

UNITED STATES DEPARTMENT OF DEFENSE

FULL DEFENSE HEALTH BOARD VIRTUAL MEETING

Arlington, Virginia

Thursday, November 20, 2008

ANDERSON COURT REPORTING

1 PARTICIPANTS:

2 DR. GAIL WILENSKY

3 DR. GREGORY A. POLAND

4 COL. ROGER L. GIBSON

5 DR. WILLIAM E. HALPERIN

6 DR. JOSEPH E. PARISI

7 DR. KENNETH W. KIZER

8 DR. BENEDICT DINIEGA

9 CDR EDMOND FEEKS

10 CMS LAWRENCE HOLLAND

11 DR. WAYNE LEDNAR

12 DR. JOHN CLEMENTS

13 DR. RAYMOND DUBOIS

14 DR. FLORABEL MULLICK

15 DR. WILLIAM BLAZEK, JR.

16 DR. GEORGE ANDERSON

17 DR. WARREN BREIDENBACH

18 DR. TOM MASON

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1 PROCEEDINGS

2 COL GIBSON: We'll go ahead and get

3 started. I'll turn the meeting over to Doctor

4 Poland, who's in Rochester at Mayo Clinic, he's

5 the Board President; Doctor Poland.

6 DR. POLAND: Good morning, everybody.

7 Roger, can I be heard well?

8 COL GIBSON: You certainly can be heard

9 in the room.

10 DR. POLAND: Okay. I'd like to welcome

11 everybody to this virtual or E-meeting of the

12 Defense Health Board. While other Federal

13 Advisory Committees have conducted meetings using

14 web based technology and teleconference formats so

15 that the public and members who couldn't

16 physically attend are allowed to participate, this

17 is a first for our Board. We intend to conduct

18 the meeting as efficiently as possible. Bear with

19 us if we have to work through any technical

20 glitches during the proceedings.

21 We have four important topics on our

22 agenda today that will require deliberation and

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1 decisions and discussion by the Core Board before
2 their associates reports would be forwarded to the
3 Department of Defense and made available to the
4 public. Since DOD has requested three of the
5 reports by the 1st of December, we will have to
6 work hard to attempt to meet that request. I do
7 want to mention that the room I guess has to
8 physically be empty by 12:15; track the discussion
9 and the time and keep things moving in a timely
10 way.

11 So to get started, we'll need a
12 designated federal official to call the meeting to
13 order, which I believe is Ben Diniega. Ben, are
14 you there?

15 DR. DINIEGA: I'm here, Greg. Good
16 morning.

17 DR. POLAND: Good morning.

18 DR. DINIEGA: I'm here as the Senior
19 Leadership in Health Affairs is - they're all
20 involved with an off- site pertaining to the
21 transition with the Undersecretary at Personnel

22 and Readiness. So there's a mandatory statement

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1 to be read for the Board before we start the

2 meeting.

3 But it's always my pleasure to be
4 associated with the Defense Health Board, the old
5 AFEB. As the ultimate designated federal officer
6 for the Defense Health Board, a Federal Advisory
7 Committee, in a continuing, independent,
8 scientific advisory body to the Secretary of
9 Defense, via the Assistant Secretary of Defense
10 for Health Affairs and the Surgeons General of the
11 military departments, it's my pleasure to call
12 this meeting of the Defense Health Board to order.

13 DR. POLAND: Thank you, Ben, always a
14 pleasure, by the way. Ben and I have worked
15 together for well over a decade. Carrying on a
16 tradition of the Board which I hope will go on in
17 perpetuity, I would like to ask everybody to stand
18 for a minute of silence to, one, focus on the
19 reason for this Board and why we do what we do,
20 and to honor those that we're here to serve, the

21 men and women who are serving our country.

22 (Minute of silence.)

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1 DR. POLAND: May they and their families
2 all be kept safe. So thank you. Since this is an
3 Open Session, before we begin, I'd like to go
4 around the table and the phone and have the Core
5 Board and Subcommittee members introduce
6 themselves. We'll start with those around the
7 table at the meeting room in Crystal City and then
8 move to the phone. Could we first have Core Board
9 members introduce themselves, then Subcommittee
10 members? Gail, can you go ahead and start?

11 DR. WILENSKY: Yes, I'll be glad to,
12 Greg. This is Gail Wilensky and I'm with the Core
13 Board of the Defense Health Board.

14 CDR FEEKS: Good morning; I'm Commander
15 Ed Feeks, Preventative Medicine Officer at
16 Headquarters Marine Corps.

17 DR. LEDNAR: Wayne Lednar, Global Chief
18 Medical Officer for Dupont.

19 DR. CLEMENTS: John Clements, I'm the

20 Chair of Microbiology and Immunology at Tulane
21 University School of Medicine in New Orleans.
22 DR. DUBOIS: Ray Dubois, Senior Advisor

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1 at the Center for Strategic International Studies
2 and a member of the NCR BRAC Subcommittee.

3 DR. MULLICK: Florabel Mullick, Director
4 of the AFIB and Executive Secretary of the
5 Subcommittee on Pathology and Laboratories of the
6 Defense Health Board.

7 DR. ANDERSON: George Anderson,
8 Subcommittee on Health Care Delivery, Executive
9 Director of the Association of Military Surgeons
10 of the United States.

11 DR. BLAZEK: I am Doctor Bill Blazek and
12 I am at the Center for Clinical Bioethics at
13 Georgetown University, and I am on the Medical
14 Ethics Subcommittee.

15 DR. HALPERIN: Bill Halperin, I'm Chair
16 of Preventative Medicine at the New Jersey Medical
17 School in Newark, New Jersey, also Chair of
18 Quantitative Methods at the School of Public

19 Health, same site.
20 CMS HOLLAND: I am Commander Major
21 Retired Larry Holland, I am a Core Board member,
22 and my role as I see it is to look out for our

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1 service men and women and their families.
2 DR. POLAND: Amen.
3 DR. DINIEGA: Ben Diniega, Health
4 Affairs, Acting DFO.
5 COL GIBSON: Colonel Roger Gibson,
6 Executive Secretary. Doctor Poland, if it's okay,
7 we'll go around the rest of the room. We've got
8 another probably 20 or 25 people in the room.
9 DR. POLAND: That's good, and then we'll
10 do the phone.
11 COL GIBSON: We'll introduce them and
12 then turn it over to the phone.
13 DR. POLAND: Okay.
14 MR. GOULD: Philip Gould, Air Force
15 Medical Support Agency.
16 COL MOTT: Colonel Bob Mott,
17 Preventative Medicine Officer, Army Surgeon

18 General's Office.

19 MAJ WITH: Major Kathy With, Legal

20 Counsel, Armed Forces Institute of Pathology.

21 CPT LARSON: Captain David Larson, I'm

22 with the National Naval Medical Center, I'm the

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1 Lab Director there.

2 COL BAKER: Colonel Tom Baker, I'm the

3 Chief of the Integrated Department of Pathology at

4 Walter Reed and National Naval Medical Center.

5 LT COL SILVER: Lieutenant Colonel Aaron

6 Silver, Deputy Chief, Health Service Support

7 Division, Joint Staff.

8 MR. BURY: Craig Bury, Senior Advisor,

9 Information Manufacturing Company.

10 COL JEFTS: Colonel Barb Jefts, JTF

11 CAPMED, Operations Directorate.

12 MR. RAYBOLD: Ridge Raybold, Armed

13 Forces Institute of Pathology.

14 MR. PARRY: Michael Parry, Director of

15 Operations for the American Registry of Pathology.

16 MAJ SESSIONS: Major Cecili Sessions, a

17 preventative medicine resident at --

18 MR. PEIPELMAN: Eric Peipelman, Armed
19 Forces Institute of Pathology.

20 DR. WIENEKE: Doctor Jacqueline Wieneke,
21 Department of ENT and Endocrine Pathology at the
22 AFIP.

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1 DR. MURPHY: Doctor Mark Murphy, Chief
2 of Muscular Skeletal Radiology at the AFIP.

3 MR. JHA: Prakash Jha from Armed Forces
4 - Pathology.

5 DR. SESTERHENN: Doctor Isabelle
6 Sesterhenn, Chairman of the - Department, AFIP.

7 COL GIBSON: Doctor Poland, that
8 finishes the room. Can we start with the Board?
9 We're going to just do the Board members and
10 Subcommittee members on the phone.

11 DR. POLAND: Okay.

12 COL GIBSON: We're recording the names.
13 One of the things we have to do from the
14 standpoint of a Federal Advisory Committee is
15 capture the names of everyone who is in attendance

16 at a meeting, and that includes folks on the
17 phone.

18 DR. POLAND: Okay.

19 COL GIBSON: But for the purposes of
20 introductions, we'll just do introductions of the
21 Board members and Core Board members that are on
22 the phone.

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1 DR. POLAND: Very good; my name is Greg
2 Poland, I'm Professor of Medicine and Infectious
3 Diseases at the Mayo Clinic in Rochester,
4 Minnesota and current President of the Board. Are
5 there Board members on the phone?

6 DR. KIZER: Yeah, this is Kenneth Kizer,
7 I'm Chairman of the - Committee.

8 DR. PARISI: This is Joseph Parisi at
9 Mayo Clinic; I'm a neuropathologist here at the
10 clinic, and I'm a Core Board member and Chair of
11 the Subcommittee on Pathology and Laboratory
12 Services for the Defense Health Board.

13 COL GIBSON: Any other Board members on
14 the phone at this time? I know that are several

15 that are joining us just a little later. Okay.

16 DR. POLAND: Okay. Since I can't be

17 there in person and other members of the Board's

18 Executive Council are there in Crystal City, along

19 with a number of other Board members, I'd ask

20 Doctor Wilensky, the incoming President, to run

21 the meeting, because, you know, I won't be able to

22 see people and run the meeting in a fissile way.

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1 A reminder that we need to be out of the

2 room by 12:15. Gail, would you mind going ahead

3 and taking over the meeting physically from there?

4 DR. WILENSKY: Thank you, Greg, I'd be

5 glad to do so.

6 DR. POLAND: Thank you.

7 DR. WILENSKY: I look forward to seeing

8 you at our meeting next month.

9 DR. POLAND: Thank you.

10 DR. WILENSKY: Colonel Gibson has some

11 administrative remarks before we begin the morning

12 session; Colonel Gibson.

13 COL GIBSON: Thank you. I want to thank

14 Crystal City staff and our IT folks for all the
15 work in putting this thing together. As you know,
16 this is our first virtual meeting like this. I
17 expected a few glitches and I've been pleasantly
18 surprised at how few as we've gone through this.

19 Thanks to my staff, as well, and in
20 particular to Ms. Jarrett in the corner. She's
21 the one that really put this thing together and
22 made it happen, so thank you very much.

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1 As I mentioned, one of the requirements
2 of holding a Federal Advisory Committee meeting is
3 recording attendance, it's part of the federal
4 statute. We have a sign-up sheet here that we're
5 passing around the room to get everybody's name
6 on, please fill that in. And if we have members
7 of the media here, they should sign up on the
8 media roster. And we are offering the opportunity
9 for members of the public here in this room to
10 provide testimony on any of the issues as we go
11 forward, so we'll sign up for that, as well.

12 The meeting is being transcribed.

13 Please make sure you state your name before
14 speaking so that our transcriptionist can capture
15 the information. And this request also applies to
16 individuals dialing in and accessing the slides on
17 the web.

18 The next meeting, as Doctor Wilensky
19 mentioned, is going to be the 15 and 16 of
20 December at the Ronald Reagan Building and the
21 International Trade Center here in Washington,
22 D.C. There are a series of updates that the Board

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1 will receive at that time, both in the area of
2 health care delivery and protection issues. And
3 we'll hear from senior leaders of the Department
4 of Defense.

5 DR. WILENSKY: I'm going to begin now
6 with the introduction of our speakers. Our first
7 speaker this morning is Doctor William Halperin,
8 who is currently serving as the Chair of the
9 Department of Preventative Medicine at the New
10 Jersey Medical School. As Chairman of the
11 Military and Occupational and Environmental Health

12 and Medical Surveillance Subcommittee, he will
13 provide the Subcommittee's external review of the
14 risk assessment conducted by the Center for Health
15 Prevention and Preventative Medicine in response
16 to possible hexavalent chromium exposures at a
17 water treatment facility in Iraq. Without further
18 delay, I present Doctor Halperin.

19 DR. HALPERIN: Does anyone have a
20 pointer perhaps? Okay, well, that's the first
21 glitch of the morning, my fault for not bringing
22 one. Well, thank you for the opportunity to make

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1 this presentation. What you're going to be
2 hearing about is a work in progress, and it's
3 fairly fast moving, and I hope to - there we go,
4 thank you very much. I hope to complete the
5 presentation in about 20 minutes, leaving time for
6 discussion.

7 I want to thank the Board members who
8 have participated in this evaluation, who include
9 John Herbold, Wayne Lednar, Jim Lockey, Tom Mason,
10 and Alan Russell. This is a subset of the

11 Subcommittee, a subset defined by those of us who
12 have security clearance, who are able to see the
13 data on which this report is based. Could we have
14 the next slide, please? First the charge, which
15 came on October 6 from General Schoomaker, which
16 is to review the Occupation and Environmental
17 Health Assessment at Qarmat Ali Water Treatment
18 Plant in Iraq that was done in 2003.
19 Specifically, was the standard of practice for the
20 investigation adequate? Are the reports of the -
21 conclusions of the report as far as health valid?

