

UNITED STATES OF AMERICA

ARMED FORCES EPIDEMIOLOGICAL BOARD

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MEETING

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WEDNESDAY

SEPTEMBER 19, 2001

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The Board met at 7:30 a.m. in the Conference Room of the Armed Forces Radiobiology Research Institute, at 8901 Wisconsin Avenue, Bethesda, Maryland 20889, Dr. Stephen Ostroff, Acting President, presiding.

PRESENT:

STEPHEN M. OSTROFF, M.D., M.P.H., Acting President
 DAVID ATKINS, M.D.
 S. WILLIAM BERG, II, M.D., M.P.H.
 DOUGLAS CAMPBELL, M.D.
 PIERCE GARDNER, M.D.
 L. JULIAN HAYWOOD, M.D.
 JOHN HERBOLD, D.V.M.
 PHILIP J. LANDRIGAN, M.D., M.Sc.
 KEVIN M. PATRICK, M.D.
 DENNIS F. SHANAHAN, M.D.
 ROBERT E. SHOPE, M.D.

LTC. RICK RIDDLE, USAF
 AFEB Executive Secretary

JEAN P. WARD
 AFEB Staff Assistant

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PRESENT: (CONT.)

PREVENTIVE MEDICINE OFFICERS:

COL. DANA BRADSHAW, USAF, MC
 COL. BENEDICT M. DINIEGA, MC, USA
 LTC. MAUREEN FENSOM, CFMS
 CDR. SHARON LUDWIG, USPHS
 CAPT. KENNETH W. SCHOR, MC, USN
 CAPT. ALAN JEFF YUND, MC, USN

FLAG STAFF OFFICERS:

GEN (Ret) ROBERT G. CLAYPOOL
 RADM. (Sel) STEVEN HART, MC, USN
 RADM. (Sel) ROBERT HUFSTADER
 LTG JAMES PEAKE

ALSO PRESENT:

LARRY ANDERSON, M.D.
 LTC. ARTHUR BAKER
 CAPT. BRUCE BOHNER, MC, USN (FSS)
 SALVATORE M. CIRONE, M.D.
 MR. CHARLIE CRISS
 COL. ROBERT DRISCOLL, USAR, MS
 COL. ROBERT ENG
 JOEL GAYDOS, M.D.
 COL. JEFFREY D. GUNZENHAUSER, M.D.
 COL. MARK RUBERTONE
 CDR. (Sel) MARGARET RYAN
 THOMAS SEED, M.D.
 COL. MICHAEL STAUNTON
 JAMES A. ZIMBLE, M.D.

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(7:30 a.m.)

DR. OSTROFF: Let's go ahead and get started. We are getting behind and it is early. Let me just start by saying that my voice is giving out, but my spirit is not.

And so I am going to minimize the amount of talking that I am doing and will rely on the good Dr. Riddle to do it for me. So, take it away.

LT. COL. RIDDLE: The first thing that we wanted to do this morning before we get going is we do have a couple of board members who are going to be leaving us, but we are going to do a little bit of shenanigans and keep them on for an additional year because the appointment process is just choked down within the Pentagon with all the Presidential nominations.

So we talked to Dr. Haywood last night, and he is going to consent to staying with us for an additional year, but both Dr. Haywood and Dr. Barrett-Connor, who could not make this meeting, this would have been their last meeting.

But we are going to talk to Dr. Barrett-Connor and see if we can talk her into expending for another year. But, Dr. Haywood, if you will come up

1 here to the front. We do want to recognize your four
2 years of service with the board.

3 Well, actually five years. I guess you
4 have been on since November of 1996. So, on behalf of
5 the AFEB, we want to give you this plaque, really just
6 to show our appreciation for your contributions as a
7 member of the board.

8 And, you know, you can't just
9 underestimate the impact of the recommendations of the
10 AFEB has for the Department, and again the
11 appreciation that we have for all of the efforts that
12 you go through uncompensated for the time that you
13 serve, and the contributions that you make to the
14 Department of Defense.

15 So on behalf of the AFEB, we certainly
16 appreciate it, Dr. Haywood.

17 (Applause.)

18 DR. HAYWOOD: Thank you very much. Let me
19 simply say that it is not that I am uncompensated.
20 I've gotten much more out of it than you have gotten
21 from me.

22 I will also say and affirm that the road
23 to senility is paved with plaques, and I am happy to
24 have one more moment on that road. Thank you very
25 much.

1 DR. OSTROFF: Very well stated. We have a
2 couple of administrative remarks before we get
3 started. For today's meeting, Colonel Robert
4 Driscoll, the Acting Deputy Assistant Secretary of
5 Defense for Health Operations Policy is going to be
6 the designated Federal official.

7 This morning, we have with us Colonel John
8 Powers. Colonel Powers is the Acting Deputy Assistant
9 Secretary of Defense for Clinical and Program Policy.

10 Also here today, again we have Rear Admiral Robert
11 Hufstader, with the Medical Office of the Marine
12 Corps.

13 For the Board Members, please, for Jean,
14 remember to fill out and sign your 1352s, your travel
15 settlements, with your expenses, and we will take care
16 of that.

17 This afternoon, for any taxi requirements
18 or transportation, just see Lisa, and she can make
19 sure that we have the transportation here to get you
20 to the airport or wherever you need to go. Also,
21 folks, sign in at the registration desk if you didn't
22 this morning coming in.

23 There is a couple of agenda changes. As
24 you know, Commander Ryan could not be here. NHRC only
25 allowed absolutely mission essential travel given the

1 circumstances.

2 But Colonel Chuck Engel, who is the
3 Director of the DoD Clinical Center for Deployment
4 Health, is going to fill in, and he is going to give
5 us an overview of the operations of the clinical
6 center, and some of the work that DoD has been doing
7 in developing clinical practice guidelines.

8 Just for a little bit of background, a
9 couple of years ago, in response to some legislative
10 initiatives, and initiatives within the Department, we
11 really established a triad of effort, which is the
12 surveillance effort that the Army Medical Surveillance
13 Activity, a DoD Center for Deployment Health Research
14 out at NHRC, and the DoD Center for Deployment Health
15 clinical work up at Walter Reed.

16 And so we are glad to have Chuck here, and
17 I think it is pertinent with the work that they are
18 doing given the current situation. And also in
19 response to yesterday's discussion, Dr. Mallon, from
20 CHPPM is going to come down at 1330.

21 And he is going to give an overview of the
22 questionnaire and the work that CHPPM is doing over at
23 the Pentagon. And I think what General Peake had
24 intended was to probably have that questionnaire
25 reviewed and validated by the Board, and so I think

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1 that is what Colonel Mallon will present.

2 We will have refreshments this morning and
3 this afternoon, and again today lunch will be on your
4 own, either at the cafeteria or at McDonalds over at
5 the Naval Medical Center. And so to go ahead and get
6 started this morning, Colonel Engel.

7 This is Lieutenant Colonel Chuck Engel,
8 and he is the director of the DoD Deployment Health
9 Clinical Center. Chuck was integral to the Gulf War
10 response, and the clinical center really evolved from
11 the Gulf War health center, which was DoD's tertiary
12 referral center as part of our comprehensive clinical
13 evaluation program.

14 Chuck is a Gulf War veteran, and has been
15 involved in post-deployment health care and
16 development of some clinical practice guidelines for
17 quite a while.

18 LT. COL. ENGEL: Thanks, Rick. If it
19 looks like I am sweating up here, it is not because I
20 am nervous, but because I have been running around for
21 about the last 15 minutes trying to make sure that my
22 slides were going to work.

23 But I really appreciate the opportunity to
24 address you and tell you a little bit about the
25 Deployment Health Clinical Center, a sort of history

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1 as Rick has presented it in brief terms.

2 I am going to back us up a little bit and
3 provide some background which I hope will sort of lead
4 you fairly logically into our perspective and our
5 emphasis at the center.

6 This is from an editorial that Steve
7 Straus did for Lancet a couple of years ago to
8 accompany an epidemiologic study looking at Gulf War
9 veterans. It says, "Over 50,000 British, Canadian,
10 and American troops returned from battle as changed
11 men. Once vital young men, who left to engage a
12 foreign tyrant, began to complain of breathlessness,
13 grinding fatigue, irritability, headache, insomnia,
14 paraesthesias, rendering 70 percent of them unfit for
15 further duty."

16 "Five years later, fewer than 1 in 6 had
17 recovered fully. Specialized research units were
18 commissioned, and best medical minds were enlisted" --
19 I would like to assume that that sort of includes
20 people like myself -- "to formulate therapeutic
21 approaches, devise strategies for preventing similar
22 outcomes in future military campaigns. There were
23 reports of vascular instability, hyperventilation,
24 bacilluria."

25 And one researcher in the Gulf War

1 situation at Tulane has hypothesized finding things in
2 the urine that other people can't see. Other
3 physiological and laboratory anomaly in the veterans,
4 et cetera, et cetera. Some people thought it was
5 psychiatric.

6 So it sounds pretty much like the Gulf War
7 situation until you get to paragraph three of Dr.
8 Straus' editorial, and you see that this is really
9 World War I. After the Gulf War, as Rick said, we
10 started out as the Gulf War Health Center, and what
11 really was the instigation for us to get started was
12 that both the VA and the Department of Defense started
13 up a clinical registry of people who reported illness
14 that they related to their Gulf War experiences.

15 And as those got fairly big the list
16 turned into a clinical evaluation as a fairly sizeable
17 group of those, about a fifth, turned out to have
18 medically unexplained physical symptoms.

19 And it was determined that we needed to
20 have a treatment program for those with medically
21 unexplained physical symptoms that we could not do
22 other things for.

23 And that was about mid-1995 when the
24 treatment program was initiated, and it was initiated
25 at the Gulf War Health Center, and we were also a

1 place that was doing this CCEP evaluation as it came
2 to be known, the Comprehensive Clinical Evaluation
3 Program.

4 I am not going to belabor the point, but
5 to just sort of review the basic point that there were
6 health issues among Gulf War veterans after the Gulf
7 War, perhaps not surprisingly. There were 700,000
8 Gulf War veterans, about the size of the City of San
9 Francisco.

10 And people over time get sick, and
11 epidemiologic studies showed, and continue to show
12 really, that Gulf War veterans are not dying faster,
13 and in some of the early studies, which are difficult
14 to continue on, suggested that they were not getting
15 hospitalized faster than their counterparts who were
16 not deployed.

17 A lot of people said, well, you know,
18 problem-no problem, I guess, but it is really not as
19 simple as that. If you look at about a dozen
20 epidemiologic studies that have been done since then,
21 in varying degrees of rigor, and some quite good, they
22 all really show that virtually across-the-board that
23 physical symptoms are elevated among Gulf War
24 veterans, and that Gulf War veterans to a modest
25 degree rate their health as more poorer than those who

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1 didn't deploy.

2 And some have argued, right or wrong, that
3 perhaps the most healthy people are actually deployed.

4 So you would almost expect, all things equal, to see
5 the reverse of that relationship.

6 Craig Hyams went on to say with others,
7 went on to say that there is a history of this dating
8 all the way back to the Civil War, and we still don't
9 really understand it very well, and we should
10 understand it better.

11 And there is some more recent examples of
12 this, which our group has looked at fairly carefully,
13 and others have looked at fairly carefully, and we
14 have tried to ferret out some -- let's just call them
15 social context kinds of factors that can help us maybe
16 to understand these kinds of events.

17 And the common elements, just looking from
18 the 10,000 foot level, seem to be that there is some
19 sort of instigating event, some mass violence sort of
20 event.

21 And subsequently there are symptoms and
22 concerns that emerge in people who are around that
23 event. There is suspicion and mistrust all around,
24 and the sources may differ from situation to
25 situation.

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1 There is an ensuing debate about causes,
2 and often a fairly concerted effort to understand the
3 causes through clinical investigations, and sometimes
4 epidemiologic studies, and almost universally nothing
5 is found.

6 To give you some fairly recent examples of
7 this, and there are many, that sort of suggest that
8 this trend that we saw after wars is, if anything,
9 escalating. It is becoming faster.

10 I had the opportunity to go to Canada and
11 testify before a Board of Inquiry, where peacekeepers
12 there were concerned about their health; and
13 subsequent investigation found nothing, but there was
14 a lot of concern about environmental exposures.

15 Certainly those that in the room are quite
16 familiar with concerns around the anthrax vaccination,
17 and in our clinical center we have taken care of
18 people with illness after anthrax vaccination that
19 they relate to the anthrax vaccination.

20 And often it is very hard for us to as
21 clinicians, given a one-on-one patient encounter, to
22 know whether this is a very rare idiosyncratic
23 reaction or not.

24 We are probably all in this room quite
25 familiar with the situation involving depleted uranium

1 in Europe. There are some lesser known circumstances
2 dating back to the '80s that the Dutch have
3 encountered, peacekeepers in Lebanon that subsequently
4 developed unexplained symptom illnesses.

5 And in the '90s, they had a group that
6 went to Cambodia that came back and complained of what
7 came to be known as "jungle disease," which
8 essentially were similar types of symptoms to the
9 symptoms of people in World War I that I related
10 earlier.

11 And then peacekeepers in Bosnia in the
12 middle '90s, they had a large fraction of them
13 complain of various difficult to understand illnesses.

14 This is a very interesting event, particularly as it
15 relates to the recent incidents that we have suffered
16 here in the U.S. in the last week.

17 This is the crash of an El-Al airliner in
18 the middle of a large residential area in Amsterdam,
19 and this is where it crashed. It almost looks like a
20 familiar scene, given some of the things that we have
21 been looking at on television of late.

22 And subsequent to this crash in this
23 residential area, people became ill, and conspiracy
24 theories evolved. And up here, which you can't really
25 see, there is a blurb out of a Boeing memo that says

1 there is depleted uranium in the tail fin of a 747.

2 Down here, you see a picture of a person
3 in the neighborhood who swears that he saw people in
4 the aftermath of the accident in suits that looked
5 like this, who were doing something that nobody really
6 quiet knew what they were doing.

7 There were other theories, and one
8 included weapons grade sarin, and that the rumor came
9 that this plane in its belly had weapons grade sarin,
10 and that was responsible for ailments.

11 There was even a hypothesis that a
12 microorganism, called mycoplasma, which has been sort
13 of attributed to some degree out of left field as the
14 cause of illnesses among Gulf War veterans, may be
15 responsible for this. So almost the same litany of
16 conspiracies after an aircraft.

