth whiter, I  
7           mean, just everything. But the fact of the matter  
8           is, is that we need to have good objective  
9           measures on what we're doing because we're  
10          spending lots of Treasury money on things and we  
11          need to make sure that every penny goes to  
12          improving the health of the force. And if it's  
13          not improving the health of the force, we need to  
14          call it what it is, kill the program, and fund  
15          something else, but that means developing  
16          objective measures to do that.

17          The next one, realign the organization  
18          and funding of DCoE and subordinate centers. Now,  
19          this seems rather tactical, you know, it's a  
20          center. It's one piece of a very large  
21          organization called Department of Defense. But  
22          remember, the Defense Centers of Excellence is the

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1 TDA. And then develop resiliency and  
2 rehabilitation programs focused on operational  
3 health using evidence-based traditional, as well  
4 as complementary and alternative medicine  
5 approaches. And, you know, I do want to say that  
6 the chairman wants us to look at all options. And  
7 again, you can have evidence-based, complementary  
8 and alternative medicine integrated, but we're  
9 hearing that every time we go out to  
10 installations, every time we go out amongst the  
11 troops where it's here in CONUS or overseas,  
12 people are asking about, you know, new methods,  
13 new therapies, and we need to be open-minded about  
14 that.

15 The fourth one, establish a uniformed --  
16 and that means the Vice Chairman, the Joint Chiefs  
17 along with the Vice Chiefs, basically reestablish  
18 the DMOC. So, there is this organization. For  
19 those of you that don't know, there's an  
20 organization created called the Miser. And I  
21 would just implore people to go into Google or  
22 open up a dictionary and look up the word "miser,"

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1 and it says it all. Okay? Whoever was the genius  
2 that came up with the word "miser" to describe how  
3 we allocate our Defense Health line dollars, you  
4 know, they may have been a very smart person, but  
5 they're pretty stupid if you actually look the  
6 definition of "miser" up. And by all means, if

7 you have a BlackBerry and you want to look that  
8 definition up now, you can go ahead and do it.

9 So what the Chairman would like is that  
10 members of the military, who are the constituency  
11 that actually receives military health care, have  
12 some say in the way health care dollars are  
13 allocated within the Department of Defense. So  
14 that's a priority of the Chairman.

15 Joint electronic medical record used all  
16 the way from theater of operations through the MHS  
17 and into Veterans Affairs. And actually we need  
18 to change that slide because it also needs to say,  
19 "and for life into the civilian health care  
20 system." In other words, whatever happens to Joe  
21 on the battlefield needs to be visible all the way  
22 to people when that person ends up being in Blue

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1 Cross/Blue Shield after they separate from the  
2 service. And, you know, obviously we have to get  
3 it right in-theater first and we don't even have  
4 that one solved. If you're getting care in a Role  
5 1 facility or half of our Role 2 facilities in  
6 Afghanistan, you're still getting your health care  
7 done on paper. And even if it's done  
8 electronically, ironically, we're still losing  
9 that stuff, too. And I know this because I just  
10 came out of Afghanistan three weeks ago and we're  
11 still seeing it. And I can tell you, as few as  
12 two days ago, one of the people in my office who's  
13 a severely wounded soldier, had almost his entire  
14 medical records related to his prosthetics lost by  
15 Walter Reed. So we've got to get this right,  
16 guys, okay? Do I have a little passion in my  
17 voice when I talked about my soldier having his  
18 records lost? I'm not happy about that. As a  
19 physician who is in the Walter Reed and Bethesda  
20 health care system and takes care of patients, it  
21 bothers me tremendously we still lose records.

22 Improve mental health services for

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1 service members and dependents. You know, I think  
2 given the events of last week, I don't need to  
3 hammer this too, too hard. I think, hopefully,  
4 everybody here gets it. We've got to reduce the  
5 stigma of receiving care for services related to  
6 post traumatic stress. We've made great strides.  
7 You know, the change in question 21 was huge, but  
8 we have to do more and this is a complex problem.  
9 It's not as easy as saying, hey, there's no  
10 stigma. You can't do that. Again, that's part of  
11 the culture change, but we have to open up some  
12 ability for people to be able to talk in the open  
13 and get help.

14 We need to improve access to residential  
15 and mental behavioral health care for our  
16 dependents. It's a huge problem because remember,  
17 this war doesn't just take a drain on the combat  
18 wounded, it takes a huge drain on families. And  
19 really, we have certain gaps and one is in our  
20 dependent health care, particularly on the  
21 residential mental health side.

22 DR. FOGELMAN: Excuse me, what does

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1 "residential" mean?

2 COL MACEDONIA: So, for instance,  
3 somebody receiving -- a for instance is if you  
4 have a 14-year-old child and they have a drug and  
5 alcohol problem related to --

6 DR. FOGELMAN: You mean in-patient?

7 COL MACEDONIA: That's correct. But,  
8 you know, there are facilities that are kind of  
9 stand alone facilities outside of hospitals,  
10 residential facilities.

11 Standardize the DoD and VA crisis  
12 prevention and suicide hotline. And I'm not going  
13 to get in the detail of that because there is so  
14 much whirling and swirling around that one, but I  
15 will tell you that that is an ongoing discussion.

16 And then DoD and VA aggressively account  
17 for, assess, and support homeless veterans. I

18 might add, we just need to account for all the  
19 veterans, everybody who's filled out a DD-214 is  
20 no longer in the service, but the homeless,  
21 obviously, are a target for the Chairman. He and  
22 I flew up to Holyoke and actually visited a group

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1 that was doing tremendous work for homeless  
2 veterans and we need to promulgate more programs  
3 like that dealing with the homeless. And there is  
4 a growing problem with female homeless veterans  
5 and they represent kind of a different population  
6 than the traditional homeless. That population,  
7 they tend to be single parents and they tend to  
8 bring their children to the homeless shelter.  
9 It's very different than the Vietnam generation  
10 homeless. And then we estimate about 12,000 of  
11 those in the system right now.

12 And then develop mechanisms where  
13 service -- Wounded Warrior programs can closely  
14 work with nongovernmental organizations in order  
15 to support validated requirements. This is  
16 basically, we need to have means by which people  
17 in uniform and people from the charitable  
18 organizations, the VSOs and others, can work  
19 hand-in-glove in helping wounded veterans.

20 And then establish a DoD family programs  
21 standards for service programs which leverage the  
22 best practices from each service. In part, we do

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1 this every week in what we call the Warrior  
2 Roundtable where right now it's confined to the  
3 Wounded Warrior programs, but we want to expand  
4 this across all programs. And there are others, I  
5 realize, but the Chairman's committed to that, so  
6 is Deborah Mullen, Mrs. Mullen.

7           Develop programs that focus on the  
8 ability and retention of quality Service members.  
9 So, you know, we have a disability system right  
10 now, and the key word there is "disability." And  
11 what we want to focus in on is abilities, okay,  
12 and not disabilities. We want programs that  
13 maximize the potential of that individual in  
14 society, whether it's in the society of the  
15 military or the civilian society as a whole. So,  
16 for instance, allowing disabled members of the  
17 military to remain on active duty, but somehow  
18 receive their benefits. And we are in discussion  
19 with VA on this one.

20           Allow service members to grow beyond  
21 end-strength to accommodate for recovery of  
22 wounded, ill, and injured. This is really -- this

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1 is not just a problem for being retained on active  
2 duty. This is also a problem for deploy ability,  
3 particularly for the Army, because the Army  
4 basically says if you've got somebody who is  
5 injured in any way, in order for you to  
6 requisition a new person, that person has to be  
7 out of your unit, which means they have to go to  
8 the WTU, which means the WTU gets flooded with  
9 lots of people who are in the business of getting  
10 their disability evaluation done in order for  
11 units to deploy. If those units were allowed to  
12 go above strength, encode that person as being in  
13 the middle of a board process, and that not count  
14 against that unit, then the units could retain  
15 those people and the person wouldn't have to leave  
16 their military family. That paratrooper wouldn't  
17 have to leave the paratroop unit to go to the WTU.  
18 They would be able to -- okay, so it has all sorts  
19 of second and third order effects.

20 Allow wounded, ill, and injured to  
21 accrue leave while hospitalized, on con-leave, or  
22 vocational rehabilitation. I think that's pretty

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1 simple.

2           And then that home adaptation business  
3 has to do with the fact that we have a whole  
4 generation of people now who get care in one  
5 regional center that has expertise, say, in TBI,  
6 and then perhaps has to go for long-term therapy  
7 for their orthopedic injury. And the problem is  
8 that there are variations in the cost to the  
9 individual, and we want to eliminate that so that  
10 it's neutral to the individual.

11           And then obviously, we want to complete  
12 actions already underway, so DES reform, caregiver  
13 compensation, equalizing that out, and abolishing  
14 concurrent receipt for military retirees.

15           So, anyway, that was a quick once-over  
16 of the world of sort of where the Chairman's mind  
17 is at. It's not totally limited to that.

18           Let me just finish up by saying that  
19 it's all about changing the culture, about  
20 thinking about people as people and not as  
21 widgets, not as numbers, but faces. You know, I  
22 think if you look at the events of Ft. Hood and

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1 the way that was handled, in the President's  
2 address he talked about each person as a person  
3 and what they did and what they lived for. That's  
4 a very, very different President and it's a very,  
5 very different way of thinking about our  
6 individuals than in previous generations. And it  
7 has to do with the fact that what you saw in the  
8 previous presentation, which is the complexity of  
9 global threats, means we have to have individuals  
10 in uniform who never before had to do the complex  
11 kinds of tasks that any military has asked of  
12 them: running very complex weapons systems,  
13 having to learn multiple languages, all these  
14 other things, very small force carrying on very,  
15 very big missions. And because of that, we have  
16 to think about our people differently.

17 So that's all I have subject to your  
18 questions.

19 DR. LEDNAR: Thank you, Colonel  
20 Macedonia and Lieutenant Colonel Coke. I think  
21 what we've heard now in the last 45 minutes is the  
22 array of threats and military activities that are

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1 going on around the world. What Colonel Macedonia  
2 shared with us is how a non-health care provider  
3 thinks about the importance of health to the  
4 force, to the families, and to the mission. And  
5 that isn't always necessarily how we doctors and  
6 nurses and other health care people think. And I  
7 think it's very helpful to get that insight and it  
8 really is clear that Admiral Mullen is engaged.  
9 He's there for us. And if we can be understanding  
10 his agenda as he sees it and being responsive, you  
11 can't get a better advocate of the Chairman of the  
12 Joint Chiefs.

13 With that, we have time for a few  
14 questions for Colonel Macedonia or Lieutenant Colonel Coke.  
15 Any questions from the board?

16 DR. WALKER: Yes, Walker. Under the  
17 Developing Resiliency in Rehabilitation, you  
18 talked about evidence-based tradition, you talked  
19 of complementary and alternatives. Is that also  
20 evidence-based?

21 COL MACEDONIA: Yes, I think everything  
22 needs to have evidence, you know. And along those

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1 lines, there's going to be a conference at the  
2 Uniformed Services University, I think the 6th to  
3 the 9th, and it was convened at the behest of the  
4 Chairman to include speakers to come and actually  
5 present any type of evidence they have for  
6 complementary and alternative medicine. But it's  
7 much more. The conference itself is on what's  
8 called total fitness, so it includes programs on  
9 physical fitness, mental, spiritual fitness,  
10 comprehensive soldier fitness. So General Cornum  
11 will be briefing at that and the people from the  
12 complementary and alternative medicine world will  
13 actually present some of their information. But  
14 any type of broadly spoken program that we use out  
15 with the force, people need to show evidence that  
16 it works. Otherwise, we could be foisting things  
17 on people that actually makes them worse.

18 DR. LEDNAR: Dr. Oxman?

19 DR. OXMAN: Mike Oxman for Dr.  
20 Macedonia. When you said that the records, the  
21 data on your colleague's limb was lost, was that  
22 paper data or was it electronic data?

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1 COL MACEDONIA: It was both. And, in  
2 fact, it wasn't -- it was an eye and palate  
3 prosthesis, so you know, we have to consider that.  
4 I mean, there are -- if you look at the HL7  
5 standards, there are standards for compiling  
6 information about, you know, all sorts of things,  
7 not just text data. And the reason -- I don't  
8 know the reason behind the loss. I happen to know  
9 that he's having to undergo a repeat CT scan to  
10 rebuild and refashion the models under which his  
  
11 prosthetics were formed.

12 DR. LEDNAR: Dr. Mason?

13 DR. MASON: Tom Mason. Question for  
14 each of you. If we look at the Post-Deployment  
15 Health Assessment and we admit candidly that it  
16 doesn't capture the information that we need, and  
17 as a ready Reserve officer who gets the officer,  
18 and look at Post-Deployment Health Reassessment,  
19 having soldiers go back to soldiers, I really  
20 appreciate hearing from you guys as to where the  
21 devil are we and how are we going to get to where  
22 we need to be?

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1                   LtCol COKE: As a victim of being  
2 reassessed, I can speak to -- at least from the  
3 Marine standpoint, it kind of made you wonder  
4 where, you know, where we were going with this and  
5 certainly, you know, where was the focus as far as  
6 where the concern was, I guess, but, you know,  
7 that's more from an individual standpoint.

8                   I can't really speak to the broader  
9 standpoint.

10                  COL MACEDONIA: That's an excellent  
11 question. And not to beat up on the  
12 Post-Deployment Health Assessment and  
13 Post-Deployment Reassessment, for what it was set  
14 up to do it's a pretty good instrument. But  
15 remember what it was. And I had this discussion  
16 with Dr. Casscells just before he left over an  
17 article that Dr. Hoge was about to publish.

18                  The Post-Deployment Health Assessment  
19 was a stopgap measure. It was never intended to  
20 be used in 2009, eight years into a conflict. It  
21 was a stopgap for the fact that we didn't have  
22 accurate medical records in-theater so the

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1 conclusion was, well, at least when they come  
2 back, we can take a decent assessment when they  
3 roll back in. Then they studied the accuracy of  
4 the data that people gave when they first came  
5 back in and, like me, who wanted to go back home,  
6 we were like, no, no, no, I didn't see dead  
7 bodies. I didn't shoot people. I didn't -- you  
8 know, because you know what, I want to get back to  
9 my family. I know the answers -- I know if I hit  
10 those, they're going to want me to see somebody,  
11 so I'm going to lie.

12 Okay. So they said, well, it turns out  
13 that people are a little bit more honest in their  
14 answers if you hit them up four to six months  
15 later. So they came up with this Post-Deployment  
16 Health Reassessment, okay? The fact of the matter  
17 is, what are we trying to fix? We're trying to  
18 fix accurate medical records. And if we did it  
19 accurately in-theater, we wouldn't need  
20 Post-Deployment Health Assessment/Reassessment.  
21 We would have it in their medical record to begin  
22 with. So let's fix the problem in-theater. Let's

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1 give the requisite bandwidth, let's get the  
2 electronic medical record on the ground, usable by  
3 the providers and the medics, the corpsmen, the  
4 people that have to enter data, and let's do it  
5 right.

6 Look, they use Blue Force Tracker in the  
7 Humvees and MRAPs have this sophisticated computer  
8 where they tap in, you know, where they engage the  
9 enemy and this and that. We've got planes flying  
10 around unpiloted with full motion video eating up  
11 all sorts of bandwidth and we give this little  
12 tiny sliver of bandwidth to what? Our most  
13 important asset which is our people. Let's fix  
14 this problem.

15 DR. MASON: Would it be helpful for this  
16 board to go on record as being supportive of what  
17 you've just suggested?

18 COL MACEDONIA: Oh, absolutely. I'd  
19 shine your shoes, you know, whatever. If you need  
20 your driveway shoveled --

21 DR. MASON: Thank you, Colonel. My  
22 shoes are shined. Don't ask my students because

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1       it's rare for me to be in closed-toed shoes  
2       because in Florida, I can wear sandals. But the  
3       issue is a very simple one: Is there something  
4       that we can do?

5                   COL MACEDONIA: Absolutely.

6                   DR. MASON: Because this facilitates so  
7       much of what we talk about, whether it's the  
8       Subcommittee that I proudly serve on with Dr.  
9       Halperin or whatever. If we don't have a clue  
10      over an expanded period of time as to the  
11      experiences of our workforces -- of our forces,  
12      our fighting forces and the support forces, we're  
13      doomed to failure from the standpoint of making  
14      informed evidence-based decisions.

15                  COL MACEDONIA: You know, amen to that.  
16      Let's look at the TBI and PTSD issue, and this is  
17      in part one of the conundrums. When you assess  
18      people at Post-Deployment Health Assessment and  
19      Reassessment, they may be eight months out from  
20      the inciting events or injuries or whatever and  
21      our ability as people to recall, whether it's  
22      being blown up with TBI or whether or not we fell

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1 off our bike, you know, on Old Georgetown Road, or  
2 whatever. I fell off the left side of my bike or  
3 the right. You know, I mean, it's not just in war  
4 that collecting data 8, 10 months after the fact  
5 is kind of counter to good medical practice. We  
6 were doing it because we felt that we didn't have  
7 the sophisticated electronic records system  
8 in-theater. Let's solve the sophisticated  
9 electronic record problem. Keep the PDHA and  
10 PDHRA as the stopgap, but let's not get so wrapped  
11 around polishing Post-Deployment Health  
12 Assessment and Reassessment to the point where we  
13 forget what it was stood up for originally, which  
14 was just as a stopgap.

15 DR. LEDNAR: I'm going to have to bring  
16 this session to a close. I'd like to just share,  
17 however, with Colonel Macedonia, because I believe  
18 it was on our third slide about what the  
19 chairman's priorities are for the health of the  
20 force, you're talking about bringing to conclusion  
21 important initiatives which have been started.  
22 And I'll call that, you know, executing to the

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1 objective. You also mentioned the importance of  
2 an electronic medical record and the flow through  
3 the entire chain. More than 10 years ago, this  
4 Board recommended to the Department of Defense  
5 exactly that issue be addressed. Ten years ago,  
6 and it hasn't happened yet. So there's  
7 opportunities to execute and I think it's fair to  
8 say that the Board is supportive of your desire,  
9 your interest, and the need. And we can talk  
10 offline structurally about how we can put  
11 something together in writing that we can share  
12 back with DoD. But thanks.

13 (Recess)

14 DR. LEDNAR: Can we take our seats,  
15 please?

16 Okay, I'd like to call us back to order.  
17 We are a little bit behind, but I think it's  
18 important that we spend the time that we should in  
19 the discussion.

20 The next topic deals with international  
21 military health issues. And Commander Bill Hughes  
22 is here with us, and he's going to introduce this

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1 topic and our speaker for the next briefs.

2 Commander Hughes? Thank you.

3 CDR HUGHES: I'm from a similar school  
4 to Colonel Macedonia on this regard, too.

5 You know, when I was at the Naval War  
6 College a couple of years ago, there was a  
7 favorite line that a number of the professors  
8 liked to put up there and it was about slides.  
9 And there was a Russian naval officer who came  
10 over after the fall of the Soviet Union. And when  
11 he was asked by a public affairs officer who would  
12 have won a war between the Soviet Union, and the  
13 United States, and NATO, and he said, well, while  
14 you were making your slides we'd be killing you.

15 I have four slides but they're not going  
16 to be broadcast for you because I want to give you  
17 a history of what led to the development of the  
18 International Health Division and what our  
19 initiatives are that we're doing now in health  
20 affairs.

21 Two years ago, the International Health  
22 portion of the Civil Military Medicine Division,

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1 was established with contract support and one Navy  
2 05. Shortly thereafter, Dr. Casscells, the  
3 Assistant Secretary for Health Affairs, called up  
4 Dr. Anderson. Dr. Butch Anderson is a -- I should  
5 say is -- yeah, once you are Special Forces,  
6 always are Special Forces. Kind of like once a  
7 Marine, always a Marine. He just recently retired  
8 as a Special Forces physician combat-wounded  
9 veteran. And he had taken his job with the Indian  
10 Health Service out in his home state of New  
11 Mexico. He's a Health and Human Services Officer.  
12 And he was called by Dr. Casscells and asked to  
13 come in and start the International Health  
14 Division, which had been going just a bit but  
15 inside Civil Military Medicine. He thought about  
16 it, I guess, for a little bit. Well, he's with us  
17 now. He's not with us today; he's out in New  
18 Mexico on emergency leave. But Dr. Anderson got  
19 this going.

20 What led to International Health being  
21 developed? Now, back in the 60s, there was a Dr.  
22 Robert Wolinsky, an Army battalion surgeon. He

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1 wrote about the results of Medical Civil Affairs  
2 Programs (MEDCAPs). Largely, a lot of money  
3 thrown in to doing these MEDCAPs. They were  
4 unplanned. They made a lot of patient contacts.  
5 Nothing about measures of effectiveness. It was  
6 strictly about the outcomes that we had.

7 But over time, we've seen other things  
8 develop that led us up to this point, too. The  
9 National Security Strategy of the United States  
10 has made it clear that one of the major strategies  
11 for the United States will be to secure global  
12 public health. We have the Laws of Armed Conflict  
13 in the Geneva Convention. We will -- if we are  
14 currently occupying a country, we will have to  
15 oversee the health care for the people. Not just  
16 military personnel, mind you. The Geneva  
17 Convention makes it clear that we have to provide  
18 health care for all as long as we are in occupying  
19 power, which clearly we are. As long as we argued

20 about it, it's clear what we are and have been in  
21 Iraq.

22 But also in 2005, DoD came out with the

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1 Joint Operation Concept that said Stability Ops  
2 would be on par with major combat operations.  
3 Around that time, Homeland Defense was also made a  
4 joint operating capability. Those joint operating  
5 capabilities are part of the JopC family. The  
6 JopC family says this is a problem and here's a  
7 solution that you will look at 8 to 20 years down  
8 the line. That was in November of 2005. Four  
9 years ago. So it's developing quite clearly.

10 Also came out back then was the  
11 Department of Defense Directive 3000.05, which at  
12 that time was called Military Health Support to  
13 Stability Security Transition and Reconstruction  
14 Operations. Now, it developed primarily out of  
15 two and a half years of our experience in  
16 Afghanistan and in Iraq. It was nation building.  
17 Listening to NPR on my way in this morning as they  
18 were talking to the former head of the  
19 International Crisis Group (ICG). And when she  
20 was in Iraq, she was talking about nation  
21 building. Still talking about it. Not a very  
22 popular subject with our DoD senior leadership.

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1 And it wasn't.

2 But the directive came out this month  
3 four years ago, and it reflected quite a bit what  
4 direction we took as a government. Now, this is  
5 Bill Hughes' opinion on this. You don't have to  
6 say you agree with it or not because I really  
7 don't care; it's my opinion. And that is that it  
8 reflected the unilateral approach that the United  
9 States was taking in its foreign policy. It was  
10 very heavy handed. It said that not only would  
11 stability operations be comparable to major combat  
12 operations, but it also said DoD will be prepared  
13 to provide for its medical personnel and stability  
14 operations, these nation building concepts, if the  
15 rest of the government wasn't willing or able to  
16 do it. Wasn't willing to do it. Now, it seems to  
17 me that was somewhat a reflection of our  
18 leadership. Looking across the Potomac and saying  
19 unwilling, incapable, unable.

20 Well, over time that has changed. It's  
21 really reflecting what it is we had to do. Just  
22 as our stability operations have changed, this

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1       notion of stability operations has changed and it  
2       has really influenced our other federal partners  
3       in this. Now, recently when I was giving a  
4       lecture to the Joint Medical Planners Course at  
5       Bethesda, I asked the Army, Navy, and Air Force  
6       personnel -- I didn't expect the two Canadian  
7       personnel to know this -- had you ever heard of  
8       Department of Defense Instruction 3000.05? Not  
9       one of them raised their hand. But you can sure  
10      bet that our interagency partners heard about it  
11      back then. It scared the daylights out of them.  
12      They thought here comes DoD to militarize  
13      diplomacy and development.

14                   Well, that Department of Defense  
15      directive changed a little bit. It is now a  
16      Department of Defense instruction. The Department  
17      of Defense instruction 3000.05 clearly shows the  
18      direction we are trying to take with stability  
19      operations. No longer is it Military Health  
20      Support to Security Transition and Reconstruction  
21      Operations. It's flat out Stability Operations.  
22      And it makes it clear that what we are going to do

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1 as a Department of Defense, is we are going to  
2 have our military portion of our whole government  
3 approach and all the elements of power, which we  
4 heard Lieutenant Colonel Coke talk about -- diplomacy,  
5 informational, military and economic -- to be used  
6 together to change and shape an environment. And  
7 changing that shape and environment isn't just  
8 pre- conflict or post-conflict, but it can also  
9 include humanitarian assistance and disaster  
10 response. They are now part of Stability  
11 Operations.

12 Where does that leave us as a Military  
13 Health System? We now have what's developing and  
14 will be ready for signature soon, I hope, is a  
15 draft instruction, 6000.AA, Military Health  
16 Support to Stability Operations.

17 There are some key components to it, and  
18 some of them have been quite difficult for us.  
19 One is what will be the standard of care? How  
20 will you provide care in an environment, whether  
21 it's hostile; whether it's for humanitarian  
22 mission; whether it's a planned or unplanned

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1 humanitarian mission; how are we going to fund  
2 these things? You know, Department of Defense  
3 Instruction 3000.05 said that it will be funded.  
4 I have yet to see it. That it will be part of the  
5 planning programming budget and execution process.  
6 I still have not seen that. Where is this money  
7 going to come from? We have strict rules about  
8 what it is the Defense Health Program's money can  
9 be used for.

10 But we already have rules in place on  
11 what money can be used for for humanitarian  
12 operations, humanitarian civic assistance  
13 programs. The only difference between those two  
14 is one is unplanned; the other is planned.  
15 Disaster response, homeland defense issues. We  
16 have rules in place for money. There is money  
17 available, but it is going to entail a change.  
18 It's part of the paradox of military success.  
19 When the bullets stop flying, commanders have gone  
20 out with a robust surgical capability in the  
21 field. Well, when you have these highly trained  
22 medical professionals sitting around, not

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1 necessarily doing -- seeing just patience. I  
2 shouldn't say that they have nothing to do.

3           But as they see their workload decrease  
4 in these environments, what do we do with them?  
5 We send them out on these MEDCAPs. We send them  
6 out on these other missions -- these humanitarian  
7 assistance missions. Well, is it going to be any  
8 different if we're not planning for them than what  
9 it was for Dr. Wilensky in his view of how we  
10 approached medical civil affairs in Vietnam. If  
11 we are not planning for these things, we are not  
12 training, staffing, and equipping our personnel to  
13 do this. How much of what we have seen for our  
14 military since 1985 -- how much actual time has  
15 been spent in major combat operations?

16           I can certainly think of a lot of times  
17 through there where our Military Health System has  
18 been called upon for disaster response,  
19 humanitarian assistance. Not just because it's a  
20 good photo op. I mean, we saw tsunami relief  
21 efforts really making a difference in terms of  
22 what the indigenous population thought about the

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1 American people and the American government after  
2 tsunami relief. Well, how did we sustain that?  
3 How do we sustain that effort? How have we gone  
4 out to make those continuing -- those little  
5 bites.

6 Those are some of the things that have  
7 helped shape the International Health Division and  
8 brought us here today.

9 DR. LEDNAR: Commander Hughes, the Board  
10 will certainly follow with interest as the  
11 Department of Defense evolves in its approach to  
12 medical stabilization operations. I propose we  
13 move to the brief on Afghanistan as a way to  
14 inform us that what has been our experience over  
15 the last nine years, and obviously will be helpful  
16 to the Board, and I think relevant to the thoughts  
17 of the Department.