22 To accomplish this, we had an initial

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1 meeting of our Subcommittee on October 17 and
2 planned for a site visit so that we could see the
3 report and discuss this with CHPPM staff, which
4 required a security clearance meeting which was
5 held last week, November 12 and 13 in Arlington,
6 Virginia, as I recall.

7 The report is quickly nearing
8 completion, but it is not done yet, it's not been
9 finalized by the Committee, and it's certainly not

10 been reviewed, so this is a progress report. Next
11 slide, please.

12 I want to first put this into some
13 perspective. You know, for two decades more I
14 worked for Centers for Disease Control, really in
15 various jobs, but always thought of myself as a
16 field epidemiologist. There are arm chair
17 epidemiologists and there are field
18 epidemiologists. And field epidemiologists need
19 to go into the field during an episode of
20 something, with the idea of understanding what's
21 going on and suggesting interventions, and coming
22 out of that having controlled an epidemic, if you

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17

1 will, or an exposure or whatever. And the slide
2 that you see here is the first example of field
3 epidemiology that society ever undertook, which
4 was the investigation of cholera in London in
5 about 1850 or '53, as I recall, by John Snow.

6 It was in a very hazardous situation
7 that this epidemiology was done, with mortality
8 rates in certain areas of London being very, very

9 substantial, unknown what the risks were to the
10 investigators or the population, and the goal was
11 to identify the exposures and to control those
12 exposures to control health and to protect health
13 in London.

14 This is the tradition I think with which
15 we are now dealing with this CHPPM investigation.
16 It is not arm chair epidemiology, it was field
17 epidemiology. Next slide, please.

18 The site is in Basra, Iraq. It is an
19 industrial site that produces industrial water for
20 oil production. There is nothing potable water
21 about this. This is water that is pumped into oil
22 wells to produce oil. So first revelation, we're

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1 not talking about potable water. This is a site
2 that, I use the simple term ransacked. The
3 condition of the site, we have no idea what the
4 conditions were before the war. We know that the
5 conditions that the site was found in were - there
6 was disruption, buildings had been taken apart,
7 there was definitely environmental contamination

8 with visible yellow contamination, turned out to
9 be sodium chromate, which was used as a corrosion
10 inhibitor in the water, so that you could keep
11 pumping through these pipes and they didn't
12 corrode and obstruct and so forth.

13 There was a continuous contractor
14 presence at this site throughout successive
15 cohorts of military who served as guards. So
16 there's a continuous contractor who's working to
17 get the site up and running, contracted to the
18 U.S. government in some fashion, but there are
19 successive cohorts, including the British first,
20 then various National Guard units. So in the
21 Roman sense of military cohorts, these are cohorts
22 moving through this exposure environment. Next

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1 slide, please.

2 I thought it would be valuable to show
3 you where the site is, and since that information
4 is classified, I went to Google to show you this
5 information. So this is Kuwait. This is Iraq.
6 There is a highway that takes you from Kuwait up

7 to Qarmat Ali, and I presume that Nahr in Aerobic
8 probably means north, I presume. So this is
9 Qarmat Ali, and it's valuable to have this
10 perspective of where this plant really is. It's
11 not out in the middle of the desert. Can we see
12 the next slide?

13 This is closer, but I tell you, not the
14 closest observation of the site that I can get
15 down to house level, if you will. This is a
16 closer view of Qarmat Ali, the river here with
17 water channels going through. I could have gone
18 back and forth and identified the site if I really
19 knew what I was looking for.

20 It is an industrial site. This is the
21 University of Basra. This is residential housing.
22 This is in a peri- urban area. Next slide,

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1 please.

2 This is the chronology of what happened
3 back then. In the spring of 2003, after the
4 initial war efforts, there was an effort to
5 provide security at Qarmat Ali for the contractors

6 and for getting this site up and running as part
7 of a project, I think it was called RIO, Restore
8 Iraqi Oil Production.

9 In the summer of 2003, the contractor
10 identified a hazard, it's a hazard identification
11 in the risk assessment sense, and remediated by
12 paving it over with asphalt and gravel, the hazard
13 being contamination of the site with yellow
14 pigment which was identified as dichromate. In
15 2003, U.S. soldiers observed the contractor staff
16 in personal protective equipment. And any of you
17 have worked - this has happened to me while
18 serving with NIOSH, you're out of sight, and
19 suddenly somebody comes with a whole level -
20 different level of protection. And it is
21 stimulating to everyone as far as, you know, who's
22 right and if there is a right or who's appropriate

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1 or whatever. But it did definitely stimulate
2 questions, which went back to the health clinic.

3 Now, I apologize to those of you who
4 know these terms much better than I, but I'm just

5 using them broadly. The question went from the
6 soldiers themselves to the health clinic, which
7 happened to be directed by a preventative medicine
8 officer who had occupational health experience,
9 and very quickly - after this there was a visit to
10 the site, access to the site was restricted, this
11 was on local initiative, there were health
12 communication, it was called a town meeting, but
13 this was really a town meeting of the DOD, not a
14 town meeting of Basra, if you will.

15 On September 29, a CHPPM field
16 investigation started. I don't mean it was
17 initiated; they were on the ground in Iraq coming
18 from the U.S. by September 29. That is - I almost
19 wanted to characterize that, but I'm going to
20 resist that. I'm just going to say that's a very
21 few days. By October 17 there were personal
22 protective equipment required. This is already

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1 after the site had been restricted, so this was -
2 if you were now going to go into this restricted
3 site, you have to have PPE. And by October 30, a

4 field investigation was completed. So this is the
5 chronology, the fast pace of this field
6 investigation. This is shoe leather epidemiology
7 happening fairly expeditiously. Next slide,
8 please.

9 Now, in order to understand what they
10 found, I mean I would simply have to talk about
11 primary, secondary, and tertiary prevention, which
12 we all know what that is and I'm not going to
13 dwell on this. But I will now take this cascade
14 of prevention and go the next step. Next slide,
15 please.

16 So what do occupational field
17 epidemiologists have in their back pocket that
18 they can use, if you will, that is the equivalent
19 of taking the pump off of - the handle off of a
20 pump handle, as in John Snow? And it starts all
21 the way at the beginning with design, if you will,
22 which is a little irrelevant here. I mean the

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1 industrial site was already in place. But it goes
2 to issues of substitution and elimination,

3 engineering controls, environmental monitoring,
4 and when each of these are instituted, there's
5 always a fail safe, which is the one lower down
6 the pike, if you will. So this is primary
7 prevention, secondary prevention, and tertiary
8 prevention, and there's this cascade of
9 prevention. We have a great menu by which to
10 choose to figure out what we can do to make things
11 better.

12 Surveillance is not on this cascade
13 because surveillance by itself does not prevent
14 anything. Next slide. What surveillance is is
15 the taking of information, the collection of
16 information about any one of these things, its
17 assessment, then feeding it back to change
18 something higher in this cascade. So what
19 surveillance is is a prevention feedback loop by
20 which one takes information, analyzes it, and then
21 decides things have to be done differently or
22 things are happening just fine the way they are.

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2 epidemiology with the idea of, there's a cascade
3 of prevention, what did they have available for
4 them to do, how did they do it, et cetera, et
5 cetera. Next slide, please. So let's start with
6 exposure assessment, which is one of the elements.
7 Well, the contractor had already identified the
8 hazard and had identified elevated concentrations.
9 They had moved on to encapsulation with asphalt
10 and gravel, and samples that they took after the
11 encapsulation showed minimal exposure to chrome 6.
12 Chrome 6, by the way, is the major hazard that
13 we're talking about. There are a few other issues
14 here, but this is the major hazard. Chrome 6 has
15 been associated with various health outcomes both
16 in the short and the long term.

17 BRITFOR, apologies if this is not the
18 appropriate name, a successive military cohort
19 from UK obviously, also did exposure assessment
20 and found minimal exposure to chrome 6. CHPPM
21 then did a successive exposure assessment, at this
22 point, in some instances having to dig through the

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1 asphalt to see what was being encapsulated, if you
2 will.

3 So CHPPM was there really after the
4 encapsulation, and it found elevated chrome 6 in
5 soil, particularly off site. And area samples and
6 breathing zones found no chrome 6; that was
7 because the soil samples were underneath the
8 macadam, if you will, and the air breathing
9 samples were in the environment after it was
10 essentially remediated. So this is the sum of
11 exposure assessment that was done, and it
12 definitely identifies an exposure and identifies
13 where it is and that there is a potential for
14 exposure to people on the site. Next slide,
15 please. So the next issue then is biological
16 monitoring. So if there's an exposure, right,
17 that's an exposure, but it's not a dose, so did
18 anybody absorb anything, if you will.

19 And the issue here is to test for the
20 presence of the toxin and biologic medium, which
21 is urine, blood, breath, that's biological
22 monitoring. And the choice of the test here was

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1 appropriate. Now, I really have to beg your
2 forgiveness for the last slide, but in the last
3 few days I've not been able to find this in any
4 text. So if I could have the next slide.

5 It's remarkable how these new systems
6 can produce something that looks like it's
7 handwritten, right. So, you know, you've got
8 chromate in serum, you have chromate in urine, you
9 have chromate in red blood cells, if you will. At
10 the way left of the slide basically is - people
11 have already been exposed. Exposure stops, right,
12 then the question is, depending where you are
13 going out to a month here at the far right, what
14 will you find depending what medium you look in?
15 Well, if you look in serum and urine and you find
16 nothing, that's a false negative, right, because
17 you wouldn't expect it a month later still to be
18 there. But chrome attaches itself to red blood
19 cells, red blood cells have a life span of
20 approximately 120 days, if I'm still correct, if
21 the AFIP will comment, thank you. So in a month,
22 you know, 120 days divided by 30 is four. So we

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1 should find three quarters of the level of
2 chromate at a month in the red cells, et cetera.

3 So the medium that they used for
4 biological monitoring in this instance was
5 essentially blood chromate. We should have found
6 something substantial if there was a substantial
7 exposure, and that's the point of this curve. And
8 the next slide, please, okay.

9 The result of the assessment was that of
10 the many, many samples that were taken,
11 essentially the biological monitoring showed that
12 this was essentially in the range of
13 non-occupationally exposed, not in the range of
14 the occupationally exposed, not in the range of
15 the excessively occupationally exposed.

16 So as a fail safe to, yes, there was
17 exposure at the site, but the last cohort that was
18 at the site, and that's important to say, and
19 biological monitoring did not find levels that
20 were excessive, alarming, et cetera, et cetera,
21 no. Fail safe to biological monitoring is the
22 issue of medical assessment, which is looking for

1 early signs and symptoms of disease, right. Well,
2 that's done by a history and physical examination.
3 And examples of things that could be found, I have
4 seen these, some of these in practice, are chrome
5 ulcers and perforations, impressive holes in
6 peoples' fingers when they're involved in chrome
7 plating and chrome has gotten into the skin, et
8 cetera, et cetera, or the same kind of holes, but
9 through the septum of the nose. And none of this
10 was found or reported on medical examination,
11 history, or from the soldiers at the site.
12 There were many more tests that were
13 done, including assessment of respiratory
14 irritation from a subjective point of view, and
15 pulmonary function tests, and the respiratory
16 irritation was high, but not high apparently for
17 respiratory irritation complaints in Iraq in
18 general. So there's some positives, but they're
19 non- specific to this site. But there are some
20 very key essentially pathoneumonic negatives here.
21 So that's the medical assessment. Next slide,
22 please.

1 Then there's an epidemiologic
2 assessment, that is, taking all of the clinical
3 data that was collected. It's the assessment of
4 that data vis-à-vis epidemiologic parameters, like
5 how long was this person at the site, et cetera,
6 et cetera. So as I reported before, the blood
7 levels of chrome 6 were consistent with
8 background, not with occupationally exposed, and
9 there was no association essentially of the
10 levels. Now, they were all low, but there are -
11 some are higher in the low category, but they're
12 all low, but there was no association of the level
13 of exposure with such things as - level of chrome
14 6 in the blood with the length of exposure, et
15 cetera. So the epidemiologic assessment is
16 reassuring, if you will, as well. Next slide,
17 please.

18 Now, the issue then is, you know,
19 they're there to do something, they're there to
20 protect health, you know, safety, health, et
21 cetera, et cetera. So there are various issues
22 that can be - should be considered.

1 Control of exposure, which had been
2 accomplished, site remediation, which had been
3 accomplished, site access, which had been
4 restricted, and medical care, which should be
5 provided if there's, you know, there's a specific
6 need above and beyond normal medical care. So
7 these are some of the primary interventions that
8 can be accomplished based on this field
9 investigation. Next slide. Well, let's talk
10 about health risk communication. The first one I
11 mentioned that was done in the very early stages
12 of the investigation, there were seven in total
13 health risk communications to the various cohorts
14 of military, to the current and the former units.
15 So the results of the laboratory and the medical
16 evaluations were incorporated into medical charts
17 for the individual use by the soldier's medical
18 care provider. So there was both feedback in
19 general and also feedback in the medical context
20 so that the information would be available in the
21 chart. And that chart is available, my
22 understanding, it's the chart I got when I left

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1 the PHS. This is the one you put, you know, this
2 is the record of your health and you carry it
3 around, it's supposed to be in that chart for all
4 of the soldiers. Next slide, please.