17 Now, this is -- and you probably can't
18 read it, but I pulled this -- you know, this was so
19 striking to me that I had to pull it down. This is an
20 E-mail that I received on Friday, September 14th,
21 2001, written at three o'clock in the morning by
22 somebody named Cindi Norman, who went out over an e-
23 mail list that I am on, a public e-mail list, for
24 people who are interested in multiple chemical
25 sensitivity, chronic fatigue syndrome, fibromyalgia.

1 It says, "I have created a web page to
2 discuss and present information related to toxins
3 created or released by the plane crashes in New York
4 and Washington, D.C. This site will have links to
5 news articles, government information, and a variety
6 of reports on smoke, dust, asbestos, and other toxins,
7 that rescue workers, survivors, and residents are
8 dealing with."

9 "I also hope to have a section for people
10 with MCS/CFS/FMS and other disabilities who were
11 displaced by the crashes' evacuations, or who need to
12 get out of the city to avoid the smoke."

13 "The government officials at all levels
14 are downplaying any possible dangers from smoke and
15 dust, but even they are saying that people, including
16 New York City residents, not at the crash site with
17 asthma, immune disorders, and chemical sensitivities,
18 are at risk."

19 "You can find the site here at" da da da
20 da. Signed, Cindi. And down at the bottom she says
21 -- she has this little blurb at the bottom that says
22 -- you know, this is like her banner, which says that
23 there is nothing wrong with me. Maybe there is
24 something wrong with the universe.

25 Now, I don't mean to poke fun really.

1 Maybe I do, but this is the way that clinicians sort
 2 of feel when they are encountering this sort of a
 3 patient, because they cannot diagnose a disease. They
 4 are not sure what is going on, and all they know is
 5 that they want to get out of there, and they want to
 6 see another patient real fast.

7 This is not a unique problem, but that's
 8 difficult to convey to a general public audience. It
 9 is difficult for them to understand that medically
 10 unexplained physical symptoms in clinical practice
 11 accounts for 30 to 40 percent of clinician time
 12 according to some studies.

13 And that there are good population
 14 epidemiologic studies of symptoms that show about a
 15 fourth to a third of physical symptoms, both in
 16 clinical practice and in populations, in general
 17 populations, are unexplained.

18 And in medicine, we have this habit of
 19 putting or developing an epidemiology. By the way, I
 20 am an epidemiologist, too, and so we have this habit of
 21 developing a case definition that is grounded in some
 22 sort of theoretical perspective which has yet to be
 23 proven, and it's -- wow, I have got a smorgasbord
 24 here. I have multiple chemicals here.

25 But they are grounded in a theoretical

1 perspective that has yet to be proven, but as you know
 2 in epidemiology, the reason that you develop the case
 3 definition is so that you can understand the cluster
 4 or constellation of symptoms or findings better.

5 And in clinical practice, we often make
 6 the diagnosis and record it in the record before we
 7 really know that it is a valid syndrome, and we do
 8 that for a variety of different reasons.

9 We conceptualize it as reassuring for
 10 patients, and sometimes it is, and other times it
 11 might not be. And other times we have sort of by
 12 faith we believe in these things.

13 Now, there is a belief among -- I would
 14 say across society, but particularly among clinicians,
 15 that medically unexplained physical symptoms are not
 16 important, and unless there is a disease driving them,
 17 they are really not important.

18 But there is fairly good-sized literature
 19 that suggests that they are, and that they are related
 20 to mental disorders, and psychosocial distress, and
 21 some of those quite treatable and under-recognized.

22 There are very robust associations across
 23 a wide-variety of study designs, longitudinal as well,
 24 looking at the relationship of functional impairment,
 25 to medically unexplained physical symptoms. Back pain

1 is often a medically unexplained physical symptom
2 which accounts for a great deal of functional
3 impairment in our society.

4 It leads to health care use which if it
5 can't be of benefit, it certainly can be of harm, and
6 so as the potential benefits go down, the risks sort
7 of go up, and it can lead to iatrogenesis.

8 And really from my perspective as a
9 military clinician/epidemiologist, I think this is --
10 I view this as a public health problem. That is
11 separates us from the people that we are supposed to
12 care for. It causes a lack of trust, a lack of
13 creditability.

14 They don't see us as -- if I walk in while
15 in uniform, they don't see us as on their side, really
16 trying to do the best that we can to care for them.
17 And in that vacuum, they may seek other answers, and I
18 call it heros here, but in the aftermath of the Gulf,
19 there were a lot of people who stood up and said I
20 have the answer.

21 Sometimes the answer included multiple
22 evasive procedures and medications that was sort of
23 capitalizing on desperate people looking for unlikely
24 solutions.

25 And there has been a discussion in the

1 academic literature, increasingly moving in the
2 direction that these syndromes which we tend to label
3 in different ways, are in a phenomenologic sense are
4 essentially medically unexplained, and they are
5 overlapping.

6 And rather than dividing them out before
7 we really know that we should, maybe we should
8 conceptualize them as one. Simon Weseley in
9 particular has done a lot of excellent work in this
10 area, and shown that the risk factors for development
11 of medically unexplained physical symptoms, regardless
12 of case definition, are largely the same.

13 The clinical outcomes are largely the
14 same, and the treatments are largely the same that are
15 supported by evidence in the literature, and makes the
16 argument that we should be conceptualizing this until
17 proven otherwise if you will as one syndrome.

18 The irony is that it is essentially not
19 one syndrome. It is one heterogeneous collection of
20 symptoms. And the problem on some level is our usual
21 high-powered tool.

22 Our problem is the medical model; that
23 when patients come in to see the clinician, and they
24 go through a history and an examination, and testing,
25 and the exam and testing come up empty, but the

1 history is yielding of all kinds of symptoms,
2 clinicians tend to discount the symptoms.

3 So the history is on some level less
4 important to them, and this creates a sort of
5 untenable clinical solution, which is -- or clinical
6 occurrence or context, which is amplified in the
7 military setting I think.

8 It is not unique to the military setting.

9 Anybody here who has practiced civilian primary care
10 medicine knows that it is not unique, but it certainly
11 is amplified I believe in our setting, and that is
12 what I would describe as a contest.

13 That you have a situation with a patient
14 feeling like garbage, and trying to convince a
15 clinician that they perceive as putting barriers in
16 the way, and sometimes clinicians who because of dual
17 obligations to organization and to patients may
18 identify with the barrier role.

19 So that both sides of this -- this is sort
20 of a caricature of a situation, of a context, that
21 really exists in military medical care. So in some
22 fashion on a social level, one can think of these as
23 contested illnesses and contested exposures, which I
24 have attempted to operationalize here in some fashion.

25 So, exposures with plausible health

1 consequences, and certainly not proven, but plausible,
2 or illnesses that are based on symptoms alone, that
3 become a matter of public debate, political
4 controversy, or litigation.

5 So there is a context that can create
6 mistrust, and this one rheumatologist who has spent
7 his life doing research in back pain wrote an article
8 entitled this, which I think illustrates the point if
9 you have to prove that you are ill, you can't get
10 well.

11 So on some level this is a fundamentally
12 iatrogenic. This is not just a humorous situation as
13 we look at it from the outside perspective. This is
14 not just a disappointing situation. This is an
15 iatrogenic situation. This is a situation that causes
16 harm to real people with real problems.

17 Part of it as I alluded to before is
18 wrapped into this notion of trying to identify the
19 cause of medically unexplained physical systems. Not
20 that we shouldn't try, but at some point maybe there
21 is a limit to how far we can go.

22 And we can actually up front -- you know,
23 if you ask clinicians, they can -- in fact, in the
24 U.K., they called them "heart sink" patients, because
25 usually their heart sinks when they see the folder in

1 the file.

2 They can predict at face value that this
3 is a low yield diagnostic evaluation. They still go
4 through it for a variety of different reasons in many
5 cases, if not most.

6 But in my mind, and my conceptualization
7 of this, is that we should be looking at this notion
8 of interpretative space, which is the space between
9 something that is proven, like an association between
10 cigarettes and lung cancer, and the space between --
11 and that territory of what is plausible.

12 And obviously there is disagreement about
13 what is plausible, and as epidemiologists, I think you
14 recognize that this is a fairly wide space for most
15 situations.

16 And when you are a clinician, and you are
17 dealing with one patient, it is often very difficult
18 to know exactly what the cause is, or whether the
19 patient's hypothesis of their illness is correct, or
20 whether it is stress, which often the invoking of that
21 hypothesis is somewhat inflaming.

22 And if there is any sense that there
23 really is some fundamental agreement about this, these
24 are data from a study that a group of us did in the
25 Seattle VA. There is three of them in the Seattle VA

1 area.

2 And we compared beliefs of clinicians with
3 regard to causes and treatments of essentially Gulf
4 War illness, and what you see is that internists tend
5 to conceptualize this as more of a mental disorder,
6 and that psychiatrists or psychologists tend to
7 conceptualize this as more of a medical disorder.

8 It is sort of the opposite of the -- you
9 know, if you have a hammer, everything looks like a
10 nail; and the way that I make sense of it is that we
11 are dealing with an uncertainty syndrome.

12 There is legitimate uncertainty when these
13 patients encounter the clinician. The clinician just
14 knows that after they look for their things that they
15 feel expert in that whatever this is, it is not on
16 that list. So they naturally turn to the other.

17 And this I would hypothesize, there is not
18 data to support this at this point, but I believe that
19 this contributes to this medical merry-go-round that
20 happens with patients like this, where they go from
21 place, to place, to place in our medical system.

22 It is because they get different messages
23 from different clinicians, and it's because we don't
24 really know what the cause is. This is a political
25 cartoon that came out at about the time that there

1 were problems with tires.

2 It says, "We have mapped the human genome,
3 mastered artificial intelligence, and unlocked the
4 secrets of the universe. The wheel though still needs
5 some work."

6 And really this is really what is -- well,
7 on some level, this is what our clinical center is
8 about. That we know a lot of high-powered things in
9 medicine. We are not very good where the rubber meets
10 the road.

11 We sort of leave out some important
12 elements of care. As we know more scientifically, we
13 seem to forget more that we are not dealing nuts and
14 bolts. We are dealing with flesh and blood,
15 essentially black boxes with huge variation from
16 person to person in their responses to various kinds
17 of exposure situations, et cetera.

18 Another way of framing it, Leon Eisenberg
19 at Harvard wrote an editorial about an article in JAMA
20 recently, where he -- where the title I think sort of
21 captures what I am trying to say. "Good Technical
22 Outcome, Poor Service Experience: A Verdict on
23 Contemporary Medical Care."

24 We have gotten good at technology, and we
25 have gotten lousy at delivering a service. So our

1 clinical center is how can we do better at delivering
2 a service to people who often have things that are
3 very difficult to understand and explain, medically
4 unexplained symptoms, unclear exposures that are often
5 contested and undergoing public debate, which will
6 always be the situation after deployments. Always.

7 We know -- I mean, let's be honest. We
8 can't know the 10 year health outcomes of prozac until
9 people have been on it for 10 years. We can't know
10 the 10 year outcome of the plane crash in the Pentagon
11 for 10 more years.

12 That is an empirical question and so until
13 then, we are going to be stuck. We have got to figure
14 out what to tell our patients who come in with
15 concerns related to this.

16 Our goal at the clinical center is to try
17 and evolve -- and I don't pretend that this is easy,
18 but we have a DoD-wide mission. Our goal at the
19 clinical center is to create a system of collaborative
20 care.

21 And to contrast this, I would say that in
22 general medical care that the way it works is that the
23 lay person goes to see the expert clinician
24 scientist, and the expert clinician scientist tells you
25 what is wrong, and tells you what to do, and tells you

1 to go away.

2 In collaborative care, it is much more of
3 a human mode. You know, it recognizes human factors.

4 It recognizes that you can tell somebody what to do,
5 but it doesn't mean that they will do it.

6 It doesn't matter if you are a general and
7 they are a private. It's just that the world doesn't
8 work that way. And, in fact, if there is that big of
9 a power differential, the patient usually won't even
10 be frank with you about it.

11 They will just leave and do what they
12 would have done otherwise without telling you. So the
13 goal is to collaborate and to negotiate a process of
14 care, to negotiate what are the outcomes of care that
15 you are interested in.

16 And to come up with some negotiation of
17 those things that you as a physician think are most
18 important to change, and that the clinician or that
19 the patient is ready to change, and that there is some
20 understanding that they need to change.

21 And the monitoring is often of behavioral
22 parameters, such as self-reports, and how much
23 activity they are engaged in. And in many respects
24 maybe the fact of a planned follow-up is more
25 important than what you do during that follow-up

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1 itself.

2 You know, we are very good in medicine at
3 having or doing an initial assessment. In psychiatry,
4 for example, we now do our board certification as a 30
5 minute oral interview of a patient, and then we turn
6 around and we get "pimped" as you might put it by the
7 examiners.

8 So everything that we learn in psychiatry
9 it seems like these days is oriented towards the acute
10 initial assessment. We don't know what to do after
11 the first visit. And I am being facetious, but it's
12 true.

13 And in collaborative care, in many
14 respects -- let me see if I can get this arrow back
15 up. I was doing so good.

16 (Brief Pause.)

17 CPT. YUND: There is a laser point there.

18 LT. COL. ENGEL: Is there?

19 DR. OSTROFF: Yes, right at the top.

20 LT. COL. ENGEL: So, in biomedicine, you
21 know, we look for this, and once we know what this is,
22 which is usually a disease of some sort, something
23 with clinical correlates on -- and some structural
24 correlate on testing or examination, and if we can do
25 something about that -- if we can make it go away, if

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1 we can cut it out and we can cure it -- then this goes
2 away.

3 In real life, there are multiple factors,
4 and these are particularly exaggerated in chronic
5 health conditions. In acute health conditions that
6 may work relatively well, but in chronic health
7 conditions, like medically unexplained physical
8 symptoms, and various mental disorders, and a whole
9 bunch of other things, there are downstream effects of
10 illness that compound this impairment.

11 I am using impairment loosely now. So if
12 there are folks here who are experts in disability,
13 please don't -- I understand that this is not exactly
14 the right term to use. I tend not to use disability,
15 because I speak a lot with veterans.

16 So the downstream effects of these factors
17 compound impairment to such a degree that in people
18 with chronic illness, even if you could cure this on
19 some level, arguably there is this large snowball of
20 perpetuating factors that keep impairment going and
21 that you would have to intervene there to bring them
22 back to a regular state of health.

23 And in most cases, of course, we can't
24 really cure. So how do we get to that point in a
25 health care system. Well, the first thing is that we

1 have to recognize that we need to get to that point.

2 It is sort of a morbidity reduction system
3 instead of one that only focuses on reducing
4 mortality, not that that is not important, because
5 obviously it is.