18 CDR HUGHES: That's great. You just  
19 beat me to the punch. Thank you. That was  
20 actually my next --

21 I'd like to introduce to you, Dr. Lynn  
22 Lawry. Dr. Lawry is a member of our staff in the

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1 International Health Division. She has  
2 significant experience in the NGO community. She  
3 can tell you a little about herself. She is a  
4 certified internal medicine physician. She has a  
5 number of teaching positions, including Harvard,  
6 Uniformed Services University of Health Sciences,  
7 but significant experience out in the field. And  
8 she's going to talk to you about what DoD is  
9 doing, how we have put our division into action  
10 overseas in Afghanistan as an example.

11 DR. LAWRY: Thanks, Bill. So my way of  
12 doing this is to give you sort of a historical  
13 approach. I think it's always good to go back so  
14 many years later. To go back and look at the  
15 history. Because a lot of the history changes  
16 with media, and I think it's important to make  
17 sure that we understand.

18 So this is all of the visas that I've  
19 ever gotten from Taliban Daison. So you've got  
20 Taliban visas, Northern Alliance visas, interim  
21 government visas, and finally, the newest one. My  
22 entire passport has the history of Afghanistan in

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1 it.

2 So let's start with Afghanistan 2000 to  
3 2001. I was there. I was working for Physicians  
4 for Human Rights, and I was doing research on  
5 women's health and human rights issues. Usually  
6 alone. And I want to be able to present to you  
7 some of these studies only because I think the  
8 contextual nuances are important.

9 So let's go back to the history. At the  
10 time -- and this is 2000 -- there had been 20  
11 years of armed conflict and human rights  
12 violations. What is sort of forgotten is that  
13 during the Soviet occupation, a million Afghans  
14 were killed. A million. That's a huge portion of  
15 their population. And what is also forgotten is  
16 at the time it was the largest refugee caseload  
17 with 1.4 million refugees in Iran and 1.2 million  
18 in Pakistan, primarily in the Peshawar area.  
19 Seventy-five percent of these refugees were women  
20 and children. And during this time, after the  
21 evacuation of the Russians, there was Mujahedin  
22 groups that were fighting violent struggles, and

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1 this is when the Taliban came about.

2 This is a picture of the refugee camps  
3 in Peshawar. Sort of typical housing. So,  
4 Afghanistan during the Taliban years. The Taliban  
5 came to be with that sort of vacuum in power.  
6 They were -- the term Taliban actually means  
7 student of Muslim religious studies. And the  
8 Taliban at that time -- and I think this is an  
9 important point -- were not generally Afghan.  
10 They were foreigners. They were Saudis, Chechens,  
11 Wahban groups from other countries. Although they  
12 were poorly educated Pashtun youth, they weren't  
13 necessarily Afghan Pashtun youth. They were  
14 primarily Pakistan Pashtun youth. And one of the  
15 reasons that it was so common to have so many  
16 young boys in these madrasas or these religious  
17 schools was this was a place where you could get  
18 three meals a day, a place to sleep. And so many  
19 Afghan families turned their boys over to these  
20 groups to be able to get them "educated", not  
21 quite understanding that the education was  
22 memorization and not really school education.

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1           At the time, the Taliban were led by  
2 Mullah Omar. And in 2000, they controlled 95  
3 percent of the country; only 5 percent of the  
4 country was Northern Alliance. And their real  
5 claim was to restore peace through Islamic law,  
6 imposing Taliban interpretation of Sri Allah. And  
7 institutionalizing women's rights so that there  
8 were absolutely none. Not one.

9           Women in Afghanistan before this and  
10 during -- at the time of the Taliban, women could  
11 only leave home when escorted by a male relative.  
12 This was problematic for widows who may not have a  
13 son who was old enough or did not have a family  
14 member that could come and escort them, meaning  
15 they couldn't get to health care. They were  
16 limited to seeing male physicians. It's really  
17 not well known, but women in Afghanistan will see  
18 a male physician. They will be examined by a male  
19 physician if it's an emergency. If it's not an  
20 emergency, then they prefer to go to women, not  
21 unlike what we have in the U.S. where 75 percent  
22 of my practice were females because they just

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1 prefer to go to females.

2           They were not allowed to attend school,  
3 other than religious schools up to the age of  
4 eight. Another unknown fact is that actually  
5 during the Taliban years it was the highest number  
6 of girls in school up to that point because what  
7 they had done was create underground schools, many  
8 of the NGOs. And so you had the highest number of  
9 girls in school during Taliban years.

10           Prior to that, 70 percent of the  
11 teachers were women, 50 percent of the civil  
12 servants were women, and 40 percent of the  
13 physicians were women. Civil society ran with a  
14 huge number of women involved.

15           In 2000, I was asked to do a  
16 population-based health and human rights survey.  
17 We needed a survey that was written in English and  
18 translated to Dari. It had to be easy to  
19 administer. There had to be some safety measures  
20 built in. And I'll go back to that.

21           We translated it and back translated it  
22 three times with Dari speakers. And then we had

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1 all kinds of other things that we needed to do.  
2 One, because I couldn't be caught with data sheets  
3 or data on my computer, and so we had to be able  
4 to satellite -- get the data out. And so we  
5 needed to enter data while we were in the field.

6 The safety measures that we undertook  
7 were coded words and phrases. Basically what we  
8 did was if we wanted to know about Taliban's  
9 edicts against women, we would use a two letter in  
10 Dari -- two letter acronym and then that meant  
11 that the data collectors knew. Instead of saying  
12 the financial situation, which is what it looked  
13 like, they would say Taliban's edicts against  
14 women.

15 We had data collectors. And here's a  
16 picture of my data collectors, both under burqa  
17 and out. I think this is a wonderful picture.  
18 And I had eight medical students who helped to do  
19 this survey. We had letters of safety. How did I  
20 do this? I went to Taliban leaders. I usually  
21 picked Afghan Taliban leaders because they were  
22 not particularly wedded to the Taliban movement.

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1 They were there because they could be fed and  
2 clothed and they could support their families. I  
3 also knew that they were illiterate, so I would  
4 pass them the survey written in Dari. And by  
5 Afghan culture, they will not tell you that they  
6 can't read. They'll pass it back to you because  
7 they don't want to lose face, particularly in  
8 front of a Western woman. And so I was able to  
9 get letters of safety by asking them to review the  
10 survey.

11 We had unidentifiable data sheets. We  
12 buried questions about human rights issues,  
13 primarily because that gave us a chance to figure  
14 out what households we were in. These were  
15 randomized, you know, knock on the door surveys.  
16 And we didn't want to be in a Taliban leader's  
17 house and start asking about Taliban's issues.  
18 And this gave the data collectors a way out.

19 We used informed consent. It was a  
20 randomized survey. We looked at places in both  
21 Taliban-controlled areas and non-Taliban  
22 controlled areas. I believe the papers are in

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1 your folder. If you'll notice, they're under my  
2 previous name and not my name currently. But one  
3 of the interesting things about that publication  
4 was at the time it was too dangerous to publish  
5 exactly where we were. So we only said  
6 Taliban-controlled and non-Taliban-controlled. It  
7 was actually Feyzabad, which was Northern  
8 Alliance-controlled, and Jalalabad that we did  
9 these surveys.

10 So let me just sort of go through the  
11 data. I'm not going to go completely into the  
12 data. But we asked about equal education for  
13 women, equal work, health services, and freedom of  
14 movement. And of course, women thought that this  
15 was important for them. But if you look, men also  
16 thought that it was important. This is not what  
17 we were hearing in the media. We heard that  
18 Afghans don't want human rights. And again,  
19 remembering that the foreign fighters of Taliban  
20 were outsiders, this was not the case for Afghan  
21 men and women.

22 When we looked at freedom of expression,

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1 participation in government, protection of rights  
2 and freedom of dress code, you see sort of varying  
3 about 45 percent supported. What's interesting  
4 about this is we did the same survey in Iraq and  
5 the data is completely different. Only 20 percent  
6 of men and women supported these same rights,  
7 whereas the Afghans actually had some more  
8 support. And we're seeing that. We see that  
9 there's a ministry of women's affairs. There are  
10 women in government; there are women that run for  
11 office. We don't see that in Iraq. So, clearly,  
12 Afghanistan did have sort of a sense of rights for  
13 women.

14           When we asked about food, shelter,  
15 clothing, emergency relief, demining, of course,  
16 everybody thought that was really important. And  
17 at the time where basic needs were quite not  
18 there, it was extremely important for them.

19           Again, we looked at community  
20 development, infrastructure, and peace. All men  
21 and women thought that it was important that women  
22 participate in all of these. The only one that

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1       they weren't so -- they wanted -- they thought  
2       that these were all important for them but they  
3       weren't so sure that women should be participating  
4       in all of this. A lot of this at the time may  
5       have been because of the safety issues that women  
6       had to deal with then.

7                   When we looked at community development  
8       compared to basic needs and human rights, human  
9       rights, again, we're not seeing huge, you know, 20  
10      percent numbers. We're seeing above 50 percent of  
11      men and women that supported human rights. And we  
12      didn't just ask about human rights. We asked  
13      directly about each type of human rights,  
14      understanding that all human rights violations  
15      have a health consequence. And that was how we  
16      got at these.

17                   We did the first mental health study  
18      among Afghan women. This was done in Feyzabad and  
19      in the Pakistan refugee camps, as well as  
20      Jalalabad. This was before CDC did their study in  
21      the mid-2000s. And what you see is huge rates of  
22      major depression, suicidal ideation, and somewhat

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1 rates of suicide attempts, particularly bad among  
2 Taliban areas, but also bad in the Pakistan  
3 refugee camps where it was actually quite --  
4 depending on the camp that you were in, it could  
5 be quite conservative. And it was as though you  
6 were living in a Taliban area.

7           So our summary at the time was that  
8 Afghan women and men believe community development  
9 included basic human rights and individual  
10 freedoms; that anything restricting these rights  
11 was not consistent with opinions and attitudes;  
12 and health practitioners should involve the  
13 community in promoting health and well-being.

14           So let's move to October 2001. I'm  
15 skipping a whole lot of trips, but I was actually  
16 there with my daughter in August of 2001, just  
17 before 9/11. We then had a planned study that was  
18 going to go on, and it became apparent that  
19 working for a human rights organization that we  
20 needed to have somebody on the ground. So I went  
21 back in late September, early October. And then  
22 made my way into Afghanistan by the Farhar Passing

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1 which was from Tajikistan forward. And that could  
2 take another entire story of how that happened.

3 I did this at night. I ended up in  
4 Afghanistan, I believe, on October 30, 2001. This  
5 was before the civil affairs teams made it over.  
6 I met them in the Northern Alliance leaders' hut

7 at the time. And these are pictures of some of  
8 the IDPs that had occurred in this area. This was  
9 the Kunduz-Faizabad area. These were the Uzbek  
10 tribe of women, and then you see a picture of me  
11 with the tribal leaders talking about their needs  
12 and laying the groundwork for the next study.

13 In 2002, we needed to do a maternal  
14 mortality study. But using it more as an index of  
15 the status of women's rights, as opposed to  
16 looking at how bad maternal mortality was. We  
17 knew it was bad, but we really needed a rapid and  
18 accurate estimate of maternal mortality. And at  
19 the time, because of the Congressional funding  
20 directives, we needed data. And we wanted to do  
21 this quickly, so we chose one province. Why did  
22 we pick Herat? Herat was one of four provinces

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1 that has a maternal hospital, and so it would be  
2 interesting to see what the maternal mortality  
3 rate is in this one province, given the fact that  
4 there is a hospital that can address these needs.

5 We also wanted to look at women's human  
6 rights, and we wanted to assess maternal health  
7 services in the region. And again, we wanted to  
8 use this data to present with the Minister of  
9 Public Health to a Congressional Panel when they  
10 were talking about emergency funding and making  
11 sure that there was a line for women's health in  
12 that. Otherwise, if it gets mixed up into health  
13 it doesn't necessarily go to women's issues.

14 We interviewed women 15 to 49. We  
15 interviewed more than 5,000 households, 7 of 13  
16 districts. It was random sampling. At that time,  
17 73 percent of the population was represented by  
18 this study. And again, Herat is primarily rural,  
19 like most of the provinces in Iraq. And then only  
20 25 percent was urban.

21 So what did we find? Mean age of our  
22 respondents were 31, 88 percent were married, 10

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1 percent were widowed. On average, they had been  
2 there 17 years, so certainly we could get a good  
3 idea of stability and we didn't have migration in  
4 and out.

5 The mean years of formal education for  
6 these women was .35 years of formal education.  
7 This actually went against many of the  
8 nonrandomized studies where the mean age of -- or  
9 the mean number of years of education was 12  
10 years. Those were the highly educated and elite  
11 Afghan women. This is the sort of generalized  
12 Afghan woman. And 84 percent ranked food,  
13 shelter, and clean water as their primary problems  
14 at the time.

15 We used something called the indirect  
16 sisterhood method. What we found was that 92  
17 percent of the deaths were in the rural areas,  
18 despite the fact that there's a functioning  
19 maternal hospital in Herat that is pretty well  
20 funded. And the rate that we got was 593 per  
21 100,000 live births. Again, if you put this in  
22 context in the U.S., it's 8 per 100,000. And in

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1 the developed world, it's 8 to 12 per 100,000. So  
2 we're talking about a huge discrepancy.

3 Now, if you go back to the number that's  
4 now quoted for Afghanistan, which is 1,600 per  
5 100,000, or a woman dying every 30 minutes, again,  
6 this number is not actually correct. If you use  
7 the CDC data that Linda Bartlett had, including  
8 the Wahkim Pass, which is that narrow part that  
9 goes into the Himalayas, it's actually about 3,500  
10 per 100,000. But she was not allowed to present  
11 that data.

12 We looked at marriage, family,  
13 reproductive health characteristics. And why do I  
14 tell you this? I think this is sort of grounding.  
15 It gives you an idea of what the health issues  
16 are. The mean age of marriage was 15, but again,  
17 the range was 5 to 39. Five being that in Afghan  
18 culture, you can be promised to a male in another  
19 family. It doesn't mean that you go to that  
20 family at that age, although some will do it if  
21 the bride price is high enough. But in general,  
22 they wait until they're all of the great age of 11

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1 before they send them, which means that they're  
2 sexually active at 11. They have much higher risk  
3 of having a child young. Their pelvises are  
4 small. The most common cause of maternal  
5 mortality in Afghanistan is actually hemorrhage  
6 because of obstruction, which is that sort of  
7 back-end of or the outside the curve reasons that  
8 maternal mortality occurs.

9 The desired age they stated was 18.  
10 Again, the range was 5 to 30. Eighty-five percent  
11 said they wanted to marry at the time of marriage,  
12 but 20 percent also reported feeling pressured.

13 When you looked at the number of  
14 children or the age that they really wanted to  
15 start having children, it was 19. When you looked  
16 at the number of children that they wanted, it was  
17 six. It was actually about eight children was  
18 what we found as the number of children in this  
19 sample. But again, the difference between six and  
20 eight probably means that despite the fact that  
21 they can't get birth control, they do have some  
22 control over timing and spacing using other

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1 methods. And so when they said that 88 percent of  
2 them reported timing and spacing was decided  
3 equally between husband and wife, I think they  
4 were actually accurate. They were able to somehow  
5 do that despite the fact that they didn't have  
6 birth control.

7           One of the other things that we heard  
8 was that women could not get to health care  
9 because they needed permission. The other part of  
10 that is, well, if you needed permission, did you  
11 get permission? And that was the question that we  
12 asked. And less than one percent were ever  
13 refused. So it's traditional to ask the male in  
14 the family whether they can go, but it doesn't  
15 necessarily mean that they won't be able to go.

16           And, of course, in any study you end up  
17 with data that is the data that you never thought  
18 would make a difference, but this was the data  
19 that made a difference. In this province, we  
20 looked at how many of these people -- how many of  
21 these women had actually delivered with a trained  
22 birth attendant. It turned out that only one

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1 percent had delivered with a trained -- actually  
2 99 percent delivered with either an untrained  
3 traditional birth attendant or alone in an area  
4 where there is a maternal hospital. And so when  
5 we used -- presented this data at the  
6 Congressional meeting, we sort of said, well, if  
7 you've got women who have not had education for  
8 six years, to get them to the level of being  
9 midwives, we're talking a 10, 15 year balance of  
10 trying to get trained health care providers. We  
11 have to do something immediately given the number  
12 of deaths. Traditional birth attendants, although  
13 there's no good data to support this -- although  
14 later there was data that was better -- then USAID  
15 needs to start thinking about supporting interim  
16 programs for training traditional birth attendants  
17 in concert with training women to become the  
18 providers, OB-GYNs, or midwives. We were able to  
19 get some money for that.

20 We looked at attitudes and beliefs about  
21 marriage, family. A woman should have the right  
22 to freely choose a husband. Ninety percent agreed

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1 with that, although that is not the case in  
2 Afghanistan. They can say no, but generally they  
3 don't have that right to say no. A woman should  
4 have the same right as her husband to decide  
5 number and spacing. And if you look down, the one  
6 that is a little more disturbing is a husband has  
7 the right to beat his wife if she disobeys him.  
8 Forty-four percent of men and women thought that  
9 was the case. So domestic violence and  
10 gender-based violence rates are high in  
11 Afghanistan.

12 So the key recommendations -- and I  
13 think this is actually interesting -- and when I  
14 found this slide, to go back and look at what our  
15 key recommendations were in 2002. And frankly,  
16 they're not any different than they were then.  
17 Although some of this has moved -- and I'll talk a  
18 little bit about that -- the recommendations still  
19 stand.

20 So let's move to 2005. In 2005,  
21 Afghanistan was much more open. Again, we could  
22 travel. I have a penchant for eating at roadside

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1 cafes. Most people wouldn't do that but I do. So  
2 we were there looking at something called the  
3 Afghanistan Talking Health Book, and I have  
4 brought that for any of you who would like to take  
5 a look at this. This was a health education  
6 module for women, primarily. And we were testing  
7 it for health and human services to see if it was  
8 a valuable way to get health education out to  
9 women in very austere areas.

10 Here you see a picture of an Afghan  
11 woman. Using these -- again, these are all my  
12 pictures. One of the good things about being a  
13 female is that you can get pictures of unburqaed  
14 women, and so I have a lot of pictures of  
15 beautiful women's faces in Afghanistan.

16 The problem with this book was there was  
17 a ceiling effect on knowledge. The assumption at  
18 the time by HHS was that there was no health  
19 education. Remember, I told you civil society was  
20 running, despite the fact that there were numerous  
21 wars, numerous issues. Civil society still ran.  
22 There was a huge cadre of community health workers

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1 who were doing health education. So when they  
2 went in and talked about hand washing and then  
3 looked at it after the book, of course, 98 percent  
4 already knew about hand washing. So getting  
5 another two percent to understand hand washing was  
6 not a big thing.

7           It was developed by HHS by  
8 Afghan-Americans. Again, this was problematic.  
9 Many of these were Afghan- Americans who were in  
10 their twenties who had never been to Afghanistan;  
11 had never been on the ground; who were actually  
12 part of, you know, the elitist society. And  
13 therefore, understanding what a tribal or village  
14 Afghan woman needed was problematic.

15           The translations were poor. We had it  
16 both in Pashtun and both in Dari. The problem was  
17 whoever recorded the Dari translation did this in  
18 a mixed Herati translation and an east  
19 translation. So when they went to put the talking  
20 -- the stick on the word, the word would come out  
21 in Herati and they didn't understand what it was  
22 because the language in Jalalabad was very

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1 different -- or the dialect was different.

2           There was no coordination with the  
3 Ministry of Health. The Ministry of Health was  
4 not contacted; was not told; was only informed  
5 when it was happening. And so that was  
6 problematic. Also, Leap Frog made 80,000 of these  
7 without doing testing, and they're currently  
8 sitting in a warehouse in Afghanistan. Their  
9 batteries are probably corroding. And also, they  
10 used batteries in these that are AAAs, which you  
11 cannot find in the market. The only thing you can  
12 find is AAs. So a sustainable way of using these  
13 would be impossible until now.

14           Afghans like the idea, but they  
15 preferred to have it actually administered with a  
16 community health worker. Again, this is cultural  
17 Afghanistan. They like the community health  
18 workers. They trust them, and trust in  
19 Afghanistan is a huge part of the society. So if  
20 the community health worker came and worked with  
21 them on the book, it was better for them. And  
22 what we found, in the paper -- you have the paper

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1 -- is that the children actually like this as  
2 well. And so you had an up-level of teaching to  
3 the parents through the children.

4           So in August of 2009, this year, we went  
5 back. I went to meet with the Afghan Surgeon  
6 General to talk to him about the Afghan National  
7 Army and the Afghan National Police. These are  
8 the two different health care systems. If you  
9 don't know this already, Afghanistan actually has  
10 three health care systems -- has the civilian, the  
11 Afghan Army, and the Afghan National Police. This  
12 is problematic. If you can't support one, how can  
13 you support three? And there's varying amounts of  
14 equity among those three.

15           What we were there for at the time was  
16 to discuss the issue of doing a traumatic brain  
17 injury study among the military police. This was  
18 based on a study that our division did in Liberia,  
19 which found that of the third of the ex-  
20 combatants in Liberia, many of them had TBI much  
21 higher than what we had suspected. And that if  
22 this is one of the things that our military is

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1 doing with their military, than we need to pay  
2 attention to this given that DoD is the expert in  
3 TBI.

4 They gave us the typical Afghan huge  
5 spread for lunch, and these are all of the CSTCA  
6 staff that were there, as well as the Afghans.  
7 Now, the CSTCA Surgeon is the surgeon for the --  
8 and Bill, you'll have to help me with the combined  
9 --

10 CDR HUGHES: Security and Training  
11 Command.

12 DR. LAWRY: Security and Training  
13 Command for Afghanistan. So this is the CSTCA  
14 surgeon and this is actually the surgeon general  
15 of the police in Afghanistan.

16 So let me move to DoD health efforts,  
17 because that's my cue to tell you what you  
18 actually wanted to hear. So what is DoD to do?  
19 Or what can it do? It's based on authorizations,  
20 and it's based on legalities. Our role is mil to  
21 mil. And I say "our" as a contractor because I  
22 work within DoD. I can't speak for DoD, but I say

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1 "our" because I'm part of this.

2           Within the military to military things  
3 that they're doing -- and this is not completely  
4 inclusive -- again, I didn't -- I'm not going to  
5 talk to you about the care for troops. That's  
6 obvious. What I want to talk to you about is the  
7 more international issues and how the  
8 reconstruction of the Afghan health system.

9           There is a military medical school that  
10 has been started by CSTCA. It's actually quite  
11 remarkable. There are 27 female military members  
12 in that military medical school. It is somewhat  
13 patterned after the Uniformed Services University,  
14 but it is remarkable that there is a military  
15 medical school, as well as the Kabul Medical  
16 School and about 10 others in the region. A lot  
17 of what the military does is train the trainers in  
18 emergency care, professionalism, first responder.  
19 There's some work to improve the ANA and the ANP  
20 hospitals and clinic. Again, there's a lot of  
21 discussion about whether there should be one  
22 system for both ANA and ANP, but politically, it's

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1 just not going to happen. And for us to think  
2 that it will takes us down a path we don't want to  
3 go.

4 Now, when you're looking at civilian  
5 health care -- the way the military can do  
6 civilian health care -- so to add to the effort in  
7 Afghanistan is quite minimal. One of the reasons  
8 is because there are so few authorizations.  
9 There are three types of funding. One is the  
10 overseas humanitarian disaster and civics  
11 assistance money; the civics assistance money; and  
12 then CERP funds, which are the, you know,  
13 caseloads of dollars that the commanders carry  
14 around to do projects like that without having to  
15 go through a whole paperwork trail.

16 OHDACA funding is about 58 to 85 million  
17 plus, but it covers all COCOMS, so it can't all be  
18 used in Afghanistan. It requires that you put in  
19 a proposal to do it. It doesn't require any type  
20 of monitoring and evaluation, and it does not  
21 require any type of coordination with the host  
22 nation whatsoever, although it would be better if

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1       it were.

2                   The HCA funds can only be used for  
3 projects that involve the training of military  
4 health personnel. Sometimes you can find a  
5 secondary benefit to it, but again, it's primarily  
6 set for training military health professionals.  
7 And so this is where you get the MEDCAPs and the  
8 DENCAPs and all of these types of projects.

9                   The CERP funds are more common in  
10 conflict. They kind of dry up in an extended  
11 reconstruction or development phase. It's usually  
12 based on the commander's intent, and it may not be  
13 coordinated with the COCOM Surgeons or any of the  
14 surgeons for that matter. And so they are a bit  
15 more difficult.

16                   We were able to look at the OHDACA  
17 database, which was from 2000 to 2007. And we  
18 have a study that is coming out in the disaster  
19 medicine and public health preparedness which  
20 talks about how the OHDACA funds were used in that  
21 period.

22                   Afghanistan was second to Iraq for

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1 projects. The primary projects were school  
2 construction and refurbishment; health and water  
3 infrastructure, meaning they went in and  
4 refurbished clinics. It didn't necessarily mean  
5 they paid providers, because they couldn't with  
6 those funds. Disaster response infrastructure and  
7 disaster response training projects. Only 15  
8 percent of the projects in OHDACA were actually  
9 health infrastructure. The largest percentage  
10 were actually school. The problem was -- and if  
11 you want to look at education as a means for  
12 health -- again, education is the primary  
13 indicator of health -- then it counts as a public  
14 health project. However, if you only build a  
15 school, you don't do the curriculum, and you don't  
16 pay the teachers, it's not helpful. And if you  
17 build it a block from the one that the NGOs built,  
18 it's problematic, as well.

19 So going back to more DoD health  
20 efforts, let me just tell you what our division  
21 has done primarily for Afghanistan. Our role is  
22 to respond to the needs of the COCOM Surgeon. We

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1 recently were able to help CSTCA in the  
2 procurement of medicine and medical supplies in  
3 Afghanistan. Not from the usual ways of doing it,  
4 but on the market there is a procedure for doing  
5 that. It is somewhat difficult, but we were able  
6 to help a bit with that.

7 We also assess, research, and evaluate  
8 topics relative to health stability. One of the  
9 things that we're looking at doing is the TBI  
10 study of the ANSF. We also did an evaluation of  
11 the overall interagency health coordination in  
12 Afghanistan. And I know that you got a  
13 presentation from Dr. Peterson, who said that the  
14 Ministry of Health is great. Let me just nuance  
15 that a bit. It is great. If you look at the  
16 strategic documents that the Ministry of Health in  
17 Afghanistan has created, there are 11. If you  
18 look at the number of strategic documents that  
19 Iraq has for the Ministry of Health, it's zero.  
20 So we're talking about quite a difference in the  
21 ability and capacity of the Ministry of Health.

22 The Ministry of Health also has control

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1 over its funds, whereas, most of the ministries in  
2 Afghanistan do not. And the Ministry of Health  
3 coordinates all NGO activities. So if an NGO  
4 wants to go in and do a project, they have to  
5 coordinate with the Ministry of Health. This is  
6 unheard of in most of the places that I've worked  
7 in.

8 We've also discussed the need for a  
9 health attaché. Again, we've got multiple  
10 interagency groups in Afghanistan. We've gotten a  
11 lot of resistance from some of our interagency  
12 partners, but we're still steadfast on the need  
13 for a "health attaché," someone that would be able  
14 to sort of walk the lines within the interagency  
15 to be able to say what DoD can and cannot do, what  
16 they're doing, what the PRTs are doing, and what  
17 the Minister of Health recommends in his newest  
18 strategic document.