5 Now, the other issues being considered
6 by the Committee, and you know, we're deliberating
7 this and understand - we're essentially a week
8 past collecting this data, so the Committee is
9 chewing through the draft report, which was
10 already written. And see, here's some of these
11 issues. Next slide, please.

12 The full examinations that I've
13 described and the biological monitoring, et
14 cetera, was done on the cohort that was there at
15 the time of the investigation, not the prior
16 cohort. So we've got one National Guard unit that
17 was thoroughly examined, not the prior National
18 Guard units. So is it reasonable to go back or
19 not go back and repeat this investigation with the
20 prior groups? Well, that assumption,
21 understanding the environment that this is being

22 done, this is not - this is war environment, lots

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1 of things to do, et cetera, et cetera.

2 One has to make an assumption based on
3 what was found in this investigation for this
4 group to decide whether it was reasonable to
5 extrapolate the results to other groups or whether
6 to go through the same process with all of the
7 other groups, realizing that many of them are much
8 farther out than 30 days from exposure. A
9 decision was made, and that was essentially to
10 extrapolate from this group, not to examine the
11 other groups. Next issue, please.

12 Activism, there's probably a better term
13 for this, but, you know, something needs to be
14 said given that this is field investigation
15 associated with intervention, that this
16 investigation started locally, started in a very
17 timely fashion, resulted in a rapid succession of
18 interventions. In addition, the request to, you
19 know, the home team, if you will, 6,000 miles
20 away, resulted in a response team going to Iraq in

21 very short order and getting to work. So we are
22 going to comment on the issue of activism. This

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1 is the kind of thing that needs to be done when it
2 needs to be done, not a year or years later. So
3 the issue is, is the system, the SOP for the
4 system set up such that they're in the field at
5 the right time. And this is the data we've
6 collected. I'm kind of signaling some of my
7 thoughts on the appropriateness, but the report
8 isn't done. Next comment.

9 Other issues in progress, access to
10 industries specific experts. As somebody who
11 worked for many years, really decades for the
12 National Institute for Occupational Safety and
13 Health, with a huge field team of industrial
14 hygienists, et cetera, but a much huger array of
15 industries that there are in this country and in
16 other countries, the question always is, no
17 generalist industrial hygienist can know all of
18 them; at some point you have to find the people
19 who really know each of these industries in very

20 much depth.

21 So the question is, is there ready

22 access to CHPPM to industry specific experts who

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1 can be called up, that's in a non-technical - who

2 can be asked for their advice immediately, not

3 when papers are signed or classifications can be

4 offered and so forth. The next issue - and again,

5 I forgive this if it's somewhat alienating the

6 terms I've used, but I think there is an issue of

7 Silos versus Bridges. Various groups have

8 responsibilities for different - various public

9 health groups within the military have

10 responsibility for various groups, the Army for

11 the Army, the Navy for the Navy, the U.S. for the

12 U.S., the British for the British, somebody for

13 the civilians, et cetera, et cetera.

14 So the question is, what is the effect

15 of Silos and Bridges in this context of doing

16 rapid investigation when you have various groups

17 in the field and various public health groups are

18 related to them and there may not be communication

19 between them, or there may not even be contractual
20 requirement for communication between them? So
21 the issues of Silos and Bridges is an important
22 one.

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1 Classification is a real issue. Once
2 something is classified, it's hard to review it
3 with people who are unclassified, and I imagine
4 it's hard to get people with general expertise
5 from the civilian community involved in the
6 classified episode. So there's a real issue of
7 the effective classification of the investigation
8 on the report, on the conduct of the report.
9 Dissemination of results to similar sites, this is
10 probably not the only industrial water treatment
11 site in Iraq. Hazard recognition by field units,
12 this is a really challenging issue. You cannot
13 turn every worker in an industry into an expert on
14 everything that might be hazardous to them. And
15 it's particularly true of workers who may be going
16 from industry to industry.
17 So how does one prepare the foot soldier

18 for recognition of the hazard so that they can
19 immediately, the foot soldier or their field
20 supervisor, so that they immediately know that
21 there's a problem?

22 In this instance, remember, it was not

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1 the foot soldier that recognized the problem, it
2 was recognized by the prior contractor, if you
3 will. So there is an issue of how does one
4 prepare for hazard recognition by field units.

5 The other issue that we're going to
6 think about is the number of available experts
7 within CHPPM, that is, intox and epi and
8 industrial hygiene, and what are the issues like
9 career ladders that have some determination on the
10 number and variety and depth of expertise that's
11 available?

12 In this instance, you know, there was
13 only requirement for one field investigation of -
14 concurrently during a war scenario. There could
15 be requirements for two or three or ten if you
16 happen to be essentially in an industrial

17 environment. I mean if this were New Jersey, you
18 know, you wouldn't go five miles, if you were
19 going plant by plant by plant, before one would be
20 overwhelmed by the details and intricacies of
21 fairly arcane industrial processes. Next slide,
22 please.

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1 We have the two basic questions, did the
2 investigation meet standard operating procedures
3 for something like this? And we can compare this
4 all the way back to John Snow. How does this
5 essentially shape up, compare with how it would be
6 done elsewhere, not some ideal, but how in reality
7 this would be done within CDC or et cetera, et
8 cetera, and we expect to have our conclusions on
9 this really fairly soon.

10 And the other issue were the health
11 conclusions appropriate that were made in the
12 field? And we also will have our recommendations
13 - our evaluation on this done fairly rapidly. And
14 I think that should be the last slide, if I'm
15 correct, yes, it is. Okay. Happy to take some

16 questions. And there - Wayne is here. Am I
17 ignoring somebody else on the team? Okay. And
18 there may be somebody on the phone who's also part
19 of the team. And I have to explain that for the
20 two days at the site, I think there were four of
21 us who could be there - three of us who could be
22 there for the entire two days, other people came

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1 for a day and left, so if there's, you know, it's
2 the usual thing, as far as responsibility for
3 errors and whatever, I'm the constancy through
4 this, so that's my fault if there are any errors.
5 Thank you.

6 DR. WILENSKY: Thank you, Doctor
7 Halperin, for that very interesting and
8 informative presentation. At this time we will
9 begin the question and answer session. For those
10 members on the phone, if you would like to ask a
11 question, please press star followed by the one on
12 your telephone key pad. If you would like to
13 withdraw your question, please press star followed
14 by the two.

15 If you're using speaker equipment,
16 you'll need to lift the handset before making your
17 selection. Let's start with questions from those
18 of you who are here at the table. And for those
19 on site asking questions, you'll need to speak
20 into the microphone, which we will share. Anyone
21 have any question? Yes, Doctor Clements.

22 DR. CLEMENTS: John Clements; was there

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1 any attempt to assess the health of the local
2 population or inform the local population about
3 potential health risk associated with the
4 contamination of the site?
5 DR. HALPERIN: This gets back to the
6 issue of Silos. In many ways, John, let me put my
7 blinders on. We're evaluating the field
8 investigation done by CHPPM for soldiers under the
9 command of CHPPM. We're not evaluating the role
10 of CHPPM vis-à-vis the contractors or the civilian
11 site, right.

12 Now, that having been said, I know that
13 the - I know because it's reported that the

14 contractors had health and safety personnel
15 access. I do not know from the report what kind
16 of information, evaluation, et cetera, was done
17 for the civilian population.

18 There is commentary in the report of a
19 civilian population being in the area outside the
20 parameter fence, so that is a relevant question
21 and gets to the issue of Silos and Bridges, et
22 cetera. It also gets to the question of, as an

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1 evaluation team having a true pictorial sense of
2 where this is, which I think the Google maps are
3 revealing.

4 If I've gotten the right Qarmat Ali, and
5 you know, lots of ifs here, but - if I'm there,
6 okay. So if I'm there, then there is a real sense
7 that this is in a peri-urban area, the report does
8 not address the exposure to - and understand, a
9 lot of the variables are different, you know.
10 It's time and concentration, so time and
11 concentration for a civilian population could be
12 quite different, time and concentration for

13 somebody on site. So a long winded answer, but
14 the answer is, it's outside of the area of purview
15 of CHPPM and this report, it does not mean it's
16 not a relevant question.

17 DR. LEDNAR: This is Wayne Lednar. As
18 part of the team that Doctor Halperin led, one of
19 the observations was that, in trying to understand
20 the event, there were these streams of
21 information, Silos, if you like, that were
22 inviolate, did not cross, were not shared, may

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1 have been collected at the same time, or maybe
2 even information that could help the military that
3 was collected in advance of the military seeing a
4 question that then needed to respond to.

5 So just from a protecting the health of
6 the soldier point of view, one of the lessons
7 learned of this I believe is to have a structure
8 that supports the exchange of information that is
9 helpful to understand the hazards at a site to
10 which the military has an assigned mission so that
11 that can be appropriately used to protect the

12 military. That did not appear to occur in this
13 situation. So what could be, and we will have to
14 understand more about this, but what could be
15 potentially a solution to this root cause issue is
16 a contractual sourcing solution, language written
17 into DOD contracts for vendor support that specify
18 when and how information that's relevant to
19 protecting the health of the military can and will
20 be provided, and that did not exist in 2003.

21 DR. WILENSKY: Any other?

22 DR. DUBOIS: Ray Dubois; Doctor, the

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1 issue about similarly exposed with respect to the
2 Guard units, I presume that when you use that
3 term, you mean in terms of deployment period, in
4 terms of length of time were similar between the
5 various Guard units so that you could extrapolate?

6 DR. HALPERIN: Yes; I think - in
7 thinking about the extrapolation issue, let me put
8 this down here because I'm going to have to use my
9 hands. The, you know, there's extrapolation to
10 the soldiers who were in the Guard unit that was

11 investigated, if you will, who did not have
12 laboratory tests done, so that's the first
13 extrapolation. This extrapolation to two prior
14 Guard units, if you will, and to the British,
15 that's another extrapolation that should be
16 considered, could be considered. Then there's the
17 issue of, there are other industrial treatment
18 water facilities that soldiers may be entering now
19 or in the future, it's another extrapolation.
20 There are a series of extrapolations, some which
21 are of immediate concern and some of which are
22 essentially for the point of view of preparation

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1 for either future similar encounters. So there
2 are a whole series of different kinds of
3 extrapolations.
4 DR. DUBOIS: So you feel comfortable
5 that your extrapolations with respect to length of
6 exposure will withstand scrutiny?
7 DR. HALPERIN: The issue really here is,
8 given that the prior Guard units at this facility,
9 given similar circumstances that this Guard unit

10 had, a reasonable assessment I think was done that
11 one could extrapolate to them. But if the
12 circumstance is changing, I mean we've already
13 heard questions about, you know, outside the fence
14 is different from inside the fence,
15 pre-incapsulation could be different than
16 post-incapsulation and so forth. If the
17 circumstances are the same, the extrapolation
18 seems like a very reasonable thing to do. If the
19 circumstances change, one has to be much more
20 cautious.

21 DR. DUBOIS: Would you recommend testing
22 the units that you're not testing?

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1 DR. HALPERIN: Okay. This goes back to
2 -- remember the hand drawn thing that I described?
3 The length of time on that was a month, right, if
4 you extrapolate that to four months, you should
5 see no blood chromate. Even if there were
6 elevated blood chromate, if you extrapolate that
7 from four months to a year, or two years, five
8 years, right, then your biological monitoring is

9 essentially worthless. It's going to be falsely
10 negative - it's going to be negative, whether it's
11 truly negative, false - it's going to be negative.
12 You're just too far out to do any kind of
13 biological monitoring.

14 The issue of dermal ulcers, chrome
15 ulcers, and nasal perforation should have been
16 picked up in the medical examinations, medical
17 evaluations through the health risk assessment, et
18 cetera, et cetera, of which a lot was done way
19 back when, it should already have been done.

20 DR. DUBOIS: Not being a doctor --

21 DR. HALPERIN: Yes.

22 DR. DUBOIS: -- I would just suggest

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1 that there's a political aspect of this. If I
2 were a governor of the state of Indiana, my Guard
3 unit, and they'd come back, and this assessment
4 has now been done, I wonder whether those Guard
5 members, when they came back and had their
6 post-deployment physicals, were those
7 post-deployment physicals focused on chromium fix,

8 red blood issue, et cetera, and if not, I think it
9 makes some sense to at least recommend, even
10 though time, X, months, years has taken place,
11 because it's kind of saying to mom and dad of
12 Sergeant Dubois, you know, we've done everything.

13 DR. HALPERIN: Yes; the question that's
14 really being asked is - the mic, it's fine, okay.
15 The question that's really being asked, I think,
16 you know, it needs to be parsed a little bit. The
17 history of what happened here, it's our
18 understanding, is now in the medical records of
19 all of the people, all of the U.S. soldiers who
20 were there at that time.

21 So for the physician who is responsible
22 for an individual, that they had an exposure, what

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1 the level was, what the assessment was at the
2 time, what the - it's all in the medical records,
3 so that's on a one-on-one relationship with the
4 physician and the individual, that's an
5 accomplishment.