6 Arguably, it is something that we have
7 done very well at. If you look at the Gulf War
8 experience, there were very few casualties, but from a
9 mortality sense, large numbers -- you know, over a
10 hundred-thousand people, signed up for registries in
11 the VA and DoD because of health concerns that they
12 related to their wartime experience.

13 It doesn't necessarily mean that all those
14 things were related to their health or their wartime
15 experience, but it gives you some sense of the
16 magnitude of concern.

17 So how do we get to a more collaborative
18 health care system, a system more oriented towards
19 morbidity reduction? This is sort of the road map
20 that we have laid for ourselves, and the first step is
21 clinical experience, which we believe we have gained a
22 lot of on the heels of the Gulf War, and working with
23 patients from other deployments, and those who have
24 received the anthrax vaccination.

25 And designing and collating clinically

1 relevant research that guides our practices, and once
2 those are collated, to develop guidelines from them,
3 and to make concerted efforts to implement those
4 guidelines.

5 And then to do what I have called
6 pragmatic studies, which other people might call
7 effectiveness studies, or studies of implementation.
8 An efficacy study asks can this therapy work under the
9 most ideal circumstances usually.

10 And effectiveness studies ask the question
11 does it work, and does it work in a military setting,
12 where incentives are markedly different than at an
13 HMO, or a fee-for-service setting, and then to
14 continuously be engaged in this process.

15 The Institute of Medicine essentially
16 agreed that this was a good approach, and that their
17 group that has been considering force health
18 protection fairly carefully has recommended that in
19 the Department of Defense that we implement strategies
20 to address medically unexplained physical symptoms.

21 Some of the ways that they suggest here,
22 getting down into the weeds of it, is information
23 about them so that we can make people aware that they
24 happen. And we have narrowed our focus on some, I
25 believe, and in psychiatry, to PTSD.

1 And, you know, PTSD, that is what trauma
2 does. Well, trauma does lots of things. It has lots
3 of outcomes. PTSD is one slice in the salami, and it
4 is actually the modal slice, but it is a thin slice.

5 So we need to make people aware that
6 symptoms are common, and that we know things about the
7 general outcomes of unexplained symptoms, because we
8 do. We tend not to pay attention to them in medicine.
9 They are not the most exciting world-beating findings
10 out there.

11 We need to carry out training for health
12 care providers, and how to manage them, and how to
13 carry out clinical trials to look at how guidelines
14 work, and also essentially develop a health services
15 research program.

16 That's where we are. This is our center,
17 the Deployment Health Clinical Center, and the
18 original conceptualization was that there would be
19 three DoD centers for deployment health.

20 One would be the clinical center, and the
21 other would be the research center at NHRC,
22 essentially a population research center; and the
23 other would be a surveillance center. And the idea,
24 which would be headquartered in CHPPM, the idea would
25 be to use data that is currently being monitored for

1 the purpose of informing clinical care.

2 Our program at the clinical center sort of
3 has some different elements, which look a little bit
4 like trying to be all things for all people, but I
5 would like to focus it here a little bit.

6 Our mission is the delivery of services,
7 and its research around services, and education around
8 services, and the services that we are specifically
9 talking about are post-deployment services. Not all
10 services, but post-deployment services.

11 And we are very good in the military I
12 would put forward at rushing to the scene, or at
13 battlefield casualties, but when the sexiness wears
14 off, and patients have longer term problems, we are
15 sort of not very interested anymore.

16 And that I think is where our center needs
17 to be focused, and again the reason why is because I
18 think that this is fundamentally a public health
19 problem, and that we have to use this to foster trust
20 of the people who are using military services.

21 They have to know that we are going to be
22 there for them, and we promised them that we will be
23 there. And when people perceive that Gulf War
24 veterans are being abandoned, it doesn't matter what
25 is really happening, it breaks a bond of trust.

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1 So this is another way of thinking about
2 what we are doing. There are these three elements of
3 our program; services delivery, services research, and
4 education. You know, continuing medical education,
5 and patient education.

6 And it is all centered around a clinical
7 practice guideline or a group of clinical practice
8 guidelines. So we have sort of put our eggs into some
9 baskets, and more than this, but these are some key
10 ones.

11 The one that we have focused most on so
12 far is this one, post-deployment health and evaluation
13 clinical practice guideline, and Rick Riddle and a
14 whole bunch of other people, I think, around the room
15 have had some contact with this over time.

16 And this guideline is currently being
17 pilot implemented at three sites; Fort Bragg, Camp
18 Lejeune, and Maguire Air Force Base. This one is
19 nearing completion.

20 This one is a twinkle still, but we have
21 been talking about that, and actually in PTSD, the
22 nice thing about PTSD is that there is actually
23 existing guidelines that we can just modify. We don't
24 have to recreate something.

25 Whereas, with the first two really, we

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1 have to start from scratch, and unlike many disease
2 states, where you develop clinical practice
3 guidelines, as you can imagine, there is a paucity of
4 evidence, certainly a paucity of randomized control
5 trials to help us to make decision points in the
6 guidelines.

7 So what is a guideline? It systematically
8 develops statements to assist practitioner and patient
9 decisions about appropriate health care services for
10 specific clinical circumstances. Note that it doesn't
11 say a disease. It says specific clinical
12 circumstances like someone seeking care after
13 deployment.

14 Why do a guidelines? It is a -- one way
15 of thinking of it in the broadest sense is the quality
16 improvement method. Why do it in the military? Well,
17 there is a nice mechanism for doing them that also
18 promotes the practices that have been laid out in
19 those guidelines.

20 These are some of the other guidelines
21 that are going on within DoD and VA. It is a
22 collaboration between the two health care systems, and
23 so there is an opportunity to share ideas about how
24 care is delivered for various problems across our two
25 systems.

1 Rand has been involved in helping --
2 Department of Defense in particular -- figure out how
3 to implement these, which is a tall order, and not
4 jumping out and saying that clinicians are grabbing on
5 to these and running with them.

6 There are these things that the quality
7 management directorate at Army MEDCOM calls tool kits,
8 which are essentially that you can think of them as a
9 variety of different things that help clinicians to
10 put the guidelines into action.

11 There is -- right now we are working on
12 developing a video, a satellite broadcast for the
13 opening of the post-deployment guideline. That is
14 supposed to happen in late January, and late January
15 is when the post-deployment guideline is to go into
16 effect.

17 There are efforts to develop DoD specific
18 patient education tools. So there is an
19 infrastructure in short for supporting guidelines.
20 Also, I see this as kind of an organizational solution
21 on some level.

22 If you look at the different guidelines,
23 there should be some -- you should have some sense of
24 what are our priorities about health care. So it
25 strikes me -- and especially since no one else has it

1 as their big priority, except perhaps the VA -- that
2 we should have a pos-deployment care guideline.

3 So let me tell you a little bit about the
4 specifics of that guideline, including the process to
5 put it together. I am still going to stay a little
6 bit at a distance because there is a lot in this
7 guideline, and believe me when I say you don't want to
8 hear it all, but maybe another time.

9 The development of the guideline involved
10 lots of organizations. This is important. One aspect
11 of guideline development is evidence, and that is only
12 one aspect. Another aspect of guideline development
13 is getting organizational buy-in, and developing a
14 product that each of the respective organizations that
15 are going to carry it out see as credible, and
16 something important to implement.

17 So there is a variety of VA and DoD
18 clinicians and academics who were involved with the
19 development of these. There were a variety of
20 different disciplines, perhaps the most important of
21 which are primary care disciplines.

22 As a psychiatrist, I was also involved in
23 the major depressive disorder guideline effort, and
24 there is always a bunch of psychiatrists and
25 psychologists around the room who think that we should

1 swoop in and do four years of psychoanalysis on every
2 patient with depression.

3 And then the primary care folks and family
4 practice guys grab us by the throat and say, no, it
5 doesn't work that way in primary care. You can't do
6 that. So, this gives you some sense of the back and
7 forth process that has to go on.

8 If we are going to have success helping
9 depressed people in primary care, we have to do it in
10 a way that integrates depression care into the process
11 of primary care.

12 So there is a variety of disciplines
13 involved, and two that are a little different for many
14 guidelines, or we had a toxicologist involved in this,
15 and we had more than one risk-communicator involved in
16 this, because as you will see here in a minute, we
17 agreed that an important element of this, and perhaps
18 the backbone of this, was how to communicate to
19 patients about risks that in many respects we had to
20 acknowledge we wouldn't know the answers to.

21 It is very important to me as a Gulf War
22 veteran was involving veterans in this process. You
23 know, it brings health care from behind closed doors
24 out into the open, and allows stakeholders to say is
25 this really the way that I want my doctor to practice

1 care.

2 And that doesn't mean that we revamp the
3 guideline if the patients don't like it, but they have
4 a voice at the table. The evidence -- like I say,
5 there was distinctly evidence lacking in many places
6 in this particular guideline. This was sort of the
7 priorities.

8 These were the priorities that we used.

9 It was scientific evidence first. You will notice
10 that I am not even talking about clinical trials. It
11 is scientific evidence first, and there usually wasn't
12 a lot.

13 There was independent policy review groups
14 next. Consensus of experience clinicians next. And
15 then if all else failed, what do we around the table
16 think should go on.

17 And another thing to emphasize is that
18 this is all really a starting place. It is a
19 recursive process. Every two years the guidelines get
20 revisited and revised based on current experience.

21 And places where we see that we don't have
22 evidence to guide us, we are able to formulate
23 clinical research priorities to inform future clinical
24 care in the post-deployment context.

25 Some general guideline features. One

1 thing that we have recommended in the guideline is
2 what we are calling a military-unique fifth vital
3 sign.

4 The use of a step care approach, and the
5 use of clinically based risk-communication strategies,
6 and web-based clinician support to provide information
7 for them about exposures relevant to various
8 deployments.

9 Some guidance on longitudinal follow-up,
10 which is what we got criticism for in the CCEP, one of
11 the things that we were criticized for was that it was
12 a one-time evaluation, and then off they go; and then
13 some monitoring of longitudinal outcomes, and a
14 supporting center. Basically, the deployment health
15 clinical center.

16 This is the military-unique fifth vital
17 sign; is the issue causing you to seek care today
18 related to a deployment. The guideline recommends use
19 of the vital sign for all visits, except wellness
20 care, and it is a patient based question, rather than
21 a clinician based question.

22 We are not interested here -- I mean,
23 obviously we are interested ultimately, but we are not
24 interested at the time that this question is asked and
25 answered on what "the real answer to this question

1 is." We are interested in what the patient thinks.

2 In the piloting that we have done, one of
3 the obvious concerns in the early going was, oh, my
4 gosh, if we ask this question, everybody will say
5 everything is deployment related.

6 In the pilot testing, about 1 to 2 percent
7 of patients are saying that their problems are
8 deployment related. Step care is used in the
9 guideline, which is a generic sort of clinical service
10 organization approach, and increasingly a health
11 services research approach, and that is a way of
12 organizing care across the continuum.

13 It involves sequencing of different
14 strategies, and it involves matching the clinical
15 strategies based on the patient's identified need.
16 And then matching the level of care to the patient
17 based on what has been used in the past, and something
18 that health services researchers have described as the
19 illness trajectory, essentially cernicity and
20 severity.

21 And I will give you an example of one
22 place where this risk or where the step care approach
23 is built into the guideline, which is a very important
24 aspect of it from my perspective, and that is in the
25 risk communication domain.

1 What we did was we identified four groups
2 of patients who we felt had special communication
3 needs in the post-deployment context. They are those
4 who are recently deployed, and a second group that we
5 called asymptomatic concerned.

6 These are folks who will tell you that
7 they don't feel ill, but they just have questions
8 about things that they have heard about. That's about
9 10 percent of folks, our best estimate is, after the
10 Gulf War who sought care in the CCEP.

11 Patients with unexplained symptoms of
12 relatively recent onset after a primary care
13 evaluation essentially; and then those with chronic
14 unexplained symptoms that have sort of been the gambit
15 of different tests, and have usually see lots of
16 clinicians.

17 And there is a different communication
18 approach spelled out in the guideline for each of
19 those. And some tools built into the guidelines to
20 try to assist clinicians to implement that.

21 And this slide is really just to remind us
22 that sometimes as clinicians we are a little bit --
23 you know, sometimes we can be a little bit thoughtless
24 about what we say with patients. You know, we see so
25 many patients that it sneaks out.

1 I finally tracked down your records, and I
2 had them in the dead file. This is a Gulf War
3 veteran, and you can kind of imagine -- or what
4 somebody used in that apartment building in Amsterdam
5 -- you know, what does this mean. Does this mean that
6 I am going to die, or you are expecting me to die.

7 So they draw inferences based on what you
8 say, which then becomes nidus for harmful beliefs.
9 This is the website that we are piloting along with a
10 guideline, which has the guideline on it, and it also
11 has information related to exposures and health
12 outcomes of soon all deployments.

13 There is a section in there for family
14 members, as well as for clinicians. Most of our
15 energy to date has been focused on getting the
16 clinician side ready.

17 Some features of the site. One is that it
18 covers all deployments as I mentioned. This is some
19 input that we had from the primary care folks, is that
20 it had to adhere to what they called the two-minute
21 rule.

22 They said that if it didn't adhere to the
23 two-minute rule, if I can get in and out within two
24 minutes, forget it. So there is a tiered approach,
25 which actually the first level allows them to get in

1 and out in two minutes hopefully.

2 And then subsequent tiers which allows
3 them to look more deeply at something. You know, if
4 at the end of the day they decided that they want to
5 go back and read an executive summary style thing,
6 then they can do that.

7 And then there is a third tier, which is
8 like if they want to spend the weekend becoming expert
9 in this, they can do that. We are developing on-site
10 structured PubMed searches, which will look at
11 exposures of concern and dialogue, public dialogue
12 related to various deployments.

13 And then a section on what your patients
14 may be reading, which is relatively unfiltered media
15 information for clinicians. So, some people said,
16 well, why do you want to just put anything up there.
17 Well, on some level, we want to put anything up there
18 because we want clinicians to read it and know why
19 their patients are coming to see them.

20 I can't tell you where we got the money to
21 do this yet. I will be able to tell you in a couple
22 of more days, but suffice it to say that it is a place
23 in Atlanta that does a lot of population research.

24 We are developing an on-line risk
25 communication tool for teaching clinicians how to

1 implement this stepped care risk communication
2 approach, and it is classic health services research.

3 The first step is development of the tool,
4 and uses ethnographic techniques, focus groups. The
5 second step involves a clinical trial that looks at
6 provider behavior; and the third step is a clinical
7 trial that looks at its impact on patient
8 satisfaction.