19 We serve as a resource for the Ministry  
20 of Public Health. We have a great relationship  
21 with him. We sit with him one on one. I was  
22 invited in August to sit with him for an hour and

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1 20 minutes of his time. That's kind of unheard of  
2 in most of these places that I've been, but I was  
3 able to get a lot of helpful information of his  
4 needs and his worries at the time.

5 We serve as a liaison for civil military  
6 issues. Again, I think Dr. Peterson said that  
7 NGOs don't want the military near them. I don't  
8 think that's nuanced enough. That's not  
9 necessarily the case. Although NGOs will publicly  
10 say that, behind the scenes they are doing many  
11 things with the military, particularly the PRTs.  
12 So they will do it, but it has to be with confined  
13 rules and lines in the same to make sure that NGO  
14 security is complete and stays the same.  
15 Remember, NGOs rely on their local perception of  
16 not neutrality, but impartiality, to be able to be  
17 safe.

18 And we have just recently finished the  
19 Guide to Nongovernmental Organizations for the  
20 Military. This is a 400-page book that will be  
21 online, BlackBerry downloadable. It has a lot of  
22 helpful hints for the military about how to work

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1 with NGOs and work within the strategic documents  
2 of the military so that there's an understanding  
3 that, yes, you use this term but the NGOs use this  
4 term. And if you want to really be effective, you  
5 need to use their term because the interagency  
6 doesn't understand your term.

7 So some of the things that you may not  
8 have seen about Afghanistan, everybody things  
9 it's, you know, completely shut down. I will tell  
10 you that my view from 2000 to 2009 is hugely  
11 drastic. And there's huge changes. This is a  
12 wedding hall in Afghanistan, and this is one of  
13 about 20 on a stretch of road. It looks like Las  
14 Vegas. And who knew that lights actually came in  
15 pastel colors? But one of the reasons the power  
16 grid I have a feeling can't keep up is because of  
17 this. The number of lights are just unbelievable.

18 You can't see this very well. Anyway,  
19 this is a picture of an Afghan wedding. One of  
20 the good things about being a contractor is you  
21 can have a little bit of leeway in where you go  
22 and what you do. And so I was able to go to some

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1 of these weddings at night. And what you do see  
2 is you see women now in short sleeve and  
3 sleeveless outfits. This -- I didn't come to say  
4 that I went native in this outfit; I actually came  
5 because the most common question is what did you  
6 wear when you were in Afghanistan. And this is  
7 what I wore.

8           When I went to the tailor in Afghanistan  
9 that I used previously, there were no longer any  
10 of the salwar kameez; they were all sleeveless for  
11 the summer. And so things have really changed.

12           And on the street, I passed groups of  
13 five and six women without -- or girls -- with  
14 makeup on, western dress, no burqa, just a head  
15 scarf. So it really has changed.

16           There are now more than 35 restaurants  
17 and bars. There are two shopping malls in  
18 Afghanistan. You can buy Christian Dior in Kabul.  
19 That to me is just unheard of. And I actually  
20 pulled this from the Safi Airway book that they  
21 had in the back of the seat. And for those of you  
22 who want to see very interesting pictures, it's in

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1       there.

2                   There are 10 hotels, compared to the one  
3       that I stayed in during Taliban years and during  
4       the wars. Several of them are 4-star. I ate at  
5       them. I could hardly believe the food that was  
6       coming over. It was no longer greasy goat and  
7       rice; it was real food.

8                   And when I traveled through Europe, I  
9       used to call -- every picture I had of Europe they  
10      had Euro-cranes and it was the ever present  
11      Euro-crane. Now in every photo that I have in  
12      Kabul is the ever present Afg-crane. Why?  
13      Because rebuilding is happening. There are  
14      mansions. The entire valley in the Kabul area is  
15      lit up. There are mansions that have been built.  
16      The terminal is full of Afghan-Americans and  
17      Afghan-Europeans that are bringing their family  
18      back to visit and then leaving. It's no longer  
19      filled with U.N. Officials and NGOs. It is a  
20      completely different place than it was.

21                   And there is now an international and a  
22      domestic terminal. The airport that I knew in

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1       2000 was one you didn't fly into; you flew into a  
2       dirt road somewhere on a U.N. Flight, if you  
3       could. Generally, you went over Smuggler's Pass  
4       or you hired a taxi in Jalalabad and drove to  
5       wherever you needed to be. But the left picture  
6       -- and this is not one that I took -- is what the  
7       airport looked like. This is what the airport  
8       looks like now, and this is actually a picture  
9       from 2004. It only shows one airline. There are  
10      about six airlines now that fly in and out of  
11      Kabul. One of them actually flies from Europe  
12      straight because they've been able to secure the  
13      European and American security measures that allow  
14      direct flights now.

15                 This is pictures of -- if you look in  
16      the book, this is the picture of the mall. It  
17      looks like any mall. And any of you who have been  
18      in a mall anywhere in the U.S., it looks exactly  
19      the same. And then the number of hotels.

20                 Ten years ago I would have laughed if  
21      you told me I'd be buying Lego in the Kabul  
22      airport duty-free, and I really would have. This

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1 is unimaginable to me. Considering the places  
2 that I generally go to, there has been no change  
3 in Darfur; there's been no change in the Congo;  
4 there's been no change in many of the places that  
5 I've been. In Afghanistan, there are huge  
6 changes.

7           And although I'm telling you about  
8 Kabul, you have to understand that Afghanistan is  
9 not one place. It's -- as many provinces as there  
10 are, that's the many Afghanistans. The tribal  
11 cultures will still exist no matter what. It's  
12 the cities that you have to look for the marker of  
13 economic improvement and security. The rural  
14 areas will always stay the same, and you will  
15 always see these different tribes. And this is  
16 actually the Timoni tribe in Afghanistan. A very  
17 small tribe that I actually ran across and who are  
18 quite different from many of the others.

19           And that's it.

20           DR. LEDNAR: Dr. Lawry, thank you for  
21 sharing your experience and all the changes that  
22 have occurred in Afghanistan.

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1 Lawry? Dr. Silva.

2 DR. SILVA: Thank you for your report.  
3 You've been very courageous to go into some of  
4 these areas, particularly in the early years.

5 I'm interested, the Russians were there  
6 for over 10 years. Are there any residuals of  
7 their culture, language, or anything of that sort  
8 that stuck? Because we're not going to be there a  
9 long time, and I wonder how much stuff will stick  
10 besides Legos and shopping malls. So, anyhow,  
11 sociologic question.

12 DR. LAWRY: Yeah, there's more Pakistani  
13 culture because of the 20, 30 years that a huge  
14 portion of the population lived in Pakistan, so a  
15 lot of the food has changed. One of the things  
16 that I didn't talk about was that, you know,  
17 within a few years the rice fields were up. There  
18 were no longer sheep because of the drought, but  
19 they were bringing in Pakistani bulls and  
20 livestock. So some of that has changed.

21 As for Russian, absolutely not. There  
22 is one exception, and that's within the drug areas

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1 where they no longer use the term "warlord"; they  
2 use the term "mafia." And I think that refers to  
3 -- from all of my communications, it refers to not  
4 the government of Russia, but the mafia of Russia  
5 that are heavily embedded in the drug trade.

6 DR. LEDNAR: Dr. Lawry, thank you very  
7 much for spending this time with us and for this  
8 presentation. Thank you.

9 Okay. I'd like to move to our final  
10 speaker of the morning. We on the Defense Health  
11 Board have a real opportunity today in some shared  
12 learning. And Group Captain Alan Cowan, who is a  
13 regular member with us as a liaison officer, has,  
14 in fact, arranged for us to learn about a sister  
15 organization that does work similar to ours, but  
16 for the U.K. military. So I would ask Group  
17 Captain Cowan if he would please introduce  
18 Professor Blain.

19 CAPT COWAN: This is on? I'm delighted  
20 to introduce Professor Peter Blain.

21 Peter is a consultant physician in Acute  
22 Emergency Medicine Directorate of the Newcastle

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1 Hospital's NHS Foundation Trust and a consultant  
2 in emergency response medicine of the United  
3 Kingdom Health Protection Agency. He's a  
4 Professor of Environmental and Occupational  
5 Medicine, and a Director of the Medical Technology  
6 Research Center, a joint facility of the U.K.  
7 Health Protection Agency and Newcastle University.

8 Professor Blain has extensive experience  
9 in the health effects of industrial chemicals --  
10 industrial environmental chemicals -- with a  
11 specific interest in clinical neurotoxicology. He  
12 leads chemical, biological, radiation, and nuclear  
13 research in the United Kingdom Health Protection  
14 Agency where he provides (inaudible) advice to the  
15 U.K. government, and also serves as a medical  
16 toxicologist at a number of U.K. government  
17 advisory committees, both in the Department of  
18 Health and the Ministry of Defense.

19 He also chairs the Advisory Group on  
20 Military Medicine, a non-departmental public body  
21 providing specialist advice to the U.K. Ministry  
22 of Defense. The Advisory Group on Military

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1 Medicine performs a similar function in the United  
2 Kingdom to that of the U.S. Defense Board. And it  
3 was with that connection in mind that I proposed  
4 to my Surgeon General last December that we should  
5 offer to highlight the role of this advisory group  
6 and provide you, the members of the Defense Health  
7 Board, with an overview of its function.

8 I'm delighted, therefore, that Peter is  
9 able to join us today. And I'm most grateful to  
10 Dr. Lednar, your Co-Vice President, for agreeing  
11 to his attendance in this presentation.

12 So, as I stand between you and lunch,  
13 without further ado, I give you Professor Peter  
14 Blain.

15 DR. BLAIN: Thank you, Alan. And good  
16 morning, everyone. Thank you very much for  
17 inviting me here.

18 Just following Alan's introduction, as  
19 someone did say to me that a wife should give the  
20 introduction because you get a far better,  
21 accurate character reference than you get there.  
22 It was my wife that said that.

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1           I'm sorry I brought British weather with  
2 me, but I've been here two weeks and I know the  
3 sun does shine in Washington, and I'm sure it will  
4 again.

5           I'm very pleased to present to you some  
6 of the information and the background to the  
7 Advisory Group on Merchant Medicine. Our Surgeon  
8 General is very keen that we explore how we might  
9 benefit from working together on areas of mutual  
10 interest. And I hope as I go through this that  
11 some of these might arise and we can explore some  
12 of them later on if there's time before lunch.

13           As Alan said, I'm a Director of the  
14 Medical Toxicology Centre. Because of all the  
15 other things I do, it's often commented I'm a  
16 visiting professor rather than the actual  
17 professor. But we'll leave that.

18           Do I press the arrows?

19           SPEAKER: Yes.

20           DR. BLAIN: Excellent. Now, the AGOMM,  
21 which is the acronym, the Military Medicine  
22 Committee, was actually set up a year ago. And

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1 previous to that it was known as the Advisory  
2 Group on Medical Countermeasures, which had been  
3 in place since the late '90s. What happened there  
4 was, as I'm sure you'll remember, there was some  
5 issues over the anthrax vaccine policy. And the  
6 U.K. politicians thought that one way of putting  
7 this issue to one side, particularly as the Gulf  
8 War -- the Gulf had flared up again and we were  
9 deploying, was to give it the question as to what  
10 should be the policy on anthrax vaccine to a group  
11 of academics, in the hope that it would be kicked  
12 into long grass and nothing really would come out  
13 that would cause political problems.

14 Unfortunate for them, the group which I  
15 chaired, very quickly recognized that among a  
16 (inaudible) policy was really the only way forward  
17 in order to maintain protection of the service  
18 unit. We couldn't just have some people or some  
19 people not protected. That was not politically  
20 what was expected, but it did at least show that  
21 we were independent and that we actually gave  
22 objective advice on issues. It's still an issue

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1 as to whether that policy for vaccinations should  
2 be mandatory, and we're still running a voluntary  
3 program, but we're trying very carefully and very  
4 hard to persuade people that the uptick should be  
5 as near 100 percent as possible. We can come back  
6 to such issues later.

7           However, last year our current Surgeon  
8 General, Lou Lillywhite -- Lieutenant General Lou  
9 Lillywhite -- recognized that there were other  
10 pressures going on which needed advice and needed  
11 a group of independent experts to provide advice  
12 to the Secretary of State, in particular for  
13 Defense. Some of those issues were the  
14 operational need. There was a broader need than  
15 just on medical countermeasures. The development  
16 of new medical interventions and the advice on the  
17 use and the risks associated with some of the new  
18 technologies. And also within the U.K. military  
19 there were capability gaps in certain medical  
20 areas. I think it's a problem in lots of  
21 countries' military as to what spread they've got  
22 and what resources they've got in their military

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1 specialties.

2           So in light of that, General Lillywhite  
3 proposed that we converted the Advisory Group of  
4 Medical Countermeasures to the Advisory Group on  
5 Military Medicine.

6           Now, the reason I'm here, as I said  
7 earlier, is, hopefully, we can identify, as I go  
8 through what we do and what we've been recently  
9 doing, similar areas of interest and work. And we  
10 can develop a scope, if indeed a scope comes  
11 through, for interaction between the two bodies,  
12 sharing views on relevant issues. We may  
13 eventually look towards joint working groups for  
14 common, mutual problems common to both military.

15           We could exchange (inaudible)  
16 documentation obviously with the usual caveats and  
17 the usual considerations. And perhaps more  
18 importantly, just simply maintaining awareness of  
19 each other's work and looking for how we can  
20 support each other.

21           Now, Dr. Lednar provided me with this  
22 list of topics that he felt would be useful to

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1 discuss for the Defense Health Board to discuss  
2 with me. I'm going to run through them one by  
3 one. I won't read them all on that list because  
4 each title will come up as I go through them.

5 The first one is the charter or purpose  
6 of AGOMM. It's constituted as a non-departmental  
7 public body. That's a classification in the U.K.  
8 that means it's not part of a government  
9 department; it's independent, although it's  
10 supported by a government department in the sense  
11 of the Secretariat and the organizational side of  
12 it is provided by that department.

13 There are some restrictions on who is  
14 appointed. And because of the changes to the  
15 requirements for governance and probity and public  
16 life, the posts have to be advertised and people  
17 short-listed, interviewed, and the like. There's  
18 a little bit of a difficulty when you're dealing  
19 with something military or other areas that are  
20 classified in that for our -- the Advisory Group  
21 -- because we deal with issues that are of a  
22 sensitive nature frequently, then the membership

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1 of that body is classified and not released to the  
2 public.

3 So you have this paradox that you apply  
4 for a post on a committee and then no one ever  
5 knows or should know whether or not you got it.  
6 But that's just to protect the individuals. The  
7 Chairman, I have to say, is not protected and we  
8 have certain ministers standing up in Parliament  
9 naming the Chairman for which I'm eternally  
10 grateful to the Minister for that.

11 Our function is to provide independent  
12 expert advice to the Secretary of State for  
13 Defense. And we work through the Surgeon  
14 General's Department, as well, on specific areas  
15 that come to light for Surgeon General. We can be  
16 tasked, obviously, by the Secretary of State.  
17 I'll come to that shortly.

18 We're also increasingly being used to  
19 provide expert advice for urgent operational  
20 needs. Now, that can be something quite  
21 administrative, like moving the expiree date of  
22 combo-pens and approving that on the evidence base

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1 that this will not be a health issue. It can be  
2 quite significant matters, such as the use of  
3 various haemostatics or the issues of blood-borne  
4 viruses for which there is a major problem and  
5 needs a quick response. For that we tend to put  
6 together a small group of relevant experts and the  
7 Chairman's action can transfer that conclusion of  
8 that group into the Surgeon General Department's  
9 advice.

10 The thing for the bottom there was one  
11 of the previous Surgeon Generals when I asked  
12 early on what exactly -- this was for the Medical  
13 Countermeasures Group -- what exactly was my role.  
14 And he, being a RAF or an Air Force chap, said I  
15 was Top Cover, which made me feel rather grand.  
16 You know, I was important. That was in the  
17 spit-fires, as it were. But then I realized that  
18 Top Cover is the first thing that goes down when  
19 you go and attack on a squadron. So I think I  
20 knew what he was saying.

21 The second topic was what skills and  
22 expertise do we have. Now, I've listed them all

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1 clinic of toxicology, and medical microbiology.  
2 We also have an expert in vaccinology,  
3 specifically one of the people in the Health  
4 Protection Agency whose role there is on vaccine  
5 development.

6 Clinical infectious diseases,  
7 occupational medicine, radiation medicine, and  
8 psychiatry -- an increasing problem. And I think  
9 you already referred in your own work to the  
10 psychological aftermath and issues associated with  
11 combat. And finally, the bottom, we're just  
12 retreating a trauma surgeon onto the new  
13 committee.

14 How the committee is structured.  
15 There's a Chairman and a Deputy. The Secretary's  
16 Committee, as I alluded earlier, is part of  
17 Surgeon General's compliment. And that's the  
18 Staff Officer I for MBC and Medical Intelligence.  
19 The staff officers rotate, and obviously, this is  
20 part of their -- a small part of their very big  
21 workload. But we get well served, I have to say,  
22 by the Military Secretaries.

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1           The Executive Officer is the Surgeon  
2           General, himself and then we have the members.  
3           And we also have attendance by officials -- both  
4           military officials, the Defense Civil Service  
5           officials, and also we invite health civil  
6           servants. So we have on the membership the  
7           Director of Emergency Preparedness and Response  
8           for our Department of Health. And this helps to  
9           -- well, first of all, make the awareness of each  
10          other's -- the two departments' activities better.  
11          You won't be surprised, I suppose, to realize that  
12          often the Department of Health didn't know much  
13          about what was going on in MOD, in the Ministry of  
14          Defense, and vice versa. And so often they have  
15          common issues, certainly around the medical field.  
16          So we have on the committee the Director from the  
17          Department of Health.

18                 We have the main committee, and then the  
19          structure allows us to have Subcommittees and  
20          workgroups and Task Force and the like. Two of  
21          the Subcommittees that are almost standing  
22          Subcommittees is the one on Special Medicine

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1 Countermeasures and the one on the Medical  
2 Implications of Less Lethal Technologies. The one  
3 on Special Medical Countermeasures, it covers the  
4 use of perhaps novel medical countermeasures or  
5 the nonconventional use of medical countermeasures  
6 for Special Ops and special operational needs.  
7 And that one is quite a challenging committee at  
8 times because we're working in areas where we're  
9 looking for a solution and then we're looking to  
10 overcome the hurdles to that solution in as best  
11 way as we can.

12           The medical implications of less lethal  
13 technologies. This was set up originally because  
14 of the medical issues around the use of the baton  
15 rounds in Northern Ireland. And as part of the  
16 Patton Report that led to the peace process within  
17 that was an obligation to develop safer -- if you  
18 can have that -- less lethal technologies for  
19 civil disturbance control. So the committee looks  
20 at the developing technologies and provides an  
21 objective medical assessment, which goes to the  
22 Secretary of State of Defense, as well as the

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1 Northern Ireland office and the home office in the  
2 UK. It's perhaps a recognition of its objectivity  
3 is that both Amnesty International and the  
4 Ministry of Defense and the home office are  
5 satisfied with its output in the sense it would  
6 not view it as being parties on what appeared as  
7 being totally objective.

8 More recently we've been dealing with  
9 tasers, the electronic stun gun, and the medical  
10 implications of the use of those in dealing with  
11 individuals causing problems. And we also have  
12 worked on human incapacitants and looking at the  
13 threats posed to our armed forces, as well as our  
14 civil forces from the use of incapacitants, such  
15 as were used at the Moscow Theater siege.

16 We have short-term working groups -- one  
17 on vaccination policy, which I've mentioned.  
18 These are just examples: Blood-borne viruses, the  
19 haemostatics, I've mentioned. Because of the  
20 problems with amputees, a blast injury, and the  
21 other trauma received by our troops in  
22 Afghanistan, in particular, we're looking more and

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1 more at rehabilitation and recovery from the  
2 effects of trauma. And we've recently started to  
3 explore working with the Armed Forces Institute  
4 for Regenerative Medicine, which is obviously a  
5 U.S.-based grouping. And that we hope will help  
6 us with even simple things, like development of an  
7 adequate stump for a prosthetic in the amputee.  
8 It's a difficult problem and it's become a very  
9 significant problem for us.

10 On the bottom there is a new  
11 development. It's the Pfizer (inaudible) hyoscine  
12 patch, which replaces the previous prophylactic  
13 treatment for nerve agent exposure. And this is a  
14 patch that the drugs are released at a set rate  
15 through the skin, into the skin, and absorbed.  
16 And this, we've been looking at the science about  
17 the kinetics and making some comments on its  
18 efficacy as a replacement.

19 How do we connect into the U.K.  
20 military? As I said earlier, the committee is  
21 based in the Defense Medical Services, which is  
22 the Surgeon General's department. And we're

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1 networked through the military by our secretary,  
2 our staff office, to whatever part of the military  
3 units are relevant.

4 All of the members on the committee, the  
5 independent members, have a security clearance.  
6 The basic one is to say security and there are  
7 some who sit on the Subcommittee -- the relevant  
8 Subcommittees who have clearance to direct  
9 (inaudible) and DV clearance, which I think is  
10 comparable to the U.S. situation. We all have  
11 national ranks, which, first of all, made us feel  
12 very -- well, for one thing, they made us feel  
13 slightly humble that we were given ranks, but they  
14 also made us feel quite puffed up a bit. Until I  
15 asked someone why are we given national ranks?  
16 Oh, it's just so we know where to sit you in the  
17 plane or in the convoy or which cabin to give you  
18 on the ship. It's just so we know where to put  
19 you; it's nothing more than that. And I think I  
20 brought us down to earth. It was just to know  
21 where we sat; it wasn't anything else.

22 Regular interaction has been the uniform

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1 civil leadership, the example being the other  
2 Services' Surgeon Generals. Well, we only have  
3 one Surgeon General in the UK. We do have  
4 Director General of the Medical Services in the  
5 three Services. So, we relate to Surgeon General,  
6 but the Directors obviously can relate to us  
7 through the Surgeon General's department. And we  
8 do have direct dealings with each of the services.

9 We make visits to military  
10 establishments. We no longer have military  
11 hospitals in the UK. They've all been devolved  
12 into the National Health Service. So you have,  
13 for example, in the Royal College of Defense  
14 Medicine in Birmingham, you have uniformed  
15 doctors, nurses, and other health care staff  
16 working in a National Health Service hospital,  
17 while there is a dedicated military ward, but the  
18 consultants and nurses also work with civil  
19 patients. There's a lot of discussion as to  
20 whether this has been a good idea or not. I don't  
21 think I'll explore that here, but it certainly is  
22 the situation we are now in.

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1           We visit other military establishments,  
2           though. We visit Institute of Naval Medicine, the  
3           Center for Aviation Medicine, and we also, until  
4           fairly recently, we were able to attend exercises.  
5           Because of the operational stretch and also the  
6           economics, the funding side of things, exercises  
7           have been reduced quite markedly. I was going to  
8           put a picture up to show that I actually got sand  
9           on boots and things, but one of my children made  
10          the comment that it made me look -- I was in  
11          uniform in Amman -- it made me look like somebody  
12          called Gunner Sudgeon. It was a comedy character  
13          in one of the British comedy shows, so I decided I  
14          wouldn't do that in case any of you have seen it.

15                 We also attend research reviews from  
16          military research establishments. And in  
17          particular, the Defense, Science, and Technology  
18          Laboratories, DSTL, which is (inaudible) and many  
19          of you have known about that as CBDE or CBD. It  
20          changes its name, but essentially it's the  
21          (inaudible). In particular, they have a research  
22          program in CBRN, although they are expanding the

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1 areas that they research, including battle trauma  
2 and various other areas, as well. And we attend  
3 as independent assessors. It's also very useful  
4 for keeping us up to speed on the research  
5 activities within MOD.

6 And finally, we get regular operational  
7 updates, as much as you've heard this morning. We  
8 also get threat briefings, intelligence briefings,  
9 on new agents, on conventional agents. I was  
10 giving a talk last week to the G8 on the clinical  
11 requirements for responding to mass casualties of  
12 a chemical attack. And I put up a new book that's  
13 come out called "State Secrets" by a former  
14 Russian scientist working on their chemical  
15 weapons program. And within it, it has for the  
16 first time the structure of some nonconventional  
17 agents -- the first time in public that they've  
18 been put out. And when I put it up, one of the  
19 colleagues from -- I forget which agency --  
20 pointed out that that book was actually now  
21 classified. And I said, well, you can buy it on  
22 Amazon. Yes, but once you've bought it, it's

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1 classified.

2 So, enjoy yourselves if you're going to  
3 get it. How does AGOMM receive requests for  
4 assistance from the U.K. Ministry? Well, first of  
5 all, we are directly tasked by the Secretary of  
6 State, and that's where the anthrax vaccination  
7 policy came from. That's where a lot of the major  
8 requests come from.

9 The Surgeon General's departmental staff  
10 and also other military staff -- procurement and  
11 various other departments -- can request  
12 assistance from us to review and give an opinion.  
13 Other specific departments, such as the CBRN  
14 policy and also the Chief Scientists at the  
15 Ministry of Defense, can request some work of us.  
16 And the Director General of Science and Technology  
17 can ask us to review research or to recommend  
18 research requirements in order to meet the  
19 particular objectives.

20 As I said earlier, the individual  
21 service can request advice and request us to  
22 participate in work with them. And we do get

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1 frequently, as I said earlier, requests from  
2 Operational Command for quick response and advice.  
3 And that has been getting more frequent recently.

4 This is the other way around. As an  
5 independent advisory body, can we suggest areas to  
6 cut, particularly if we have issues of concern?  
7 And we do do that. The way we manage it is so  
8 that there is some control on this, is that the  
9 agent is approved by the Chairman. It's put  
10 forward, obviously, by the Surgeon General's  
11 department, but it's approved by the Chairman who  
12 can amend it as he sees fit. Members raise areas  
13 of concern through the Chairman, and they will  
14 then be discussed with the Surgeon General, in  
15 particular, about including them in the agenda.

16 Sometimes there are other issues --  
17 other context about a problem that we may not be  
18 aware of. And that is the safeguard to prevent us  
19 creating problems or to prevent us from raising  
20 things at the wrong time.

21 The opinion -- the output that we have  
22 is taken by the Surgeon General to the rest of

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1 MOD. And we always ask for feedback on our  
2 opinion, on our work, to make sure that we  
3 actually -- well, we're actually being useful, for  
4 one thing, and that also to make sure that our  
5 recommendations -- if we feel strongly that they  
6 are significant -- they are taken forward. They  
7 are actually recognized and taken forward. That  
8 we do have an impact on the military requirements.

9 We produce an annual report of the  
10 Secretary of State. This can be quite  
11 comprehensive. It can include all the work we've  
12 done and examples of, well, conclude all our  
13 output, essentially, although we are advised to do  
14 one page only for the Secretary of State because  
15 that's as much as he can read. So we do a list of  
16 the most important things on the first page in the  
17 hope that he'll at least get to the bottom of  
18 that.

19 Other defense advisory groups that we  
20 have -- and this is three here as examples -- we  
21 have Surgeon General's Research Strategy Group,  
22 and that is largely made up of military personnel,

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1 who are identified -- medical military personnel,  
2 who are identifying areas of concern, and the  
3 group develops the research strategy to address  
4 them. That may feed down to us for advice as  
5 whether this is the best way forward or for us to  
6 actually review the research, the output from that  
7 particular project.

8 We also have the Defense Scientific  
9 Advisory Council, which a wee while ago I was on.  
10 This is primarily tasked with dealing with the  
11 hardware of military science. That is to say the  
12 electronics, the weapons platforms. That end of  
13 science. It does still have a human factors role,  
14 as well, primarily because the human factors of  
15 the use of the weapon or how the human fits into  
16 the weapon system, which we heard about earlier  
17 from one of the earlier speakers.