6 Now, the next question would be, is

7 there a reason for doing a population based
8 assessment of these populations to see something,
9 right? Well, there the issue is, well, what are
10 you going to see and is what you see going to be
11 indicative of a problem or indicative of a non-
12 problem? So if you're five or six years after
13 exposure, there's not going to be any evidence of
14 chromium on board in any one of these potential
15 tests. So essentially this would be not a
16 valuable test to do at this point. One has the
17 information about extrapolation, but studying this
18 population biologically isn't going to contribute
19 new information about their levels at the time
20 back six years prior.

21 Now, in addition, you have information
22 from the individuals about their symptoms at the

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1 time that they were there. So, for example, did
2 they have irritation, did they have respiratory
3 irritation? That could be determined. But did
4 they have nasal perforation or cutaneous ulcers
5 and so forth? It should have been picked up by

6 this process long before now.

7 A doc who is asking - has a one-on-one
8 relationship with those individuals, and it's in
9 the chart, would be prompted to inquire, discuss,
10 et cetera, et cetera. So I'm being long winded,
11 but the real question is, these folks, in my
12 opinion, deserve medical care. The value of an
13 epidemiologic investigation at this point would be
14 almost guaranteed to prove nothing, even if there
15 had been an exposure, which is, by extrapolation,
16 unlikely if the circumstances were the same. So I
17 hope that answers your question.

18 DR. DUBOIS: It does; thank you very
19 much. I know we only have one or two minutes
20 left. I want to just give some context here and
21 specifically in relationship to Doctor Halperin's
22 questions and comments about Silos versus Bridges

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1 and the similar hazards and similar site issues.

2 I was the Deputy Undersecretary of
3 Defense for Installations and Environment and had
4 responsibility for environment safety and

5 occupational health, and I had developed a
6 relationship with all the combat and commanders,
7 but specifically the CENTCOM commander with
8 respect to environment issues, because there are a
9 number of situations, in particular, when we went
10 in to take over an air base that had been, for
11 instance, a former Soviet air base, which was
12 highly contaminated.

13 I got an intel report fairly quickly,
14 and depending upon, and this is a Silo/Bridge
15 issue, whichever military department had executive
16 agency responsibility, I directed that military
17 department to dispatch and deploy an environmental
18 assessment team, such as the Army did with CHPPM.
19 I can remember several examples in Afghanistan,
20 Kajikstan to Tajikistan, and Iraq, where we did
21 this. The policy issue is at the OSD level. And
22 it is a matter of concern, was a matter of concern

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1 to me, how quickly would I find out about these
2 issues, and therefore, be able to direct an
3 assessment or direct some kind of remediation if

4 necessary.

5 And I'll be glad to sit down with you,
6 Doctor, afterwards to discuss sort of the food
7 chain here, the chain of command, because we were
8 very definitely aware of these issues a the OAD
9 level, which is, you know, considerably distant
10 from base X, forward operating base Y in
11 Afghanistan, but it was an important development
12 that we were aware of it and we took action.

13 COL GIBSON: Go ahead; we really need to
14 move on.

15 CMS HOLLAND: This is Command Sergeant
16 Major Retired Larry Holland. Thanks, Doctor
17 Halperin, for your comments. I am still concerned
18 that all of the National Guardsmen and maybe our
19 brother, the British troops, some annotation,
20 maybe once this report is finished, should go to
21 their senior headquarters or Guard Bureau and make
22 sure that we really have something on record for

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1 these individuals in case something happens to
2 them down the road and someone is not sure of,

3 Ray, what it is, because these National Guard
4 units were not just from those states, they were
5 scattered all over the United States, and catching
6 up with all those troops I think would be a real
7 tough situation.

8 DR. WILENSKY: I'd like to see whether
9 there are any questions from people who are on the
10 phone.

11 OPERATOR: Thank you. We do have a
12 question from Doctor Tom Mason. Please go ahead
13 with your question.

14 DR. WILENSKY: Okay. Can I ask, Doctor
15 Mason, please keep your question short and the
16 response equally short. Thank you.

17 DR. MASON: Thank you, Doctor Wilensky.
18 I was serving on the Subcommittee with Doctor
19 Halperin, and one of the issues that Command
20 Sergeant Major just raised is consistent with one
21 of our discussions, looking at post- deployment
22 health assessments and looking for similarities or

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1 dissimilarities between that which we got from

2 Indiana and may have from the other Guard units
3 and potentially basically the parallel issue with
4 regards to British forces. So I think that we
5 should pay attention to what information is there,
6 look for consistencies, and follow up on the
7 Command Sergeant Major's recommendation, which I
8 applaud.

9 DR. WILENSKY: Thank you. Any other
10 comments or questions?

11 OPERATOR: We have no other questions
12 through the audio participants.

13 DR. WILENSKY: If there is no
14 disagreement or additional comments, the Core
15 Board accepts Doctor Halperin's and the
16 Occupational Environmental Health Subcommittee
17 Report by consensus. Thank you very much.

18 Our second speaker this morning is
19 Doctor Joseph Parisi, Professor of Laboratory
20 Medicine and Pathology at the Mayo Clinic. As
21 Chairman of the Scientific Advisory Board for
22 Pathology and Laboratory Services, he will discuss

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1 the draft report of the review of the Department
2 of Defense Concept of Operations document for the
3 establishment of the Joint Pathology Center.

4 DR. PARISI: Thank you very much, Doctor
5 Wilensky. The Defense Health Board review of the
6 documents that were provided and the presentation
7 that was provided at the September meeting formed
8 the basis of this report. Can I have the next
9 slide, please?

10 The review panel was actually made up of
11 the members of the Scientific Advisory Board for
12 Pathology and Laboratory Services. The members
13 are listed there, as well as selected members from
14 the Defense Health Board Core and some selected
15 Subcommittee members, and they are also listed on
16 the Powerpoint slide. And I was the Chair of this
17 session. Can I have the next slide, please?

18 The review process was related to the
19 sequence that's shown on the screen. We initially
20 had a question presented to the Board by Doctor
21 Kelley back in June, and this was followed in
22 September by a presentation at the Defense Health

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1 Board meeting that was presented by Doctor Kelley
2 and Colonel Baker.

3 We then had a teleconference with all
4 the review panel members, as well as Doctor Kelley
5 and other DOD officials on October 2nd. We
6 provided a draft review document which went
7 through several alliterations and was now just
8 recently circulated to members of the Subcommittee
9 and the entire Defense Health Board Core members.

10 And, of course, today we're discussing this, and
11 the intent then is to provide a revised report and
12 submit this to Doctor Casscells and the DOD
13 leadership in the near future. Can I have the
14 next slide?

15 The public law, 110 to 181, specifies
16 the establishment and maintenance of the Joint
17 Pathology Center that should function as the
18 reference center in pathology for the federal
19 government. There was a clause in the law that
20 also said if the President cannot determine that
21 this would be established in the Department of
22 Defense, then the JPC could be established

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1 elsewhere. The law also details some of the
2 activities of the Joint Pathology Center. Could I
3 have the next slide, please?

4 And as a minimum, the law dictated -
5 could you please go to the next slide? The Joint
6 Pathology Center would provide a minimum -
7 activities, diagnostic pathology and consultation
8 services for - in medicine, dentistry, and
9 veterinary pathology, pathology education to
10 include graduate medical education, including
11 residency and fellowship programs, and continuing
12 medical education. I think I'm on the next slide,
13 please, and that's slide number five. Can someone
14 please advance - thank you.

15 So these are, again, the activities that
16 were specified in the public law. Diagnostic
17 pathology research and the maintenance and
18 continued modernization of the tissue repository,
19 and as a corollary to this, the utilization of the
20 repository in conducting the activities that are
21 detailed above. And we'll go through each one of
22 these activities as we continue with the report.

1 The Board charge - could I have the next slide,
2 please - was presented by Doctor Kelley, and there
3 was a request that the panel review the Department
4 of Defense Implementation Plan for the
5 establishment of the JPC, that the Board review
6 the Implementation Plan, and that we also comment
7 on the plan's appropriateness and the feasibility
8 within - for DOD within the context of the BRAC
9 law, which is - which has been passed, as you well
10 know.

11 The JPC Working Group was formed. Could
12 I have the next slide, please? To come up with a
13 concept of operations for this Joint Pathology
14 Center. The vision of the - as presented by the
15 Working Group, was to be the federal government's
16 premier pathology reference center in support of
17 the Military Health System, the DOD, and other
18 federal agencies.

19 And the mission, I think these are both
20 very important, concepts, the mission was that JPC
21 will provide world class diagnostic subspecialty
22 consultation, education, training, research, and

1 the maintenance and modernization of the tissue
2 repository in support of the mission of the
3 Department of Defense and other federal agencies.
4 So taking the Working Group findings, the concept
5 of operations provided by the Working Group, and
6 the presentations that were presented to the
7 Board, we deliberated some of the details in the
8 ConOps. If I could go to the next slide, please.
9 So the review panel assessment then is, in
10 conclusion actually, concurs with the vision and
11 the mission as provided by the - provided in the
12 documents and presentations by the Working Group.

13 The panel believes, however, that the
14 Department of Defense needs to consider a number
15 of other findings and recommendations as they
16 develop a more strategic - more extensive
17 Strategic Plan in the designing of the JPC.

18 There's a unanimous opinion that this is
19 really a unique opportunity to develop a center of
20 excellence. The panel recognizes the enormous
21 contributions of the Department of Defense to
22 medicine and the very important - and the

1 importance of continuing this legacy and providing
2 world class pathology consultation, as well as
3 research and educational opportunities. So we
4 view this as an unequal opportunity, again, to
5 design a very unique and important center. If
6 you'd go to the next slide, please.

7 Some special attention - I'd like to now
8 discuss in detail some of the findings of the
9 panel and some of the recommendations that we'd
10 like the Department of Defense to consider as they
11 move forward with their Strategic Plan. First of
12 all, regarding the clinical scope of service, the
13 concept of operation provided diagnostic services
14 to - was going to provide subspecialty diagnostic
15 services, but these subspecialties were not
16 specified, and the panel believes that this is a
17 very important - this is very important to define
18 as it will determine a variety of parameters in
19 the design of the JPC, including staffing, cases
20 that would be viewed there, et cetera. So
21 subspecialty services need to be defined.

22 Also, the process of handling individual

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1 cases, including the assessment, the triage, the
2 deposition, disposition, flow, reporting, and
3 quality assurance of the - of cases, individual
4 cases, needs to be refined.

5 The quality assurance is a very
6 important piece of this. Since good medical
7 treatment, as you know, requires an accurate
8 tissue diagnosis, without a good diagnosis,
9 treatment may be inappropriate or ineffective and
10 may have medical legal implications, obviously, so
11 this is a very important part of the clinical
12 services that the JPC would provide.

13 We suggested in-theater support might be
14 expanded to include the support of other
15 diagnostic technologies that would service the
16 soldier in combat. Also, we recognize the
17 important need of interactions with other federal
18 agencies, including the VA, NCI, Indian Health
19 Services, CDC, NIH, the list could go on and on,
20 but other federal agencies also ought to be
21 considered in the scope of service of this JPC.

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1 Armed Forces Medical Examiner need to be
2 considered as far as general pathology review of
3 case material. The positioning of the JPC within
4 the command structure generated considerable
5 discussion among the panel.

6 The conclusion was that DOD was a
7 logical choice for the location of the JPC,
8 however, everyone - there was unanimous agreement
9 by everyone that the JPC should be a high level
10 and ideally an independent entity with high
11 visibility within the leadership and not buried in
12 a hospital Department of Pathology, where the
13 priorities, the vision, mission and so on are
14 considerably different. So we've got to emphasize
15 that point.

16 We believe that the JPC would be best
17 served at a higher level than what was presented
18 in the ConOps. In support of this, if I can go to
19 the next slide, please; in support of this, there
20 should be a Board of Governors established that

21 would provide oversight. This should include
22 federal agency representation, obviously, with

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1 possible representation from civilian medicine and
2 even industry. That, again, would provide active
3 oversight and potential advocacy for funding
4 should these become important issues. The
5 development of performance metrics needs to be
6 done, as well.

7 With further detail, the organizational
8 structure, we believe that there ought to be
9 periodic assessment of the resources as the
10 workload and the activities of the JPC become
11 better defined. And utilization of business
12 principals and practices to increase cost
13 efficiency ought to be employed, as well. Go to
14 the next slide, please.

15 Regarding staffing, go to the next
16 slide, please, it's very important that
17 appropriate administrative and secretarial support
18 be provided for the subspecialty pathology
19 personnel. At Mayo, for example, each pathologist

20 has at least one secretary that's dedicated to
21 doing the secretarial activities related to his or
22 her workload, and many of us actually have even

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1 more than one secretary that's responsible for our
2 workload. Again, identification of the
3 subspecialties needs to be defined. Also, the
4 staffing by the JPC needs to be considered. For
5 example, will this be made up more of senior or
6 junior level pathologists, what will attract these
7 pathologists to the JPC? Obviously, salary is an
8 important consideration, and the salary at the
9 GS-15 level is often times not competitive with
10 the salaries in mainstream medicine.