9 So the final part of the guideline that I
10 want to emphasize is that tip of the iceberg group of
11 patients at the top, those with chronic, unexplained
12 conditions which they relate to their deployment.

13 And we have gained a lot of experience
14 working with folks as I have said several times after
15 the Gulf and other situations. And I guess to drive
16 home my public health point, I would just like for you
17 to compare for a minute.

18 These are articles, and we had a couple of
19 front page articles in the Post about 3 years ago
20 about our program. This is an article in the American
21 Legion magazine, which is about as high of a
22 compliment as any military thing is ever going to get
23 from the American Legion. It says, "Decent
24 Treatment."

25 So I would like you to compare that with

1 this. "The Tiny Victims of Desert Storm: Has Our
2 Country Abandoned Them?" And which do you think is
3 going to foster more trust in our beneficiaries? That
4 is kind of a no-brainer.

5 So this is the specialized program, which
6 is our referral program, and it is based on a chronic
7 pain treatment model, and almost all of the patients
8 that we see by the way have chronic pain.

9 And we have a toll free number, which is
10 listed here, and can be accessed through our website
11 as well. Other features of the guidelines are
12 outcomes monitoring, using some tools that are --
13 let's just say that are more detailed and more effort
14 to use than most guidelines would recommend.

15 And in part because we think that various
16 groups, like AFEB, and the Institute of Medicine, and
17 so on, will be looking in, and they are going to want
18 to know about the health of people after these kinds
19 of events.

20 So these are validated measures of
21 functioning mental health status and medical status.
22 population metrics have been developed which I am not
23 going to belabor here, that are the nuts and bolts of
24 these metrics are still not conceptually clarified.

25 And in my experience with the depression

1 guideline is that each one of these population metrics
2 is about a 4 or 5 page document that describes how it
3 is supposed to be measured.

4 And as I mentioned before, if you don't
5 like the guideline that's okay. Neither do those of
6 us who made it. And I say that only partly tongue in
7 cheek to say that as you get into it, you realize that
8 there is just a lot of things that you can't do right,
9 or that you just have to try and see what happens.
10 And the good news is that two years down the road, we
11 can go back and reassess it.

12 In our services research side, just to
13 give you some example of the kinds of things that we
14 are doing to investigate care, we published some stuff
15 on uncontrolled outcomes of our three week program.

16 We are also involved in multi-center
17 clinical trials. We formed a collaboration of sorts
18 with the Co-op Studies Program and the VA. I would
19 like to see us down the road work towards an
20 independent multi-center clinical trial capability
21 within the Department of Defense that would pursue
22 pragmatic health policy research in recognition of the
23 fact that we can't really generalize very easily
24 health care research done in other settings.

25 We are also involved in some mechanistic

1 studies with Georgetown, a group at Georgetown, Dan
2 Clauw's group, which is about to move to Michigan.
3 And we are looking ahead to various other services'
4 research projects involving the clinical practice
5 guidelines.

6 And this is also a blurb from the Steve
7 Straus editorial that I started out with from Lancet.
8 "Unless... wars are fought solely by machines, the
9 human cost of welfare will remain high. Troops must
10 be given a commitment for all necessary care for war
11 related illness."

12 And in the risk communication literature,
13 there is a lot of talk about commitment, and what
14 fosters trust in the patient is a sense of continuity
15 and commitment. That you are going to be there.

16 And that is the central thrust of our
17 center, is the recognition that we need to try to
18 prevent, and we need to try to do primary prevention.

19 But there will always be things that happen that we
20 can't anticipate as we have learned again in the last
21 two weeks.

22 And as people develop health issues
23 subsequent to that, regardless of what scientifically
24 our rational mind tells us is related or not related
25 to these events, to step forward and be there for

1 patients who have real needs, and real reasons for
2 people to step forward on their behalf. That is my
3 presentation.

4 DR. OSTROFF: Thank you very much. Let me
5 just speak from the -- I think speaking for the Board,
6 to congratulate you on a wonderful presentation, and I
7 had an opportunity to visit the clinical center a
8 couple of years ago, and think that you do an
9 absolutely fantastic job in a very, very difficult
10 circumstance.

11 I have a couple of questions to ask, but
12 my major one is that with the events of the last week
13 or so, we are going to get ourselves into situations
14 over the next couple of months that are likely not to
15 be as pleasant, in terms of outcome, as some of the
16 Balkan conflicts have been.

17 Is there something that can be done pre-
18 deployment to potentially predict who is likely to
19 have problems post-deployment, and what can we do pre-
20 deployment to help minimize the potential problems
21 that will happen afterwards?

22 LT. COL. ENGEL: Right. Well, it is a
23 very important question, and certainly one that --
24 well, on some level, I wish there was good news in
25 terms of what one can do to prevent something like

1 medically unexplained physical symptoms.

2 But we are not dealing with something
3 where there are vaccinations for, and that many of the
4 things that may predispose people to develop these
5 sorts of things are what mental health people call
6 trait characteristics.

7 You know, they are chronic
8 characteristics; things learned about in childhood,
9 and reactions to injury and illness. Again, I am not
10 saying necessarily that these are psychologically
11 caused, but psychological factors mediate how people
12 respond to various injuries and illnesses.

13 So I think that I have actually written
14 with an investigator at the University of Washington a
15 lengthy paper for the Institute of Medicine addressing
16 population strategies, and we talk about pre-event,
17 post-event, and then primary care, collaborative care,
18 and more intensive care, and specialty care for
19 medically unexplained physical symptoms.

20 In short, there is probably a good bit of
21 evidence that is emerging, although it doesn't apply
22 directly to medically unexplained physical symptoms.
23 It is more towards post-traumatic stress disorder, and
24 that prior to these events, and in the immediate
25 aftermath of these events, we have to be careful

1 because a lot of -- because good intentions aren't
2 enough.

3 That on some level that strategies that we
4 may jump in with, such as to name one that has gotten
5 a lot of attention recently, critical incident stress
6 debriefing, that there is evolving randomized trial
7 evidence that these strategies don't work very well.

8 They don't on a grand scale make patients
9 feel better, and if one looks at the evidence
10 carefully, there is probably more evidence that they
11 make people worse than that they make people better.
12 And there is some theory and speculation about why
13 that would be.

14 Again, I mentioned Simon Weseley earlier
15 for some of his work around medically unexplained
16 symptoms, and also the health of Gulf War veterans.
17 He has done a Cochran Collaboration review, which is
18 ongoing, of critical incident stress debriefing.

19 And essentially strongly recommends that
20 compulsory critical incident stress debriefing should
21 stop, which I think is probably a stronger
22 recommendation than is justified.

23 But I think it highlights the point that
24 on some level our -- you know, that when something
25 happens, like what has happened in the last couple of

1 weeks, everyone's impulse is to go there and do
2 something.

3 Everyone's impulse is to go there and
4 talk, and embrace, and I was at Walter Reed, and on
5 our toll free number, we received 500 phone calls in
6 the two days after the aftermath, with people wanting
7 to help, people wanting to locate family members.

8 You know, it is a time where the impulse
9 is to action, and not that we shouldn't act, but on
10 some level we have to be aware that what we do isn't
11 always constructive.

12 And in my experience around -- you know, I
13 have had opportunities to interface with the folks
14 after Oklahoma City, as well as after the Gulf and
15 other events, and it has been my -- one of the things
16 that I have seen is that lots of people collect after
17 these events.

18 That if anything that one of the major
19 challenges is controlling the area, and trying to keep
20 interested, well-intentioned parties away so that the
21 work can get done. So the short summary of all of
22 that is that I think -- that I would like to be
23 optimistic about our ability to prevent.

24 And the epidemiologist in me would like to
25 be about prevention, but the clinician in me says this

1 is an area where no matter what we do, we will see
2 consequences.

3 And that what we have to get good at is
4 secondary prevention, and tertiary prevention, and
5 perhaps the best population prevention is through the
6 images of reaching out to our own beneficiaries
7 advertising those images so that on a grandeur scale,
8 on a population-communication scale, our beneficiaries
9 see us taking care of our own.

10 And then that fosters trust. I mean, as I
11 see it, that is the best prevention. One-on-one --
12 and I know that I am jumping around here a little bit,
13 but to go back to the critical incident stress
14 debriefing, I think it is a well-intentioned
15 application of a clinical intervention to a population
16 problem.

17 You know, you are doing face-to-face
18 intervention for what is a population problem and that
19 is distress after this sort of event. And you have to
20 apply population based interventions, which as I see
21 it is advertising the good that you are doing for
22 people.

23 LT. COL. RIDDLE: I had Dave pull this
24 slide up right here to kind of give an idea of how we
25 are building a program to be able to answer just that

1 question; is how do we in essence predict and
2 intervene.

3 And really a lot of the things that we put
4 in place subsequent to the Gulf War is Chuck Center,
5 the research center, the Millennium Cohort Study,
6 which is in your slide, working on the recruit
7 assessment program.

8 So that at pre-induction, you get an
9 epidemiological characterization of the population
10 coming in using standardized tools, such as the 36,
11 the PHQ, and others, throughout their period of time
12 in the service that we continue to administer those
13 standardized stools.

14 We have a pre-deployment assessment, and
15 we have a clinical guideline with unique ICD-9 codes
16 that we built into the system that identifies
17 individuals that come in for post-deployment care so
18 that we can sort that information out to do population
19 based studies.

20 And the Millennium Cohort Study, which is
21 the largest prospective cohort study ever implemented
22 in the Department of Defense, that is designed to
23 follow 140,000 individuals over a period of 21 years,
24 focusing on deployment health and health outcomes, all
25 of this built in with the clinical program with Chuck.

1 And how following these individuals once
2 they separate, a collaborative relationship with the
3 Department of Veterans Affairs, so that this cohort,
4 this follow-up, not only while on active duty, but we
5 look at them once they separate.

6 And how those outcomes can relate back to
7 really build that body of evidence to help answer that
8 question. How do we identify, and is it combat
9 hardening, and do people self-select, and can we
10 identify individuals that may have problems and
11 intervene.

12 So it is not a quick answer, but I think
13 at least we have got the infrastructure and many of
14 the things in place to do that.

15 DR. OSTROFF: All right. Bill, and then
16 Dana, and lots of others.

17 DR. LANDRIGAN: This is Dr. Landrigan
18 again. I thought that was lovely work. For my sins,
19 I served on the Presidential Commission on the Gulf
20 War Illnesses, and I spoke with a man in New Orleans
21 who found a treatment for chronic bacilluria.

22 I spoke with a doctor from Texas who has
23 the treatment for chronic mycoplasma. We dealt at
24 lengths with the other doctor from Texas who used to
25 be associated with an organization in Atlanta that

1 found that it was flea collars.

2 I mean, the common thread in all of these
3 and that ran across those characters was that each one
4 of them came up with a particular silver bullet, which
5 in one fell swoop was going to solve these incredibly
6 complex problems.

7 And it is clear that what you are engaged
8 in is just so much more fundamentally sensible. So I
9 have got two questions for you. The first thing is
10 are you getting any evaluation data back from the work
11 that you have been doing for the past several years.

12 And the second question is one of how
13 replicable is this. It is clearly wonderful work, but
14 how much of it depends upon you and your charisma and
15 the team that you built. Are those human traits that
16 can be replicated elsewhere.

17 And what does it cost? Is it so labor
18 intensive at Walter Reed that it constitutes a
19 wonderful ideal, but something that just can't be
20 organized at each of the Vas across the country?

21 LT. COL. ENGEL: Right. Well, those are
22 important questions. We do have data on three month
23 outcomes of our program, again uncontrolled. However,
24 what we have done is as part of this collaboration
25 with the VA Co-Op Studies Program, we have developed a

1 20-site clinical trial that takes the elements of care
2 that are inherent in the specialized care program, and
3 sort of boils it down to two fundamental elements,
4 physical reactivation and what essentially many people
5 now are calling cognitive behavioral therapy.

6 And we were doing a 2-by-2 factorial-
7 design study, and that actually the last person
8 received their year follow-up visit this month, and we
9 expect to have a manuscript of the result of that for
10 publication probably in December or January.

11 So the short answer with regard to our
12 program is that I think we have sort of come to the
13 fact that our site isn't conducive to doing a
14 randomized controlled trial for various reasons.

15 So we have gone and used this mechanism,
16 which is ideally suited for multi-center trials, and
17 it will also help us to answer the question that you
18 raised, which is, is this something that advocates can
19 do, but nobody else can.

20 And in the multi-center trial -- and let's
21 put it this way. I have listened to a lot of
22 sessions, because part of what we have to do is
23 evaluate the fidelity of the session, and how well
24 therapists are delivering it. And some of the
25 fidelity is pretty awful, I think.

1 So let's put it this way. If it works in
2 this trial, I think we will have a much closer
3 estimate of how well it will work in usual clinical
4 practice than what you would get in just evaluating
5 our center.

6 There have been -- I won't say lots of
7 randomized controlled trials, but there has been on
8 the order of approaching 10 randomized controlled
9 trials, and if you pool studies across different
10 symptom based conditions, like chronic fatigue
11 syndrome, and fibromyalgia, irritable bowel, and look
12 in that way, that there is on the order of about 20
13 different randomized controlled trials that Kurt
14 Kroenke has recently pooled.

15 And not in a systematic meta-analysis,
16 because they are different enough that it is hard to
17 do that, but comes to some conclusions about its
18 overall effectiveness for medically unexplained
19 physical symptoms.

20 But those are -- and he essentially
21 concludes that it is effective for several different
22 outcomes, but the -- and I think that those are all
23 single site trials, and it will be very interesting I
24 think to see whether in a multi-site trial we are able
25 to demonstrate benefit.

1 Our outcome variable is functional status,
2 using the SF-36 physical health functioning. And we
3 are also told by the VA that we will be able to go
4 back and use existing cost data to do econometric
5 modeling to come up with some estimates of cost
6 benefit or cost effectiveness.

7 So that will give us some sense of how
8 much gets poured into doing this for a unit of
9 benefit. But I think it is --

10 DR. LANDRIGAN: It probably won't be cost
11 effective in a narrow econometric sense because the
12 costs are going to fall to either the DoD or the VA,
13 depending on whether the person is active or retired.

14 And the benefits, or lack thereof, are
15 going to fall on the patient. So, sure, it is
16 important to do the cost figures because --

17 LT. COL. ENGEL: Right.

18 DR. LANDRIGAN: -- the bean counters and
19 the Congress are going to require them at some level.

20 But I think that you are absolutely right in saying
21 that the underlying issue is not one of cost
22 accounting, but rather fulfilling the commitment.