18 The important thing about not only its  
19 role there, but the other important thing is it  
20 has a register of security cleared subject matter  
21 experts. So, we have a register of people in  
22 particular areas of expertise. And we can call

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1 upon them throughout the MoD, throughout the  
2 Ministry of Defense, and also sometimes across the  
3 government departments, if we need something done  
4 quickly and we need to have experts brought  
5 together. They're security cleared.

6 I don't know -- well, I do know what  
7 it's like in the States because I've been security  
8 cleared in the states, and it takes a little while  
9 to get through that process. Whereas, here we can  
10 simply have them together by the end of the week  
11 if we need to move fairly quickly with advice. We  
12 also have an independent Ethics Board, which looks  
13 at the research ethics, in particular. There are  
14 also other aspects, and that's across the whole of  
15 MoD.

16 Now, I was suggested that since it's bad  
17 weather I finished with a funny cartoon. This is  
18 just showing that risk isn't always what you think  
19 it is.

20 Anyway, thank you very much, ladies and  
21 gentlemen.

22 (Applause)

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1 DR. LEDNAR: First, Professor Blain,  
2 thank you very, very much from all of us on the  
3 Board. I was reflecting back on some of the  
4 thoughts I was building and sending through Group  
5 Captain Cowan. You were very patient with my long  
6 list of requests. Thank you for going through so  
7 much of that. I think for those of us on the  
8 Board, I hope you see many similarities, and also  
9 some new ideas, potentially.

10 Why don't we spend a few minutes and  
11 open it up for questions for Professor Blain. Any  
12 questions?

13 Dr. Shamo, did you get some ideas on  
14 the importance of ethics?

15 DR. SHAMOO: Yeah, we should have an  
16 independent Ethics Board for DHB.

17 DR. LEDNAR: Dr. Parisi?

18 DR. PARISI: Thank you very much. That  
19 was very interesting. I noticed, though, there  
20 was a conspicuous absence of histopathology and  
21 post-mortem medicine.

22 DR. BLAIN: Say it again?

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1 DR. PARISI: There's an absence -- a  
2 conspicuous absence of post-mortem medicine and  
3 histopathology. Are those also included in your  
4 -- or maybe there's a different organization.

5 DR. BLAIN: It is. There are other  
6 directly military committees which deal with those  
7 areas. We haven't, as yet, had an independent --  
8 need for independent expertise. That's why it's  
9 not on that list.

10 I personally think we will get there, we  
11 will have one, because I think we need -- at times  
12 when we're interpreting results of either research  
13 or we're looking at straightforward histopathology  
14 data, we need someone who knows what they're  
15 talking about. And I think you're right. I think  
16 it is a capability gap that you've identified.

17 DR. LEDNAR: Dr. Mason?

18 DR. MASON: Tom Mason from the  
19 University of South Florida.

20 As an epidemiologist and an  
21 anthropologist by marriage, I'm very interested in  
22 why our disciplines aren't specifically mentioned.

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1 And apropos the discussions we had earlier today,  
2 this interface and this intersection -- because,  
3 unfortunately, in too many organizations -- and  
4 it's not just the military, and it's not just we,  
5 in academic medicine -- there are too bloody many  
6 silos and very little cross fertilization.

7 DR. BLAIN: I'm happy to agree with you.  
8 I mentioned that the DSAC, the Defense Scientific  
9 Advisory Council, had human factors as part of its  
10 skill, its portfolio. And on there it does have  
11 epidemiology and it does have -- the person is not  
12 an anthropologist -- a sociologist. And there is  
13 a psychosociologist person. Now, they may not be  
14 in the right place anymore because when I left the  
15 Defense Scientific Advisory Council, the medical  
16 emphasis moved across with me, as it were, to the  
17 now -- the Group of Military Medicine.

18 We do have a need -- and I'll give you  
19 an example of where we have a need -- when we were  
20 doing some work with the Less Lethal Technologies  
21 Group on crowd control, there were some very  
22 interesting things that came out of the impact of

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1 firing baton rounds on crowds. Such things like  
2 the fact that some smoke appears is a very good  
3 deterrent and makes a crowd disperse. You don't  
4 have to fire anything, but the smoke -- the new  
5 baton rounds were much more efficient that you  
6 didn't get smoke. And that was, you know, a  
7 negative. But we wanted to know also about how  
8 you control crowds from the point of view of the  
9 psychology of the crowd. Because you shouldn't  
10 really be firing at people. You should be able to  
11 passively control them, if you see what I mean.

12 And we drew upon expertise actually at  
13 DSTL, the Defense Science Technology Laboratories,  
14 that there are papers for us on issues around  
15 crowd control and what you might do to in order to  
16 disperse crowds and what technologies you could  
17 use that would be less -- even less lethal than  
18 what we had been considering.

19 But, again, the Military Medicine  
20 Committee has only been going for a year in that  
21 sense, and we are building up our expertise. We  
22 do have access, if we want, to epidemiologists and

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1 the like from that register. And we have used  
2 them. When we've looked at issues around  
3 vaccination uptake rates, we've looked at the  
4 reporting of adverse effects with the vaccine  
5 around Gulf War illness, basically. We have drawn  
6 in epidemiologists to advise us on that. But as a  
7 substantive member, we're not, again, like the  
8 histopathology, we are not other yet.

9 DR. LEDNAR: Dr. Luepker, Dr. Shamo, and then Dr. Halperin. Dr. Luepker.

11 DR. LUEPKER: Yes, Russell Luepker.  
12 Thank you for the presentation.

13 It sounds like you have quite a broad  
14 charge and I'm curious about one practical aspect  
15 after listening to all the positions you hold.  
16 How much time is actually spent -- how often do  
17 you meet as a group?

18 DR. BLAIN: Yeah, we meet at least three  
19 times a year, sometimes more, the main committee.  
20 Outside -- and that's for a day. Outside of that,  
21 there's a lot of work that goes on by mail, by  
22 consultation. And we would draw in the small

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1 groups that I referred to for very specific issues  
2 to be addressed.

3 We probably will start to meet more  
4 frequently because the workload is increasing.  
5 Once we've moved from being just focused on  
6 medical countermeasures itself into the broader  
7 charge, we're going to have to meet more often.  
8 Either that or we're going to have to spin off  
9 more Subcommittees that are focused on a  
10 particular area. And it may be that we have to  
11 have, for instance, have a Combat Battle Injury  
12 Committee itself. Because I think there are some  
13 topics that require more energy on them.

14 I'm also aware at meetings that when we  
15 may be discussing something that I'm particularly  
16 keen on and, therefore, we're spending a bit more  
17 time on it, the other members who are -- it's not  
18 in their area, they switch off. And I don't -- I  
19 want them all to be participating. So, it's a  
20 balance.

21 And I think you're right. Sometimes we  
22 just have to accept that there's going to be a

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1 bigger workload and look at ways of doing that, of  
2 meeting that without putting upon the experts.  
3 Because they've all got day jobs, as you all have.  
4 And more and more the day job is getting to be a  
5 bigger task on you as well. So it's quite a  
6 difficult problem at times.

7 DR. LEDNAR: Dr. Shamoo.

8 DR. SHAMOO: Yeah, Adil Shamoo. Since  
9 this whole process is to learn from each other, so  
10 since we have an issue really, the Defense Health  
11 Board is very hard and it's complicating our  
12 function. And that is the length of term of each  
13 of your Board members. And do they require an  
14 annual renewal?

15 DR. BLAIN: Now, what am I supposed to  
16 say here, Chairman? At the moment the way this  
17 works is that members are appointed for three  
18 years. They can be renewed for a third or three  
19 years, and then they have to be off the committee  
20 for one year before they can be considered to come  
21 back again. It's under what we call Nolan  
22 Guidelines. Nolan was the chap who was asked by

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1 the government to look at governance and probity  
2 in public life and came out with these  
3 recommendations.

4           They are guidelines. You don't  
5 necessarily have to follow them because if, as  
6 there are in the UK, there may be one person who  
7 is our world expert on a particular topic. Ricin,  
8 for instance, we have one chap who really is our  
9 world expert. We're not going to say goodbye to  
10 him at the end of his sixth year just because it  
11 says in the guidelines that's what happens. So  
12 there are exceptions. If it's a very sparsely  
13 populated area of expertise, you can have  
14 exceptions.

15           DR. SHAMOO: So there is no requirement  
16 for annual renewal then?

17           DR. BLAIN: No.

18           DR. LEDNAR: Is somebody hearing this?  
19 Duly noted. Dr. Halperin?

20           DR. HALPERIN: If I understand, military  
21 hospitals are now part of the National Health  
22 Service.

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1 DR. BLAIN: Yes. Yes.

2 DR. HALPERIN: There are no military  
3 hospitals?

4 DR. BLAIN: Hospitals still exist, but  
5 that's been taken into the local trust there. If  
6 you remember (inaudible).

7 DR. HALPERIN: Could you give some pros  
8 and cons? That's quite a different system than we  
9 have.

10 DR. BLAIN: Right. Personal opinion,  
11 yes? I think there is a need, personally, to have  
12 a military hospital. And I think that what's  
13 happening at the Royal College of Defense  
14 Medicine, which is in Birmingham, where initially  
15 there was a focus on a ward and that was given to  
16 the military. And they still remained separate.  
17 They are expanding out into treating civilian  
18 patients, and that broadens the experience and  
19 maintains skills. So, although I think there's a  
20 need to maintain the corporate identity of the  
21 military, which I think is very important. I  
22 mean, you have more experience and more knowledge

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1 about it.

2 I also think that from the health care  
3 professional there's a need to maintain skill --  
4 give the opportunity to maintain skills by breadth  
5 of experience. Because I think a lot of the  
6 younger doctors when I talked to them, they're  
7 concern in the past was that they be -- set  
8 themselves on a training program and then they get  
9 posted. And they'll be posted for however long  
10 and the training program would have moved on and  
11 they couldn't get fit back in. They'd have to  
12 start again. There were problems with training  
13 people up. But also, once they were trained up,  
14 maintaining the skills. Because if it was purely  
15 a military establishment, the range -- the case  
16 mix was limited.

17 So there are pros and cons. And I think  
18 the balance that's being attempted now at  
19 Birmingham, particularly when the Surgeon  
20 General's department is going to move from London  
21 up to close to Birmingham as part of a move, I  
22 think that is possibly going to achieve the best

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1 of both worlds. You'll have a clear military  
2 establishment for medicine, but they'll also will  
3 be contributing to the civil health care  
4 provision. And some of the civil people, vice  
5 versa, so there will be an opportunity to maintain  
6 skills and develop skills, but also the case mix  
7 will be good.

8 So I think now it's taken how many years  
9 to get there?

10 CAPT COWAN: In '94, I began to be  
11 involved in this, and that's 15 years.

12 DR. BLAIN: So we move quickly, don't  
13 we? But I think the message is there. I don't  
14 think having six -- five or six military hospitals  
15 was sustainable at all, but I think the model of  
16 all being at Birmingham may well be the right one.

17 DR. LEDNAR: We'll have one final  
18 question by Dr. Mason.

19 DR. MASON: Tom Mason, University of  
20 South Florida. Follow-up on an earlier discussion  
21 this morning.

22 You're way ahead of us with regard to

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1 "the seamless transition from military hospitals  
2 to VA hospitals to civilian hospitals." Where is  
3 the UK with regard to electronic medical records  
4 for all of your National Health Service?

5 DR. BLAIN: Um, yes, right. The  
6 government, as governments do, set up a contract  
7 with -- I won't say which company it was -- to do  
8 this. And the cost of this went up and up. I  
9 think it's something like 20 billion pounds at the  
10 moment, which is -- I don't know what the rate is  
11 at the moment, but it's probably about 35 or  
12 something million dollars -- billion. And they  
13 haven't produced anything.

14 They didn't listen to us physicians as  
15 to what we needed and started to produce things  
16 that are not right, not what we want. The same  
17 with the nurses on the ward. It wasn't what they  
18 wanted. It was what the computer nerd thought we  
19 wanted and things. And what's happening now is  
20 that some of the trust -- these are the hospitals  
21 -- I don't know if you're aware, but in the UK,  
22 although it's a National Health Service, hospitals

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1 are semi-independent in the sense of they're  
2 responsible for their own budgets and what care  
3 they produce, the quality of care, and they're  
4 assessed and everything else.

5           Some of the trusts have now gone to  
6 alternative sources. And my own trust has an  
7 American -- somewhere north of here in  
8 Pennsylvania it comes from -- electronic record  
9 system, which went live -- although it's been  
10 trial, obviously, it went live a couple weeks  
11 back. And it seems to be working because I was  
12 saying last night to some people that I no longer  
13 have to write anything. It's all sort of, you  
14 know, keyboard stuff now. Even prescribing.

15           So it's not -- the NHS, it has not been  
16 done well by government basically, because they  
17 don't listen to the right -- my view. They don't  
18 listen to the right people when they're designing  
19 these things.

20           DR. LEDNAR: Professor Blain, thank you  
21 for sharing with us about the Advisory Group of  
22 Military Medicine. And I think we can explore

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1 opportunities for continued sharing and  
2 experience.

3 And special thanks to Group Captain  
4 Cowan for having the foresight to see from his  
5 interactions with us as a liaison officer how we  
6 could learn from the Advisory Group on Military  
7 Medicine in the UK. So, thanks to both of you.

8 Professor Blain has agreed -- he's been  
9 very gracious to spend the rest of today and  
10 tomorrow with us. So he will be here if you have  
11 other questions that you'd like to ask him. I  
12 hope that you'll be able to join us this evening  
13 over dinner.

14 CAPT COWAN: Just a correction.  
15 Professor Blain has got an engagement tomorrow, so  
16 he's here all day today. So make the most if you  
17 need to with him today.

18 DR. LEDNAR: That's right. So make the  
19 most of today, everyone. And again, thank you.

20 Commander Feeks has just a word to say  
21 about lunch and when we will then reconvene for  
22 the afternoon sessions. Commander Feeks?

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1 business.

2 (Whereupon, at 12:17 p.m., a  
3 luncheon recess was taken.)

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1 content. This group came up with the content and  
2 I'm just immensely impressed.

3 So, Anne, the floor is yours.

4 MS. MOESSNER: Thank you. What a kind  
5 introduction. And so I've got about 45 minutes  
6 here. I'm actually hoping to get through the  
7 slide presentation, at least my part of the  
8 presentation, in about 20 minutes. We have a  
9 couple of family caregivers that are Panel members  
10 who are going to each speak for a couple of  
11 minutes as well about the process and the product,  
12 and just some words of wisdom from the voices of  
13 actual family caregivers, and then we'll certainly  
14 entertain questions at the conclusion. And  
15 certainly our hope in presenting this afternoon is  
16 that we can put the curriculum to the DHB for an  
17 approval vote today. So, that is the goal of our  
18 presentation.

19 Some specific objectives are listed,  
20 just a quick review for those of you who haven't  
21 heard us speak before. What was this Panel  
22 convened for, what have been the objectives? We

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1 will spend a few minutes summarizing what was  
2 accomplished in our very last Panel meeting, which  
3 was a few weeks ago, also again requesting  
4 approval of the curriculum. We'll also try to  
5 summarize some Panel recommendations in terms of  
6 maintaining the curriculum and distribution,  
7 evaluation, so what happens to the curriculum  
8 after the content is approved. And also, I'll  
9 give you a brief update on where we are with  
10 content in terms of mild traumatic brain injury.

11 So, again, as a reminder, the National  
12 Defense Authorization Act of 2007 is the act that  
13 convened this particular Panel. And the goal was  
14 to have 15 individuals be identified as Panel  
15 members to develop coordinated, uniform, and  
16 consistent training curricula to be used in  
17 training family members who are caregivers of  
18 active Service duty -- active Service members and  
19 veterans that have sustained a severe traumatic  
20 brain injury.

21 The Panel members were appointed in  
22 March of 2008, reappointed in June of 2009, and

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1 the appointments actually officially expire in  
2 June of 2010. There are -- just as a side note as  
3 we're discussing where things stand today, there  
4 are several Panel members who are very devoted to  
5 this project, and as we move forward into  
6 distribution and marketing phase of the  
7 curriculum, that have certainly spent a lot of  
8 time on the curriculum and are willing to stay  
9 involved as civilians, as subject matter experts,  
10 to continue to move forward with the project.

11 The tasks of the Panel are listed here:  
12 that it be an evidence-based product, that the  
13 curriculum is consistent, that it's accessible to  
14 family caregivers, and that the Panel go ahead and  
15 develop some recommendations for dissemination of  
16 the curriculum throughout the DoD and the VA.

17 DVBIC has been the agency of support and  
18 staffing for our Panel. And I'll pause for a  
19 moment and recognize them as really the perfect  
20 agency to work with us, with their subject matter  
21 experts and their previous experience with TBI  
22 education and dissemination.

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1           So, the agenda for our final meeting was  
2           as follows: reviewing the curriculum; voting to  
3           approve it as a Panel; we had another presentation  
4           from CEMM, I'll talk more about that in just a  
5           minute; that we also as a Panel wanted to discuss  
6           dissemination, marketing, evaluation of the  
7           curriculum. And I know last time I presented to  
8           the DHB in August, that was on the minds of many  
9           individuals in this room, that it looks like it  
10          will be a good resource, but what's going to  
11          happen to it from here on out. So we spent quite  
12          a bit of time talking about all that and collating  
13          our thoughts, examining the mild TBI module, and  
14          then also considering responsible agencies for,  
15          again, policy, budgeting, programming,  
16          maintenance, and evaluation.

17                 So, for each agenda item, we didn't  
18                 spend too much time at our meeting going through  
19                 the approval process because we had all spent so  
20                 much time with the content and the curriculum, so  
21                 there were some minor changes that were made. We  
22                 had the writers and the graphic specialists in the

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1 room with us at the meeting to make those  
2 last-minute changes. Those were incorporated  
3 within a couple of days and the curriculum went to  
4 printing so that it could get into your hands.  
5 I'm not sure when you received it, but, hopefully,  
6 within the past week to 10 days you were able to  
7 receive the curriculum and take a look at it.

8 We did go through -- when I presented in  
9 August, I shared with you a preliminary verbal  
10 report on the focus groups who had reviewed the  
11 curriculum, the end users. We were able to go  
12 through a very detailed written report at the  
13 meeting and there were no major findings that we  
14 hadn't already heard about through the verbal  
15 reports. So we did review that. And there was a  
16 unanimous vote to approve the curriculum by the  
17 panel. Our recommendation today then would be for  
18 the DHB to approve the curriculum.

19 The final title of the curriculum, by  
20 the way, which as you try to put together a title  
21 sometimes will end in a lively discussion and very  
22 detailed discussion, but the title that the group

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1 ended up approving was, "Traumatic Brain Injury:  
2 A Guide for Caregivers of Service Members and  
3 Veterans." So that would be our first  
4 recommendation of today's presentation.

5 We also wanted to address -- when I  
6 presented in August, there were a few suggestions  
7 by individuals in the room and we wanted to get  
8 back to you to let you know that we did discuss  
9 those items and what decisions were made. I don't  
10 have time to go into great detail here, but just  
11 to let you know, we did talk about -- we had  
12 interviewed some family caregivers and inserted  
13 their quotes, vignettes, into the curriculum. And  
14 somebody had mentioned it might be nice to lend  
15 credence and sort of a sense of reality if there  
16 were pictures of the actual caregivers embedded in  
17 the curriculum. And that was approved by the  
18 Panel as something that we would definitely be  
19 interested in doing.

20 There was discussion about providing a  
21 certificate to family caregivers who have worked  
22 their way through this curriculum. Again, that

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1 was a lengthy, detailed discussion with the idea  
2 that the implementation agency will need to work  
3 on that a little bit more. So there really was  
4 partial support that there be recognition, a  
5 letter of recognition, and perhaps a pin or  
6 something given to the family caregivers, but that  
7 it won't be an official certification of  
8 competence, per se, as a caregiver, but an  
9 acknowledgement that individuals got through the  
10 curriculum and we would like to acknowledge that  
11 in some way. So that, we did discuss in detail.

12           Someone mentioned social networking  
13 opportunities. We discussed that at length and  
14 there are some opportunities within CEMM and some  
15 of the other websites where the curriculum will be  
16 linked to. So that requires a little bit more  
17 discussion and study by the implementation agency.  
18 And then also the recommendation from the folks in  
19 this room was that there would be a very robust  
20 plan of communication marketing, and we certainly  
21 spent much time talking about that and completely  
22 concur.

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1                   CEMM, as you may remember, is the Center  
2                   for Excellence and Medical Multimedia that's run  
3                   out of the Air Force base in Colorado Springs by  
4                   Lieutenant Colonel Randy Mauffray. He came to  
5                   give us a final presentation. His website is  
6                   really a thing of beauty, and he is poised and  
7                   ready to upload the curriculum as soon as it is  
8                   approved by the people that need to approve it.

9                   He has a lot of features on his website.  
10                  They actually are nearing the point of completing  
11                  interviews with family caregivers. Those will be  
12                  available. It's really -- and there's an  
13                  interactive brain model on his website that people  
14                  can really learn about the brain and the functions  
15                  and the common difficulties and so on and so on.

16                  He also has quite a bit of capacity on  
17                  his website to help with the evaluation phase of  
18                  this project whereby we can take feedback in  
19                  through their website. There will be some steps  
20                  involved with that, but at least the capacity is  
21                  there. So we had a very nice presentation from  
22                  Lieutenant Colonel Mauffray. Again, this is just

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1 the face page of that website and you'll notice  
2 already on the bottom right-hand corner, the  
3 picture of the tree coincides with the cover of  
4 the curriculum that you received. And so the  
5 button is actually there, again, poised and ready,  
6 and then we'll load content onto there -- or  
7 Lieutenant Colonel Mauffray will when approval  
8 comes forth.

9 We spent a lot of time on this  
10 particular issue: communication, training,  
11 dissemination, and evaluation. I'll recognize  
12 Shannon Maxwell who's in the audience today, who  
13 will be speaking in a few minutes, and she is a  
14 family caregiver, but concurrently has a degree in  
15 marketing. And she and some other members from  
16 the Panel spent quite a bit of time putting  
17 together a fairly detailed marketing -- suggested  
18 marketing and rollout plan that includes many of  
19 these items: A market trend analysis, barriers to  
20 entering the market, channels of distribution, you  
21 know, market metrics.

22 The primary goals of that plan was to

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1 get that legwork done, so, again, whatever agency  
2 will be assigned to move forward with the  
3 curriculum, again, this information has been  
4 thought about, pulled together, and that we really  
5 want the curriculum to be given out to family  
6 caregivers at appropriate intervals, in person  
7 whenever possible, so as not to overwhelm, but to  
8 educate in a supported, kind of regimented manner.  
9 And we also want to make sure the people who are  
10 handing out the curriculum or those on the  
11 provider end of the spectrum know about the  
12 curriculum and know about how to get it into the  
13 hands of the people that need it.

14           Some of the messages, the marketing  
15 messages, that we'd like to get out, or, again,  
16 the agency that will be taking this project  
17 forward to the audience of caregivers, the message  
18 will be that you really are a vital part of the  
19 recovery process. You're part of the healing  
20 process. You're not alone on this journey. So,  
21 again, the marketing plan would incorporate that  
22 type of message to the caregiver audience. To the

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1 audience of high-level decision and policymakers,  
2 it would be that, again, the Panel feels this is a  
3 critical tool for caregivers, and that policies  
4 and funding are necessary for effective  
5 distribution and maintenance of the curriculum.  
6 To the advocates and the providers of care, that  
7 this exists, it's a comprehensive tool, help us  
8 get it into the hands of the folks that need it.

9           We spent some time -- this is just a  
10 very brief description. We actually have a lot  
11 more information about how this would be announced  
12 in a marketing communications sort of plan,  
13 certainly using electronic media. There are a  
14 multitude of existing websites that could link  
15 over to the curriculum at CEMM in an online  
16 manner, but even to announce the arrival of the  
17 curriculum. There was a lot of support for a  
18 mass, enormous marketing and communication plan to  
19 get the word out about this curriculum after  
20 approval is gained.

21           Certainly, there will be some, also,  
22 further efforts in terms of print media and

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1 posters and flyers going out to announce it as  
2 well. And then there are existing conferences and  
3 meetings that providers and caregivers have that  
4 we would recommend be places to also share the  
5 information about the curriculum and its  
6 availability.

7 In terms of training, we do need to, of  
8 course, get information to the people who will be  
9 handing out the curriculum. So the various care  
10 coordinators, direct care staff, really need a  
11 little bit of training; not a lot, but we decided  
12 they needed some sort of a preparation to be able  
13 to hand this curriculum out to those who need it.  
14 So between webinars and, again, infusing staff  
15 into existing meetings and presentations, we  
16 thought we could develop a train the trainer type  
17 of approach. And the Panel felt strongly that not  
18 only getting to the people in those key positions  
19 now, but as things move forward, that these  
20 announcements and trainings would happen on an  
21 ongoing basis.

22 And we also have Panel members who are

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1 scattered throughout the country who would be  
2 willing to continue to serve as proponents of the  
3 curriculum, but also as subject matter experts to  
4 help with rollout.

5 So, again, Panel members are very  
6 devoted to the project. So, we, as a Panel,  
7 really are supported of DVBIC continuing to do  
8 what they can now to prepare for rollout and  
9 DVBIC, as we've been in communication, would be  
10 willing to do that.

11 We actually put some pretty aggressive  
12 goals together in the marketing plan that right  
13 away, the minute approval is gained, we would like  
14 to get the curriculum into the hands of 80 percent  
15 of current caregivers or caregivers just entering  
16 -- just starting their journey, and that within  
17 six months or, you know, a reasonable amount of  
18 time, that we would actually up that to 90 percent  
19 of people. These are Service members and veterans  
20 with severe traumatic brain injury. They're in  
21 the system. They're fairly well known.

22 The mild traumatic brain injury group is

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1 a different story, but for these individuals we  
2 thought very aggressive goals were reasonable  
3 because of the ease of which we can identify the  
4 Wounded Warriors. But also there was a lot of  
5 discussion about how do you go backwards to the  
6 people that have been injured in the years leading  
7 up to today? And so some fairly aggressive goals,  
8 but with more of a phase-in approach, were set for  
9 those groups of individuals as well.

10 The group thought about a 5,000  
11 curriculum print run would be a place to start.  
12 Again, the agency that's designed to implement  
13 this project, you know, will have to figure out  
14 about housing, warehousing, distribution, those  
15 types of activities, but it seemed like that might  
16 be a reasonable number for a first print. And  
17 these were just some other goals of the Panel,  
18 that the curriculum, as you received it -- you  
19 know, it's quite large, and may look a little  
20 overwhelming. The focus groups told us they would  
21 rather have it all at once and not be given to  
22 them in a piecemeal manner. That was discussed

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1 again at this Panel meeting and everybody in the  
2 room agreed that though it's large, you know, the  
3 expectation isn't the family member read the  
4 entire thing right away; that parts of it or more  
5 reference material, but that it really should be  
6 given out all at once and in person, absolutely,  
7 whenever possible.

8 In terms of evaluation, the Panel is  
9 recommending that evaluation of this project  
10 happen on a regular basis. So, within a year of  
11 implementation, that evaluation be conducted and  
12 that metrics be, you know, gained, data collected,  
13 that the evaluation of the curriculum is  
14 synchronized with the marketing plan goals, and  
15 that to accomplish this, you know, there would  
16 likely need to be funding for proper qualitative  
17 and quantitative feedback. But that would be  
18 something hard for DVBIC, let's say, to do without  
19 the proper funding and support to engage in such  
20 activities.