11 More importantly than salary actually
12 are probably the research and educational
13 opportunities that the staff could engage in, and
14 these are often times, again, more important to
15 the individual staff member than salary issues.
16 But, again, these staffing issues need to be
17 better defined. We also would suggest that a full
18 manpower allocation review be done based on a

19 viable business plan.
20 Regarding the workload, the workload
21 that was provided to us in the documents included
22 cases only from the Military Health Service and

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1 the VA. However, if one agrees in principal that
2 all federal agencies, that this is a national
3 federal resource for all federal agencies, then
4 the workload or potential work from other federal
5 agencies needs to be determined and also be
6 included in the workload.

7 Also, regarding individual cases, I
8 think the case complexity is a very important
9 piece of this that was not addressed. I suspect
10 that the model that was presented was based more
11 on a general pathology practice rather than a
12 subspecialty pathology practice, where case
13 complexity is very important and requires much
14 more detail and time per case to perform.

15 So, for example, a general pathologist
16 seeing any run of the mill surgicals, for example,
17 hernia sacs and gall bladders, can process many of

18 these, while a pathologist that's dealing with a
19 very unusual tumor or a complex neurodegenerative
20 disease, for example, would require considerably
21 more time per case. So, again, the case
22 complexity needs to be part of the equation in

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1 projecting realistic workload for the pathology
2 staff. If I can go to the next slide, please.
3 The crown jewel in all of this, of
4 course, is the tissue repository that resides at
5 the AFIP currently. And I was delighted to learn
6 of a new independent study by Asterand that
7 provided a monetary value to the tissue
8 repository, it's somewhere in the range of 3 to
9 \$3.6 billion. So this has enormous ramifications
10 for potential use by industry, partnering with
11 industry, partnering with academia in a research
12 venue. It's very important to maintain and expand
13 the tissue repository, and this requires active,
14 committed professionals, both pathologists and
15 support services, again, to maintain the
16 repository. We also recommend that a process be

17 developed for access and usage of the material
18 within the repository, and these processes also
19 facilitate inner agency and civilian access to the
20 materials. Go to the next slide, please.

21 Regarding research, go to the next
22 slide, please, the panel recommends that a health

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1 research management process be implemented, and
2 this would include approving protocols,
3 collaboration with other federal agencies,
4 civilian academic centers, and even industry, and
5 obviously that has the detail criteria for
6 inclusion and protocol approval priorities need to
7 be part of this process. If I can have the next
8 slide, please.

9 The panel recognizes the vast
10 educational and training opportunities that have
11 been provided in the past by the Department of
12 Defense for pathology, and we believe that these
13 also need to be supported. The contributions by
14 USUHS and the JPC need to be more clearly defined,
15 and there need to be some recognition of pathology

16 training, subspecialty pathology training, and
17 subspecialty pathology education that, again, has
18 been provided in the past by the Department of
19 Defense. In addition, we recognize that there are
20 a broad spectrum of interest areas that have a
21 major part of this being pathology, and this
22 includes, for example, aviation, and accident

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1 forensics, and investigation, and, of course,
2 these need to be consistent with military
3 treatment priorities and challenges as they
4 evolve. So there needs to be obviously very
5 flexible. But we believe that the educational and
6 training component of this JPC is a very important
7 one and one that should be continued.

8 Regarding the equipment and special
9 design requirements, the Strategic Plan needs to
10 address the design of state of the art laboratory
11 and support services. This needs to provide high
12 quality histology and immunohistochemistry and
13 even electron microscopy to provide the
14 pathologists with appropriate material to

15 interpret. The design of the molecular laboratory
16 is very important, and this is especially true as
17 more molecular pros become available and advances
18 in genomics and individualized medicine are made.

19 There was also a concern expressed by
20 the separation of the JPC between Bethesda and
21 Forest Glen campuses, and we - there is a sense
22 that this was not ideal for work flow and for

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1 communication between the two sites, so this also
2 needs to be addressed in the Strategic Plan. What
3 I'd like to now present are some of the final
4 recommendations that the panel - that evolved from
5 the panel's discussion. First of all, we believe
6 that the Department of Defense has a unique
7 opportunity to build a center of excellence. This
8 obviously has to be within the constraints of the
9 law, but it should meet the needs of all the
10 federal agencies.

11 We also would like to emphasize that the
12 JPC should be sufficiently flexible and adaptable
13 since the needs will vary depending on health care

14 issues that potentially arise, so that this,
15 obviously, to meet future requirements of the
16 Department of Defense and other agencies, again,
17 as they arise.

18 We also would like the Department of
19 Defense to consider that all federal agencies have
20 a piece of this or certainly can take advantage of
21 the services provided by the JPC. Again,
22 subspecialty areas need to be identified. Could I

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1 have the next slide, please?

2 The organizational structures should be
3 sufficiently flexible. There should also be
4 collaborative relationships made between civilian
5 entities and perhaps even industry. These can
6 provide funding, streams of funding, but more
7 importantly, increase intellectual and academic
8 activity by the center. The education and
9 training components need to be further developed.
10 And, of course, all this should meet military
11 health needs as things evolve. There should be a
12 governance structure in place to ensure

13 stakeholder interest. The next slide, please.
14 Performance metrics should be developed
15 and periodically reviewed. And we, as members of
16 the Board, we like to be a part of this review
17 process. There ought to be appropriate funding
18 and resources allocated to ensure that the staff,
19 space, and equipment, and facilities are
20 sufficient to provide premier pathology services.
21 And again, we view these as very important
22 components of the Strategic Plan.

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1 We recognize - could we go to the next
2 slide, please? We recognize that the current
3 budget that was presented may be inadequate for
4 all the projected activities. However, we believe
5 that the funding opportunities are available.
6 Collaboration with other federal agencies is one
7 place, but also partnering with civilian and
8 industry also could provide funding sources. The
9 tissue repository needs to be maintained and
10 modernized, and all these will permit the JPC to
11 thrive and meet its mission. Can you go to the

12 next slide, please? The tissue repository, again,
13 is a national treasure, it's the crown jewel in
14 this entire process, and every effort must be
15 pursued to guarantee that the repository is
16 preserved, modernized, and utilized appropriately.

17 The Defense Health Board also would like
18 to review the Strategic Plan and we'd like to be
19 involved early in the review process. Those are
20 our major findings of the panel. I'd like to now
21 open this up to discussion and any questions that
22 might be available. Thank you.

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1 DR. WILENSKY: In order - thank you very
2 much, Doctor Parisi. In order not to get too much
3 off of our schedule, I'm going to ask people to
4 please keep their questions short and the
5 responses equally short. We will use the same
6 procedure we used before.

7 Those of you on the phone, if you'd like
8 to ask a question, press star followed by one, and
9 if you want to withdraw your question, press star
10 followed by two. If you're using speaker

11 equipment, you'll need to lift the headset. Let
12 me start with those of you who are in the room.
13 Again, please keep your questions short and to the
14 point. Ray.

15 DR. DUBOIS: Ray Dubois; Doctor, did the
16 review panel reach any consensus with respect to
17 the work flow considerations and the separation of
18 assets between Bethesda and Forest Glen, i.e.,
19 should there not be a consolidation of the mission
20 areas in one place?

21 DR. PARISI: I think ideally a
22 consolidation would be best for work flow. It

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1 often - it allows ready communication between the
2 support services and the professional staff. So
3 ideally a location that provides all those
4 services in one unit would be ideal.

5 We thought that the separation of the
6 assets between the two campuses actually was
7 problematic. Even though there is a shuttle
8 service available, it takes between 15 and 20
9 minutes to get things back and forth. But I know

10 from my own work on a daily basis, I often will
11 walk downstairs to the technicians, you know, if
12 there's a problem with a stain or if I need
13 immunochemistry, that lab is only, you know, a
14 floor away, the EM is up two floors, and so it's
15 very - it makes the communication and the work
16 flow much more efficient. And also, our
17 secretaries are also on sight here right adjacent
18 to our offices.

19 DR. WILENSKY: Any additional questions?

20 DR. POLAND: Gail, this is Greg Poland.

21 Can you hear me?

22 DR. WILENSKY: Yes.

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1 DR. POLAND: Just a quick thing. First,
2 Joe, thank you, and to Wayne Lednar, who's there,
3 too, for the tremendous amount of work that I know
4 has gone into a large and difficult issue. One
5 quick question for you, and it revolves around the
6 tissue repository. I've had some interactions
7 with them in the past.

8 Is there an existing or sort of

9 benchmark model that we don't have to go through
10 today, but that could be proposed for how the
11 utilization and access to that repository could
12 occur?

13 DR. PARISI: I believe the current model
14 at the Armed Forces Institute of Pathology
15 actually works fairly well, Greg, works well.
16 Again, there is this new report that was an
17 assessment by this company called Asterand from
18 Michigan, who reviewed the tissue repository in
19 great detail and found that it was very viable and
20 provided appropriate access to it and so on. The
21 tissue certainly was very valuable. Maybe someone
22 from AFIP would like to speak to that.

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1 DR. POLAND: Not so much the mechanics
2 of it, but just your general feeling that there is
3 a benchmark way to do it.

4 DR. PARISI: I believe so, yes.

5 DR. POLAND: Thank you.

6 DR. WILENSKY: Are there any questions
7 from members on the phone?

8 OPERATOR: Yes, we have a question from
9 Kathy Slaunwhite. Please go ahead with your
10 question.

11 MS. SLAUNWHITE: Thank you. Yes, it's
12 Commander Kathy Slaunwhite from Canada here.
13 Currently the Canadian Forces sends aviation
14 incident or accident related specimens to AFIP for
15 analysis. Under the proposed national structure,
16 Joint Pathology Institute structure, is there any
17 reason to be concerned that that continued access
18 to sample analysis would be threatened or in
19 jeopardy of being able to continue in its current
20 manner?

21 DR. PARISI: Well, I would hope that it
22 would continue. I would hate to see that go away,

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1 because I think it provides a very important
2 source of case material both intellectually, as
3 well as providing a service to you folks.

4 MS. SLAUNWHITE: Yeah.

5 DR. PARISI: The plan as it was
6 presented I don't think had any mention of that,

7 but that ought to be considered within the scope

8 of service, I believe.

9 MS. SLAUNWHITE: Thank you.

10 DR. WILENSKY: Any other questions on

11 the phone?

12 OPERATOR: We do not have any at this

13 time.

14 DR. WILENSKY: Okay. The Board has

15 received written statements regarding

16 establishment of the Joint Pathology Center.

17 These statements have been reviewed by the

18 Executive Council and will be part of the formal

19 meeting record. I understand there are members of

20 the public who have registered present their

21 comments on the JPC issue. I will ask Ms. Jarrett

22 to assist us in having them come forward. Please

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1 keep your statements as a summary statement to

2 within two to three minutes.

3 COL GIBSON: Do we have members of the

4 audience who would like to make a statement? We

5 understood there were four.

6 DR. WILENSKY: If they're written,
7 they're in the record.

8 COL GIBSON: If they're already written,
9 they're already in the record. Okay, then fine.

10 DR. WILENSKY: Okay, thank you. If
11 there are no additional comments, I would like to
12 know whether among the Core Board members the
13 Board is comfortable in receiving the JPC report
14 by consensus. Okay, I'm getting nods of people
15 around the room here. Is there anyone on the
16 phone who is a Core Board member who is not
17 comfortable with accepting the recommendations by
18 consensus? In that case, please regard the report
19 as being accepted by the Core Board, and thank you
20 for all of your difficult work. I appreciate your
21 activities. We are now going to take a short
22 break. We will reconvene at 10:15. Thank you.

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1 (Recess)

2 COL GIBSON: Okay, let's get started.

3 DR. WILENSKY: Doctor Poland will now
4 cover the activities of the Defense Health Board's

5 Task Force reviewing the Department of Defense
6 Biodefense Research Portfolio. This is a new
7 question before the Board since the last formal
8 meeting. We've been tasked to provide an external
9 review of the Department's Biodefense Research
10 Infrastructure and answer a series of questions
11 relating to DOD's scientific and strategic
12 investments. It's processes and procedures
13 related to product development and licensure and
14 to evaluate the scientific or strategic return on
15 investment for previous and current research
16 development, training, and education efforts.
17 Doctor Poland, the floor is yours.

18 DR. POLAND: Thanks, Gail. If we can
19 have the next slide. There seems to be a delay in
20 how the slides come up.

21 OPERATOR: Pardon me, Doctor Poland.
22 There is going to be a slight lag in the slides.

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1 DR. POLAND: Okay, thank you. So just
2 to reiterate, the Army Office of the Surgeon
3 General, Major General Schoomaker requested that

4 the DHB address the three questions. And for
5 simplicity, let me just characterize each one of
6 them with a headline.

7 The first question revolves around need.

8 Is there a national and strategic need for the
9 military service departments to own and operate
10 infrastructure in support of biodefense
11 capabilities?

12 The second headline is translation. Are
13 the current processes effective in transferring
14 the results of basic research into advanced
15 product development and licensure? And the third
16 headline is sort of return on investment. Does
17 the current system and processes provide a
18 strategic return on investment for these efforts?