23 LT. COL. ENGEL: Right. The public health
24 issue as I see it.

25 DR. LANDRIGAN: That, but I mean -- and

1 you said it yourself, the deep commitment of the
2 nation to the people who serve.

3 LT. COL. ENGEL: Yes, which I see -- as a
4 psychiatrist and epidemiologist, I see that as a
5 public health issue. That that effects the health of
6 people who hear it.

7 DR. OSTROFF: Colonel Bradshaw.

8 COL. BRADSHAW: Yes. This is Dana
9 Bradshaw. I just wanted to comment a little bit to
10 Dr. Ostroff's earlier question about some of the
11 things that we could find, or that might be markers,
12 or associated factors that might help predict people
13 that might have problems.

14 Part of my MPH project and actually some
15 things that I did even prior to that time involved
16 health utilization research, and issues of
17 traumatization and violence, particularly domestic
18 violence, but other related things.

19 So I may be speaking to the modal salami
20 slice here, mainly PTSD and related disorders, but
21 folks who have been victimized earlier, there is quite
22 a bit or a fair amount of body of research that shows
23 that those people have increased health utilization to
24 a significant degree.

25 And that some of these same individuals

1 may be more likely to develop a post-traumatic stress
2 disorder after being exposed to combat situations.
3 And interestingly enough, there is Deborah Bostock
4 here at USUHS and some others who have done studies
5 that have suggested that there is an increased number
6 of people, for instance, that have been sexually
7 victimized that come into the military for whatever
8 reason, for whatever selective factors there are that
9 that happens.

10 That is something that we find, and that
11 those sort of individuals may be more predisposed to
12 be -- maybe we should say less resilient, and more
13 likely to perhaps develop some of these problems and
14 issues if they have had prior victimization.

15 And there is even some studies that have
16 shown people that have been exposed to that, for
17 instance, will have decreased pain tolerance and
18 thresholds for pain. And that may relate to things
19 like fibromyalgia and many of the other things that we
20 see in these kinds of populations.

21 But you can look at things like irritable
22 bowel syndrome, chronic pelvic pain, fibromyalgia, and
23 you can go on, but a lot of these are people that
24 happen to have as one of their common respecters prior
25 victimization.

1 That is only one thing, and as Chuck has
2 mentioned, this is a very complex problem. I know
3 that in science we are really interested in
4 reductionism a lot of times, but sometimes that may
5 lead us down the road path, because a lot of these
6 things I think are multi-faceted.

7 DR. GARDNER: Thanks. I was on the Ohio
8 Steering Committee for the Gulf War, and I was
9 impressed with a couple of things that I relate to
10 what Steve brought up.

11 First, how little was known or how little
12 data there were regarding any sort of mental health or
13 other kinds of testing of what the recruits had before
14 they went.

15 So it sounds to me as if we are doing much
16 better on that now. There are a number of assessment
17 tests that recruits are getting that I think were not
18 the --

19 LT. COL. ENGEL: Yes and no. And I will
20 jump in and respond. Part of the reason that I was
21 running here and sweating this morning is that I was
22 up late last night with this CHPPM group trying to
23 figure out a group of questions to integrate into
24 their questionnaire.

25 And an adage that I have thrown around,

1 which is wherever there is two psychiatrists, there is
2 three opinions. So it is very difficult to come to
3 some agreement about a set of questions.

4 Of course, there is a lot of questions
5 that have to be asked in an active surveillance effort
6 that go beyond mental health. But I was a little bit
7 frustrated yesterday that it had gotten -- that I saw
8 a -- and I am editorializing now, but I saw about a 16
9 page questionnaire and that had a grand total of eight
10 mental health questions in it.

11 And this was in preparation for doing some
12 Pentagon surveillance, and the eight questions that I
13 saw were grossly deficient as I saw it, and I really
14 didn't see a specific rationale for them.

15 I think that these are -- you know, these
16 are sensitive issues to ask about, and even methods
17 that have been validated in the civilian world are
18 often hard to know how they will be received and
19 responded to in military settings.

20 So it is hard to select the right items,
21 and it is hard to break through systemic barriers to
22 getting them into questionnaires. I mean, many of the
23 questions in this questionnaire as I saw it were which
24 direction were you faced at the time that the plane
25 hit the Pentagon. Meanwhile, there were eight, and so

1 the --

2 DR. GARDNER: I am focusing much more on
3 the intake side of things.

4 LT. COL. ENGEL: I understand.

5 DR. GARDNER: And the morbidity of mental
6 health is significant, even in non-stress settings.

7 LT. COL. ENGEL: That's right.

8 DR. GARDNER: So it seems to me that we
9 check people out for hernias and heart disease much
10 better than we do for what their mental health
11 conditions are.

12 And I suspect that this would be important
13 in a variety of efforts, and so I guess I am really
14 urging -- I don't know what goes on, but it certainly
15 is an important area that I think was poorly done when
16 I learned about it at least over the Gulf War thing.

17 The second thing that was very impressive
18 to this committee was how little the field data, how
19 poor the quality was, even in terms of any kind of
20 dose response. How many days you were there, and did
21 you visit or did you need medical attention while you
22 were there.

23 And somebody who flew over at 30,000 feet
24 was considered the same as somebody who spent six
25 months on the ground, and there wasn't the kind of

1 dose response that you would like for an epidemiologic
2 study.

3 So I guess as we think that there may be
4 interventions in the offing, these would be the kinds
5 of things that should be shored up so we don't end up
6 in the same morass as we did in the Gulf War.

7 LT. COL. ENGEL: Then I will say that on
8 some level I am criticizing myself by saying or
9 speaking to this struggle, because as Rick knows, you
10 know, since the Gulf War, we have worked with Dr.
11 Hyams, and others to develop the RAP, the Recruit
12 Accession Program, which is a fairly detailed
13 questionnaire.

14 There is quite a lot of mental health
15 stuff that has been built into that, and it takes us a
16 frustratingly long time to get to the places where it
17 needs to be implemented, and to build it into the
18 process of recruit accession. Now, these are key
19 efforts, and it just takes a long time.

20 LT. COL. RIDDLE: If you look at the
21 accession standards on mental health, you know, they
22 are fairly obvious mental conditions that individuals
23 have suffered.

24 And that is one of the things with the
25 Recruit Assessment Program, and the Millennium Cohort

1 Study, and others, is to better build a body of
2 evidence so that you can develop the kinds of
3 questions that can be administered from an accessions
4 standpoint, or even early on, because if you look at
5 the leading causes of in-patient and out-patient care
6 in DoD, mental health is the second leading cause of
7 hospitalization, and I think in the top 3 of 10.

8 LT. COL. ENGEL: Second to pregnancy. So,
9 among men, it is obviously the leading problem.

10 LT. COL. RIDDLE: So there is tremendous
11 focus there, and we are not there yet, but at least we
12 think we have recognized that and are working on the
13 issues, especially with the Millennium Cohort Study.
14 Our questionnaire is quite focused on a psychosocial
15 assessment, because those are where the deficiencies
16 are.

17 Look at the exam questions in here that we
18 have for the accession. There is not a lot there when
19 we look at psychosocial or mental health, and so we
20 think the recruit assessment program and what we are
21 doing will get us there. We are not there yet.

22 LT. COL. ENGEL: I think actually the
23 Millennium Cohort Study, too, as I was just looking at
24 that last night as we were developing questions for
25 this, but as I see it, it is a model for the kinds of

1 mental health questions that can be asked, because it
2 has been very well designed.

3 DR. GARDNER: Can I ask one other very
4 unrelated question? I saw it in Commander Ryan's
5 slides here, and that is that I don't think that I had
6 heard previously about the pneumococcal vaccine trial
7 with 200,000 people to be enrolled, and I would love
8 to hear about that.

9 Allegedly, CDC and the Mayo Clinic are in
10 on this, and has this been presented at this group
11 before?

12 LT. COL. RIDDLE: No. And that's why we
13 wanted to just get it out. Unfortunately, I can't do
14 it justice. I mean, I know some of the work.

15 DR. GARDNER: That is underway and going
16 on now?

17 LT. COL. RIDDLE: Yes. We will get her
18 before the board, hopefully at the next meeting.

19 DR. GARDNER: I would like to hear about
20 that.

21 LT. COL. RIDDLE: Yes, sir.

22 DR. OSTROFF: Colonel Gardner.

23 COL. GARDNER: Colonel Gardner, Fort Bragg
24 and USUHS Faculty. Just to begin with, I have been
25 involved in these issues since the very first

1 committee, where we tried to define a case definition
2 for Gulf War illnesses.

3 And Chuck, your presentation has addressed
4 these issues in the best way that I have seen in 10
5 years. It is just amazingly well done and I wanted to
6 congratulate you on that. I think that was very well
7 done.

8 But I just very briefly want to say and
9 address this question about what can we do. Our
10 problem in the very beginning was that we didn't have
11 the data to be able to say here are the death rates
12 before, during, and after the war.

13 And here are the disability rates before,
14 during, and after the war. Here are the
15 hospitalization rates before, during, and after the
16 war. And it comes down to the issue of trust and
17 credibility, which you have emphasized so well.

18 It took us four years to get the data to
19 go back and look at those issues, in terms of deaths
20 and hospitalizations, and disability, and so on. And
21 in that period of time, we lost such tremendous
22 credibility with the public, because they simply can't
23 believe that we don't know what is going on with our
24 people.

25 Either we don't care or we are

1 incompetent, either of which means there is no
2 credibility, and I think that ability to track what is
3 going on with our people, in terms of deaths,
4 hospitalizations, disability, and clinical outcomes,
5 is critically important to establish the credibility
6 and trust that our government cares about its
7 soldiers.

8 And without that, we can't ever win this
9 battle, and what I have seen over the past 10 years of
10 this is a big push late to go back and measure
11 exposures, and very little focus on measuring clinical
12 outcomes.

13 And I think that really has to be the
14 focus of what -- well, there is no sense of measuring
15 exposures when there is no clinical outcome to relate
16 it to. And we have to build into this -- and this
17 data slide that you addressed, Rick, is great.

18 And that really is in large part in
19 response to these issues that we have talked about for
20 many, many years, but still there is not the focus on
21 clinical outcomes in the soldiers and veterans. It is
22 more focused on exposures and superficial
23 measurements, as opposed to good solid clinical
24 outcomes.

25 And the medical side of it has been in

1 large part ignored, and that's why we really need to
2 get from this group a focus to say that this medical
3 side of it has to be resourced to establish the
4 clinical outcomes follow-up.

5 LT. COL. RIDDLE: Actually, I think it
6 really is based on clinical outcomes, because we are
7 unable virtually to relate the exposure to the
8 individual. I mean, we do not have the biomonitor on
9 the individual soldier on the battlefield.

10 We are doing a lot of work looking at
11 biomarkers, utilization of the serum repository, and
12 others, but like the Millennium Cohort Study was
13 designed or at least to have the power to look at rare
14 outcomes, and then to collect the data that we have
15 deficiencies on, really focusing a lot on clinical
16 outcomes.

17 The exposure piece is a very difficult
18 piece, and they are working extremely hard on that,
19 with CHPPM. They have just recently promulgated some
20 additional guidance, and they are doing a better job,
21 but it is difficult to relate, you know, other than
22 generically the battlefield exposure to the individual
23 on the battlefield.

24 DR. BERG: Bill Berg. I would like to
25 comment on a part of your presentation that I think

1 has a significant potential in the preventive spirit,
2 the stepped response.

3 As a local health director, I get
4 questions like this all the time, and in the past
5 couple of weeks, I have gotten questions and calls
6 from a woman who thinks there is an excess of cancer
7 in her college class, because she went to what is
8 called a historically black college, and thinks that
9 this represents some sort of biological experiment.

10 I have gotten a call from a woman who
11 rents a house, and the owner is not keeping it up, and
12 there is rain leaking, and it is musty, and she thinks
13 that her ulcerative colitis is due to stachyose
14 batris.

15 When I was in charge of her preventive
16 medicine unit, I got a call from a woman who was
17 convinced that her family was safe because the Naval
18 Air Station Oceana was dumping jet fuel in the storm
19 drains. It is very helpful if you can have ways to
20 approach that that match the level of concern.

21 So I don't need to cite chapter and verse
22 from medical journals to convince someone who just
23 wants a simple reassurance and vice versa. Somebody
24 will take a simple reassurance as being dismissive;
25 and then teasing out those who are just convinced and

1 you are not going to change their minds.

2 So I think that this has significant
3 preventive potential in helping to deal with matching
4 the response to the level of concern.

5 LT. COL. ENGEL: Well, I think you are
6 absolutely right, and I think that is more
7 articulately said than sort of my stumbling around. I
8 don't want people to think that I was saying that we
9 shouldn't do anything to try to prevent.

10 In fact, the message that I was trying to
11 get at is exactly captured by your comments; that the
12 stepped approach is the way to match the interventions
13 that we have in our armamentarium if you will to the
14 specific needs of subgroups within the population.

15 And we have to plan it, you know, or
16 otherwise some patients with modest needs will get
17 very intensive treatment that they didn't need; and
18 then likewise, some people will go unrecognized and
19 not receive a higher level of intensity of care that
20 they really could have been identified fairly early as
21 needing.

22 DR. OSTROFF: Colonel Engler.

23 COL. ENGLER: Dr. Engler from Walter Reed,
24 and part of the vaccine health care center initiative.

25 I just wanted to thank Chuck, because in the course

1 of the challenges that arose with anthrax, adverse
2 events management, he was a beacon to the allergy and
3 immunology community because we were frustrated with
4 the fact that the larger part of the health care
5 delivery system didn't understand the basic principles
6 of adverse drug reaction management.

7 And the issues, and the questions, and the
8 validity of the questions about continued
9 immunizations in the face of adverse events, and the
10 fact that individuals -- and our specialty deals a lot
11 with multiple chemical sensitivity, and chronic
12 fatigue syndrome, and also known as chronic immune
13 disfunction syndrome.

14 And the fact that a single patient, the
15 advocacy and the need to build an infrastructure that
16 supports, and that has competency, and supports both
17 the providers and the patients, and a single patient,
18 who was eloquent, and a reservist, who was badly
19 treated through the VA system.

20 The acknowledgement of his illness, and
21 people being more focused on saying it is not anthrax,
22 as opposed to providing the care. You know, his
23 eloquence was partly responsible for the legislation
24 in the States in New England to try to shut the
25 program down.