21 In terms of the mild TBI module, as I've  
22 presented to you all before, the Panel, although

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1 not specifically charged with developing caregiver  
2 education for soldiers and veterans with mild TBI,  
3 we all know that this is the largest volume of  
4 injury. And the Panel is very devoted to also try  
5 to develop a companion piece explaining the  
6 nuances of mild TBI and the complexities with PTSD  
7 and other concurring conditions. Well, that is a  
8 more difficult topic to pull together in a  
9 succinct way and, you know, every week the  
10 information seems to be changing about mild  
11 traumatic brain injury and the findings and  
12 recommendations. So, the Panel remains  
13 interested. Specific members have offered to be  
14 ongoing content experts to work with the  
15 implementation agency on trying to pull together  
16 some curriculum, again, some means of putting  
17 together education for caregivers on this  
18 particular issue. But at this point in time,  
19 there is a rough draft that's finished and that's  
20 where it ended up due to time constraints.

21 So, moving on to policy and execution,  
22 again, this was the other topic that received a

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1 considerable discussion at our meeting. And  
2 really -- and I got the sense when I was here last  
3 time as well that what we don't want to do is have  
4 this curriculum, which we hope is meaningful and  
5 accurate and really useful for caregivers, to sit  
6 and not be rolled out as quickly as possible and  
7 then not be maintained in a regimented way. But  
8 we decided this certainly will depend on the  
9 designation of an agency to publish policy for the  
10 curriculum, and then also for the execution of the  
11 policy and an implementation agency to be  
12 designated. And these were the thoughts of the  
13 Panel in terms of that the policy agency must  
14 cover the following elements: assignment of  
15 responsibilities, communication, training,  
16 dissemination, programming and budgeting,  
17 evaluation, and maintenance and updates.

18 So, the Panel set about establishing  
19 some criteria that they felt were important for  
20 this particular agency to have and that it be a  
21 policymaking body, that there be a DoD and VA  
22 collaborative track record, that this agency have

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1 the capacity to influence chains of command, and  
2 that also they could influence across medical  
3 personnel, finance, other domains. And so the  
4 Panel's recommendation to the DHB is that the  
5 Office of the Under Secretary of Defense for  
6 Personnel and Readiness be the agency on record  
7 for policy and propensity.

8 In terms of the implementation agency,  
9 the Panel discussed the most reasonable agency for  
10 this act of the plan would be someone who's got  
11 experience with dissemination of materials, again,  
12 across the DoD and the VA, extensive knowledge of  
13 the curriculum, and a commitment to sustaining the  
14 curriculum. And our thought, after some  
15 discussion, was that DVBIC, or the Defense and  
16 Veteran's Brain Injury Center, who supported this  
17 project, would be a logical choice for an  
18 implementation agency.

19 So the summary of our recommendations  
20 today, again, I believe the item that would go  
21 particularly up for a vote would be approval of  
22 the curriculum itself. The other two items on

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1 this particular side have to do with what I just  
2 mentioned, you know, that there be a policy agency  
3 and an implementation agency designated. And then  
4 these were the other recommendations: that DVBIC  
5 continue to do some preparation now so when  
6 approval is gained, they're poised and ready; and  
7 that funding will be needed for proper evaluation  
8 of the curriculum; and that also we would like to  
9 continue to work or serve, in a civilian capacity,  
10 serve as experts on the mild TBI content.

11 So, I'm going to move into -- Liza  
12 Biggers is here and she served as a Panel member  
13 from the beginning. She's going to talk just for  
14 a couple of minutes about her perspective, as will  
15 Shannon Maxwell. So they've each got three or  
16 four or five minutes of sharing to do with  
17 everyone. And then as a group, along with Meg  
18 Kotler, who is from DVBIC, and Dr. Barbara Cohoon,  
19 who also sits on the panel, we thought as a group  
20 of five of us that we would field your questions  
21 before we go to vote.

22 So, please, Liza?

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1 MS. BIGGERS: Hi, my name is Liza  
2 Biggers. I was -- my brother Ethan Biggers was a  
3 Specialist in the Army and -- actually, I have two  
4 brothers, they're twins, they're both my younger  
5 brothers. I'm only two and a half years older  
6 than them, so they've been my best friends since  
7 they were born. They both served in the Army,  
8 both did tours of Iraq. And all of us share kind  
9 of a weird sense of humor. And I thought this  
10 picture was great showing Ethan, he's leaving out  
11 cookies and milk for his First Sergeant and CO for  
12 barracks inspections.

13 Ethan was shot in the head by a sniper  
14 on his second tour in Iraq on March 5, 2006. So,  
15 I would end up spending the next year taking care  
16 of him. I like to call it the VA Tour 2006 for  
17 the Biggers family. And from the beginning, my  
18 family and I were completely unfamiliar with this  
19 injury and we had no idea what to even expect or  
20 what was going on. Ethan was just bloated and  
21 huge and unconscious. And at that time it seemed  
22 -- it's really hard, you really want to help and

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1 you want to do anything you can to help your loved  
2 one. And it's this defining point in his life  
3 where he's either going to live or die and it's so  
4 traumatic. And you'll take any information you  
5 can get as gospel, like, especially even from  
6 people whose cousin was in a car accident 10 years  
7 ago, you know, are telling you all kinds of stuff  
8 and you're just soaking it in.

9           So this is where this curriculum would  
10 be just outstanding to have. It would help the  
11 families, it would help the doctors and the nurses  
12 talking with families, describing this injury. It  
13 can also empower that caregiver to really feel  
14 like they can help instead of just standing around  
15 and staring at your loved one in the ICU for hours  
16 on end.

17           The other thing that was really  
18 important at the time, immediately, was finding  
19 other people that were going through this  
20 situation. So, anybody that you found, you just  
21 clung to because you wanted any kind of, you know  
22 -- just the fact that they knew what you were

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1 going through was just the consolation you needed,  
2 just to hear from them.

3 So, once again, this curriculum gives  
4 that right away, that network of caregivers that  
5 have already been through this. They can read  
6 those quotes, they don't have to feel alone; it's  
7 not such a mystery of what's going to happen in  
8 the future.

9 So, at the beginning of Ethan's injury,  
10 it was my father and my stepmother and I that took  
11 care of Ethan. And then halfway through, my  
12 father was killed in a car accident, so my other  
13 brother Matt completed his service, came, and we  
14 took care of Ethan, and it was like starting all  
15 over again. So everything that my dad had been  
16 keeping track of paperwork-wise, now me and my  
17 brother had to do for Ethan. Once again, this  
18 curriculum would have been awesome to have then,  
19 even just to look up module IV, some of the stuff

20 that we had no idea about.

21 At any point in this caregiver  
22 experience, I think this curriculum is completely

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1 helpful.

2           One of the other things that I just  
3 wanted to bring up, I know there was a little bit  
4 of some critiques about the curriculum being  
5 written in a way that was almost too hopeful or  
6 unrealistic. And I would argue that you will get  
7 enough pessimism from doctors and nurses just  
8 doing their job, doing what they should be doing,  
9 so this was written in a way that should not be  
10 adversarial to any hope that the family members  
11 have. So, it should empower the caregivers to do  
12 the best job they can to help their loved one and  
13 not be adversarial to them in any way.

14           So, what I just really wanted to  
15 emphasize was the need for this. This was needed  
16 not yesterday, but like years ago. So I really,  
17 really would hate to see, after all this work --  
18 it's been a year and a half that we were on this  
19 and I still feel like that's a year and a half too  
20 late, but I want to see this out to people now  
21 because it's just -- it would be so helpful to  
22 these people going through this particular hell.

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1 They need any kind of helping hand they can get.

2 Thank you. Shannon Maxwell will be  
3 speaking next.

4 MS. MAXWELL: My name is Shannon  
5 Maxwell, and my husband, Tim Maxwell, Lieutenant  
6 Colonel, now retired, in the Marine Corps, was  
7 wounded October 7th of 2004, when a mortar landed  
8 outside his tent and he took shrapnel fragments to  
9 his brain.

10 When I joined the Panel, I joined it  
11 with a couple of different hats on: Not only just  
12 as a caregiver, but also as an advocate, not only  
13 for my husband and my family, but for the many  
14 families that we have attempted to work for over  
15 the past few years since my husband was wounded.

16 Tim has had a great recovery, really  
17 remarkable recovery, but there are certainly some  
18 challenges. There was a lot of information, even  
19 as highly educated individuals with master's  
20 degrees, that we could have used in his early  
21 phases and still could use. We have actually gone  
22 through two separate recoveries: the initial

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1 recovery when Tim was wounded; and then about a  
2 year ago last summer, Tim had to go through  
3 another brain surgery to remove a piece of  
4 shrapnel from his brain that was leaching heavy  
5 metal toxins. That set about a course of extreme  
6 decline in his cognitive abilities, his motor  
7 functioning. And when the doctor removed that,  
8 again there was hope, again there was new  
9 information that we needed that we didn't have  
10 access to, new sequella that we were dealing with.  
11 So this curriculum, not only is it comprehensive  
12 in that it gives a family military -- Basic  
13 Military 101 when they don't know all the acronyms  
14 that are being thrown at them, it gives them basic  
15 definitions of what a TBI is and what the effects  
16 of that traumatic brain injury are. But it also  
17 has longevity in that it teaches the caregiver to  
18 be a caregiver, to remember to take care of them  
19 self. So many caregivers are very, very strong,  
20 and you have to be, but they will kill themselves  
21 giving everything they can to their Service  
22 member. And along with that, they're also taking

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1 care of other family members: children, a sick  
2 husband, many of our families have exceptional  
3 family members along with the traumatic brain  
4 injury Service members. So, definitely longevity  
5 throughout recovery, which is, as you know, a  
6 traumatic brain injury is ongoing for a lifetime.  
7 The resources are extremely valuable.

8 But as Liza said, this curriculum needs  
9 to get into the hands of these caregivers now. It  
10 is relevant, it is pertinent, it is a lifeline for  
11 some of these families, not only for the caregiver  
12 to become educated themselves, but to educate the  
13 traumatic brain injury service member who's trying  
14 to understand why all these things are happening  
15 to them. It also has application in educating the  
16 children and why daddy is behaving this way, why  
17 can't he do the things he used to do, or our son  
18 trying to educate other family members, sisters,  
19 brothers.

20 I also see it have application in a  
21 greater forum as a severe or moderate traumatic  
22 brain injury patient moves through his or her

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1 recovery and becomes a -- again, a contributing  
2 member of society. They start to adapt to a  
3 purposeful occupation, whether it's still in the  
4 military or in his civilian life. This curriculum  
5 has great capacity to educate the employer as  
6 well.

7 The Panel has really thought this out  
8 well. It is comprehensive. The application --  
9 the partnership with CEMM to be able to get this  
10 application online so that everybody has access to  
11 it is incredible.

12 We did look through -- I don't know if  
13 you want me to get into this or not, when we were  
14 putting together the marketing and dissemination  
15 plan for this, the recommendations were to really  
16 again focus on the caregiver, the points of  
17 contact that we as a government, by the DoD or the  
18 VA, would have contact with the caregivers ongoing  
19 to get this curriculum in their hands. There were  
20 some consistent points of contact, both directly  
21 through the federal recovery coordinators, and the  
22 RCCs. They're recovery coordinators that are on a

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1 DoD level. They provide consistent contact with  
2 the families.

3 DVBIC also is a very, very strong  
4 proponent well thought of by caregivers in the  
5 community. It's when you look at that  
6 peer-to-peer contact between caregiver to  
7 caregiver, DVBIC is consistently an organization  
8 that is referred to. So having them continue to  
9 be involved in the dissemination of this  
10 curriculum and the maintaining of it, it's  
11 timeliness and relevance updates will be very  
12 crucial.

13 And I appreciate the fact that you all  
14 have considered this curriculum and that you're  
15 willing to vote on it today. I hope that you will  
16 vote on the curriculum in full. Every single  
17 module is important. Every single module will be  
18 important to give to the caregiver as a whole.  
19 The education-based thought of distributing this  
20 curriculum is very important because as a  
21 caregiver, when you're going through so much, some  
22 caregivers will take the time to read through, but

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1       you also need a sounding board. You need somebody  
2       who can walk you through the curriculum, to give  
3       you a better understanding of what you're reading,  
4       to answer questions, and just to guide you through  
5       that process.

6                     So, thank you very much.

7                     MS. MOESSNER: Thank you. So, as a  
8       group, we're willing to entertain questions.

9                     DR. POLAND: So, what I'd like to do is  
10       we'll have discussion, we'll have a vote, and then  
11       one other activity related to this topic. So,  
12       first, any questions or discussion?

13                    DR. MASON: Tom Mason, University of  
14       South Florida, Tampa. Not only do I applaud what  
15       you've done, what I'm really interested in is the  
16       thought that you've given to maintaining currency.  
17       I mean, as it exists right now, it's a spectacular  
18       piece of work in my considered opinion, but,  
19       hopefully we will make progress.

20                    MS. MOESSNER: Yes.

21                    MR. MASON: And I would really  
22       appreciate your sharing with us, as you move

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1 forward and as you find this is working really  
2 well, this really needs to be fine-tuned, which  
3 will come as no surprise to anyone. How do you  
4 propose using CEMM in a real world environment, in  
5 real time, to then keep and maintain the currency?  
6 Because, as you know, there's an awful lot of  
7 work, you know better than most, and a lot of that  
8 -- many of those reports and research findings  
9 will become available in the next months? So,  
10 what is your plan and proposal? And how do you  
11 see, basically, getting the materials out, but  
12 getting the feedback back in a timely manner and  
13 then acting on that feedback that you get?

14 MS. MOESSNER: Thank you. That was  
15 discussed at length, and basically, you know,  
16 everybody at the Panel meeting agrees that, again,  
17 what you don't want to do is put it out there and  
18 then not keep it current. There was risk in  
19 putting together a print product versus an  
20 electronic, that you could change at a moment's  
21 notice, but we had so much feedback from family  
22 caregivers that there had to be a print of

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1 available, they need something they can take with  
2 them. And so the Panel's thoughts were that at  
3 least on an annual basis, the curriculum needs to  
4 be reviewed for accuracy and updates made. Again,  
5 we seem to, and all the discussions go back to,  
6 there has to be an agency designated to do that  
7 and support given to that agency to do that.  
8 There needs to be somebody and an agency  
9 identified to keep that up or otherwise, you're  
10 right, that will become an issue. So that would  
11 be one of our, you know, recommendations as a  
12 panel that this be part of the plan.

13 DR. MASON: If I might --

14 MS. MOESSNER: Please.

15 DR. MASON: -- just one additional  
16 thought. If perhaps you would use as a model the  
17 online resource that we use in disaster  
18 preparedness, lessons learned, information  
19 sharing, and have a hot button for hot topics, so  
20 that you can basically then share in real time.  
21 This is something that I've just seen, something  
22 that I've just learned.

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1           On a regular basis, you're not going to  
2           go through everything, but something's going to  
3           happen, you can count on it. Something's going to  
4           happen a few months out that you really want to  
5           disseminate.

6           MS. MOESSNER: Yeah. Wonderful. Those  
7           are great ideas. Please.

8           MS. MAXWELL: One more point that I just  
9           wanted to add. When we were, as a Panel, talking  
10          about the dissemination and marketing and we  
11          looked at the agencies that could be involved, the  
12          education base, the direct contact with the  
13          families through, whether it's the FRCs or RCCs,  
14          they are going to be able to get that timely,  
15          direct feedback, and then feed that back to DVBIC.  
16          So that's one more avenue.

17          MS. MOESSNER: Yeah, as mentioned  
18          previously, the CEMM website, as this is uploaded,  
19          that there will be some real-time opportunity for  
20          feedback there. Also a lot of discussion about  
21          feedback cards going out with the curriculum.  
22          But, again, somebody being charged with keeping

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1 track of the literature, the scientific findings  
2 that may impact the curriculum, that there needs  
3 to be folks designated to do that as well.

4 DR. POLAND: Could you identify  
5 yourself, please?

6 MS. CAMPBELL-KOTLER: Oh, I'm sorry, Meg  
7 Campbell-Kotler. I'm the manager of the Office of  
8 Education for DVBIC. And as the TBI operational  
9 component of the Defense Centers of Excellence, I  
10 think DVBIC is in a unique capacity to be sure  
11 that the curriculum remains current scientifically  
12 and medically. The component that perhaps will be  
13 more difficult is getting family feedback, getting  
14 user feedback, but certainly through the federal  
15 recovery coordinators and through the recovery  
16 coordinators and around DVBIC, TBI care  
17 coordinators will have enough touchstones that we  
18 can pull that together.

19 I already had a chance to speak with the  
20 Federal Recovery Coordinators about this and they  
21 seem very receptive to even tracking to make sure  
22 that they keep track of who in their client base

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1 has actually received the curriculum, so I think  
2 we'll have good cooperation.

3 DR. POLAND: Dr. Parkinson?

4 DR. PARKINSON: Yeah, Mike Parkinson.  
5 Congratulations again to everyone. I think,  
6 though, what I just want to put an exclamation  
7 point after again -- and I appreciate Anne going  
8 back. I probably was the most vocal person on  
9 what is almost an unfortunate term because it  
10 trivializes, I think, what it is. It's social  
11 networking, which is, I tell you, right now it is  
12 a huge, huge area of exploding discovery in the  
13 civilian health care sector, in behavior change,  
14 care engagement, cost mitigation, quality of life.  
15 It is huge and we're just beginning to learn how  
16 powerful it is.

17 Our family members, you both remarked, I  
18 just wanted to talk to somebody, I needed to talk  
19 to somebody, anybody, then, now. We have to  
20 accelerate the platforms for us to do this, I  
21 really believe that. I know the CEMM very well.  
22 I think it's a wonderful vehicle, but I would

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1 listen to your own comments. At every stage of  
2 the healing process, from the first time you see  
3 your loved one in ICU to the 3:00 a.m. in the  
4 morning when you're all by yourself in Sedalia,  
5 Kansas, and there's nobody around, you need that  
6 person or that connection to do it, and you know  
7 it. And I just urge us as an organization to push  
8 that to, if not the head of the list, very high.

9 The second thing I would argue for us to  
10 do, and I didn't hear, but I hope it's there, I  
11 understand the desire to have all the materials  
12 for the caregiver in one place. But what we have  
13 to do, frankly, as the clinical side of the  
14 enterprise, is to break down those modules into  
15 the right process, marry them up to the clinical  
16 practice, put guidelines or standing orders in our  
17 neurological units, in our recovery units, in our  
18 ambulatory care centers, so that module 4 is a  
19 checklist item just the way we would do a medical  
20 safety issue as it relates to disposal of a sharp  
21 instrument or something.

22 So, embedding the modules into the

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1 clinical practice guideline so the clinicians are  
2 expected to have that as part of their quality  
3 performance -- did the family have access to and  
4 understand module 4 -- at what 80 percent of the  
5 people will be in their clinical recuperation  
6 phase? So that's another area that we can do and  
7 that can all be automated into the EMR, AHLTA, for  
8 certain types. You can tie it into an ICD-9 code  
9 that tracks along with it. So, think about those  
10 things between DVBIC and the CEMM as you go  
11 forward.

12 MS. MOESSNER: Great. Excellent ideas  
13 as well.

14 MS. BIGGERS: I just have something  
15 quick to say on the social networking thing. I  
16 mean, that would be great, but you have to  
17 remember, too, severe TBIs are shipped everywhere,  
18 and your access to a computer is iffy. So,  
19 unfortunately, that's -- until that becomes more  
20 of a reliable, you know, accessibility, it's  
21 really hard. I was lucky to e-mail people if I  
22 could. So, I don't know, I have an iPhone now and

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1 that helps. Back then it was, you know, the  
2 waiting room, waiting in line to use a tiny  
3 computer. So that's something that maybe should  
4 be looked at, too.

5 DR. POLAND: Any other questions or  
6 comments? Otherwise, we're going to ask for a  
7 show of hands to approve the curriculum,  
8 "Traumatic Brain Injury: A Guide for Caregivers  
9 of Service Members and Veterans." Can I have a  
10 show of hands for those that would like to approve  
11 the curriculum?

12 Anybody opposed? It's unanimous.

13 MS. MOESSNER: Thank you.

14 DR. POLAND: Before you leave, Anne,  
15 could I ask you to just stay there and ask the  
16 Exec Secs and my Co-VP to join me up at the  
17 podium?

18 There are occasional times in the  
19 universe when a problem becomes manifest, an  
20 individual becomes available, a group of people  
21 who bring passion, experience and content  
22 expertise, and wonderful things happen, and such

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1 is one of those times in the universe.

2 I think, Anne, if anybody ever asks you  
3 how you served your country, you have an easy  
4 answer. Thank you so very much for the work that  
5 you and your panel have done.

6 MS. MOESSNER: My pleasure.

7 DR. POLAND: The plaque says, "With  
8 deepest appreciation for your outstanding  
9 contributions as Defense Health Board Subcommittee  
10 Chairman, Traumatic Brain Injury Family Caregiver  
11 Panel. Thank you for your selfless and dedicated  
12 support."

13 MS. MOESSNER: My pleasure. Thank you  
14 so much. And let me again advance the slides one  
15 more time here. Just so -- and you have this in  
16 your handout as well -- to the really devoted,  
17 diverse group of individuals that helped pull this  
18 project together. There were several appointed  
19 members, some ex officio members, some consultants  
20 both individuals who had survived traumatic brain  
21 injuries themselves, certain the family caregivers  
22 on the Panel were invaluable. We had contingency

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1 members, and really in deep appreciation to the  
2 writers who spent, really, countless hours on the  
3 project. The Henry Jackson Foundation provided  
4 the graphic and packaging support. Colonel  
5 Mauffray at CEMM really has a wonderful website  
6 that I think will be extremely useful as we move  
7 into the future. A lot of the focus group  
8 participants and the families who provided their  
9 personal stories for the vignettes deserve thanks  
10 as well. Thank you to Commander Feeks, who  
11 supported the project as he attended all of our  
12 meetings and was very involved in phone calls and  
13 decisions along the way. And our deep  
14 appreciation for the DHB for your support of this  
15 project. Thank you.

16 DR. POLAND: Well, Anne, all of us are  
17 going to be found wanting after your presentation.  
18 Safe travels.

19 Ms. Maxwell, Ms. Biggers, thank you,  
20 too. Our next speaker is Captain Martha Girz. We  
21 have a 30-minute slot reserved for this. She  
22 serves as the J3 Assistant Chief of Clinical

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1 Operations for the Joint Task Force National  
2 Capital Region Medical as well as being an  
3 Assistant Professor of Medicine at USSHS. She'll  
4 update the Board on the Department's progress  
5 regarding the establishment of the Joint Pathology  
6 Center, including the Department's response to  
7 this Board's recommendations, which we issued last  
8 year. Her slides are under tab 5.

9 CAPT GIRZ: Thank you, and good  
10 afternoon. I'm happy to update you where we are  
11 with the Joint Pathology Center, since I last  
12 updated you in March, based on your  
13 recommendations at that time.

14 Slide one, which is the status, you'll  
15 see that since March, the President has delegated  
16 the Joint Pathology Center establishment to the  
17 DoD. That occurred at the end of April. Within  
18 the Department of Defense, the military medical  
19 leaders all decided that the Joint Task Force  
20 would take on the leadership and would take on the  
21 Joint Pathology Center. However, that decision is  
22 still pending delegation from the Deputy Secretary

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1 of Defense. That is currently in coordination and  
2 so we're waiting on that.

3 In the interim, the JTF CAPMED created a  
4 JPC implementation team because we know we needed  
5 to continue the process while we're waiting for  
6 the delegation. That team was chartered and set  
7 in July and had membership from across multiple  
8 agencies. As you can see, the AFIP was  
9 represented. We had the service pathology  
10 representatives, the consultants, or specialty  
11 leaders as you were for the services, the JTF  
12 CAPMED, obviously, the executive agent for AFIP,  
13 which is the Army, the VA; we have a rep from OSD  
14 HA, from TMA, and from USU.

15 The charter of the group was to plan,  
16 build, and execute, which is our methodology. So,  
17 in terms of plans, the current initial operating  
18 capability for the Joint Pathology Center is set  
19 for July of 2010 with the expectation we'll have  
20 full operating capability by the end of summer  
21 2011.

22 The I Team is continuing to meet. We

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1 are completing a gap analysis based on the Joint  
2 Pathology Center Health Affairs Working Group  
3 CONOPS, which was approved, which you all reviewed  
4 and gave recommendations to. We are currently  
5 developing a detailed operations plan, an  
6 implementation plan to include milestones is soon  
7 to follow and obviously all this is going to be in  
8 coordination with the AFIP's BRAC plan because we  
9 cannot work in a vacuum.

10 This slide goes over our Joint Pathology  
11 Center capabilities and, as I've already said, no  
12 later than summer of 2011 we will be at full  
13 operating capability. And those are outlined  
14 there of what our full spectrum of pathology  
15 consultation service will be. I do want to point  
16 out that many of the things that you had  
17 recommended are in our review of the CONOPS, one  
18 of which is supporting the depleted uranium and  
19 embedded fragment analysis. So that analysis is  
20 underway and as well the support to AFME, the  
21 Armed Forces Medical Examiner System. We have  
22 plans to serve as the primary pathology reference

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1 center for them as well.

2 You'll note that the first bullet,  
3 consultation, utilizing state of the art molecular  
4 testing, histopathology and histochemistry, are  
5 also there for full operating capabilities.

6 In terms of pathology education, you see  
7 that we plan to partner with USU to provide  
8 continuing medical education. Those will include  
9 VTC, online pathology courses, and virtual slide  
10 seminars, the content of which will be written by  
11 the staff of the Joint Pathology Center. USU will  
12 be our partner in supporting those CME activities  
13 for the administrative piece, but the content will  
14 be done by the members of the Joint Pathology  
15 Center.

16 In addition, in terms of education, the  
17 integral component of the Walter Reed National  
18 Military Medical Center and DoD pathology  
19 residency and fellowship programs, the Joint  
20 Pathology Center will be a participating  
21 institution in those, specifically derm pathology  
22 and the forensic fellowships, the DoD forensic

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1 fellowships, as well as the Navy oral path  
2 residency. So the members of the Joint Pathology  
3 Center will be staff/faculty for those programs.

4 In terms of our clinical research, we  
5 obviously will be supporting military-relevant and  
6 military-critical research. The TBI Initiative is  
7 one that is currently underway, which we would  
8 plan to continue with the Joint Pathology Center.  
9 Also the Combat Wound Initiative, which you know  
10 is a Congressionally mandated initiative, the  
11 Joint Pathology Center will plan to continue that  
12 initiative. There are many U.S. Cancer Military  
13 Institute initiatives that we hope to look to  
14 partner with as part of the Joint Pathology  
15 Center.

16 Pathology research that is done through  
17 the Walter Reed National Military Medical Center  
18 and other military facilities will also be done in  
19 collaboration with the Joint Pathology Center  
20 where appropriate. Use of the repository for  
21 research is one of the areas that we need to do a  
22 lot more consideration of in determining how best

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1 to use the tissue repository and that's certainly  
2 on our list of things to do.

3 Partnering with the U.S. Military Cancer  
4 Institute in ways that we've not done previously  
5 is one of the goals for the Joint Pathology Center  
6 as well. Utilizing cohort registries, of which  
7 there are many currently, and the ACTUR database  
8 for research is another area where we hope to  
9 utilize the Joint Pathology Center in conjunction  
10 with those resources.