19 If I could have the next slide? I want to
20 acknowledge and thank the Work Group members who
21 have put a lot of time and effort into this. We
22 had a teleconference on October 24, and then

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1 meetings on November 7, November 19. And
2 yesterday John Clements, who is there, and myself,

3 spent the day crawling in and out of a black hawk
4 helicopter doing site visits to some of the
5 biodefense assets.

6 So the Work Group members included
7 myself, Wayne Lednar, Doctor Breidenbach, John
8 Herbold, who has been with us before, John
9 Clements, who's there with you, Frank Ennis, and
10 Joe Silva. Next slide.

11 As I've mentioned, we've had four
12 meetings, or really three meetings and a site
13 visit thus far. The November 7 in person meeting
14 allowed us to get briefings from DTRA, the JPEO,
15 from each of the services involved, and the Office
16 of the Special Assistant for Chem Biodefense.

17 Yesterday, as I mentioned, site visits
18 were conducted to Edgewood Chemical and Biologic
19 Center, Forest Glen, Rare and the United States
20 Army Medical Research Institute for Infectious
21 Diseases. Next slide. What I'm going to give you
22 next is in the spirit of an interim report given

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1 that all of our - all of the Subcommittee's

2 thinking hasn't yet been cohesively put together.
3 As I mentioned, the site visits finished a mere 12
4 hours or so ago. But I can give you this much in
5 the way of insight.

6 One is, we feel strongly that there's no
7 dispute, that the DOD Biodefense Research
8 Portfolio is both unique and necessary for DOD.
9 There are a number of reasons for this, and the
10 questions here seem to revolve around could
11 another federal agency, for example, NIH or
12 academia or industry do this. And, by the way,
13 let me just mention that, because Bio Surety is in
14 the title of the slide, the DSB, Defense Science
15 Board, is actually examining the issues of Bio
16 Surety.

17 We are focusing our comments on the
18 three headlines that I mentioned. And given the
19 very quick turnaround time for this, and I should
20 mention, I previously served on an IOM committee
21 that looked at similar questions related to
22 broadly military infectious disease research, and

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1 we spent over a year trying to come up with a
2 reason to data driven conclusions, so this will be
3 very high level. The reason that we think this is
4 both necessary and needed by DOD is, there is a
5 deterrent capability that would not be a feature
6 of say academia or industry taking over this sort
7 of capability. The other important thing, and we
8 heard much in the way of testimony about this from
9 those involved in responding to the anthrax letter
10 attacks, by order, the responsiveness and turn on
11 a dime capability of the military labs to respond
12 to threats is not only sound, but as I say, was
13 demonstrated in real time during the anthrax
14 attacks.

15 We also heard quite clearly that
16 laboratories in academic and industry are
17 generally unwilling to engage in research that
18 have very high levels of risk. In fact, there's
19 only a few assets around the country where BSL-4
20 level research could be conducted, and for
21 industry, where there's no profit motive for
22 orphan vaccines, so, for example, vaccines against

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1 special pathogens that are not going to provide a
2 market for some public sector.

3 And the other thing which I had not
4 realized was the particularly high demand for
5 BSL-4 containment laboratories, especially for
6 animal efficacy studies, and this revolves around
7 the FDA's recent two animal rule for licensure of
8 vaccines such as these that cannot be ethically
9 tested in human populations. So not only does the
10 military use this, but academic and industry are
11 completely dependent on that DOD asset. Next
12 slide. Our second preliminary conclusion is that
13 the basic science research that we heard about is
14 sound, but that there were barriers toward moving
15 that or translating that into advanced product
16 development and licensure.

17 Some of those include a fragmented
18 organizational structure that strays away from the
19 benchmark, what we felt was the benchmark, and
20 that is industry best practices models.

21 There is not a single individual
22 accountable and whose head is on the platter for

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1 meeting timelines and translation, and in some
2 cases, senior leadership that doesn't necessarily
3 have vaccine development expertise and experience.

4 There are a number of complex management
5 and oversight issues involving DTRA that we'll
6 elaborate on in our report. We noticed a loss of
7 intellectual capital due to difficulties inherent
8 in transitioning junior level military personnel
9 to higher level leadership positions and retaining
10 qualified scientists along the lines that Joe was
11 mentioning in terms of attracting top talent and
12 retaining them. There are also, and this is a bit
13 complex, but there are separate lines of funding
14 for the different phases of, you know,
15 pre-clinical research through clinical research
16 and advanced development, and those come from
17 different entities, and that collusion of facts is
18 not amenable to project sustainability and to an
19 acceleration of the process.

20 There was also the sense that the
21 processes seem to be more concerned with inputs
22 rather than outputs. One would think that the

1 sole focus might be on an output. We will have a
2 vaccine against pathogen X in five years. That's
3 not the sense that the Committee has, rather, it's
4 a sense of, well, how many square feet do we have,
5 what kind of funding do we have, those sorts of
6 issues, sometimes politics, of course, too, and a
7 complex and unwieldy table of organization that,
8 in fact, is very difficult to get your hands
9 around, and mostly unknowable even by those
10 involved with it. Next slide.

11 There's some other issues, these include
12 a lack of the level of communication. I shouldn't
13 say lack of communication, it's lack of the depth
14 of communication that should occur between
15 responsibility - responsible entities. And a
16 strong feeling that this should be very much a
17 joint program. What we saw as a tendency,
18 although there have been recent attempts at more
19 communication, is that Army, Navy, and primarily
20 those programs might have a lot of redundancy in
21 overlap and that may or may not be even knowable
22 by the individuals in those two different

1 programs. There is now an integrated national
2 portfolio which we thought was a very good start,
3 but I think one of the things that will come out
4 of our conclusions is, this really needs to be
5 organized as a very joint program with a senior
6 level experienced level highly accountable for the
7 results of the program.

8 The TMTI is a novel experiment and has
9 only been in place I think about a year and a
10 half, two years, something like that, and those
11 results need to be evaluated and if successful,
12 generalized. This is sort of a pathway that's
13 been developed to try to accelerate advanced
14 development of products.

15 It is not clear that there are
16 systematic, agreed upon, and explicit evaluation
17 metrics to evaluate the different programs and the
18 different phases that they are in, and that
19 follows on to the ability to kill projects that
20 might not be productive. It was not clear whether
21 projects had been stopped, and if so, what
22 criteria had been used. Next slide. So some of

1 our early recommendations are that, in the vain of
2 productive biodefense research, our sense is that
3 it will require centralization and joint
4 programmatic planning, that the development of
5 evaluation metrics was going to be important, that
6 there be sustained and identifiable leader
7 accountability, that there be realistic timelines
8 and multi year funding rather than year at a time,
9 and further collaboration. Next slide.

10 I might comment that when it gets to the
11 ROI, we still have some work to do on that, but we
12 very clearly heard the large number of patents
13 that have been developed through this programs in
14 the last three to five years, the amount of CREDA
15 and collaborations that had occurred, publications
16 that occurred, and even products that either had
17 been licensed or at least passed and into the IND
18 phase. So we did feel - we did have the gestalt
19 that there has been an impressive return on
20 investment, it's just been somewhat hard to
21 quantitate that.

22 And then finally, I'll say that, again,

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1 on a very short timeline here, what you have just
2 heard will form the basis of a high level interim
3 report that will be briefed to the service
4 secretaries. And I think this date is correct
5 that we have established December 3, 2008, in
6 that. Next slide. And before I close on this, I
7 would ask either Doctor Lednar or Doctor Clements,
8 who have been particularly heavily involved in
9 this, to add any comments. It's hard to capture
10 the enormity of everything that we've heard in
11 just a few slides and they may have some important
12 insight.

13 DR. CLEMENTS: This is John Clements;
14 thank you, Greg. By the way, how is your head?

15 DR. POLAND: A small head injury. For
16 those in the audience, I skinned my head on the -
17 climbing in the hatch of that black hawk on the
18 second time, but I'm fine, thank you.

19 DR. CLEMENTS: We gave him a Purple
20 Heart yesterday for his efforts. Just a couple of
21 comments; one I think is particularly germane is

22 that our site visit yesterday was actually

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1 conducted in conjunction with the General Officer
2 Steering Committee visit to the sites. And Major
3 General Robert Lennox and Major General William
4 Rew were command officers on that visit and they
5 have a report that is actually - it's not dove
6 tailing this one, but it covers many of the same
7 areas that we are covering, and they've offered to
8 share their preliminary report with this Committee
9 and should have it to us by Friday, and I think
10 that should help inform us as we go forward in our
11 discussions.

12 DR. POLAND: That would be wonderful,
13 thank you, John.

14 DR. CLEMENTS: And I think that will be
15 important for us. There were - the site visits
16 yesterday I think were really complimentary to the
17 discussions that we've been having, and the
18 commands - each went to a great deal of trouble to
19 lay out exactly what their programs were.

20 And I think that generally we came away

21 with very favorable impressions of the effort and
22 the amount of attention to this particular

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1 question, to these questions that we've been asked
2 to address, and that will also help inform the
3 discussions of the Committee.

4 But I think there are going to be some
5 disagreements and I think we're going to need some
6 time to discuss those. There were some variance
7 at MMRC that I think we need to have a more full
8 discussion about as we go forward. So I would
9 reemphasize that we're still really at a - we're
10 not at a - we're at the ultimate stage, we're not
11 at the conclusion stage on the report yet.

12 DR. POLAND: Yeah; thank you, John. And
13 I might just add a bit onto that, dove tailing to
14 something Bill Halperin said about shoe leather
15 epidemiologists versus arm chair. I was impressed
16 once again and commend to any of the task forces
17 working on important issues like this. The
18 importance of actually seeing these sites and
19 talking to the people involved, I find it's

20 impossible to really get the comprehensive view of
21 that on paper, you've got to actually be on the
22 ground to see it.

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1 DR. WILENSKY: Thank you very much.
2 We're going to begin the question and answer
3 session using the same process that we have
4 earlier. If anyone has just joined us
5 telephonically, if you have a question, please
6 press star followed by the one on your telephone
7 key pad. If you'd like to withdraw your question,
8 please press star followed by the two. Let me
9 start with questions from those of you who are
10 here at the hotel. Doctor Halperin.

11 DR. HALPERIN: Before there was
12 Legionella, there was Legionnaires Disease. So my
13 question is whether the effort that you're
14 reviewing has to do with kind of proactive
15 research that is contemplated or whether there's a
16 reactive part, which is given the needs of either
17 the military or even civilian population in
18 identifying - newly identifying an agent, given an

19 epidemic. Is there a role for the function that
20 you're reviewing in this, and is it responsive,
21 does it have the response capability in that kind
22 of a situation?

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1 DR. POLAND: Those are excellent
2 questions, Bill, let me try to briefly address
3 them. In part, the answer to your question
4 regarding new pathogens are more classified
5 programs, so called Black Biology, and we are not
6 reviewing those aspects, so we have concentrated
7 on the non-classified, reserving the idea that,
8 given the short time line, that we would take step
9 one first and that those later steps would be the
10 focus of more detailed discussions at a later
11 time.

12 Nonetheless, they do recognize that, and
13 yes, they do have that capability. Two of the
14 sites in particular are unique in their ability to
15 receive unknowns, that is, we don't know what this
16 is, but it could be an extremely lethal agent, and
17 they have the capabilities to deal with that and

18 genomics assets for pathogen sequencing and
19 identification. You had a second I think
20 sub-question buried in there, Bill; did I catch
21 it?

22 DR. HALPERIN: No; I think you've

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1 described that there's a capability for the
2 unknown. The other question, which is a
3 peripheral one is, there are arrangements for
4 receiving these if they're let's say civilian or
5 cooperation with CDC, et cetera?

6 DR. POLAND: Oh, yes, there are. And,
7 in fact, just to give you one unclassified
8 example, as part of the confusion and turmoil
9 surrounding the initial anthrax attacks, and I
10 can't remember the volume, but it was incredibly
11 impressive ability for them to assist in the
12 identification, testing of unknowns, et cetera,
13 and they literally were able to turn that on a
14 dime and devote those assets 24/7 to solving that
15 issue and problem.

16 DR. WILENSKY: Any other questions?

17 DR. DUBOIS: This is Ray Dubois; did the
18 Task Force consider, in your tic mark here on page
19 four, at least on my page four, the sustained and
20 identifiable leader accountability issue? As I
21 remember, the question of who was in charge at
22 OSD, was it PNR or AT&L, that is to say, was it

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1 the Assistant Secretary of Defense for Health
2 Affairs or was it the Assistant to the Secretary
3 of Defense for Chemical Biological Radiological
4 Matters?

5 DR. POLAND: So your question is, were
6 we able to pin that down?

7 DR. DUBOIS: Well, I remember trying to
8 adjudicate between those two gentleman, and I must
9 confess, I don't know that I was very successful.
10 And I can tell you, the Secretary of Defense
11 wasn't very pleased. But nonetheless, did you
12 look at it?

13 DR. POLAND: Not to that level of
14 detail. And, in fact, just yesterday we got
15 mailed an organizational chart. I'm aware it was

16 mailed, I haven't seen it yet. So I can't comment
17 with that degree of granularity to your question.
18 I can just generally say that as we went from site
19 to site, it wasn't apparent even in the
20 development of this that there's, you know, so to
21 speak, a biodefense product development czar,
22 whose, as I say, whose head is on the platter for

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1 timelines, budgets, and return on investment
2 metrics.