1 One person affects 10,000. And if it
2 takes a hundred hours to provide them good care in a
3 complex center of excellence, that is a worthwhile
4 investment, because if you add up all the dollars of
5 the generals and admirals, et cetera, who went to
6 Congressional hearing after Congressional hearing, and
7 to have the GAO tell us that we didn't know where to
8 send the people.

9 And to have military providers say that we
10 couldn't get any help. We called 16 folks, and no one
11 felt comfortable to deal with the complexity. I think
12 the need for centers of excellence that then are
13 visible so that at least people know where to go for
14 help, and then to begin to evaluate what the resource
15 requirements are at the primary care level, is a very
16 important partnership.

17 And I know that I have made a commitment
18 that anything we do in the vaccine health care center
19 network will build on and collaborate with Chuck's
20 efforts, because there is a lot of overlapping issues.

21 There are also unique issues.

22 But if we are going to build trust, and we
23 are going to have creditability, we have got to deal
24 honestly with those things that we don't know. We
25 have clinical guidelines that we put together purely

1 on clinical experience, and there isn't outcomes
2 evidenced for continued immunization and certain
3 adverse events settings.

4 And we need the ability to build that and
5 I think that Chuck's efforts sort of provide a
6 template for other challenges and overlapping
7 missions, and I just want to thank you for your
8 efforts.

9 DR. OSTROFF: Colonel.

10 COL. POSTLEWAITE: Just a quick comment.

11 Craig Postlewaite from the Military and Veterans
12 Health Coordinating Board. An initiative that I think
13 that the Board should be aware of is a dovetail
14 program that is getting ready to start, and in fact
15 has already been started over the last couple of
16 months.

17 The VA has stood up two centers for the
18 study of war related illness, and they will have four
19 focus areas; clinical, research, risk communication,
20 and education, mirroring very closely what Chuck has
21 done.

22 He has been the impetus behind this, and
23 there has been Congressional interest, as well as the
24 VA interest. He has been the impetus behind this.
25 There has been Congressional interest, as well as the

1 VA interest, and they are converting some of their
2 Gulf War referral centers to these centers.

3 There is one here in D.C., and there is
4 one in East Orange, New Jersey, and the Military and
5 Veterans Health Coordinating Board will be working to
6 establish collaboration between these centers.

7 We have to remember that once people leave
8 active duty, there is a life cycle approach here that
9 we have got to make sure that we follow through with,
10 and the VA is that follow-on entity.

11 A lot of our folks that deploy are
12 National Guardsmen. There are a number of people who
13 get out soon after deployments, and we have got to
14 make sure that we have got the capability to address
15 their needs as well.

16 So we are really excited, and I think that
17 Chuck's efforts are really going to pay dividends, as
18 they mirror the model that he has developed.

19 DR. OSTROFF: I am wondering if before we
20 close this session, Admiral, do you have any comments
21 about this, or Dr. Zimble?

22 ADM. HUFSTADER: Let me just ask a
23 question. Could you clarify for us how you or your
24 centers are involved with the recent Pentagon and New
25 York events? How are you going to be involved?

1 LT. COL. ENGEL: Well, so far our center
2 has been involved at a distance, and as I was saying,
3 most of our involvement at this point has been in
4 support of Walter Reed as they have gone into a crisis
5 mode, because we operate within Walter Reed.

6 We have this toll free help line and in a
7 couple of days after, we had people staffing the
8 phones pretty much around the clock. And like I say,
9 they took over 500 phone calls on that toll free line.

10 These are people from the outside looking
11 in for the most part, and wanting to help in some
12 fashion, and wondering how they could connect up to
13 volunteer their help, or trying to locate a loved one
14 that they knew that worked around the Pentagon, or
15 frequented the Pentagon, that might have been involved
16 in this.

17 So that has been the direct service
18 involvement. Like I say, I tend to run to-and-fro
19 with various pulls, and spent the better part of
20 yesterday developing a set of questions to fit into
21 the active surveillance strategy that CHPPM is
22 developing for their surveillance efforts. So we have
23 been involved in that as well.

24 ADM. HUFSTADER: So CHPPM is going to lead
25 a surveillance effort; is that right?

1 LT. COL. ENGEL: Yes. Well, I can't speak
2 for CHPPM on that, and --

3 LT. COL. RIDDLE: That's -- I mean --

4 ADM. HUFSTADER: Yes, he is going to be
5 here this afternoon.

6 LT. COL. ENGEL: I did hear earlier that
7 they were going to be presenting the work that they
8 have been doing.

9 DR. OSTROFF: Dr. Zimble.

10 DR. ZIMBLE: The only comment I would make
11 is to reinforce what has been said earlier; that we
12 have got to get out of the business of trying to find
13 the relationship between exposure and what we are
14 going to do to take care of these people.

15 We need to, of course, study it and learn,
16 but at the same time we take care of the folks that
17 put the uniform on. It really should be the cost and
18 the obligation that this government takes to gain the
19 type of volunteers that we want to come into the
20 service.

21 And whether they are in for a month or for
22 a year, or a career, they should be entitled to care,
23 period. And they should know that going in. I think
24 that it will pay great dividends.

25 It is just hard for those with the green

1 eye-shades to be able to measure that, and most of the
2 folks that are budgeteers in this business -- and in
3 your business as well -- are rewarded for saving money
4 and don't understand investment.

5 LT. COL. RIDDLE: Unfortunately, Seth
6 Carus can't be with us today. I talked to him on
7 Friday, and he was just recently appointed to the Vice
8 President's Commission looking at domestic terrorism,
9 with his focus on biological warfare.

10 His presentation is in Tab A in your
11 notebooks, and I think it relates to the two
12 outstanding recommendations that we have on the
13 medical threat assessments, and the DoD immunizations,
14 and reinforces I think in my mind the recommendations
15 that the Board has on the table.

16 But he was called over to a meeting with
17 the Vice President this morning, and so what we will
18 do is we will just break here and then reconvene at 10
19 o'clock to take up the accession questions.

20 DR. OSTROFF: I will consider a meeting
21 with the Vice President to be an excusable reason.

22 (Whereupon, at 9:28 a.m, the meeting was
23 recessed, and was resumed at 9:57 a.m.)

24 COL. CORCORAN: I have been advised to
25 start my clock now, and hopefully you can all hear me.

1 I am Tim Corcoran, and I am from the Office of the
2 Secretary of Defense and Health Affairs, and Program
3 Policy. I am a family physician.

4 And I just wanted to give you all sort of
5 a quick overbrief of the questions that are being
6 posed to the Board, and the different aspects of these
7 questions, and so forth today.

8 The issues that are before the Board
9 actually predate any of the DoD directives and the
10 instruction that presently exist. In fact, they are
11 very longstanding issues.

12 A lot of them deal with DoDMERB practices,
13 and DoDMERB has utilized these types of things, in
14 terms of the basis for the questions, and have
15 utilized the procedures and tests actually starting in
16 the early '70s.

17 And so the directives, the Department of
18 Defense directives, came after that. Actually, the
19 first were published in 1986, and before then, they
20 were actually Army regulations.

21 Okay. There are two Department of Defense
22 level directive instructions that actually guide
23 physical standards for accessioning into the military,
24 and it is the DoD Directive 6130.3, and the DoDI
25 6130.4.

1 The DoD Directive 6130.3 is about three
2 pages long, and so it just provides the broad overview
3 as the directive does, and the Instruction is really
4 the meat of how to make this happen. It is about 41
5 pages long. So it is actually a quite detailed
6 document.

7 Okay. I just want to go over the guiding
8 principles that are outlined in the Directive, because
9 it sort of speaks to the core of why the Department of
10 Defense has accession standards. And there is
11 basically three major points here.

12 We want to screen out unqualified
13 candidates to reduce early attrition. Obviously, we
14 want them to get through basic trainings and the other
15 types of things that we ask them to do.

16 And we want to decrease failure to
17 existing medical conditions. The GAO actually
18 released a report some years back, and they estimate
19 that the total cost, for example, of just recruiting,
20 and then screening and getting through a recruit
21 through basic training is about \$35,000 each.

22 And so it is not a trivial cost when we
23 lose these people based upon their medical condition.

24 We want to exclude conditions leading to excessive
25 time lost from duty. This seems almost obvious. We

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1 want them to spend more time doing their job than we
2 want them to be in medical clinics and in hospitals.

3 We want them to -- you know, again make
4 sure that this sort of emphasizes, that we want them
5 to not have to separate because of medical unfitness.
6 And, of course, we want to have them medically
7 adaptable without geographical area limitations.

8 So the bottom line here is this, and this
9 is really brought into light given the recent events.

10 It is fine to have people in the military, but unless
11 they can deploy, and unless they can do the mission,
12 that it doesn't do us any good.

13 So we really do want to deliver on demand
14 a healthy, medically ready force to the war fighting
15 commanders without excessive costs. This actually
16 isn't directly stated in the Directive or in the
17 Instruction, but it is the accumulation, it is the
18 intent, of the Directive and the Instruction.

19 All right. Now, again, this is from the
20 DoD Directive, the 6130.3. It maps out what the
21 responsibilities are, and I just want to emphasize a
22 couple of things.

23 The document has this statement in many
24 different areas, and it says here that the Assistant
25 Secretary of Defense for Health Affairs, and Assistant

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1 Secretary of Defense for Force Management Policy
 2 shall, eliminate inconsistencies and inequities based
 3 upon race, sex, or examination/location, and in the
 4 application of the Instruction, and the Secretaries
 5 and military departments assure uniformity of
 6 applications and implementation of this directive in
 7 DoD Instruction.

8 Nowhere in the Directive or the
 9 Instruction is there anything that says that officers
 10 should be treated one way, and enlisted another, and
 11 so forth. And so this is again a recurring theme of
 12 the documents.

13 Now, just to give you a broad overview of
 14 how this is set up. The accession medical standards
 15 steering committee was established by the Under
 16 Secretary of Defense P&R in 1996.

17 And it was co-chaired -- it is co-chaired
 18 by the Deputy Assistant Secretary of Defense for
 19 Military Personnel Policy, and the Deputy Assistant
 20 Secretary of Defense for Clinical and Program Policy.

21 The reason why these two chairs were
 22 chosen is that you bring the personnel community
 23 represented here with the medical, and the Department
 24 of Defense recognized that to develop proper accession
 25 policy, you really do need the input from both the

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1 personnel and the medical community.

2 And apparently in the past there was a
 3 tendency for the medical community more to drive that
 4 train, and so this was put into place to allow the
 5 personnel community to also weigh in on those
 6 decisions.

7 The Accession Medical Standards Working
 8 Group, called the AMSWG, which I co-chair, along with
 9 Mawhee Edmondson, who represents Force Management
 10 Policy actually, she and I co-chaired this meeting.

11 And our members of this group are
 12 basically representatives for the members of this
 13 higher level committee. And so Reserve Affairs is
 14 represented, and the Service Surgeon Generals are
 15 represented.

16 You also have DoDMERB represented, and
 17 USMEPCOM representatives, and you have the Deputy
 18 Chiefs of Staff of Personnel represented. So, you
 19 see, you have a large group of people that represent
 20 both the Personnel and Medical community on this
 21 group.

22 And essentially we are charged with -- the
 23 actual words are receives and reviews issues pertinent
 24 to effect good policy, at least at the AMSWG level.
 25 And then we have the Accession Medical Standards

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1 Analysis and Research Activity, which also stood up in
2 1996. All of these were.

3 And they are a division of preventive
4 medicine from WRAIR, and what they are is the group
5 that helps us, in terms of providing evidence-based
6 feedback from analysis of data that exists presently.

7 And also another little salient point here
8 is that the present standards primarily that you see
9 are based upon expert opinion, and not necessarily on
10 epidemiologic data linked to military performance.

11 So all of this was put into place to bring
12 us to more of an evidence based approach, and hence
13 the role of AFEB here, too. Okay. Just to give an
14 overview and an idea of how the process and structure
15 is sort of set up.

16 We have the U.S. Military Entrance
17 Processing Command, U.S. MEPCOM, which is responsible
18 for conducting all enlisted exams, including the
19 reserve components and the Coast Guard. They do the
20 great majority of the physical examinations, and I
21 won't say too much about that, because Colonel Lee is
22 going to present two today.

23 And then also they conduct exams of
24 individuals not included in the Military Entrance
25 Processing Station workload. And it actually opens up

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1 sort of a broad category here. So, for example, they
2 do all non-scholarship officers as an example of what
3 they can do here.

4 Oh, and just backing up here, there are 65
5 of the MEPS stations, and they are all across the
6 country. And DoDMERB is the DoD Medical Examination
7 Review Board, and they are responsible for these
8 categories.

9 The U.S. Service Academies and the Reserve
10 Officer Training Corps Scholarship Program
11 specifically, and not non-scholarship. And the
12 Uniform Services University of the Health Sciences,
13 USUHS.

14 Okay. The first question put to the
15 Board, and I sort of paraphrased it. The exact
16 language is -- you all have that, but the exact
17 language from Dr. Clinton is if any evidence-based
18 literature supports utilization of the ECG as a
19 predictor of cardiovascular problems among
20 asymptomatic individuals between the ages of 17 and
21 35.

22 And DoDMERB screens all applicants with an
23 ECG, and the MEPS do not screen applicants with an
24 ECG. And when I present this question, I struggled
25 with a lot of these questions because actually they

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1 are a little bit more complex than they first appear.

2 There are multiple facets to each
3 question. This is one facet of the ECG question,
4 where we are asking for a predictor. Is it a good
5 predictor of disease.

6 The other parts of the question is whether
7 it is cost effective, and AMSARA is going to address
8 part of that issue today. And also there is an aspect
9 of the question that concerns policy. Do the
10 standards as they are published presently require this
11 be done.

12 And then the other aspect of the question
13 is specific customer needs, and that's why Colonel Lee
14 is going to present, and Colonel Weien is going to
15 present, to give the Board a perspective of what the
16 customers are requesting.

17 So when we consider these questions, there
18 is layers of the question actually, and the AFEB can
19 certainly help us with providing help in terms of
20 answering some of this.

21 Now, the standard from the DoD Instruction
22 states that, and so as it relates to ECG, it says that
23 the cause for rejection for appointment, enlistment,
24 or induction are symptomatic arrhythmia, a history of
25 such condition.

1 In the backup slides at the end, which I
2 think you have all been provided with, I list the
3 complete section, because you could also have per
4 chance -- an ECG might be able to detect, for example,
5 hypertrophy, or pericarditis, or a cardiomyopathy,
6 including myocarditis.

7 That's true, although history probably
8 plays more of an important role than an ECG. But that
9 is also in the standard, and they are provided in the
10 backup slides for you.

11 And also one other point here. Often
12 times people get confused, and they think that if you
13 are disqualified based upon this standard that you
14 can't come into the military.