11 The Tissue Bio Repository, by statute,  
12 we must maintain and modernize and that is one of  
13 the areas in which we need to do a lot more  
14 planning. And then we've already talked about use  
15 of the repository for research.

16 Also on this slide you'll see utilize  
17 strategic partnerships to leverage and enhance  
18 existing capabilities. This is one of the things  
19 that we think is very important that the Joint  
20 Pathology Center cannot function on its own in  
21 DoD, that there are many resources in DoD and the  
22 federal government that we need to partner and

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1 collaborate with. And obviously USMCI, Uniform  
2 Services within the DoD, are two that we would  
3 plan to collaborate extensively with. And then  
4 other federal agencies, we haven't begun that  
5 list, but we know that there will be a long list  
6 of other federal agencies that we will need to  
7 collaborate with in terms of research, education,  
8 and clinical care.

9 In response to your recommendation that  
10 we reconsider where the placement of the Joint  
11 Pathology Center is within DoD and based on the  
12 CONOPS that we had originally presented, we did  
13 recommend that the JPC be a direct report to the  
14 JTF Headquarters, removing it from the Pathology  
15 Department of the Walter Reed National Military  
16 Medical Center up to the headquarters level. So  
17 that recommendation has been enacted.

18 In terms of resources, you also had  
19 recommended that we reconsider our staffing  
20 models, and we have done that through the gap  
21 analysis of the Implementation Team and you can  
22 see where our staffing currently stands. We've

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1 added several areas of specialty that in the  
2 initial CONOPS were not thought to be needed, but  
3 on review of the gap analysis, we determined that  
4 we did need several of the specialties that were  
5 not initially thought, and those include  
6 cardiovascular, nephro, environmental, and I  
7 believe we added additional GU expertise to  
8 increase the number of board-certified  
9 pathologists from 23 to 29.

10 Additionally, we looked at our technical  
11 support and, based on your recommendations and,  
12 once again, the gap analysis, what the I Team is  
13 doing, we've increased the number of technical and  
14 administrative support as well.

15 In terms of the budget we are working  
16 closely with Health Affairs, TMA, to determine  
17 where the funding will come from. This will not  
18 be an earmarked organization and so looking at  
19 where the funding is going to come from DoD is  
20 going to be underway once we're further along in  
21 our operating plan and have our full staffing plan  
22 completed.

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1           So, our way ahead is completing the gap  
2           analysis and our Operations Plan, the OPLAN. The  
3           I Team is continuing to deliberate on these  
4           things. Obviously we're working closely with AFIP  
5           so we can coordinate closely with their BRAC plan  
6           to ensure that there's no loss of continuity for  
7           patient care. And we're also working with all of  
8           the stakeholders to ensure that once our plans are  
9           in place that the services are programmed to those  
10          appropriate organizations.

11           And that is the end of my presentation.  
12          I'm happy to take questions.

13           DR. POLAND: Comments or questions.  
14          Joe?

15           DR. PARISI: Well, I have several  
16          comments.

17           DR. POLAND: Joe, introduce yourself.

18           DR. PARISI: Joe Parisi from Mayo  
19          Clinic. I have several questions regarding your  
20          presentation.

21           First of all, I guess I'm a little  
22          disappointed. I think we went through -- in

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1 getting ready for this meeting we had asked --  
2 actually asked you a series of very detailed  
3 questions and I see very little detail that you've  
4 provided here. So, I guess I'm a bit disappointed  
5 that we don't have the level of detail that we  
6 were expecting to receive today.

7           When someone talks about a reference  
8 center, I think the spirit of the law was that the  
9 President establish a reference center for the  
10 federal government, and so far I just see you  
11 providing service. Reference center, to most  
12 people, means that it's an academic center; it has  
13 very extensive research and educational activities  
14 embedded with the service. And what I see you  
15 emphasizing here is just the service part of it.  
16 And actually I see a conspicuous absence of other  
17 federal agencies being listed.

18           So, my question to you is, actually, was  
19 a survey of the other federal agencies done? What  
20 was the result of that? And can you comment on  
21 that?

22           CAPT GIRZ: Yes. That's not been done

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1 yet, but is in the plan.

2 DR. PARISI: We talked about this more  
3 than a year ago.

4 CAPT GIRZ: Mr. Wardell, do you have any  
5 comments to answer?

6 DR. PARISI: What are you waiting for?  
7 We talked about a lot of these issues for over a  
8 year. And again, the level of detail -- the devil  
9 is in the details here -- is very lacking, I  
10 think.

11 CAPT GIRZ: One answer to your comment  
12 is that because the Joint Pathology Center has not  
13 officially been delegated to the Joint Task Force,  
14 we have been wading through the process of that to  
15 happen. The Joint Task Force is not in the  
16 business of getting out ahead of the process of  
17 being delegated.

18 However, knowing that this needs to  
19 happen, we've been moving along at a pace --

20 DR. PARISI: I'm hearing two different

21 --

22 CAPT GIRZ: -- and that we don't get

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1 beyond what has been delegated to us.

2 DR. PARISI: I'm hearing two different  
3 things. You're moving along in one direction, but  
4 you can't do the other things that seem to be very  
5 critical to establishing what the ultimate scope  
6 of this new JPC will be. So, I'm hearing two  
7 different things from you.

8 There's a lot of detail questions that I  
9 could ask that probably are not really appropriate  
10 for this forum, but I think, again, there's very  
11 little -- we're left with a lot of goals and  
12 things that sound perfect, pie in the sky stuff,  
13 but I don't see any real substantive points here  
14 directed.

15 You know, if someone came to me and  
16 said, Joe, design a federal reference center for  
17 pathology, I would go about it by, first of all,  
18 getting the smartest guys I knew, the  
19 academicians, the people that had vision, and  
20 getting together in a room for a day or a couple  
21 of days, and putting things out on the table. And  
22 you guys really have just -- at least what I see

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1 here, you really just have designed a  
2 hospital-centric, anatomic pathology center that  
3 just is going to provide service and really very  
4 little else.

5 DR. POLAND: Let me make a suggestion.  
6 And I suspect without knowing, that there's more  
7 detail than what necessarily is in the slides.  
8 And I was just conferring with my colleagues here,  
9 and given Joe's point, I think an appropriate way  
10 to handle it would be to ask the Department for a  
11 detailed written response to the thoughtful  
12 questions that the Board raised last time rather  
13 than -- we've sort of forced you to artificially  
14 condense it into a handful of slides. And I think  
15 that would be an important document then for this  
16 Board to review and would allow you the  
17 opportunity to lay out in more detail what the  
18 timelines and what the responses to those  
19 questions would be. Is that fair?

20 CAPT GIRZ: Certainly.

21 DR. POLAND: Joe, is that helpful?

22 DR. PARISI: That would be very helpful.

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1 You know, I think this is a golden opportunity  
2 that we're -- the Department of Defense is missing  
3 it. This is an international resource. If you  
4 look at the history of the AFIP, look at what it's  
5 done for medicine throughout the 150 years of its  
6 existence. And I understand there's issues and we  
7 need to move forward, but you have an incredible  
8 opportunity here. The government is asking you to  
9 make a reference center for the federal government  
10 that's going to be an international resource. And  
11 what we've got designed here --

12 CAPT GIRZ: I'd like to say it's for the  
13 federal government. There's nothing in the  
14 statute that says it's international.

15 DR. PARISI: Yeah, I know, but if it's  
16 for the federal government, by virtue of that,  
17 it's going to be an international resource.

18 DR. POLAND: Okay. I think then, in  
19 fairness, then what we'll do is we'll ask for a  
20 timely written response and we'll ask the Exec  
21 Secs to work with establishing that timeline, but  
22 a timely written response that would have the

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1 level of detail that the questions envision behind  
2 them, and then ask the committee and Board to  
3 review it again.

4 Dr. Lednar also has a question.

5 DR. LEDNAR: The spirit of the Congress  
6 was to be sure that there was created a Center of  
7 Excellence for the -- I'll say the U.S. Federal  
8 Government, and you've identified a number of the  
9 pathology subspecialties that you see in the  
10 pathology staffing. The question I have is, as a  
11 reference center operating at the highest levels  
12 of pathology, how will you assure that not only is  
13 a physician credentialed and trained in an area of  
14 pathology subspecialty, but has the adequate  
15 experience and skill to be of a stature to be  
16 really a U.S. federal leader in their  
17 subspecialty?

18 Part of the concern I would have is in  
19 this time of transition, in this time of  
20 uncertainty, I would expect, without knowing, that  
21 you may be losing some current top talent. So you  
22 may be standing up the JPC as soon as next summer

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1 in its earliest stages with sort of a diminishing  
2 pathology staff. So, I'm wondering how you're  
3 planning to address that, to recruit the caliber  
4 of talent that you need to really operate a Center  
5 of Excellence as the Congress expects?

6 CAPT GIRZ: Do you have a thought on  
7 that? I'm going to defer to Captain Larson, who  
8 is one of our pathologists who's been working on  
9 the Joint Pathology Center.

10 CAPT LARSON: I'm David Larson. I work  
11 at the National Naval Medical Center. I was the  
12 Navy consultant for pathology.

13 We appreciate that comment. It is  
14 something that we have concerns about, too, are we  
15 going to get the right talent? I think we are  
16 looking for a good number of folks from the Armed  
17 Forces Institute of Pathology currently to come  
18 over and I know that a good number of them have  
19 spoken with Colonel Baker about wanting to come  
20 over and join us at the Joint Pathology Center, so  
21 we're hopeful that we're able to.

22 We recognize that we need to move

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1 quickly. I think we are undergoing a deliberative  
2 process to come up with the plan. You know, July  
3 is an aggressive timeline, but we want to do that  
4 in order to give them a goal and say this is when  
5 we're going to start up and that there is a job  
6 available for you as a part of this world-class  
7 federal resource.

8 DR. LEDNAR: If I can ask a follow-up  
9 question. If I remember, Colonel Baker was the  
10 Chair of the Department of Pathology in the  
11 Medical Center.

12 CAPT LARSON: He still is. He's the  
13 Chief of the Integrated Department. I am the  
14 Chair of the National Naval Medical Center because  
15 we still have two hospitals. So I'm the Lab  
16 Director, he is the Chairman of the Integrated  
17 Department.

18 DR. LEDNAR: The director of the JPC,  
19 when it stands up, would not be a second hat to  
20 the Department --

21 CAPT LARSON: No, no, and actually we  
22 have already undergone a process to select an

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1 interim Director. That is pre-decisional because  
2 they are waiting for a delegation from DEPSECDEF  
3 to the JTF. Admiral Mateczun cannot name somebody  
4 to be the interim director of the JPC until he has  
5 official delegation of that. But they've already  
6 met -- I think there's a decision on who that's  
7 going to be, but it's pre- decisional and can't  
8 release that just yet.

9 But we're ready to go. I mean, as soon  
10 as they get it, we've got an interim director,  
11 we're developing the OPLAN, the Operations Plan,  
12 we're ready to go.

13 DR. POLAND: We've got a few more  
14 questions -- Dr. Walker, Dr. Silva, and then Dr.  
15 Oxman and, I'm sorry, I don't know your name.

16 DR. BARTON: Dr. Barton.

17 DR. POLAND: We'll get you fourth.

18 DR. WALKER: So, this is on our agenda  
19 here, is recommendations and progress updates, so  
20 clearly it's not a final -- it's not final. And  
21 in the recommendations, or what I read as  
22 recommendations under the JPC capabilities, are

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1 three things related to tissue battle repository,  
2 the use of the battle repository material for  
3 research, maintain and modernize it -- modernizing  
4 it is certainly a good idea -- and use the  
5 material for clinical care and develop a process  
6 for utilization.

7 So, what's missing there is -- and it  
8 says here, implement the plan to modernize the  
9 tissue repository and to implement the plan to  
10 expand research and education. Those are things  
11 that I would really like to know what's planned

12 and what resources are going to be put into them  
13 because --

14 DR. POLAND: And I think that's  
15 appropriate to ask and to receive in this more  
16 less-abbreviated format than what we're seeing  
17 today.

18 DR. WALKER: Right, but there's one  
19 detail here that I would like to just address and  
20 that 29 board-certified subspecialist pathologists

21 sounds like a lot, and it certainly would be for  
22 any one hospital, but that's less than two per

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1 subspecialty. And as the Chair of a department, I  
2 know that if I'm going to have a subspecialist,  
3 I've got to have at least two per subspecialty  
4 because somebody's going to be on vacation.

5 But the more practical thing is, the  
6 more realistic thing for the purpose of this, is  
7 that you have to have at least one of those in  
8 every subspecialty that is research- oriented to  
9 utilize the repository to create new knowledge, to  
10 push prognostics, theragnostics, and those things  
11 forward.

12 And so I would ask that that be thought  
13 through how that's going to be accomplished.

14 DR. SILVA: Yeah, I liked what Dave --  
15 Silva -- I like what Dave suggested. I want to  
16 know how they're going to put them to work, also.  
17 While it looks heavy, it looks thin from many  
18 dimensions.

19 The other thing is, this thing has a lot  
20 of eddy currents to it. I barely understand all  
21 of them, and we keep seeing it and there's -- you  
22 know, there's not much movement. And if Joe

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1 Parisi has questions that he's framed, maybe he  
2 wants to put them in writing and have them asked  
3 to the staff to see what they're going to do with  
4 it. Because it sounds like there are layers here  
5 that no one's going to be happy until we get  
6 answers, yea or nay.

7 Thank you.

8 DR. POLAND: Mike?

9 DR. OXMAN: This is the United States  
10 Center of Excellence, if you will, or that's the  
11 plan. The distinguished pathologists are in  
12 academic centers around the country, only a small  
13 fraction of whom are with the military. And I'm  
14 concerned, and I think the Subcommittee was  
15 concerned, about the ultimate oversight and  
16 decision-making process and that it be represented  
17 by a broad spectrum of the top pathologists in the  
18 country irrespective of their linkage to the  
19 Uniform Services Medical School or any other  
20 agency that's directly linked to the military.

21 The military needs help in this area if  
22 it's going to have an international reputation for

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1 excellence.

2 DR. POLAND: There was a comment back  
3 there? Please come up and introduce yourself.  
4 And then one more and we'll move on.

5 DR. BARTON: I'm Dr. Joel Barton. I'm  
6 currently a member of the Gerontology Urinary  
7 Pathology Department at the AFIP. I think it's  
8 fair to say with the sparse nature of the  
9 presentation that we could spend hours in here  
10 trying to flesh out major, major gaps in the  
11 presentation. Hopefully, she will be able to  
12 provide those details to Dr. Parisi's questions  
13 and a number of others that we've had unanswered  
14 for months if not longer at the AFIP.

15 But two major things I'd like to bring  
16 up, you know, to reiterate what was said over  
17 here. There are 19 subspecialties of pathology  
18 listed in this presentation supposedly covered by  
19 29 pathologists. If any of you have actually been  
20 at AFIP and seen the workload as it comes through  
21 various departments, that's less than two people  
22 per department. When someone's gone, when

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1 someone's sick, there is no way you can keep up  
2 with the workload.

3           The other thing I did not see addressed  
4 here is a very, very crucial point, and that is  
5 where we're going to be located and what kind of  
6 space allocation there is per pathologist  
7 involved. What we have been told at this point is  
8 basically a large room, perhaps not even the size  
9 of this room, in which these "distinguished  
10 pathologists" that will be attracted to the JPC  
11 will be placed in cubicles in one room, probably  
12 along with their support staff, which is really  
13 very, very inadequate, and I would like that point  
14 addressed, please.

15           DR. POLAND: General Anderson. We'll  
16 let those be addressed in writing.

17           GEN ANDERSON: This is your relief  
18 coming. I'm George Anderson. I serve on the  
19 Defense Health Board Subcommittee on Healthcare  
20 Delivery. I'd like to make a statement and then  
21 ask a question that's really an opinion. The  
22 statement is that at least from my observation

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1 point, having the Joint Pathology Center directly  
2 assigned to the Task Force during CAPMED is a nice  
3 thing given where we saw it originally.

4 Now, I do want to state, though, there  
5 is some ambiguity about the whole organization of  
6 the Joint Task Force. So what we would like you  
7 to continue to think about is the eventual home  
8 for this Center, which will be, you know, given  
9 the nature of the politics surrounding a task  
10 force that's still directly reporting to the  
11 Deputy Secretary of Defense, there's going to be  
12 an evolution there, too. So, when you go through  
13 your deliberations, when your OPLAN comes up, you  
14 know, we'll be watching that, too, from the  
15 Defense Health Board.

16 So, I just wanted to make that  
17 statement. You can't respond to that, so, there  
18 we go.

19 The question is really more one of an  
20 opinion. And we looked at a rather aggressive  
21 schedule here from what you reported, where you  
22 have the AFIP BRAC generated timeline for action,

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1       which has end dates in 2011 for sure. And you  
2       have your CONOPS moving to OPLAN now. And my  
3       question really is, are you seeing any roadblocks  
4       between those two different sets of directives as  
5       you move into the OPLAN? And then, you know,  
6       related directly to that was, how's the budget?

7                CAPT GIRZ: So, two questions --

8                GEN ANDERSON: You know, in the  
9       Department of Defense, what gets budgeted is what  
10      gets done, okay. So it's one question, but, you  
11      know, if you don't have the money to do it and are  
12      there roadblocks that you see coming?

13              CAPT GIRZ: Mr. Wardell, do you want to  
14      address the money piece?

15              DR. WARDELL: Yeah, I'm Mr. Scott  
16      Wardell, the Deputy Chief of Staff with the JTF  
17      CAPMED.

18              Great question, sir. Right now there  
19      are no roadblocks. TMA has been a -- TRICARE  
20      Management Activity, has been part of the  
21      deliberations and the formation of the OPLAN thus  
22      far. Really, quite frankly, what they're waiting

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1 on is the exact figure of the number of personnel,  
2 you know, highlighting the fact, for instance,  
3 that driven by the original CONOPS, the JPC was an  
4 organization of 81 personnel. It has, through the  
5 gap analysis, grown to 104 people, primarily  
6 civilian personnel. Also the bed-down for  
7 instance, is going to drive some cost of initial  
8 outfitting and so on. All of those are in the  
9 existing baseline.

10 Now, the executive agent, being the Army  
11 and certainly TMA, have not expressed any concerns  
12 about it, at this point, an ability to meet that  
13 budget, nor carry that budget forward into the out  
14 years because, quite frankly, the baseline exists  
15 today. So, it will be a reprogramming of those  
16 existing resources into this to accommodate it.

17 Now, the Joint Task Force, as a standing  
18 element, is looking for the authorities necessary,  
19 as you know well, to become an allotment authority  
20 by FY '12.

21 (Recess)

22 DR. LEDNAR: I'm going to substitute for

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1 the Chair of this afternoon's session to introduce  
2 our next speaker, Dr. Poland.

3 Dr. Poland, as everyone knows, is the  
4 Co-Vice President of the Defense Health Board and  
5 chair of the Infectious Disease Control  
6 Subcommittee, as well as its Vaccine Safety and  
7 Effectiveness Working Group and its Pandemic  
8 Influenza Preparedness Subpanel. Dr. Poland is a  
9 Professor of Medicine in Molecular Pharmacology,  
10 Experimental Therapeutics in Infectious Diseases,  
11 as well as Director of the Mayo Vaccine Research  
12 Group. And, I might add, a highly sought after  
13 speaker on national media to talk about topical  
14 interests in infectious disease.

15 He will present an update this afternoon  
16 regarding recent activities of the Pandemic  
17 Influenza Preparedness Subpanel, as well as  
18 Vaccine Safety and Effectiveness Working Group.  
19 Core Board members may find Dr. Poland's  
20 presentation slides under tab 6.

21 DR. POLAND: Who would have guessed,  
22 Wayne? I've always been told I had a face for

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1 radio and a voice for print, so.

2 And as Chair of that Subpanel, let me  
3 just say that it's bothered me immensely to watch  
4 each of the speakers drink out of the same cup  
5 here.

6 So I'm going to do the two presentations  
7 back to back. I think I'll get us caught up here.  
8 I don't think I need as much time as was given to  
9 use here.

10 This is just a list of the Subpanel  
11 membership. All of these individuals have been  
12 very involved in the deliberations that we've had  
13 and the recommendations and products that we've  
14 delivered.

15 You'll recall that this Subcommittee was  
16 established in late 2005, basically to assist the  
17 Department in the issues that you see listed  
18 there.

19 Our recommendations were to be  
20 DoD-specific, focus on areas that were within DHB  
21 and DoD's sphere of influence. So, for example,  
22 we can't make vaccine. That's outside of our

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1 sphere of influence. Focus on both immediate and  
2 try to look forward into the future  
3 recommendations and on what's feasible.

4 We have, over the few years we've been  
5 in existence, been, I think, fairly active. I'm  
6 pleased, and I think the Panel, when we last met  
7 and reviewed some of these, that there was very  
8 little of any of the recommendations we made that  
9 we felt needed to be changed or where facts had  
10 altered what we had tried to best simulate or  
11 model in terms of our recommendations.

12 Specific issues that we have dealt with  
13 and looked at include antiviral recommendations,  
14 vaccine recommendations, how decisions are being  
15 made, pandemic influenza research recommendations.  
16 You'll recall discussions we've had about  
17 convalescent sera recommendations, PPE, novel flu  
18 diagnostics, antimicrobial stockpiles, the use of  
19 pneumococcal vaccine, and clinical trial  
20 recommendations. So it's been rather a busy time  
21 and we've dealt with a lot of issues.

22 In September, we had a meeting with

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1 representatives from Health Affairs, DHHS, and  
2 MILVAX, as well as our Subcommittee. We received  
3 at that meeting updates regarding DoD's  
4 preparedness and response.

5           And is Wayne here? Yes, Wayne is there.  
6 I want to just publicly thank Wayne for being very  
7 accessible, getting information to us very  
8 quickly. I know there are many times I've sent an  
9 e-mail at all sorts of times of the day, weekend,  
10 or night. And remarkably, often within minutes to  
11 no more than a few hours, Wayne has accommodated  
12 those requests. So, Wayne, thank you for  
13 facilitating our work.

14           And we specifically focused on H1N1  
15 vaccine and pneumococcal vaccines, the stockpiles  
16 of equipment and antivirals, and what will be a  
17 bigger issue, which is the active and passive  
18 vaccine safety surveillance plans following H1N1  
19 vaccine. And this has really become now a  
20 National Vaccine Safety and Assessment Working  
21 Group. MILVAX is there. As a representative of  
22 this committee, I also sit on that Board.

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1           And we've had our first meeting now and  
2       have outlined I think I counted just under a dozen  
3       different databases and methods that will be  
4       appealed to in the civilian, on the CDC, and on  
5       the military side to examine the millions and  
6       millions of doses of vaccine that have been given,  
7       and trying to look at safety since that's a big  
8       issue in the public and in the recipient's minds.

9           Well, to get to some of these. As I  
10      mentioned, there are collaborative efforts in  
11      regards to vaccine safety. The plan is to share  
12      information in the effort to standardize and  
13      synchronize how information comes to that safety  
14      committee across the different databases. And the  
15      Vaccine Safety Datalink was used as a model for  
16      the DoD data structure approach and statistical  
17      techniques that were going to be used.

18           And, Mike, if I am misspeaking in any  
19      regard there, please speak up. Because it really  
20      is the first time that I've really sat on a  
21      federal working group like this and was truly  
22      impressed -- I think that even those words sort of

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1 fail -- truly impressed at the interagency working  
2 at getting at these data and everybody agreeing on  
3 this is how we're going to analyze them, evaluate  
4 them, communicate them, et cetera.

5 We thought there would be potential  
6 significant challenges in the event that the  
7 pandemic worsened. There's no evidence for that.  
8 But trying to, again, look forward, primarily in  
9 regards to the availability of trained providers  
10 -- there's a limit on the number of people  
11 available -- a shortage of ICU nurses and supplies  
12 were it to get significantly worse, and budget  
13 issues.

14 So, you know, we're pointing those out.  
15 It's not, I don't think, necessary at this point  
16 that we come up with detailed plans because we've  
17 been through wave one, deep into wave two, and  
18 have seen no change in the virulence of the virus,  
19 mutations in the virus, et cetera.

20 Recent activities we heard about that  
21 have been undertaken by DoD include  
22 standardization of definitions, risk windows, what

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1 ICD-9 codes were going to be looked at. They had  
2 submitted a three-phase surveillance study  
3 protocol for IRB approval, great attention being  
4 given to active surveillance looking for both any  
5 vaccine side effects and platforms, diagnostic  
6 platforms, for agent identification and  
7 confirmation. As you might imagine, and it's true  
8 for all of us on the civilian side, eventuating in  
9 CDC's recommendations, we actually test relatively  
10 few people, not everybody who would come with an  
11 influenza-like illness, or we would just spend all  
12 of our budgets and all of our time testing.

13 And finally, the pursuit of various  
14 communication approaches to inform everybody  
15 involved regarding H1N1 vaccine safety.

16 We recommended that careful attention be  
17 paid to diagnostic criteria and the role of an  
18 expert panel that would determine whether a  
19 specific case met a definition. I think this has  
20 been very well handled by this Vaccine Safety  
21 Working Group, and really is a response -- some of  
22 you may know the story behind trying to understand

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1 Guillain-Barré as a side effect with the '76, '77  
2 vaccine; a lot of messiness in that determination.

3 We reiterated our previous  
4 recommendation regarding maximizing essential  
5 resources and that they be available in the event  
6 of any sort of surge that would be necessary if  
7 things were to worsen or change.

8 And that was really it for that  
9 Subpanel's meeting. We felt that things were  
10 going well. We didn't have any specific or major  
11 directional changes or recommendations.

12 So comments or questions on that before  
13 we get into the next one?

14 And from any of the Panel members?  
15 Anything you want to add that I didn't emphasize  
16 or left out?

17 Mike, anything from your perspective?

18 DR. OXMAN: I think you did very well.

19 DR. POLAND: COL Krukar, anything you  
20 want to add?

21 COL KRUKAR: No, sir. I think we'll  
22 get a little bit more in-depth detail as to the

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1 process when Wayne gives his presentation.

2 DR. POLAND: Okay. And just to give you  
3 one bottom line in terms of vaccine safety: Some  
4 15 or 20 million doses have been given and, at  
5 least at this point, there has not been a single  
6 vaccine-associated serious adverse event  
7 attributed to the vaccine. May be early to tell  
8 some of that. There have been some febrile  
9 seizures. Some of you may have heard about a case  
10 of GBS.

11 If you're interested in this I would  
12 commend to you Steve Black's article that was  
13 published in The Lancet, a week or a week and a  
14 half ago, looking at the U.S. and some other  
15 developed countries, looking at background rates  
16 of things we might care about: GBS, optic  
17 neuritis, sudden death, spontaneous abortion, a  
18 few other things like that, and the number of  
19 cases that absent any sort of H1N1 program would  
20 occur in any given minute, hour, day, or week in  
21 relation to vaccine. And, you know, within 6  
22 weeks, if you take 10 million women, 16,000 of

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1       them, as I recall -- 10 million pregnant women,  
2       16,000 of them will have a spontaneous abortion  
3       coincidentally within 6 weeks of getting H1N1  
4       vaccine.

5                   And this will be a really important  
6       part, not only of evaluating those data, but  
7       communicating to the vaccine recipients.  Because  
8       the tendency among the public, and even among  
9       health care workers, is to assume that temporality  
10      is causality.  And how many, many times we've  
11      learned the lesson that that is not correct.  
12      Makes for good hypothesis generation, but not a  
13      good way to prove a hypothesis.