3 DR. DUBOIS: It would be nice if there
4 was one.

5 DR. WILENSKY: The comment, if you
6 didn't hear it was, it would be nice if there was
7 one from Ray.

8 DR. POLAND: Yeah.

9 DR. WILENSKY: Are there other questions
10 that people want to pose? Roger.

11 COL GIBSON: Yeah, this is Colonel
12 Gibson. Just to add a little bit to this
13 discussion, particularly with Doctor Halperin's
14 comments, we have a bio - we're talking about here

15 a review of biodefense research. We also have a
16 robust, non-biodefense infectious disease
17 biological research program. MIDRP is an obvious
18 example of Military Infectious Disease Research
19 Program component. That wasn't part of this whole
20 issue. The problem is, and this goes to the
21 command and control and who's in charge, et
22 cetera, is the missions of some of these

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1 installations, some of these research facilities
2 very much overlap.

3 DR. POLAND: Yes.

4 COL GIBSON: You've got USAMIRED doing
5 biological research and able to look at unknowns
6 that may not be a biodefense issue and a
7 biodefense mission, and in some cases it's the
8 same people. So it adds to the confusion, et
9 cetera, and I thought that was, you know -

10 DR. POLAND: Yeah, thank you, yeah.
11 Just two other comments, one is, let me just say
12 on a personal note, and, and I think reading the
13 mindset of others on the Committee, we were very

14 impressed with the quality and the dedication of
15 the people that we met and their local processes.
16 But they are, to some degree, failed by a system
17 that tolerates complexity and lack of
18 accountability at a high - truly senior level
19 champion that is sustained, not just, okay,
20 there's a crisis right now, so I just wanted to
21 make that point. The other is, I'd like Wayne, if
22 he could, to just make a point that I thought was

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1 a very insightful point that had, you know, we
2 hadn't been very explicit about until he said it,
3 and I thought really helped shape the complexion
4 of our thinking. Wayne, if you'd make your point
5 about the difference in BD research in sort of the
6 civilian and industrial sector versus DOD.

7 DR. LEDNAR: Greg, can you give me just
8 a little more of a mental jog?

9 DR. POLAND: It was the idea of
10 deterrent rather than necessarily a product that
11 would be used after an event.

12 DR. LEDNAR: My sense of - this is Wayne

13 Lednar. My sense of the - kind of the civilian
14 activity is, it's kind of what we would call
15 market focused.

16 DR. POLAND: Yeah.

17 DR. LEDNAR: There will be some
18 understood need to which there is a research
19 activity, product development, and fielding. So
20 it tends to be kind of look in the rear view
21 mirror at what you've recognized as the issue and
22 then respond to it. It does not tend to be as

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1 anticipatory, it doesn't tend to be as getting
2 into the areas of uncertain science in a major
3 way, and I think what distinguished some of the
4 discussions that the Committee had with those who
5 shared their experience and data were, they're
6 always thinking about what's out over the horizon,
7 they're thinking about how to leverage current
8 capabilities to support troops in the field, to do
9 it in a reality which is not a controlled
10 laboratory setting, but rather the real world.

11 And these are not attributes that you

12 commonly see frequently in product development in
13 the civilian sector, so these really are unique
14 orientations inside DOD --

15 DR. POLAND: Yeah.

16 DR. LEDNAR: -- which are probably not
17 buyable, if that's a word.

18 DR. POLAND: Good; thank you, Wayne.

19 DR. WILENSKY: Doctor Clements.

20 DR. CLEMENTS: Yeah, it's John Clements;
21 and I'd like to make one follow on point on that,
22 and that is that despite the fact that we talk of

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1 these issues as if they're the same, there really
2 is a difference between biologic warfare and
3 biologic terrorism, and the mission of the
4 military is primarily centered around biologic
5 warfare. The nature of the threat is very much
6 different, the agents are very much different,
7 certainly the quality of the agent is very much
8 different, and the concentration and dispersal
9 issues are very much different.

10 And so it is difficult, even though you

11 may have an academic or industrial concern that
12 could grow agent X and maybe do some stuff with
13 it, to be able to design a defense parameter
14 around that that can protect the war fighter is a
15 very special skill set and it's going to be
16 difficult to replicate that outside of the
17 environment of people who understand the entire
18 spectrum of possibilities. And so that gives this
19 a very unique character. It's difficult to see
20 how you could replicate that any place else.

21 DR. POLAND: Well said; thank you, John.

22 DR. WILENSKY: Are there any questions

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1 from people who are on the phone? Heidi.

2 OPERATOR: We have no questions from the
3 audio audience.

4 DR. WILENSKY: Great; if there is no
5 disagreement or additional comments, the Core
6 Board accepts Doctor Poland's presentation and the
7 report in its current form by consensus.

8 DR. POLAND: Thank you.

9 DR. WILENSKY: Our last speaker for

10 today is Doctor Kenneth Kizer. He's Chairman of
11 the Board of Medsphere Systems Corporation, the
12 leading commercial provider of open source
13 information technology for the health care
14 industry.

15 Previously he served as Undersecretary
16 of Health in the U.S. Department of Veteran's
17 Affairs. He is currently the Chairman of the
18 National Capital Regional Base Alignment and
19 Closure, NCR-BRAC Advisory Panel, and will provide
20 an update on its activities.

21 The group met earlier in the week in
22 preparation to review the design and construction

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1 issues regarding the new Walter Reed National
2 Military Medical Center at Bethesda and the new
3 community hospital at Fort Belvoir. Doctor Kizer,
4 please begin.

5 DR. KIZER: Thank you, Gail. Good
6 morning. If we could have the slides, the next
7 one. This is going to be primarily about process.
8 The deliberations of the group have not evolved to

9 the point where we actually have come to much in

10 the way of any --

11 DR. WILENSKY: Ken, can you speak up?

12 DR. KIZER: Sure; is that better?

13 DR. WILENSKY: Yes, thank you.

14 DR. KIZER: Okay. Let me just repeat

15 the couple points. What I'm going to say is

16 mostly about process. The Committee has not moved

17 forward enough in its work to really be at the

18 point of coming to any conclusions, recognizing

19 the short timeline we're on, we will be doing that

20 shortly.

21 The first slide there just shows the

22 Subcommittee membership and some of the subject

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1 matter experts that were invited to participate in

2 the meeting earlier this week. Monday and Tuesday

3 were spent hearing a range of briefings and

4 looking at architectural plans and a variety of

5 other input on the - to try to help us answer the

6 questions that were posed. The next slide.

7 Just in the way of background, as I say,

8 this has - to do with process. The group was
9 convened only recently, had an initial meeting in
10 August, and did some of the obligatory orientation
11 and talked about some of the issues. The next
12 slide.

13 Subsequent to that, the National Defense
14 Authorization Act was passed, which included a
15 requirement for an independent design review of
16 the new Walter Reed National Military Medical
17 Center, as well as the new hospital being
18 constructed at Fort Belvoir. Just a little bit of
19 a digression, in that legislative language, the
20 term "world class" is used to describe these
21 facilities, and, in essence, is put forth as a
22 standard by which they will be designed and

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1 constructed against.

2 In recent years, this - what was
3 historically a marketing term, "world class", has
4 been increasingly used in health care. Earlier
5 this week I went to Google and looked up world
6 class medical center and quickly was able to

7 identify at least 100 different medical centers
8 that characterize themselves or their services
9 they provide as world class.

10 This term has now made its way into at
11 least two different federal laws as a standard, in
12 this case, a standard against which over a billion
13 dollars of public money is going to be spent
14 building new hospitals. As was talked about
15 earlier, it's also a standard against which the
16 Joint Pathology Center will be held against and
17 the services it provides.

18 However, there is no agreed upon meaning
19 or objective and measurable way that this term has
20 been defined by any authoritative or reputable
21 entity. So with that as the background, turn to
22 the next slide. The Committee has spent a fair

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1 amount of its time actually focusing on trying to
2 define what is world class, and recognizing that
3 the law or the section that we're focused on here
4 requires that we submit an opinion to the
5 Secretary as to whether the design currently being

6 pursued and construction underway meets the goal
7 of providing world class facilities, and if not,
8 what should be done differently.

9 So we've, as I said, spent a fair amount
10 of time deliberating that, augmented the
11 Subcommittee with some architectural and patient
12 representatives and other expertise to help look
13 at the materials that were available. Next slide.
14 Actually, I think that covers it; let's go to the
15 next one, as well.

16 So after spending two days earlier this
17 week looking at a range of background, I think we
18 have started to form some impressions, although
19 there are a number of areas where we have
20 requested some additional data, and even since the
21 Committee adjourned on Tuesday afternoon, some
22 other areas have been identified that we probably

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1 need to look at some additional information, as
2 well. Hopefully we will get that in a timely
3 manner, next slide, so that we can review it, have
4 a chance to, next slide, discuss it with the idea

5 of having a draft report done in the first week of
6 December to present to the full Board on December
7 15, after which we would hope to finalize it and
8 submit it after the new year.

9 And with that, I think those are the
10 main points I wanted to make, and I'll be happy to
11 address any questions or hear comments.

12 DR. WILENSKY: Any questions that people
13 have here first in the hotel?

14 COL GIBSON: Just to - this is Colonel
15 Gibson. Just to add a little bit of context to
16 this, and Doctor Kizer did carefully cover it, the
17 NCR-BRAC Subcommittee of the Board was formed last
18 - basically was put on the books last spring as a
19 Subcommittee. From the Federal Advisory Committee
20 Act standpoint, the only folks who can actually
21 form a Subcommittee of a Federal Advisory
22 Committee is the Board Chairman and the Board

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1 itself.

2 So we started that process way ahead,
3 starting having meetings regarding NCR-BRAC, and

4 design and construction was only one of the
5 multitude of issues that that Subcommittee will
6 deal with. After that happened, we - Congress
7 passed the law requiring this external group. The
8 Department and the Defense Health Board agreed
9 that, with augmentation, as Doctor Kizer said, the
10 NCR-BRAC Subcommittee could serve as this external
11 group as long as they meet all of the federal
12 requirements for Sunshine Act and Federal Advisory
13 Committee Act. So that's how we're operating.
14 The reason we're briefing this today when it isn't
15 a final product yet is because one of the
16 requirements is to update the Board and deliberate
17 these issues in Open Session before a report can
18 go final to the Department of Defense.

19 In this case, the law specifically
20 outlined folks who - types of people that needed
21 to be on the Subcommittee or on the panel and
22 specifically dates when the report has to be to

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1 the Secretary of Defense, January 14, thus the
2 rapidity or the speed with which we're dealing

3 with this issue.

4 DR. KIZER: Thanks, Doctor.

5 DR. LEDNAR: This is Wayne Lednar; I
6 don't know whether this issue or this question is
7 in scope for the group that's deliberating, but I
8 think it has facility and capability implications.
9 If we think about how the Department of Defense
10 and its medical treatment response has supported
11 Iraq and Afghanistan, it has acquired really
12 unique capabilities, for example, in the care of
13 the amputee. And as we think about capability
14 that's been developed, we certainly wouldn't want
15 to see that atrophy in the future. At the same
16 time, we do not want to see a high volume of
17 patients needing this care, but we need to sustain
18 that capability in some way. Some of that is
19 facility, some of that is expertise of its
20 providers. And as we're thinking about supporting
21 the military in the future, how do we keep that
22 capability, size it to current need, yet have an

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1 ability to scale it rapidly if the need should

2 occur again in the future?

3 DR. KIZER: Well, I think that's a great
4 question. It's a little bit outside of the scope
5 of this immediate report, but I think it's within
6 the purview of where we anticipate the discussion
7 going in the future. And it also brings up
8 somewhat of a nuance in that world class as a term
9 has been described or has been used to describe
10 both specific types of health care, and in this
11 case you're referring to complicated wound care,
12 as well as facilities.

13 And the standard or the metrics by which
14 one might objectively and measurably look at that
15 standard are different for the two. And so I do
16 anticipate that we are going to have to weigh in
17 on both what might be considered a world class
18 medical center, which is required by this report
19 as far as design and construction, but also what
20 does it mean to provide world class care in
21 whatever area. And in doing that, I think that
22 sets the stage for how one maintains, or at least

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1 may help provide some guidance on how one
2 maintains those skills and expertise on an ongoing
3 basis.

4 DR. WILENSKY: Ken, let me just clarify.

5 Will there be an explicit discussion of the issue
6 that you've raised? What is it that you, as a
7 Subcommittee, we, as a Core Board, accept as
8 appropriate to the term world class medical care?

9 DR. KIZER: In our report, there will be
10 a substantive discussion of that issue.

11 DR. WILENSKY: Great.

12 DR. KIZER: And it is, for example, on
13 what is a world class medical center, there are at
14 least 11 different domains with a menu attendant
15 to each as to how we are thinking about that.