15 And in fact actually the Services can
16 waive any condition that they see fit to waive. So if
17 a person is actually disqualified for any of the
18 standards in the DoD instruction 6130.4, the Services
19 could in fact if a waiver was requested permit that
20 waiver to go forward, and the person could still
21 matriculate into the military. That is another
22 important point.

23 Okay. Now the hemoglobin question, and
24 again I paraphrased Dr. Clinton's specific question to
25 the Board. "Does screening asymptomatic individuals

1 with no history of anemia with hemoglobin have
2 utility."

3 And again DoDMERB screens all applicants
4 with a hemoglobin test, and MEPS do not screen
5 applicants with a hemoglobin test, and the standard
6 from the instruction states that the authenticated
7 history of the following -- anemia, hereditary,
8 acquired, aplastic or unspecified anemia that has not
9 been permanently corrected with therapy.

10 And again I have provided a complete blood
11 and blood-forming tissue disease in Section 4 in the
12 back with the slides. Okay. The third question I
13 will present is the one on the physical exam.

14 Should the validity period of the initial
15 qualification physical exam be extended from two years
16 to five years, with an interim medical inspection.
17 This gets just a little bit more complicated and
18 complex.

19 In the Instruction, it states that the
20 physical experience and closure don't apply to the
21 following, and then it lists these different
22 categories. Applicants for appointment as
23 commissioned or warrant officers; applicants for
24 enlistment in the Armed Forces; applicants for
25 scholarship or Advanced Course Reserved Officer

1 Training Corps, and so forth and so on, and retention
2 of cadets and midshipman.

3 So these are the groups that this actually
4 applies to. The DoD instruction does not directly
5 address the issue of physical exam validity periods,
6 but rather it states who the standards apply to.

7 So nowhere in the instruction does it
8 actually map out when a physical exam, a full physical
9 exam, has to be accomplished or done. And just as an
10 example, and almost as an aside of the present
11 experience in DoD, the Office of the Surgeon General
12 grants an exception to policy for extending the
13 physical exam validity period for the airborne school.

14 And this is a school that is very, very
15 demanding, and in terms of physically, physically
16 demanding. And in April of 2001, they changed the
17 policy as it pertains to ROTC cadets so that they
18 would accept a medical statement from the cadet
19 candidate, which they are required four months prior
20 to airborne school, that states that essentially to
21 the best of my knowledge there has been no significant
22 change in my medical condition from my prior
23 examination.

24 And they have used that, and in fact their
25 experience has been good with this. They have reduced

1 the number of physicals by about a thousand, and
 2 again, Colonel Krauss, from AMSARA, will sort of
 3 present more information that sort of goes through
 4 that.

5 I think that's about it, and these are
 6 just the backup slides. And so without further ado, I
 7 would like to introduce Captain McKinley, who is going
 8 to take up the fourth question on the dental question.

9 LT. COL. RIDDLE: Thanks, Dr. Corcoran.
 10 In your books, in the tabs, you have the DoDD, the
 11 DoDI, that Tim was talking about, the backup slides,
 12 and you also have the Service Implementing Instruction
 13 for all of the accession standards.

14 And we have provided the abstracts on the
 15 literature reviews, and we will have the full text
 16 articles for the members considering the review. So,
 17 Captain McKinley is from the Office of the Assistant
 18 Secretary of Defense, the TRICARE Management Activity,
 19 and he is going to present the fourth question, which
 20 is the utilization of the dental examination and
 21 panoramic x-ray for screening.

22 CPT. MCKINLEY: Thanks very much. The
 23 question for dentistry, and I think I misunderstood my
 24 mission slightly today, as I am going to give you both
 25 the question, and from the dental communities'

1 perspective the desire to answer, and we will move on.

2 The question really is, is a professional
 3 dental examination necessary for service academy and
 4 ROTC scholarship applicants.

5 The DoDMERB, which is the screening board
 6 to select applicants, requires a professional dental
 7 examination by a dentist, and a panoramic radiograph
 8 for service academy and ROTC applicants.

9 That is opposed to the MEPS dental
 10 screening, which is essentially a look through with a
 11 dental mirror, and just a quick visual examination.
 12 The answer is -- and I bounced this question off the
 13 Tri-Service dental chiefs -- General Sculley, General
 14 Murray, Admiral Johnson, and now Admiral Woofter, and
 15 also the service academy dental commanders, and to get
 16 their take on this.

17 Universally, they came back and requested
 18 that the current DoDMERB examination process remain in
 19 place for these select applicants. I am going to pass
 20 on this slide.

21 If we are going to take the dental
 22 standards that our dental communities take on this, is
 23 that if we are going to take the dental standards
 24 seriously, we need to have a dental examination. A
 25 visual look-and-see with a mirror just will not do the

1 job.

2 And the standards are four; essentially
3 one of pathology and dental, general oral disease, and
4 the most significant of which in this case is
5 myofacial pain disfunction syndrome, seen very
6 commonly in folks under stress, both on your recruit
7 and the officer side.

8 But there are many other diseases and
9 entities of the heart structures that require a
10 radiograph. The best radiograph for a general look in
11 the oral cavity is the panorex.

12 Another standard is severe malocclusions.

13 Malocclusions can cause a number of problems, either
14 immediate or down the road, over a period of time; and
15 an imbalance between the maxilla and mandible, and the
16 potential or the future prosthodontic replacement is a
17 key issue here.

18 If these malocclusions are to be corrected
19 down the road and usually they have to be, a
20 satisfactory prosthodontic replacement has to be in
21 place, and the complexity and ability to do this is a
22 very costly and time consuming endeavor for dentistry.

23 Insufficient natural healthy teeth, or the
24 lack of serviceable prosthesis, again it is a
25 prosthodontic issue, and the ability of the candidate

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1 to undergo the preparation for a full-mouth
2 rehabilitation that would be necessary, and the time
3 involved with that, as well as the expense, would not
4 jeopardize the success of that candidate in the
5 service academy or in the ROTC program.

6 We think that dentists are probably the
7 best folks to evaluate these conditions and the
8 standards. Also, dental implants and osteo-
9 integration is a key issue here, and it requires a
10 radiograph.

11 Lastly, orthodontic appliances, and active
12 orthodontic appliances and their presence, is a high
13 cost, high maintenance issue, and is the fourth and
14 last disqualifying factor for service academy and ROTC
15 applicants.

16 The contention are three; that the
17 professional dental examination is not necessary based
18 on the statistics, and the remedials and the
19 disqualifications. My discussions with DoDMERB seemed
20 to indicate that some of the statistics, the recovery
21 statistics -- the documentation is not very good, and
22 that we don't have a real solid database upon which to
23 make a database decision.

24 And so although we would like to make -- I
25 think that this board would be tasked with making as

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1 much as possible a database decision, and the data are
2 not collected very consistently across the Services,
3 and the outcomes are not particularly well documented.

4 Also, the MHS, the Dental Corps have a
5 heavy emphasis on dental health and dental readiness,
6 and more so, and we don't think that a MEPS level
7 screening of these select officers supports the
8 overall emphasis for dental health and dental
9 readiness as it has been established in the Armed
10 Forces.

11 Panoramic radiograph is not necessarily
12 cost effective, and the panorex is the quickest, most
13 comprehensive radiograph that we have. It is an
14 excellent tool. About 40 percent of the examinations
15 on these candidates are done in military DTFs, and as
16 a result at no cost to this organization.

17 Three or four dollars is a rough swag as
18 to what it costs to do that radiograph in a military
19 DTF, and so we don't think that elimination of this is
20 a very good idea based on the benefit that it does
21 provide at the screening, at the DoDMERB screening.

22 The MEPS dental screening is performed by
23 non-dental personnel is adequate. Colonel Lee can
24 certainly speak to what that is in the MEPS process
25 currently, and he knows far better than I.

1 But the dental community contention would
2 be that that it really takes a dentist to evaluate the
3 standards which I just talked to you about, and that
4 probably the elimination of the DoDMERB level dental
5 examination would not support the carrying through of
6 the standards of holding the candidates to the
7 standards as they are currently published.

8 So the reality is that service academy and
9 ROTC scholarship students have little availability for
10 correction of complex or disqualifying dental
11 conditions.

12 Essentially the DoDMERB exam jump starts
13 these candidates on their way to access, and does not
14 put dental barriers or roadblocks in their way, in
15 terms of time consuming dental treatments, and
16 potentially off-site treatments in the case of Coast
17 Guard and one of the other services.

18 But many of the issues or the conditions
19 that are required to be treated can't be done on-site
20 at the academic institutions. They have to be done at
21 a tertiary care facility.

22 The MEPS type dental screening of recruits
23 and officers costs MHS dearly in subsequent corrective
24 dental treatment. I don't have the statistics for the
25 Army and Air Force, but in terms of the Navy and

1 Marine Corps, a significant amount of money is spent
2 on the dental treatment of recruits.

3 The Navy jump starts up front, and
4 frontloads general care in boot camp because of the
5 nature of the follow-on service of the recruits. The
6 Army and Air Force are more in garrison organizations,
7 and can afford to pass these patients on through to
8 the system down the road and down the stream.

9 So the Navy and Marine Corps numbers
10 average somewhere between \$300 and a thousand dollars
11 per recruit of dental care delivered in the Navy and
12 Marine Corps dental treatment facilities.

13 If we are going to take that and pass it
14 on to the service academies also, it is a lot of time,
15 and a lot of expense, and we don't think that is a
16 wise idea.

17 So, in conclusion, this continuation of
18 the professional dental examination and associated
19 panoramic radiographs we don't believe are justified
20 by the available data. We would like to propose to
21 you that we collect the data.

22 The Dental Corps are -- well, we may seem
23 parochial in this. We don't want to be. We want to
24 give you the correct scoop. We want to collect the
25 data and we would like to look at this and give you a

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1 good recommendation downstream as to which way to go.

2 We are not so sure that the standards are
3 all that appropriate, particularly in the orthodontic
4 section. I know or I think the standards need to be
5 revisited, and I would recommend that.

6 But in the meantime I would not recommend
7 taking a step backwards and eliminating the dental
8 exam for these recruits or these select officers. I
9 think that's probably enough said.

10 LT. COL. RIDDLE: And what we would like
11 to do is hold off on the questions until we get the
12 DoDMERB and MEDCOM, and AMSWG presentations. So, what
13 has been presented is really the DoD standards, and
14 now Colonel Weien, the Director of the DoD Medical
15 Examination Review Board, is going to give you his
16 perspective from where the rubber meets the road
17 really for his select group of applicants, which are
18 the service academies and ROTC.

19 And then Colonel Lee will follow up from
20 the U.S. Military Entrance Processing Command, which
21 does the enlisted applicants and direct commission
22 officers. Colonel Weien.

23 COL. WEIEN: Okay. I am Bob Weien, and I
24 am the Director of DoDMERB, and a little bit about the
25 background of DoDMERB for you, just in case you don't

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1 know who we are.

2 We were established in 1972 to do
3 physicals for basically the funded officer accession
4 programs. Initially the five service academies, and
5 later the three ROTC scholarships, and later still,
6 USUHS was added. So we have nine total customer
7 programs, and that is on a later slide actually.

8 And we are at the Air Force Academy in
9 Colorado Springs, but I really work for two bosses,
10 and health affairs provides me with policy and
11 procedural supervision as you can see.

12 And General Murray over at the Air Force
13 Medical Operations Agency is tasked as the executive
14 agent providing administrative and logistic support
15 for us.

16 We have a joint staff -- Army, Navy, Air
17 Force, Coast Guard -- and as you can see, we have a
18 large staff of civilians that work with me as well.
19 The directorship rotates among the services, and the
20 last one was Navy, and I'm Army, and the next one will
21 be Air Force.

22 And here are our customers, and I have
23 already been over that, and so did Colonel Corcoran
24 cover that. Now, our examinations -- and there is
25 going to be quite a contrast between the way we do

1 these exams and the way that Colonel Lee does his
2 exams for MEPCOM.

3 Ours, as you can see, 60 percent by a
4 civilian contractor, and 40 percent at military MTFs.

5 That was prior to last Tuesday. That may have to
6 change because a lot of our applicants -- we are
7 getting lots of reports that our applicants are having
8 a difficulty getting on military bases in order to get
9 their exams performed.

10 At a lot of places it is no I.D. card, no
11 entry, and so if that trend continues, and it doesn't
12 look like it is going to be corrected, we may have to
13 adjust that formula so that we do more through our
14 civilian contractor.

15 Our contractor is a company called
16 Concord. They do a very good job for us. These exams
17 -- and there are hundreds of examiners. I think we
18 have 400 Concord examining sites alone, and of course
19 you know how many MTFs there are.

20 There are lots of examiners, and we don't
21 require them to make a decision as to whether anyone
22 is qualified or disqualified. They simply perform the
23 exam, and collect the objective data, and take the
24 medical history, and then they send that physical to
25 us in Colorado Springs and we review it.

1 And I have my staff of enlisted reviewers
2 and the three docs -- Army, Navy, and Air Force, and
3 the dentists and optometrists review the physicals and
4 determine if these people meet or fail to meet the
5 standards listed in the DoD Directive and DoDI.

6 Colonel Corcoran has already covered what
7 those are, and you have seen some of the excerpts from
8 them, but those are the source documents that we use.

9 They are intended to be revised every four years.

10 We use different forms. We don't use the
11 standard forms, and that was because in the beginning
12 the physical that we use -- when the standards came
13 out, of course, the standards don't direct what kind
14 of examination you perform in order to determine if
15 someone meets the standard.

16 So in the beginning, in '72, our physical
17 was modeled after the Air Force Class One Flight
18 Physical. That was our starting point, and modified
19 it significantly since then.

20 For instance, we don't use a cycloplegic
21 eye exam. We use a manifest exam. There are a number
22 of changes, but that was where we started. That's why
23 the EKG is there, and the hemoglobin/hematocrit, and
24 lots of different things. If you look at our starting
25 point, it was the Air Force Class One Flight Physical.

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1 Now, again, we have hundreds of examiners
2 and a widely dispersed network. The applicants are
3 never seen by us. We only see the paperwork that we
4 receive from these examiners that are out there.

5 We have consistency of outcome because we
6 have essentially only three people that make the
7 ultimate DQ decision on applicants, and that is three
8 docs. We talk all the time, and we have a pretty
9 consistent outcome among the three of us.

10 So additional information that we ask for
11 from the field only is critical to getting a good
12 disposition decision. Some of the additional
13 information that we ask for, like the increased
14 standards for the dental exam, is so that we can have
15 a consistent outcome, and that we can enforce the
16 standards better.