14                  Okay.  I'll move on, then, to the other  
15      meeting that we had, which was the Vaccine Safety  
16      and Effectiveness Working Group.  Again, the  
17      purpose of this, since I don't think we've briefed  
18      on this to the Core Board before, was to form a  
19      working group that had the objectives you see  
20      there:  focus on FDA-approved vaccines; examine  
21      post-licensure vaccine safety, effectiveness, and  
22      surveillance studies in the context of DoD; review

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1 the extant data available for vaccine safety and  
2 effectiveness for vaccines used in DoD; discuss  
3 future DoD vaccine safety, effectiveness, and  
4 surveillance studies; identify and highlight  
5 research priorities as well as gaps; and provide  
6 guidance regarding studies that could be done.

7           And here's where I want to compliment  
8 COL Krukar and Garman and MILVAX. Again, they  
9 were very, very open and transparent with us. We  
10 had an excellent meeting. Had people from around  
11 the U.S. throughout DoD who showed up and really  
12 gave a very detailed set of briefs in terms of  
13 what was happening.

14           As you can imagine from looking at those  
15 marching orders, it's an almost impossibly broad  
16 task. But we will now begin to chip away at  
17 those. This first meeting was meant to sort of  
18 get an overview of what's happening and what could  
19 be done.

20           I want to pause for just a moment here  
21 and plant the seed that a topic that could be  
22 considered for one of our "summer studies," either

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1 at the level of the Board or perhaps at the level  
2 of our Subcommittee, would be to look at the issue  
3 of biodefense vaccine countermeasures. I believe  
4 it's the only thing mandated of the Board, is that  
5 we take the validated Chairman's Threat List and  
6 develop a memo that speaks to the countermeasures  
7 available. And the whole Board hears this. The  
8 whole Board has had some questions about the  
9 methodology; we won't go into that now. But, you  
10 know, we could ask the question, well, should  
11 other vaccines be used and others not used?  
12 What's the appropriate response? And that's  
13 something that would take, I think, focused briefs  
14 and consideration by the board. So I'll just  
15 plant that thought.

16 The membership of this particular  
17 Working Group is as you see there. We met in  
18 mid-September. And I'll just take you through the  
19 agenda topics. And I've listed the briefers, too,  
20 so you'll get a sense of the diversity of things  
21 that were going on. And this is sort of the tip  
22 of the iceberg of the things we were most

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1 interested in. There's a whole lot of other  
2 things happening too, of course.

3 But we heard an update from Mike McNeil  
4 at CDC about the Vaccine Analytic Unit and the  
5 very close interactions between CDC and DoD in  
6 this regard.

7 Phil Pittman talked to us about a  
8 smallpox vaccine shedding study. As you know, a  
9 remarkable safety record with administering  
10 smallpox vaccine, particularly in the big surge in  
11 2002. Nonetheless, there were a few episodes  
12 where shedding of the virus -- or I should say  
13 transmission of the virus to a non-intended  
14 recipient occurred. And Phil's been looking at  
15 that and methods such as topical iodine, for  
16 example, to decrease that shedding and the risk.

17 A number of briefs on smallpox vaccine  
18 safety projects. We were briefed through NHRC and  
19 MILVAX.

20 Seasonal influenza vaccine  
21 effectiveness, which was very interesting and in  
22 some cases quite controversial in terms of some of

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1 the findings, which in turn will lead to  
2 refinements in new studies to try to understand is  
3 TIV or LAIV the best vaccine in a given  
4 subpopulation or in a given setting.

5 H1N1 Vaccine Safety Study in Pregnant  
6 Females. Again, more as a response to have the  
7 data to respond, rather than a known concern. But  
8 like many vaccines, they're Category C and not  
9 necessarily -- a large database doesn't exist.  
10 Manufacturers are reticent to study their vaccines  
11 in pregnant women, for example, because of  
12 liability issues.

13 I've already talked about the  
14 interactions between FDA, CBER, MILVAX, CDC, and  
15 other agencies in terms of H1N1 vaccine safety.

16 Some specific issues that we noted was  
17 we were very pleased with the enhanced  
18 interaction, coordination, and collaborative  
19 efforts that were being pursued not only within  
20 DoD, but from outside of DoD with other federal  
21 agencies. That is a topic that has come up many  
22 times across disciplines. And without trying to

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1       overstate it, I think a model for how that could  
2       occur is what we've been seeing in regards to  
3       vaccine. Many questions regarding vaccines and  
4       the interagency interactions that were occurring.  
5       We were quite impressed.

6               NHRC is involved in a huge ACAM2000  
7       post-licensure Phase IV study. I think it's  
8       40,000 people that are being recruited from the  
9       military here.

10              COL KRUKAR: Twenty.

11              DR. POLAND: Pardon me?

12              COL KRUKAR: Twenty thousand.

13              DR. POLAND: Twenty thousand. Okay. So  
14       here's an example of an FDA mandate to a  
15       manufacturer of a vaccine that is primarily used  
16       within DoD. Wonderful interaction there. A  
17       myopericarditis and myocarditis registry that's  
18       been established and is ongoing in a number of AVA  
19       studies that are occurring.

20              We also heard about ongoing efforts to  
21       improve the quality and reliability of data  
22       capture, including a universal tracking system

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1 that's under consideration to address differences  
2 across services. Right now, how they're captured,  
3 when they're captured, how they're sent and rolled  
4 up differ by Service, not too surprisingly. And  
5 what was pleasing was not only the recognition  
6 that that needed to be changed, but specifics  
7 about how that might happen.

8 Assessments that are being planned to  
9 evaluate DoD adverse event screening during this  
10 huge Phase IV study that's being done. Evaluating  
11 and looking in a metric driven way at the  
12 completeness and accuracy of the DMSS immunization  
13 database.

14 We also talked about, with MILVAX and  
15 MIDRP, what were priority research topics. And  
16 here the Working Group had been requested to  
17 comment and provide feedback on proposed studies  
18 of priority to DoD. We'll increasingly be dealing  
19 with some of those. Some of them included  
20 seasonal vaccine effectiveness, comparing LAIV and  
21 TIV because there are some controversies there,  
22 external validation of vaccine research

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1 initiatives. I won't spend more time, but this  
2 was a large piece, for obvious temporal reasons,  
3 H1N1 vaccine safety.

4           And our findings were this. One was to  
5 develop and formalize closure mechanisms to  
6 facilitate -- and while we were dealing with  
7 specific issues around vaccines, it's a broader  
8 issue than just vaccines -- to facilitate DHB  
9 reviews and inform DHB in a timely manner  
10 regarding how the Department has pursued, what  
11 progress they've made, or decided not to pursue in  
12 regards to our recommendations. Availability of  
13 new data or research progress. Short of a  
14 briefing, we're not going to really know about a  
15 new research finding that might inform clinical  
16 policy, for example, absent hearing of those data.  
17 Many of those studies are only done within DoD,  
18 and if they're not published, we won't know about  
19 them until they're published. Of course, a very  
20 dynamic situation when you look, for example, at  
21 H1N1, and trying to keep abreast of shifts in DoD  
22 policies and priorities.

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1           We thought there were continued ways in  
2           which we could improve communication between DHB  
3           and DoD, including increasingly, shall I say,  
4           inserting ourselves in discussions in the  
5           decision-making process and providing guidance for  
6           high-priority areas.

7           This is sort of along the lines of what  
8           I was mentioning as a possible summer study topic,  
9           and that is the process for evaluating whether a  
10          threat agent continues to pose a threat and what  
11          the best countermeasure or mitigation efforts  
12          might be in that regard.

13          Encouraging implementation of consistent  
14          risk analyses to inform decisions pertaining to  
15          vaccine administration. Remember that while  
16          sometimes they overlap quite a bit, in a number of  
17          areas the way vaccines are studied and licensed in  
18          the private sector/civilian setting can be  
19          different than the way they're going to be  
20          implemented in the DoD setting or the manner in  
21          which they're implemented. And so the risk  
22          analyses may well be different. The cost

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1 effectiveness analyses, for example, and  
2 thresholds are different on the civilian side than  
3 the military side.

4 And, again, we commended the MILVAX  
5 initiative to unify research and funding  
6 priorities within DoD. They've worked very, very  
7 hard. It was grossly obvious in regards to the  
8 progress made in collaborations and endeavors to  
9 advance scientific understanding.

10 And the next steps that we plan on, just  
11 to let you know what our activities are, is at the  
12 next Biowarfare Countermeasures Workgroup meeting  
13 we'll be looking at smallpox and anthrax threat  
14 updates, determine whether any change should occur  
15 in regards to those recommendations. We didn't  
16 talk at our September meeting about adenovirus,  
17 but that's something that we'll endeavor to get  
18 back on our agenda and on the Board's agenda. I  
19 think it's time. It's been about a year or so,  
20 maybe a little longer, since we last heard the  
21 progress being made.

22 So there's an overview of what we have

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1 done. We're not asking for a vote or making any  
2 recommendations at this point.

3 Questions? Adil?

4 DR. SHAMOO: My experience is even in  
5 clinical trials, so this is really word of  
6 caution. Because you said there are no serious  
7 adverse events even in 20 million vaccinated  
8 individuals.

9 DR. POLAND: Vaccine-related adverse  
10 effects.

11 DR. SHAMOO: Yes, I understand. But I'm  
12 saying in general, even in clinical trial, which  
13 is much better control than 20 million vaccinated  
14 individuals, there is a strong tendency in  
15 underreporting adverse events, and especially  
16 serious adverse events. That is by the patients  
17 --

18 DR. POLAND: Yeah --

19 DR. SHAMOO: -- by the hospital, by the  
20 doctor. They avoid it, et cetera, et cetera. And  
21 I have anecdotal, as well as published report.  
22 And for those of us who are very familiar with the

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1 ethics and regulatory compliance of clinical  
2 trials, it's a big issue.

3 DR. POLAND: Yeah, absolutely.

4 DR. SHAMOO: So, I -- wait a minute. I  
5 would warn your committee to be really more  
6 vigilant. That when you hear none, does not mean  
7 there is none and they should go and look for it.

8 And second is, I tried to do the  
9 calculation, but I don't remember. Twenty  
10 million, you have normal death rates in about four  
11 weeks, you got to report a few deaths. So for  
12 them to claim there is not even one death among 20  
13 million, that does not happen.

14 DR. POLAND: Well, again, let me be sure  
15 you understand what my words were. There is not  
16 yet known a single vaccine-related adverse event,  
17 serious adverse event. So there have been, for  
18 example, deaths. Those have been examined. One  
19 example I can think of is a, I can't remember the  
20 gender, but a person who had known cardiovascular  
21 disease, angina, congestive heart failure,  
22 diabetes, a litany of things, who, six weeks or

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1 something after having vaccine, had a heart attack  
2 and died. Well, the judgment of the Committee was  
3 that that was not a vaccine-related adverse event.

4 The second thing is about 10,000 or so  
5 people have been studied in the context of a  
6 prospective clinical trial and no serious vaccine  
7 SAEs seen. And in the remaining, they are both  
8 prospective and retrospective examinations in, for  
9 example, the Vaccine Safety Datalink, where large  
10 managed care organizations actually prospectively  
11 track what's happening with people.

12 Your point is a fair one, is there can  
13 always be underreporting. So far the sense is  
14 because of the heightened public concern about  
15 this there have been a lot of VAERS reports, which  
16 is passive reporting, much more than what you  
17 would see for your typical seasonal vaccine. So I  
18 think they're doing the things they can do at this  
19 point.

20 DR. SHAMOO: All I'm saying is there  
21 should be vigilance. And I would strongly  
22 disagree with you because I know a few serious

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1 adverse events from the vaccine that the hospitals  
2 do not want to report it that is serious adverse  
3 events. They say it has nothing to do with the  
4 vaccine. No one wants to take the responsibility.  
5 I'm not saying there are a lot of them, but I am  
6 cautioning the committee to be more vigilant and  
7 proactive in looking for serious adverse events.

8 DR. LEDNAR: Dr. Oxman.

9 DR. OXMAN: The other side of that coin,  
10 which I think affected the reputation of the 1976,  
11 '77 swine flu, was the fact that every adverse  
12 event in the general population is underreported.  
13 So that if you don't have a placebo group, and a  
14 particularly blinded, you know, a double-blind  
15 study in which you have a large placebo group  
16 which is well matched, it's very challenging to  
17 use background data as a metric for what would be  
18 an incidence that would not be affected by the  
19 vaccine because that's going to be underreported.  
20 Whereas if we follow Adil and look carefully at 20  
21 million people who are vaccinated, there'll be  
22 less underreporting of Guillain-Barré or anything

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1 else.

2 DR. POLAND: Right. And there are  
3 mechanisms to do that. There's a technique called  
4 rapid cycle analysis, for example, where you can  
5 repeatedly examine these data. And they are  
6 examined on a weekly basis and, by the way, posted  
7 to a public website. So, you know, nobody knows  
8 of another way to more closely look. I think that  
9 it will be fair to say this will be an  
10 unprecedented safety surveillance in regards to  
11 H1N1. And the limitations are the inherent  
12 limitations. If people are not going to report  
13 and we don't know about it, there's precious  
14 little we can do.

15 But what you can do is at a minimum, and  
16 even in a case like that, you can say are we  
17 seeing -- let's take sudden death -- are we seeing  
18 a sudden death incidence that crosses the known  
19 background rate of it?

20 DR. LEDNAR: Dr. Parkinson.

21 DR. PARKINSON: Yeah, Mike Parkinson.

22 Greg, thank you. I'm not a member of the

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1 Subcommittee, but I kind of date, time my  
2 awareness of DoD H1N1 when we were last at the  
3 Academy.

4 DR. POLAND: Yeah.

5 DR. PARKINSON: And they had just gone  
6 through an outbreak there. And there are at least  
7 three or four things that I think in my -- in the  
8 last period of time that I think are relevant. If  
9 you just want to comment on any of them vis-à-vis  
10 the Committee's work or anything we should be  
11 aware of.

12 One, of course, was what happened at the  
13 Academy got rapidly reproduced at a lot of  
14 colleges and universities in the subsequent months  
15 in pretty much the same pattern. If they could do  
16 the social isolation, it kind of petered out. My  
17 own community, Carnegie Mellon, Pittsburgh, you  
18 know, that type of thing, we saw that. So I  
19 didn't think there's much new there.

20 There seems to be a greater appreciation  
21 for the mortality of this, particularly in young  
22 children and the younger ages, much more so than

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1 we saw that -- than we have -- I think for me, not  
2 being an immunologist or vaccinologist --  
3 appreciated back in August.

4 The next thing is the medical-political  
5 fracas around what happened to the production  
6 supply and did we over promise before. That still  
7 is a festering boil that we have yet to see that  
8 play out. But I think it's going to be  
9 significant, just my political hunch from being in  
10 the middle of these things before.

11 And then the last issue is about the  
12 increasing public skepticism that we need to do  
13 this at all, which is --

14 DR. POLAND: Just say that again, Mike.  
15 Of whether to do it?

16 DR. PARKINSON: Increasing public  
17 skepticism that we need to do this vaccine program  
18 at all.

19 DR. POLAND: Oh, okay.

20 DR. PARKINSON: At this point. Either  
21 it came through my community; I didn't notice it.

22 So that's just a potpourri, and maybe

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1       it's better for cocktail hour. But those are the  
2       four things that not being on the Committee that I  
3       see in the last four to six months that could all,  
4       each and of themselves be significant. Together,  
5       it could be really significant. Or maybe they're  
6       just petering out. I don't know. Any reaction --

7                   DR. POLAND: I think you articulated  
8       them very well, Mike. And the sort of tagline I  
9       give it is the two extremes that we see are apathy  
10      and panic, and neither are appropriate. I think  
11      what is becoming clearer is more about the  
12      epidemiology. It is the younger people who are  
13      out of proportion infected and who get  
14      hospitalized. It is the older people that when  
15      and if they get infected and have risk factors,  
16      die out of proportion. So some differences  
17      compared to seasonal influenza. I think it is  
18      fair to say that for many people, once there's  
19      enough vaccine available, they'll sort of say,  
20      well, do I even need to get it?

21                   It might be important to note that the  
22      Southern hemisphere has already made the decision

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1 to have the A California 2009 H1N1 be the H1  
2 component of their seasonal vaccine, which for  
3 them will be this summer. Almost certainly -- I'm  
4 not predicting it because who knows, but the  
5 decision will be made in February -- almost  
6 certainly we'll do that in the U.S., too.

7 DR. LEDNAR: Dr. Luepker?

8 DR. LUEPKER: Yes, Russell Luepker. I  
9 don't want to muddy the waters further, but just  
10 another --

11 DR. POLAND: Good, thank you. Are there  
12 other questions? I'm kidding you.

13 DR. LUEPKER: I'm vacillating between  
14 panic and apathy. You know, when the selected  
15 group of people that get this vaccine are going to  
16 be a healthier group. And comparing them to the  
17 usual level of cases may mislead you a bit.

18 DR. POLAND: Actually, just to correct,  
19 just the opposite. So, among the people who are  
20 getting the vaccine right now, they are, with the  
21 exception maybe of some of the healthcare workers  
22 and some of the younger children, they are people

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1 who have risk factors and are most at risk.

2 DR. LUEPKER: You're right. You're  
3 right there. But the large numbers are in young  
4 kids.

5 DR. POLAND: Yeah, they're certainly in  
6 the younger kids. That's true.

7 DR. LUEPKER: I'm curious if we know,  
8 apropos of Mike's question or at least the  
9 illusion, so how many military personnel have been  
10 vaccinated, have there been issues, and what's the  
11 refusal rate?

12 DR. POLAND: I think, Wayne, might you  
13 get into that in your brief? We'll find out. On  
14 the civilian side, all I can tell you is the  
15 observation -- I can't quantitate it, Russ -- is  
16 that somewhere around the majority of health care  
17 workers are refusing the vaccine. By the way,  
18 about the same number as seem to be refusing  
19 seasonal vaccine, and you know how I feel about  
20 that.

21 DR. LUEPKER: That actually, we have  
22 some experience and it worries me. I mean, we

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1 have wards full of bone marrow transplant --

2 DR. POLAND: I know.

3 DR. LUEPKER: -- and kidney and heart  
4 transplant people who --

5 DR. POLAND: Dr. O'Leary is not here  
6 right now. He just told me he sits on the  
7 National Patient Safety Foundation. And  
8 yesterday, I think it was, they endorsed a policy  
9 that the clinical standard of care should be  
10 mandatory vaccination of healthcare workers. And  
11 as you know, a number of states, IDSA, other  
12 professional associations, including the DoD, have  
13 also done that.

14 DR. LEDNAR: Dr. Oxman.

15 DR. OXMAN: And a number of  
16 institutions, despite having fairly strong union  
17 representation, have mandated it and required that  
18 those people who refuse wear masks at all times  
19 when they're involved in patient care or riding  
20 the elevators, which is the whole day. Very  
21 uncomfortable. And some of them have gone far  
22 enough as to have different colored identification

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1 tags so that you know who should be wearing a  
2 mask. And we have a very strong union in San  
3 Diego, but I'm going to try to do that when I get  
4 back.

5 DR. POLAND: One approach --

6 SPEAKER: The mask.

7 DR. POLAND: One approach that I saw was  
8 that the physician ethicist who chairs or sits on  
9 the AMA's Biomedical Ethics Working Group feels  
10 that patients should have the right to know  
11 whether their health care worker refused vaccine  
12 and is unvaccinated because they represent a risk,  
13 a quantifiable risk to that patient. Interesting  
14 way of dealing with it.

15 DR. LEDNAR: Any other questions for Dr.  
16 Poland?

17 DR. POLAND: And we accomplished our  
18 goal in half the time.

19 DR. LEDNAR: If not, thank you, Greg,  
20 for this report.

21 As per the agenda, we're going to take a  
22 break. We're going to take a break early. And

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1 we're going to take a break for 30 minutes. And  
2 by my watch, 10, 20 --

3 (Recess)

4 DR. POLAND: Okay, if folks will take  
5 their seats we will get going here.

6 We have next an update on influenza that  
7 is scheduled for about a half hour. It'll be  
8 given by Colonel Wayne Hachey. He serves as the  
9 Director as of Preventive Medicine and  
10 Surveillance in the Office of the Deputy ASD for  
11 Force Health Protection and Readiness. His  
12 primary responsibility is serving as a subject  
13 matter expert in pandemic and avian influenza. In  
14 the course of his duties, Colonel Hachey has  
15 developed, to a large extent, the Department's  
16 medical policies and guidance regarding avian and  
17 pandemic influenza. He speaks to a lot of groups  
18 about that.

19 He's also responsible -- though many in  
20 the Board just know him for pandemic influenza,  
21 he's also responsible for immunization policies  
22 which effect DoD, as well as force health

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1 protection issues such as anti-malaria  
2 medications. I think many of you -- well,  
3 actually, just maybe people who were at the last  
4 meeting know that he's been promoted to Colonel,  
5 and the Board would like to extend its  
6 congratulations.

7 And I think Wayne's slides are under tab  
8 7.

9 COL HACHEY: Well, thank you for  
10 allowing me to present to the Board. And as far  
11 as the promotion, it just proves that even a blind  
12 squirrel will find a nut on occasion.

13 But I was asked specifically to give the  
14 Board a briefing on the current status of H1N1,  
15 particularly on its impact on DoD, with one  
16 specific question, if it's impacted on the DoD  
17 mission. Then to discuss anti-viral acquisition  
18 processes, as well as where DoD is getting its  
19 vaccine and to describe the vaccine's safety  
20 program. So we'll be going through those in that  
21 order.

22 Just to start out with a timeline of

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1       when this all started, back in December of 2008,  
2       there was, in fact, widespread influenza-like  
3       illnesses happening in Mexico. Unfortunately,  
4       that was unrecognized until April of 2009 with the  
5       identification of four cases of novel swine-origin  
6       influenza. This was identified because of the DoD  
7       influenza surveillance network. Those four cases,  
8       actually, were identified by three different  
9       components of our influenza network. So if it  
10      wasn't for DoD we may still be going, what is  
11      that?

12                 The disease then spread, actually, in a  
13      matter of weeks, which in previous pandemics took  
14      a number of months, with the eventual declaration  
15      of a pandemic on 11 June by the WHO. Now like  
16      most blue-haired old ladies, the flu did go south  
17      for the winter, so we were very interested in what  
18      was happening in the Southern Hemisphere. And in  
19      the Southern Hemisphere we noted that H1N1 became  
20      the predominant virus.

21                 If it wasn't there first it soon  
22      overtook the regular seasonal flu variants and

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1 became the predominant strain. It then came back  
2 to Northern Hemisphere and, essentially, now all  
3 countries in the Northern Hemisphere with a  
4 temperate climate have widespread activity.

5 This next series of slides will just  
6 give you a visual depiction of what's happened  
7 across the country. And this starts out in August  
8 of 2009 and takes you through 31 October. And the  
9 thing to look for is the dark brown, which denotes  
10 widespread activity. So, as we go from week to  
11 week, there's just more and more brown. And here  
12 we are on October 17th and then the last one on  
13 October 31st. So, in the matter of just a few  
14 weeks, you can see where we went from either  
15 sporadic or local activity to widespread activity  
16 across the country.

17 Now, right now, 99 percent of the flu  
18 isolates are the 2009 H1N1. The proportion of  
19 deaths attributed to pneumonia and influenza are  
20 well above epidemic thresholds across the country.  
21 And outpatient influenza-like illness visits are  
22 also above the national baseline.

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1           As far as hospitalizations in the U.S.,  
2           now 17,838 laboratory confirmed hospitalizations,  
3           with 672 deaths, 85 of which are pediatric deaths.  
4           Over 70 percent of the people who are hospitalized  
5           do have an underlying medical condition, as well  
6           as about the same percentage of those who have  
7           died from H1N1 also have an underlying medical  
8           condition. About a quarter require intensive  
9           care, about a little over half --

10           Percent -- requiring mechanical  
11           ventilation. And one thing that makes this very  
12           different from seasonal flu is that 45 percent are  
13           under the age of 18. Seventy-five percent are  
14           treated with antivirals with, as expected, the  
15           earlier the treatment, the better it is as far as  
16           prognosis. Almost 80 percent received antibiotics  
17           and most of those are prior to admission. And 93  
18           percent actually get discharged with an overall  
19           death rate of about 7 percent in hospitalized  
20           patients.

21           One thing that we worried about a lot  
22           when this first started was whether we'd be seeing

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1 a lot of secondary bacterial pneumonias. If you  
2 crawl back to 1918, about half of the DoD deaths  
3 were due to secondary bacterial pneumonia and  
4 those were predominantly pneumococcal. Thus far  
5 bacterial co-infections have been in less than 30  
6 percent of the cases. And now staph species are  
7 taking the lead over pneumococcal disease.

8 If you look at hospitalization's rates,  
9 again, very different from seasonal flu. Most of  
10 the folks that are being hospitalized are in the  
11 zero- to four-year age group. Almost, actually --  
12 almost but twice that of any other age group. If  
13 you look at the DoD population -- that 18- to 49-  
14 year age -- then that represents relatively few  
15 hospitalizations compared to the other age groups.

16 As far as deaths, the story's a little  
17 different. The group that had the highest  
18 hospitalization rate -- the 0 to 4 -- actually has  
19 the lowest death rate, with the highest death rate  
20 occurring in the 50- to 64-year age group.

21 Well, as far as the impact on DoD, what  
22 we just saw as statistics generated by the Centers

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1 for Disease Control that I blatantly stole. This  
2 is data from the Armed Forces Health Surveillance  
3 Center. And just looking at it over the last 10  
4 weeks, you can see that influenza-like illness  
5 visits to our clinics has substantially increased,  
6 compared to prior seasons. So, for all the  
7 Military Health System, MTFs, it's up 60 percent,  
8 CONUS up 65 percent, in Europe, activity is rather  
9 robust at 123 percent. And, depending on which  
10 state, you can see that being in the Southwest,  
11 the activity seems to be a bit more robust.

12 This just looks at, again, graphically  
13 weekly ILI for all MTFs comparing 2008 in the blue  
14 versus 2009 in the red. And you can see that  
15 activity has clearly increased compared to last  
16 year. But bringing it down, not looking at a  
17 10-week period, but just a recent 1-week interval  
18 -- for Week 41 of 2009 -- for all of the MTFs  
19 across the Military Health System, activity is up  
20 33 percent, CONUS 36 percent, Europe has settled  
21 down a bit to 29 percent; and at this time,  
22 Pacifica region was still at -4, although activity

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1 in that area now has picked up, particularly in  
2 Hawaii.

3 So, looking at a report from the Armed  
4 Forces Health Surveillance Center, as of 3  
5 November, clinic visits for ILI are substantially  
6 increased across the board. Now, significant  
7 elevations, like we said, in Korea, Europe, and  
8 Hawaii, is that that lower ILI rate that they were  
9 able to enjoy earlier no longer is the case. And  
10 our sampling of 2009 H1N1, just like with the  
11 national sampling, that strain remains the  
12 predominant strain with 98 percent of the samples  
13 evaluated being novel H1N1.

14 Our death rate remains low. These  
15 deaths occurred fairly early in the process: two  
16 inactive duty members, two family members, and two  
17 retirees. And over the past few weeks that's not  
18 changed. And one of the active duty members, in  
19 fact, had some preexisting medical conditions, so  
20 the impact on DoD has not been significant as far  
21 as deaths are concerned.

22 Just during that week, activity by

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1 services -- the Army, Camp Zama in Japan --  
2 reported an increase of influenza-like illness, a  
3 cluster of cases at the Military Academy at West  
4 Point. And because of that, they got an early  
5 supply of vaccine. The Navy, some clusters aboard  
6 a large deck ship in San Diego and then a cluster  
7 among SEAL trainees; thinking back to a visit we  
8 had with the Defense Health Board with one of the  
9 SEAL training areas in Norfolk, I believe it was.