16 DR. WILENSKY: Ray, did you have a
17 comment?

18 DR. DUBOIS: This is Ray Dubois; as
19 Doctor Kizer said, we intend to define world class
20 as it pertains to the Walter Reed National
21 Military Medical Center. And there will be an
22 appendix listing the domains and certain criteria

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1 that we believe to be applicable. To the issue
2 also which is a part of this that Doctor Lednar
3 raised, considerable discussion Monday/Tuesday on
4 - under the term or under the rubric flexibility
5 was ensued, and that included scalability, it
6 included expansion, it included also alliances
7 outside of the Walter Reed National Military
8 Medical Center with other medical centers within
9 the military, the Veteran's Administration, and
10 the so called non-government or private sector
11 hospitals and medical centers and other centers of
12 excellence.

13 So it was very robust, and several of us
14 were there, discussion over a two day period, and
15 one which we hope will yield both a satisfactory
16 answer to the Congress based on their charge, as
17 well as to the military community as a whole.

18 DR. HALPERIN: Bill Halperin; I want to
19 say this, it may be superfluous, but soldiers are
20 a distinct occupational work force, and
21 essentially given the ebb and flow of wars, the
22 issue that Wayne and you are describing is the

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1 issue of how to deal with surge and surge
2 capacity. And it's - to think of world class at a
3 static point in time and not think about surge is
4 - I mean nobody would do that rationally. So the
5 issue is that outside of the military, probably
6 the issues of occupational injury dwarf the number
7 of military injuries. So in thinking about how to
8 keep a military specialized unit in, you know, the
9 optimal treatment, let's say the amputations, one,
10 I would hope, would think about the other work
11 force, which is the civilian occupational work
12 force that in many ways different agents, but they
13 end up with the same sorts of amputations, trauma,
14 et cetera.

15 And I don't know that anybody has really
16 thought of emphasizing, giving sort of the same
17 kind of optimal care to the civilian occupational
18 injured who are, in many ways, so parallel, but in
19 many ways are so distinctly different because
20 they're not soldiers.

21 DR. KIZER: Well, actually, let me just
22 comment on that. I wouldn't characterize your

1 comment as superfluous, but more as reinforcing to
2 some of the discussion that was had. And the very
3 explicit discussion was held, can you have a world
4 class medical center or a world class military
5 medical center that does not first meet the
6 criteria being a world class medical center, and
7 so there is some tiering and there are additional
8 issues that are specific to being a military
9 medical center, including the one you just
10 identified as far as surge capacity, that go
11 beyond what may be required, or at least add a
12 different dimension to what may be required for a
13 civilian hospital to meet the requirement of being
14 "world class."

15 CMS HOLLAND: Sir, this is Command
16 Sergeant Major Retired Larry Holland; besides the
17 amputee area, you know, we have some great
18 research and a lot of good work going on in the
19 burn centers and other specialties that we have
20 that have very come a long way that, you're
21 exactly right, that we can help the civilian
22 community, but I would really like to see us reach

1 out to our brothers and sisters who are the same
2 individuals that are going to the VA, and a lot of
3 their facilities do not match up as I'm seeing now
4 as a retiree with some of the centers that I had
5 the privilege of using.

6 So as you and your group goes through
7 here, I would like to see us reaching across the
8 aisle, per se, to try to help the VA and - because
9 you're caring for the same service men and women
10 that you served the first time, sir.

11 DR. KIZER: Well, I think, again, your
12 comment is reinforcing to some of the discussion
13 that was had, in the sense that while the task
14 that we have, and the assignment is quite specific
15 and defined in law, there is at least some belief
16 that what comes out of this effort may be used
17 more broadly than the specific assignment and may
18 well be used in the future as the yardstick or
19 measure by which other federal facilities of
20 whatever type may be held against. And so we're
21 cognizant that this may have broader application
22 than just the two facilities that are requested in

1 the legislation.

2 COL GIBSON: This is Colonel Gibson;
3 exactly right, Doctor Kizer. To put it in
4 context, this charge that Doctor Lednar mentioned
5 and Command Sergeant Major Holland and Doctor
6 Halperin transcends just this question, but it is
7 perfectly aligned with the mission of the Defense
8 Health Board's Health Care Delivery Subcommittee,
9 it's aligned under the NCR-BRAC Subcommittee, and
10 it is certainly part of the overall charter of the
11 Defense Health Board.

12 So we have ample opportunities across
13 the entire spectrum of the Board to engage in this
14 issue of flexibility and adaptability and
15 extrapolation of this issue to the entire MHS and
16 beyond.

17 DR. WILENSKY: Any further comments?
18 Heidi, any comments from the phone, any questions?

19 DR. BREIDENBACH: Yes, I have a
20 question. This is Doctor Breidenbach. Doctor
21 Kizer, one of the things that world class
22 hospitals carry out is clinical research. Have

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1 you looked at the issues of how the military deals
2 with clinical research and active duty military?
3 Is that an issue which needs to be addressed or do
4 you think that's not a problem?

5 DR. KIZER: Well, the - that is one of
6 the specific domains, if you will, by which we
7 think characterizes a world class medical center.
8 The sheer volume of information that we need to
9 look at to answer the specific charge of the
10 legislative language here has been focused on the
11 design and construction plans and at least some
12 tentative look at the operational plans of the two
13 facilities.

14 And while we're cognizant that there are
15 a whole host of other issues such as you have
16 identified that need to be looked at, we just
17 haven't gotten there. But we certainly are
18 mindful that this is something that ultimately, if
19 this issue is worked through in more detail,
20 probably does need to be looked at.

21 DR. BREIDENBACH: Thank you.

22 MR. JHA: Doctor Kizer, this is Prakash

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1 from AFIP. Since you are trying to define the
2 definition of world class and it has clear
3 implication of the JPC, as a member of AFIP, we
4 have been recognized for a century as world class.
5 Do you think - will it be a good case study or a
6 model to understand what exactly is both
7 structurally and functionally the definition of a
8 world class entity be?

9 DR. KIZER: Well, I think some of the
10 things that have historically characterized the
11 AFIP as the leadership role that it has had are
12 some of the same types criteria that are being
13 looked at in our definition and how we expect to
14 characterize it. I would say that certainly what
15 was world class 100 years ago or even ten years
16 ago is probably significantly - in some ways
17 significantly different than what would be
18 considered world class in the 21st century.

19 So I think that we're looking through
20 the lens of today and in the future, which

21 incorporates many of the things that historically
22 have fit that bill. But also, there's, again,

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1 some differences between a world class service,
2 which I think is more along the lines of what
3 AFIP's role has been, than a medical center, which
4 does have different design and construction issues
5 that wouldn't apply necessarily to a service or a
6 care process.

7 DR. WILENSKY: Any other comments?

8 OPERATOR: We have no questions from the
9 audio side.

10 COL GIBSON: Okay. This is just as -
11 Doctor Breidenbach is a new member of the Board,
12 he's going to be serving, and you can give us a
13 bit about your background, if you're still there,
14 sir.

15 DR. BREIDENBACH: Yes.

16 COL GIBSON: He's going to be a member
17 of the DHB's Task Force on Health Research.
18 Doctor Breidenbach.

19 DR. BREIDENBACH: Yes; hello, everyone,

20 Warren Breidenbach, Louisville, Kentucky,
21 University of Louisville. My background is
22 plastic surgery, specifically reconstructive

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1 microsurgery.

2 DR. WILENSKY: Great; we're glad to have
3 you part of this group. We look forward to seeing
4 you.

5 DR. BREIDENBACH: Thank you.

6 DR. WILENSKY: Any further questions?

7 Ken, we recognize the importance of what you're
8 doing and what it means to this specific
9 construction, but other hospital construction in
10 DOD, and we will look forward to hearing more
11 about it at our December 15 and 16 meeting.

12 Doctor Poland, can I ask you to provide some final
13 comments?

14 DR. POLAND: Yes, thank you, Gail, and
15 thank you for being there at the physical meeting
16 and running it, much appreciated. I do want to -
17 I don't want to rush through this last part, I
18 want to pause a moment for something very

19 important, and that is, as some of you, but many
20 of you may not know, Colonel Gibson will be
21 retiring, and the plan is that we'll make some
22 more formal comments at our next Open meeting, but

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1 because he will not be in uniform at that meeting,
2 I wanted to make a couple of comments.
3 The first, Roger, and I mean these in a
4 heartfelt way, you have been an extraordinarily
5 skilled leader and administrator. And it reminds
6 me of the statement once made that he "performed
7 the commonplace under uncommonplace conditions",
8 and that really relates to, and some of the newer
9 members of the Board may not realize this, the
10 Board has gone from a couple of handfuls of
11 individuals to a quintupling when you actually
12 look at the number of people involved, well over
13 100. There is not certainly a week, much less a
14 day that doesn't go by when there isn't a
15 teleconference, an in person meeting, a site
16 visit, et cetera, and Roger and his staff have,
17 with extraordinarily - touch, organized and

18 carried all of that out, it's truly remarkable. I
19 think it's more than obvious, Roger is also a
20 patriot, and I want to commend his service in that
21 regard, and an incredibly skilled facilitator and
22 hard worker.

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1 I want to paraphrase, if I might, and
2 it's because I'm a fan of the Greek antiquities
3 and of ancient Greece, Steven Pressfield wrote a
4 book called Gates of Fire, which is sort of
5 historical fiction that was made popular in the
6 movie 300, when the 300 fought against the Army of
7 Persia, which was 10,000 in number, and during
8 that battle, one person survived, which happened
9 to be a slave who was captured by the Persians,
10 and he's interviewed by the king of the Persians,
11 who's trying to understand what a king really is,
12 and let me paraphrase, a leader.

13 So in that vein, let me characterize
14 Roger and my time with him this way, using Steven
15 Pressfield's words; "I will tell His Majesty what
16 a leader is. A leader does not dine while his men

17 go hungry, nor sleep when they stand at watch upon
18 the wall. A leader earns the love of their
19 constituents by the sweat of his own back and the
20 pains he endures for their sake." And there's
21 some literal part of that there, right, Roger?
22 "That which comprises the harshest burden, a

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1 leader lifts first and sets down last. A leader
2 does not require service to those he leads, but
3 provides it to them. He serves them, not they
4 him." And that, to me, characterizes to the endth
5 degree the quality of Roger's leadership.

6 And I just want to commend that, Roger,
7 and on a personal note, it's a wonderful thing to
8 call you a friend, and I hope that through all of
9 our years of working and retirement into the
10 future, we will always be in communication because
11 I have admired you as an individual and certainly
12 your skills to turn around an organization like
13 the AFEB into what is now the DHB is truly a
14 remarkable feat, so thank you very much, Roger.

15 DR. WILENSKY: Fortunately, although he

16 is retiring from the military formerly, we are not
17 letting him escape from providing --

18 DR. POLAND: That's right.

19 DR. WILENSKY: And so he will continue
20 with us in his civilian capacity, which is very
21 important for me going forward. It is I think
22 important, helpful that, although new to the

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1 Defense Health Board, not new to working with
2 Colonel Gibson. He was, of course, the person
3 that we had contact with in the Task Force for the
4 future of military health care that I co-chaired
5 along with General Corley, and was also our
6 federally designated official on the trip to
7 Qatar, Iraq, and Langstool that General Corley and
8 I did in August of 2007, so we are delighted, all
9 of us on the Defense Health Board, Roger, that
10 you'll continue working with us.

11 DR. POLAND: Yeah, wonderful. So unless
12 any member has other business to present to the
13 Board, we'll conclude our meeting. I look forward
14 to seeing all of you at our next Open meeting on

15 December 15 and 16 at the Ronald Reagan Building
16 and International Trade Center in Washington, D.C.
17 And Colonel Diniega, could I ask you to adjourn
18 the Board's business, please?

19 COL GIBSON: You're not going to give me
20 a chance to comment?

21 DR. POLAND: Roger, please, yes, sorry.

22 COL GIBSON: This was a surprise, I

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1 didn't expect anybody to talk about this, we were
2 trying to get this meeting done virtually, and
3 it's been a little hectic to get it all - all the
4 pieces together. I would like the Board members
5 to stick around for just a couple seconds
6 afterwards to get a little feedback from you on
7 this type of process for me. That said, I can't
8 do this job without staff, and I have absolutely
9 great, great staff. They have pulled together
10 things and really committed themselves to it. I
11 also can't do it without you. Keep in mind, I get
12 paid to do this job.

13 I don't know whether I'm a patriot or

14 not, but the folks around this table and the
15 members of the Board are true patriots. This is
16 not their day job, this is what they do in their
17 spare time for free for the service members,
18 because that's the audience, that's who we're here
19 for, is to take care of those guys and gals and do
20 it right. And politics aside, you know, we honor
21 them. So thanks for the words, thanks for the
22 applause, and more to follow, I hope.

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1 DR. POLAND: Thank you, Roger. Ben.
2 DR. DINIEGA: Before we adjourn, I'd
3 like to just remind people who are interested in
4 attending Roger's retirement ceremonies, there's a
5 luncheon on December 5 and a retirement ceremony
6 that afternoon. And on behalf of the Department,
7 I'd like to just express the Department's
8 appreciation for all the hard work in a multitude
9 of issues that the MHS has brought forward to the
10 DHB, and thanks for the Subcommittee's hard work
11 also. So I declare the meeting over.
12 (Whereupon, at 11:19 a.m., the

13 PROCEEDINGS were adjourned.)

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3 I, Carleton J. Anderson, III do hereby certify

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15 /s/Carleton J. Anderson, III

16 Notary Public # 351998

17 in and for the Commonwealth of Virginia

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