10           And then the Air Force, 41 percent of  
11 Air Force bases are reporting substantial  
12 increases in ILI. Despite that, this flu has not  
13 significantly impacted upon DoD's ability to do  
14 its job. So we're still able to continue our  
15 mission. There's been no significant degradation  
16 in our mission capabilities.

17           So, what are we doing about it? As far  
18 as mitigation measures, I'll be talking a bit  
19 about antivirals vaccine to include our vaccine  
20 safety monitoring and communication. So, first of  
21 all, antivirals. Oseltamivir represents the  
22 lion's share of our antivirals drug stockpile. We

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1 have two stockpiles. You can consider one a  
2 tactical stockpile, the other is strategic.

3 The tactical stockpile represents about  
4 a million doses. And that is divided among all of  
5 the medical treatment facilities in CONUS. It  
6 also represents the stockpiles at medical  
7 treatment facilities and the EUCOM AOR. For the  
8 other combatant commands, they have a separate  
9 stockpile that's there for their use. But because  
10 many of them don't have fixed facilities, it's  
11 stockpiled at an area where they have ready access  
12 to antivirals.

13 In addition to that, we have a strategic  
14 stockpile that's divided into three depots: one  
15 about two hours north of here, another in the  
16 EUCOM AOR, and another in the Pacific. And that  
17 represents about 7 million doses of antivirals.

18 Because of the risk of Oseltamivir  
19 resistance, we also requested for supplemental  
20 funding to increase our Zanamivir stockpile. And  
21 since then, we've been able to add almost a half a  
22 million doses of Zanamivir to the stockpile and

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1 we've received additional funding -- actually, we  
2 should have the cash in hand early next week to  
3 increase our antivirals stockpile so that at least  
4 30 percent of the stockpile will be an antiviral  
5 drug other than Oseltamivir. And right now that  
6 would be Zanamivir, but if something else comes  
7 down the pike that's FDA approved, then we'd be  
8 adding that to our antivirals stockpile, as well.

9           The DoD policy for antiviral drugs  
10 mimics that at the CDC. It's recommended for  
11 treatment to our hospitalized with either  
12 confirmed, probable, or suspected disease. If you  
13 have suspected disease it also suggests treatment  
14 if you're at high-risk for complications. And to  
15 consider post-exposure prophylaxis, if you are in  
16 a household with an index case where you have  
17 individuals, again, at a high risk for  
18 complications. The last group includes those  
19 people where operational considerations may  
20 mandate antiviral prophylaxis. And that  
21 represents a very small group of folks.

22           We also stress that treatment is not

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1 necessarily indicated if you have a healthy  
2 individual with mild disease. And then again,  
3 very limited outbreak prophylaxis. The people  
4 that we end up using outbreak prophylaxis on are  
5 the onesies and twosies that, if they go down, the  
6 whole mission fails; or folks like our Special Ops  
7 people where we would stick them on some kind of  
8 aircraft and drop them off in the middle of  
9 nowhere and then tell them, we'll see you in a  
10 couple of weeks. And if the area that we're  
11 dropping them off in has endemic disease in that  
12 particular locale, then giving them outbreak  
13 prophylaxis would be clearly an option.

14 Moving on to vaccines. As you all know,  
15 the choice was to go with an unadjuvanted vaccine  
16 and that's been approved by the FDA. And the  
17 approval was based on this being, essentially,  
18 just a strain change rather than a new vaccine.  
19 One dose requirement for those greater than or  
20 equal to 10. And the mantra that we have for the  
21 folks not on the ID Committee is that this is a  
22 safe vaccine. It's an effective vaccine. It's a

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1 good match with the current strains that we're  
2 seeing today. The same manufacturing process, the  
3 same manufacturers. And what we've been telling  
4 folks publicly is that, if the virus had been just  
5 a little bit cooperative -- just a tiny bit -- and  
6 had shown up earlier, this would have likely just  
7 been part of the seasonal flu vaccine composition.

8 As far as where the United States is  
9 getting vaccine, CSL represents -- and this  
10 represents -- CSL is an Australian company. It  
11 represents just shy of 20 percent of the U.S.  
12 vaccine supply, Sanofi Pasteur, about a quarter.  
13 GSK, most of their vaccine, I believe, is going to  
14 the UK, so this represents a relatively small  
15 portion of the overall U.S. supply. Almost half  
16 is from Novartis and then MedImmune is about 6  
17 percent. And I believe that's increased a bit to  
18 once their vaccine production was much higher than  
19 what they had anticipated. Their rate limiting  
20 step was the little applicator that squirts the  
21 vaccine up your nose. They had more vaccine than  
22 applicators. And then, both DoD and the U.S.

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1 Government have purchased adjuvants, both from  
2 Novartis and from GSK, just in case we needed  
3 them.

4           So where does DoD fit in as far as that  
5 overall picture, as far as the national vaccine  
6 supply? Well, we actually get vaccine from three  
7 different programs, one source. The one source is  
8 HHS. But through those three different programs,  
9 we have vaccine that DoD purchased -- and we'll  
10 talk about each one of these in a minute -- and  
11 that's limited to operational use. There's the  
12 Federal Employee Allocation Program, and this  
13 targets civilian employees and also includes our  
14 OCONUS beneficiaries, once they're not included in  
15 the overall state allocation program. This cannot  
16 be used for active duty members.

17           The third program is the state  
18 allocation program. This targets health care  
19 workers, dependents, and retirees, and cannot be,  
20 again, used for active duty members, with rare  
21 exceptions based on medical risk. So, the example  
22 is, if we have a pregnant active duty member who

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1 comes into a clinic and there's no operational  
2 vaccine, our policy is if you have any kind of  
3 vaccine, regardless of the source, that you  
4 protect that person.

5 So, starting out with the operational  
6 vaccine, DoD has purchased 2.7 million doses  
7 through HHS. As of 6 November, we've received  
8 390,660 doses. We'll receive our total 2.7  
9 million by Christmas. And the folks who are  
10 eligible to receive this vaccine are active duty,  
11 Reservists, National Guardsmen, and GS civilian  
12 employees. However, the priority to get the  
13 vaccine, who gets it first, are deployed and  
14 deploying, health care workers, our trainees -- to  
15 include basic trainees, but any of our large  
16 training venues -- and ships afloat.

17 After we covered those high risk groups  
18 as far as high risk for transmission, then the  
19 rest of DoD is immunized. It will be mandatory  
20 for all uniformed personnel. So that the question  
21 about vaccine refusal, that's not an option if  
22 you're in uniform. And if not medically

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1       contraindicated, you get the vaccine. It's highly  
2       encouraged for all others and our DoD medical  
3       logistics systems moves this vaccine. So we get  
4       vaccine from HHS that goes to our depot and then  
5       our depot moves it out across whoever in DoD it's  
6       required.

7                   The next one is the Federal Employee  
8       System. This is up to 1 million doses of vaccine.  
9       Thus far we've received a little over 25,000  
10      doses. This is a program that's administered by  
11      the CDC and we're allotted vaccine as it becomes  
12      available through that system. This, too, the  
13      vaccine is supplied by CDC, but goes to our depot  
14      and then we distribute it as we deem fit. This  
15      can be used for any DoD civilian employee and it's  
16      also approved for use for our OCONUS dependents.  
17      So this is where our dependents who are overseas  
18      are getting their vaccine. This again cannot be  
19      used for active duty members.

20                   The last system is the State Allocation  
21      Program. And all of these systems -- if you think  
22      this makes your head hurt, the folks who are

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1 actually with boots on the ground implementing  
2 these programs, it's been an adventure, to say the  
3 least.

4           The State Allocation Program, this is  
5 for dependents and retirees who are in CONUS.  
6 Now, in this case, CONUS represents all of the  
7 states, to include Alaska and Hawaii, as well as  
8 our possessions and territories. But this is,  
9 again, a CDC-administered course. It comes,  
10 actually, with not only vaccine, but the ancillary  
11 supplies, so needles, syringes, sharps containers,  
12 alcohol wipes, gauze pads, band-aids, and  
13 everything you need. And the allocation is based  
14 on the state population. So, the way it works is  
15 that the hospital commander, or his designee,  
16 enrolls with the state as a immunization provider  
17 and puts in his request as far as the number of  
18 enrolled beneficiaries he has, not to include the  
19 active duty members. The state then sends that  
20 information to the CDC. The CDC compiles all of  
21 this and, as vaccine is available, then each state  
22 gets their share. The vaccine doesn't go to a

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1 state distribution, but goes to a vaccine  
2 distributor -- in this case, McKesson -- who does  
3 a direct shipment to the MTF.

4 And the MTFs began receiving this  
5 vaccine in early October. And if you look at your  
6 own home newspapers, you know that vaccine is kind  
7 of trickling in. And that's what we're seeing in  
8 our DoD facilities, also.

9 Well, the question that we have is that  
10 everybody wants vaccine and everybody wants  
11 vaccine now. And the bottom line is that  
12 everybody will have access to vaccine. And,  
13 again, for uniformed personnel it's mandatory.  
14 So, shortly after the New Year, everybody in  
15 uniform should be protected. All others, our  
16 policy is that anybody who wants to get the  
17 vaccine, will get it, but you may have to wait  
18 your turn.

19 And the vaccine supply is expected to  
20 increase rapidly over the next few weeks and  
21 months. If you look at what we were receiving  
22 just a few weeks ago for our operational supply,

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1       which gives you an idea of how much vaccine is  
2       coming into the system, we were getting sometimes  
3       well under 100,000 doses, sometimes 30,000,  
4       sometimes a couple hundred thousand. And with the  
5       ensuing weeks, we're looking at 300,000 to 500,000  
6       each week. So it's clear that the supply is  
7       loosening up. And that, across the board, we  
8       should be receiving more vaccine, regardless of  
9       which program.

10               Moving on to vaccine surveillance or  
11       safety surveillance, and these slides I've,  
12       essentially, blatantly stolen from MILVAX.  
13       MILVAX, and specifically Colonel Krukar's group,  
14       is our tip of the spear as far as this program.  
15       So the Vaccine Safety Surveillance Program, what  
16       we did at Health Affairs is that we told MILVAX  
17       that you've got to do a program and it's got to be  
18       good. And they bellied up to the bar and this is  
19       what they've given us.

20               So, this will use the Defense Medical  
21       Surveillance System, or DMSS, and the military's  
22       electronic health record data. It's a project

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1 that's a collaboration between MILVAX, the Armed  
2 Forces Health Surveillance Center, the FDA --  
3 particularly CBER -- and the CDC Immunization  
4 Safety Office.

5           And the project includes three phases.  
6 The first phase is the pre-vaccination phase. And  
7 this phase, what the folks at MILVAX did is they  
8 looked at our -- with -- I should say, the people  
9 at MILVAX in conjunction with the Armed Forces  
10 Health Surveillance Center looked at a  
11 pre-specified potential adverse events.

12           What they did is, they looked at it so  
13 we can establish a true baseline. So, if we do  
14 see an increase in the number of cases of GBS,  
15 let's say, we'll know whether it's really, truly  
16 about the baseline or not. There's also a group  
17 of experts that established criteria for  
18 identifying the different adverse events,  
19 particularly like GBS, so that if it kind of looks  
20 like it, it doesn't get counted. It has to meet a  
21 fairly rigid definition. So this phase estimates  
22 the background rates that will be used for

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1 comparisons in the later phases.

2 The next one is the Phase 2, and this is  
3 when vaccine is actually in the pipeline. So this  
4 represents advanced surveillance used to identify  
5 signals of, again, pre-specified adverse events  
6 among military vaccinees for up to 42 days  
7 post-vaccination. It also uses the rapid cycle  
8 analysis techniques that Dr. Poland had mentioned.  
9 And these were developed by the CDC Vaccine Data  
10 Link Network and this serves to solidify signals  
11 and compare findings with, again, pre-established  
12 background rates.

13 In addition to that, we also have weekly  
14 case control comparisons of confirmed adverse  
15 events. And when we do have a significant adverse  
16 event, they're all referred to the Vaccine Health  
17 Care Center's network within DoD. There's also  
18 some data mining used to identify unexpected  
19 adverse events that may be associated with this  
20 vaccine.

21 The third phase is, after this is all  
22 done -- I'm hoping this will end sooner or later,

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1 but this is the post- N1H1 vaccination phase. It  
2 represents a retrospective cohort study that  
3 begins when a pre-specified number of vaccine  
4 doses have been administered. And this is  
5 designed to adequately assess the association  
6 between those pre-identified adverse events with  
7 the new H1N1 vaccine. And it compares incident  
8 rates up against those pre-specified events  
9 between H1N1 vaccine and the previous year's  
10 seasonal flu vaccine, as well as in an  
11 unvaccinated control group.

12 The last thing is just a little bit  
13 about communication. In the past, we briefed the  
14 Defense Health Board about the different products  
15 that we have to include webcasts, TV slots,  
16 printed materials. Probably the hallmark of what  
17 DoD's doing for communication is our DoD website.

18 We're surprised that is doesn't quite  
19 show up at this distance, but it essentially  
20 represents one-stop shopping for all things  
21 related to H1N1. So it includes any new policies  
22 that we have, any updates to pre-existing

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1 policies. It has a separate screen for CDC flu  
2 updates. So this is one area where anyone who's  
3 interested in anything that even tangentially  
4 impacts DoD can go here and get the latest  
5 information.

6 It also includes information from, say,  
7 the Civilian Personnel Office. So if someone is  
8 wondering if they can forcibly send someone home  
9 or not. What's the status on granting leave if  
10 you have a sick family member? They can go again  
11 to this source to get the answer.

12 And thus far -- it just started in  
13 April, April through 21 October -- we've had a  
14 little over a million and a half hits to the Watch  
15 Board, so we know that at least someone is looking  
16 at this. The most active link is our Frequently  
17 Asked Questions page. We also have a Twitter  
18 site, and we have 425 participants there, as well  
19 as a number of Facebook fans.

20 So, you know, hopefully -- you know, the  
21 fact is that compared to pigs, we humans are  
22 unforgivingly slow to learn from pragmatic

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1 experience. You know, hopefully, the lessons that  
2 learn with H1N1 will prepare us for the next  
3 pandemic -- particularly if it turns out to be  
4 more severe, as we are all worried that this one  
5 may evolve into.

6 Any questions?

7 DR. POLAND: Wayne, I'm not saying  
8 they're related, but 1-1/2 million hits and your  
9 mother has carpal tunnel syndrome, so --

10 A quick question for you. Just a week  
11 or two ago, FDA did let for emergency use  
12 authorization Permavir, and that's a little bit of  
13 a tricky thing, perhaps, within DoD. How, if  
14 needed, does it have to be a case-by-case,  
15 facility by facility application, or is there  
16 something done at Big DoD level?

17 COL HACHEY: Actually, the CDC holds  
18 all of the Permavir. And they have -- actually,  
19 on their website -- and we've taken information  
20 from their website and put it on the Watch Board  
21 for people to reference. And we've also sent out  
22 messages through the pharmacy community within DoD

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1 of how to obtain the Permavir. So what it is, is  
2 -- it is a case by case. We had one fire drill  
3 where we thought we were going to need it for a  
4 case in Germany. So we've kind of gone through,  
5 at least, the process of how we would do that.

6 And it looks like we could actually get it to some  
7 place like Germany within about 24 hours.

8 DR. POLAND: Okay. Joe, you had  
9 questions earlier, did we get them answered with  
10 this?

11 DR. PARISI: You've answered them, thank  
12 you.

13 DR. POLAND: Bill?

14 COL HACHEY: Oh, and by the way,  
15 actually it wasn't my mother. I taught my bird to  
16 just keep on --

17 DR. HALPERIN: Sorry. In DoD Phase 3  
18 Vaccine Safety Surveillance, there's an  
19 unvaccinated control group. How does that work?

20 COL HACHEY: Actually, I'm going to  
21 turf that one to my colleagues at MILVAX.  
22 Actually, this question came up during the

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1 Infectious Disease Subcommittee briefing on this.  
2 And, if I remember it, Colonel Garman did identify  
3 an unvaccinated group, but I do not recall exactly  
4 how they generated that.

5 COL KRUKAR: And sir, I'm going to have  
6 to claim a little bit of ignorance and have to get  
7 back to you on this.

8 DR. POLAND: I know that it being done  
9 on the civilian side. Is that part of it, or that  
10 was also planned on DoD side? And was that before  
11 vaccine -- I know they're looking back at a number  
12 of years to get background rates -- was it before  
13 vaccine was mandatory?

14 COL KRUKAR: Sir, I think what we want  
15 to be able to do is give the right answer and we  
16 want to do thorough search on it.

17 DR. POLAND: Yeah, okay.

18 COL HACHEY: Actually, influenza  
19 vaccine has been mandatory -- influenza vaccine  
20 was first developed by DoD back in, I believe, the  
21 late '30s.

22 DR. POLAND: Yeah.

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1 COL HACHEY: And it was mandatory then  
2 and I believe it continued to be mandatory. And  
3 we can double-check on this, but if I remember  
4 right, what that unvaccinated group represents --  
5 as far as the DoD population -- are those folks  
6 who were kind of last in line during the flu  
7 season. Comparing that interval with the folks  
8 who are immunized.

9 DR. POLAND: Okay, we'll move on. Our  
10 fifth speaker this afternoon is Dr. Charles  
11 Fogelman, who currently serves as Executive  
12 Coach and Principal Leadership, Development, and  
13 Management Consultant. He's also the Chair of the  
14 Psychological Health External Advisory  
15 Subcommittee and will provide a summary of the  
16 Subcommittee's recent activities. We have 30  
17 minutes scheduled for this. His slides are under  
18 tab 8 in your binder.

19 It's all yours, Charlie.

20 DR. FOGELMAN: I can't possibly begin.  
21 There's no hand sanitizer. What the heck, I don't  
22 care. Thereby illustrating both ends of Greg's

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1 continuum about -- too late, I don't care anymore  
2 -- Greg's continuum about apathy and panic or  
3 being a good teaching example for rapid cycling  
4 bipolar disorder.

5 We have 30 minutes allotted, but I'm not  
6 going to -- I hope I'm not going to take anywhere  
7 near that. Most of these slides most of you have  
8 seen before. I thought about administering a test  
9 to see how many of you recognized the slides, but  
10 it's late in the afternoon and I won't do that.

11 Okay, so if I go that way. That's  
12 right. Hey. You have all these things on paper.  
13 You know who we are. One of the things that we  
14 did previously, after educating ourselves  
15 generally about what was going on, was to begin  
16 whining about not having any real new questions to  
17 answer. And one of the ways we solved that  
18 problem, you may recall from my previous  
19 presentations, was we sort of walked through our  
20 own creating a set of questions. And the one that  
21 seemed, in the end, the most sensible was about  
22 Guard and Reserve and the psychological health

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1 issues that might be involved there. And we, you  
2 know, sent that question up the line and nobody  
3 said not to do it, but -- I'll finish that  
4 sentence in a moment.

5 We had a very interesting series of  
6 folks come talk to us when we met about 3 weeks  
7 ago. These are their names. The issues that came  
8 up for Guard and Reserve were -- there are just a  
9 few major ones. One was recognition. Please pay  
10 attention to the fact that there are large numbers  
11 of Guard and Reserve serving. And while they have  
12 some similar issues, they have a number of very  
13 different issues, including, for example, not  
14 having a job when they come back.

15 I know that's also true for veterans,  
16 but that's just illustrative of one of the kinds  
17 of points that was made to us.

18 And another was -- this won't be news --  
19 accessibility and number of providers who know  
20 what they're doing. You know, there was money to  
21 have those things done. And finally, most of the  
22 folks who presented to us continued to talk -- or

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1 talked in a continued way about stigma. Lots of  
2 public relations, lots of self-congratulation  
3 about how we're working on stigma. But the  
4 general sense of people who were working with  
5 Guard and Reserve was that that message wasn't  
6 getting to Guard and Reserve people, for whatever  
7 reason.

8           So, as I said, we made up this question  
9 for ourselves. And not too long after we made up  
10 that question, low and behold, two questions  
11 appeared from above. These questions were just  
12 posed to us just before our last meeting. You can  
13 see that they're essentially the evaluation  
14 questions about pre-clinical and clinical  
15 intervention programs. What do we have? How do  
16 we measure it? What's working and are we sure?

17           In order to deal with those two  
18 questions, which now move up to the top of our  
19 agenda, we had a telephone conference this past  
20 week. We divided ourselves up into two sub-groups  
21 -- actually, we divided ourselves into two sub-  
22 group leaders and I'm going to have to assign

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1 people to the two different groups, who are going  
2 to do some background stuff between now and our  
3 next meeting, which is just three or four weeks  
4 away. And try to distribute materials to folks  
5 and if anybody has any idea about good material or  
6 useful individuals for us to use as briefings as  
7 part of that next meeting, I will be happy to take  
8 those suggestions from you, but not while I'm  
9 standing here because I promised to -- not only  
10 did I say I didn't have much to say, but I also  
11 promised the inestimable Vice Presidents that I  
12 would be very brief.

13 So we're going to start working hard on  
14 that in December. And one of the things we're  
15 going to do at our December meeting is to create  
16 targets and a timeline for ourselves for how we're  
17 going to proceed, and we're hoping to do it with  
18 some dispatch. I'm going to push to aim for June  
19 as a point of being able to present something  
20 here, assuming we have a meeting in June. But,  
21 roughly, that's my intent and folks in the  
22 Committee didn't seem to think that was a terrible

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1 or unrealistic idea. Well, at least nobody said  
2 that to me.

3 I don't need to read them to you.

4 DR. POLAND: We get the point.

5 DR. FOGELMAN: And that is that. You  
6 have the background slides for this and all  
7 previous meetings and you know how to find me.  
8 And I know from the last time, you certainly know  
9 how to ask me questions. So, are there any?

10 DR. POLAND: Thank you, Charlie.  
11 Questions or comments?

12 DR. FOGELMAN: Cool. I'm out of here.

13 DR. POLAND: All right, thank you. We  
14 have one other item of business to attend to, then  
15 we'll adjourn the open meeting and go into closed  
16 administrative meeting for a few items. And that  
17 remaining item is a brief update. Dr. Kaplan, I  
18 think, is going to give on the Warren Repository.  
19 We have two and a half minutes scheduled for that.

20 DR. KAPLAN: No, that's too long. Just  
21 a brief update. On November 3rd, the Warren Sera  
22 were moved, thanks to this board. Next, please.

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1           This is just a picture of the bill of  
2 lading. Next, please. The truck is -- I'm trying  
3 to prove to you that it has been moved after all  
4 these years.

5           An amazing group. Next, please. The  
6 two movers with the freezers in the truck.

7           SPEAKER: Which one is you, Ed? I can't  
8 see from here.

9           DR. KAPLAN: I'm standing behind him  
10 there. Next, please. Rick Erdtmann, who is here  
11 -- right back there -- going through the records.  
12 As you know, these have been transferred to the  
13 Institute of Medicine and a medical follow-up  
14 agency, looking at the computerized inventory.  
15 Next, please.

16           Looking at the data cards. And then  
17 just a couple of slides to show you some of the  
18 amazing data that's in these records for your  
19 historical interest. Next, please.

20           These are the original records from  
21 studies done 50 to 60 years ago. And those of you  
22 who know the field will know that this was a

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1 classical paper. Next, please.

2 You can see the names -- forgive me, Dr.  
3 Shamoo for being unethical about this, but --

4 DR. SHAMOO: It's okay, Ed. No one can  
5 read them.

6 DR. POLAND: And it's not the first  
7 time, so --

8 DR. KAPLAN: Next, please. The records  
9 that were kept during this period of time are just  
10 amazing. Next, please. You can see that the  
11 detail that was there. And the last slide?

12 I am very grateful to this Board and to  
13 all who helped in any way. And, finally, after  
14 all of this long period of time in getting these  
15 moved. Thank you very much.

16 DR. POLAND: Thank you, Ed, for being  
17 the trusted guardian of those samples for, well,  
18 half a century.

19 DR. KAPLAN: Aw, come on.

20 DR. POLAND: You were five when you got  
21 them. Okay, I will turn it over to Commander  
22 Feeks and then our DFO to adjourn the meeting.

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1                   CDR FEEKS: This is Commander Feeks.  
2                   First, I'm going to ask one of my staff to clarify  
3                   something. My understanding is that this room is  
4                   actually going to be used for something else this  
5                   evening. If that is the case, that affects what  
6                   we can leave here, which is probably nothing.

7                   SPEAKER: Yes, you can leave it where it  
8                   is.

9                   CDR FEEKS: No? We can leave stuff?  
10                  Okay, Beth says we can leave stuff.

11                  SPEAKER: And our notebooks?

12                  SPEAKER: Yep, (inaudible).

13                  CDR FEEKS: All right, you can leave it  
14                  where it is. Let's see.

15                  SPEAKER: So what do they do in this  
16                  room (inaudible)?

17                  CDR FEEKS: You know, I'm just dying of  
18                  curiosity myself. So, all right.

19                  All right. For those of you departing  
20                  today, we have provided a manila envelope in each  
21                  of your binders, just to make it easy. You can  
22                  remove the contents of your binder, put it in the

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1 manila envelope, and, all of a sudden, it doesn't  
2 take up that space in your luggage. That is, if  
3 you don't wish to keep the binder yourself.  
4 You're welcome to take the binder if you want to.

5 Okay. Now Beth is trying to send me a  
6 signal here.

7 SPEAKER: (inaudible)

8 CDR FEEKS: Okay. So that the script  
9 is -- yes, yes, like me. All right.

10 SPEAKER: (inaudible)

11 CDR FEEKS: No you didn't, but you were  
12 thinking it. Okay. All right, where was I?

13 For Board members, ex-officio members,  
14 service liaisons, speakers, and invited guests,  
15 breakfast will be served prior to reconvening at  
16 7:30 tomorrow morning in this ballroom to resume  
17 the public portion of the meeting.

18 For those of you joining us for the  
19 dinner tonight, please convene in the lobby by  
20 6:00 p.m. The group dinner tonight, as I said  
21 this morning, is scheduled for 6:00 at Sakura  
22 Japanese Steak and Seafood House. Sakura's

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1 located about a mile from the hotel in Fair Lakes  
2 Shopping Center. Shuttle service is being  
3 provided by the hotel. The shuttle will leave  
4 from the hotel at 6:00. A second run, likely, to  
5 accommodate the group size. Return shuttle  
6 service to the hotel will also be provided. If  
7 you have not RSVPed for the dinner, please see Jen  
8 Klevenow, who is occupied with a task from me  
9 right now, but she'll be back. If, likewise, you  
10 told her you were coming and you can't come,  
11 please let her know.

12 For those who need to take the Metro  
13 after this meeting, the hotel operates a  
14 complimentary shuttle to the Vienna Metro station  
15 every 30 minutes. Please see the shuttle schedule  
16 at the registration desk, or visit the hotel's  
17 front desk.

18 And that's all I have for now, Dr.  
19 Lednar.

20 Col BADER: I'd like to thank everybody  
21 for attending today, especially for the folks who  
22 gave such outstanding presentations. Thank you

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1 all.

2 And at this time I would like to adjourn  
3 today's meeting of the Defense Health Board.

4 (Whereupon, at 4:28 p.m., the  
5 PROCEEDINGS were adjourned.)

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## 1 CERTIFICATE OF NOTARY PUBLIC

2 I, Carleton J. Anderson, III do hereby  
3 certify that the forgoing electronic file when  
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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

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