17 And I apologize here. I think I numbered
18 the questions differently than Colonel Corcoran did,
19 and I think I took my numbering from an earlier
20 version of the memo that asked the questions.

21 Now, the validity period, and increasing
22 it from 2 to 5 years. We are neutral on this issue.
23 Basically, we do the physical, and we don't care what
24 it is used for too much after that.

25 If the services want to accept our

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1 physical for two years or five years, that is up to
2 them. We will let them know anything they need to
3 know about what the quality of the physical is and how
4 we do it so that they can help make their decision
5 about that.

6 I think there are two arguments that you
7 need to consider, and one is that it shouldn't be an
8 all or one thing. You can consider it for accession
9 or you can consider it for retention.

10 I think for accession purposes that you
11 have got to remember that after you do the physical
12 the person is out of your control. There is medical
13 history being generated that you know nothing about.

14 Whereas, for retention purposes, once a
15 person is in the military, you are generating a
16 medical record. They come to you when they are sick,
17 et cetera, and you know what is going on with them
18 medically.

19 So I think that one valid outcome of this
20 proceeding might be to say that for accession that you
21 might want a shorter validity period, but one access
22 and you can then accept that physical for a longer
23 period of time.

24 One thing we do is for the two year period
25 is that we have a statement of present health that we

1 send out to all our applicants. If someone gets a
2 physical, and say we are qualifying people right now
3 for next summer's academy classes, in the spring we
4 will send them a statement of present health, and also
5 send them an instruction sheet saying that if anything
6 significant changes in your medical history, you have
7 to tell us about it. I am not sure that they all do,
8 but we do ask them that question at least.

9 DR. OSTROFF: Can I ask you one question?

10 After they get the physical, how long is that
11 physical good for before they access?

12 COL. WEIEN: Two years. The physical is
13 valid for two years for accession purposes. So if
14 someone got a physical now for the Air Force Academy,
15 for instance, they could use that to apply for next
16 year's class or the class after that, and then they
17 would have to get another physical.

18 The question of screening ECGs. We favor
19 ECGs, and we favor that because we asked our customers
20 -- and particularly the Air Force Academy and the
21 Naval Academy came on very strongly and said we like
22 the fact that DoDMERB does ECGs.

23 The reason? A significant number of their
24 grads have to get flight physicals down the road in
25 order to go on flight status, and they want us to do

1 that initial screen to determine if those people are
2 going to make it or not make it.

3 One additional wrinkle that we do for the
4 Air Force Academy alone is instead of just determining
5 if someone is qualified or disqualified, we
6 additionally say they are PPQ, Potentially Pilot
7 Qualified, or PNQ, Potentially Navigator Qualified.

8 And if they are either one of those, but
9 they are otherwise qualified, they are commission
10 qualified. And the Air Force likes us to do that, and
11 this impacts on the PPQ and PNQ decision for the Air
12 Force Academy and Air Force ROTC.

13 Another thing that ought to be in the mix
14 here is that when there is an active duty cardiac
15 death, there is a -- well, I will just tell you that I
16 was a division surgeon when we had a cluster of four
17 cardiac deaths, and I had a whole boat-load of senior
18 infantry officers asking me when the last EKG was done
19 on these soldiers.

20 And I found myself teaching epidemiology
21 to senior infantry officers, which is a real
22 challenge. But I think you need to consider that a
23 lot of people ask questions when there are cardiac
24 events that occur in the active duty population.

25 The perception is that it is preventable,

1 and the perception on the line is that it is
2 preventable by EKGs, even though we all know that that
3 is probably not true.

4 Hemoglobin. We are neutral on hemoglobin.

5 The vast majority of the ones that we see, or the
6 anemias that we see, are the iron deficiency anemia,
7 thus correctable. It is a relatively low cost test,
8 but again it is a low benefit test. So we are neutral
9 on that.

10 The dental exam and panograph. We
11 strongly support continuing this. If you want us to
12 enforce the DoD instruction as written, and if you
13 want us to enforce the standards, we need the tools to
14 do so.

15 Again, we make the Q/DQ decision at
16 DoDMERB. The people out in the field don't require a
17 dental exam and a panograph in order to make a
18 determination of qualification, and most physicians
19 wouldn't be very comfortable doing that either.

20 And we need the panographs for standards,
21 and not for identification. Every time we raise the
22 panorex issue, everyone says, oh, we aren't using
23 those for identification anymore.

24 We know that and we need it to determine
25 whether someone meets or fails to meet the standard.

1 So, a summary of the recommendations. We are neutral
2 on the validity period, and we recommend retention of
3 the ECGs, and neutral on the hemoglobin.

4 And we want to retain dentists and
5 panograph requirements for our population because of
6 the way in which we acquire these physicals, and then
7 have to make a determination of qualification or not.

8 LT. COL. RIDDLE: Thank you, Colonel
9 Weien. And we have now Colonel Lee, who is the
10 Command Surgeon, who is the Command Surgeon for the
11 U.S. Military Entrance Processing Command.

12 DR. OSTROFF: Pierce.

13 DR. GARDNER: I just had a question about
14 the iron deficiency anemias that you identified as the
15 most common. What sort of workup does that lead to,
16 in terms of finding the cause? Do they end up with GI
17 studies, or do you just treat the iron deficiency with
18 some iron tablets?

19 COL. WEIEN: Well, we don't prescribe
20 anything like that. All we do is that we send out
21 what is called a remedial, which is a request for
22 further information.

23 We say that you have an anemia, and your
24 hemoglobin and hematocrit are too low, and you should
25 go see your physician about that. And usually what

1 happens is not very long after that we get a new
2 report in that is within standards.

3 And often it will be accompanied with a
4 work up from an oncologist or hematologist, and
5 sometimes it is just evidence that they were given
6 iron pills, and everything turned itself around. So
7 we don't prescribe a work up per se. We simply say
8 that you are outside the standards.

9 DR. OSTROFF: One more question.

10 DR. ZIMBLE: Colonel, it is obvious from
11 the presentation that the people that you are
12 examining are people in whom the government, the DoD,
13 is making a considerable investment; the Academy, the
14 scholarship programs, et cetera.

15 But I am curious as to why you are doing
16 -- when you say ROTC scholarships, do you include the
17 HPSP program?

18 COL. WEIEN: No, sir. Our mission
19 includes the nine programs that are listed up there.

20 DR. ZIMBLE: And so the HPSP, that is the
21 only other program which has a very significant
22 investment of \$20,000 to \$30,000 a year for four years
23 in an individual that is going to come into the
24 military.

25 And 85 percent of the annual accessions

1 for physicians are coming from the HPSP program, and
 2 to me I think one question that we ought to ask is how
 3 come. I hate to give you more work, but it seems to
 4 me that the HPSP program is one program that ought to
 5 be under the interests of DoDMERB.

6 COL. WEIEN: That's health affairs, and
 7 they can comment on why that's not the case.

8 UNIDENTIFIED ATTENDEE: The subject was
 9 brought forward about four years ago, and it was
 10 basically a budgetary decision that didn't get made.
 11 but the same point that you brought up, Dr. Mazuki
 12 brought up, and it just never was executed.

13 DR. OSTROFF: Okay.

14 COL. LEE: Good morning. I am Brad Lee,
 15 and I am the MEPCOM command surgeon, and as I
 16 understand my tasker, it was to give you an overview
 17 of MEPCOM. If most of you are like me, I didn't know
 18 what MEPCOM was, and I have been in the service almost
 19 30 years.

20 I never had to go through a MEPS, and I
 21 didn't know what they did. What they do is all the
 22 enlisted physicals, the non-scholarship officer
 23 physicals, and sometimes the HPSP physicals.

24 Now, in addition to the medical piece,
 25 they do a lot of other things, and this is part of

1 what I wanted to make sure that everyone here
 2 understood. They do the vocational aptitude battery,
 3 which basically sees if these people are qualified for
 4 service.

5 Then the medical exam and the background
 6 screening. We check to make sure that they are not
 7 convicted felons, or have committed some other crime
 8 of moral turpitude, and we transport them to basic
 9 training.

10 Our quality benchmarks. We want to make
 11 sure that we have accurate accession data for all the
 12 services. We want to make sure that our test results
 13 on their aptitude battery is correct and timely.

14 Now, we are going to be talking timely
 15 here of a magnitude that is vastly different than
 16 DoDMERB. We do the HIV and drug/alcohol test on every
 17 applicant, and we want to decrease the processing
 18 time.

19 I am going to take you through the flow of
 20 a typical applicant as he goes through the MEPS here
 21 in a second, and we want to decrease the EPTS or
 22 "Exist Prior to Service" rate which Tim talked about
 23 earlier, which means that when they get to basic
 24 training that they are not disqualified for a
 25 condition that they already had prior to coming to

1 basic training. And we want to try and do this at an
2 affordable price.

3 Now, this is kind of a complicated flow
4 diagram, but it is only to point out that we have
5 multiple masters. We serve all the services, all the
6 Department of Defense, including the Coast Guard,
7 which is DoT; and we have to work with recruiters, as
8 well as the trainers. That is what this is all meant
9 to show.

10 Now, we are in the middle of the
11 recruiting triad, and I want to point that out because
12 we all have been talking about training. What makes a
13 great recruit applicant get the training and through
14 training?

15 Well, the other side is the recruiters.
16 Right now they are the ones who are getting all the
17 press, and a lot of the money, because we have to get
18 these applicants in. So the other side of the dilemma
19 is not to make the barrier so difficult that
20 applicants can't get through.

21 MEPCOM, as indicated earlier, is comprised
22 of 65 MEPS. We are divided east to west, and this is
23 the way that we are divided. We have roughly 2,800
24 people assigned.

25 Plus, I have 65 docs roughly, one at each

1 MEPS, who is a full-time Federal employee. And then I
2 have a cadre of about 400 docs in addition that we use
3 on a recurring basis.

4 Now, operations. This is all the things
5 that we do in a day in the MEPS, and I do mean a day
6 at in the MEPS. We try and bring the recruits in and
7 have everything finished in one day.

8 So, they get their student testing, and
9 then assuming they pass, they go through medical, and
10 then they get their job, their contract here, and
11 again their background screening, and then they are
12 enlisted in the Delayed Enlistment Program.

13 Unless they are in that program, they can
14 be in that program for up to two years, okay? This is
15 the qualification phase. This is the first time that
16 they ever come to the MEPS. Ideally, it is done in
17 one day.

18 Now, then it comes time for them to
19 actually go to basic. Well, they come back to us, and
20 we talk to them again, and we do an inspect on them.
21 We check to see that nothing has changed since we did
22 the physical, and then we ship them off to basic
23 training.

24 And what you need to know is that we do
25 these two processes every day concurrently. So there

1 will be some guys who are DEPing in, and some guys who
2 are shipping on the same day.

3 And it may not seem like a real difficult
4 thing other than all the training bases, which we will
5 talk about in a second, have windows in which we have
6 to have the recruits there.

7 Given the events of the past week, we
8 primarily used air, but now we are using trains,
9 buses, and we are putting together convoys, just to
10 get the recruits to the training bases in the assigned
11 windows which they must be there.

12 For example, like Great Lakes, which is
13 where I actually am physically located, they tend to
14 want their people between 11:00 o'clock at night and
15 2:00 in the morning, because I guess that is when they
16 start their indoctrination.

17 Now, let's talk a few numbers. As you can
18 see, MEPCOMs workload, we start with a number close to
19 half-a-million. Now, not all of those people get
20 through the ISVAP because we only do about 372,000
21 physicals a year, and then fewer than that actually
22 get to basic training.

23 That is the number to get to basic
24 training, because there are people who just don't
25 choose to continue the process for whatever reason,

1 even though they are qualified.

2 Now, another graphical representation is
3 this. Now, The first line is the DoD standard, which
4 says that you must score 11 percent. So you must be
5 in the top 89 percent in the country intellect-wise to
6 be able to join the Armed Forces.

7 Well, the services have set each set a
8 different standard that is higher than that. They
9 have raised the bar a little bit. So each service has
10 a specific standard. So we will drop out a few more
11 with different standards.

12 And then we drop out about 10 percent
13 because of medical. Then as you can see, it just
14 keeps going down until you actually get the number
15 accessed.

16 Now, this is where we send them to. There
17 are 10 training bases; one for the Air Force, one for
18 the Navy, two for the Marines, and then five for the
19 Army. So we are shipping kids every day all over the
20 United States.

21 Now, medical specifically. This is what
22 we do every day at every MEPS. We check them in, and
23 we do a routine physical exam, to include HIV and DAT
24 testing.

25 We are doing the HIV/DAT testing based on

1 statutory requirement. We turn negatives in 24 hours.

2 We have to use a DoD controlled lab, and we do that.

3 We FedEx it and get negative results back, and we
4 usually have confirmation back on positives within 72
5 hours usually. So once again we are doing this every
6 day.

7 Now, when we look at our kind of report
8 card, we try and judge what conditions could we or
9 should we have caught that got to basic training, and
10 what are the big reasons that kids are being medically
11 disqualified from basic training.

12 And these are the reasons as reported to
13 us from the training bases. The big rocks,
14 orthopedics. That knee injury that they never had
15 suddenly becomes a problem.

16 The asthma that they never had becomes a
17 problem; and, of course, psychiatric, and that
18 definition is pretty loose of what falls in there.
19 Failure to adapt may be psychiatric to some services,
20 for example.

21 If you want to break it down further, we
22 have done it by category, and this is all in your
23 handouts. But again I wanted to point out that the
24 big rocks, as we indicated earlier, and they really
25 weren't or didn't affect the questions posed to this

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1 group.

2 In other words, dental was not a big
3 disqualifier. EKG and cardiovascular was not a big
4 disqualifier.

5 Now, this is where our budget goes. That
6 \$20 million should be \$30 million, but we pay for the
7 consults that we get on these kids. So our current
8 budget to do this is \$30 million. Dr. Weien submitted
9 to you that getting a panograph at MTF was 3 to 4
10 dollars a pop.

11 I submit to you that getting it out in the
12 civilian community, which is what I would end up
13 having to do, would be significantly more than that.
14 So when you are looking at accession in standards
15 across the board, if you are going to include this
16 group of people, please bear in mind that I will be
17 getting that out in the civilian community.

18 And the transportation, because most of
19 these 65 MEPS are not co-located with military
20 treatment facilities. So, in terms of the EKG and
21 panorex -- and this is for us now. I am not speaking
22 about DoDMERB, the academies, the scholarship folks.

23 We recommend that there is no change to
24 the current practice, and not routinely doing either,
25 and we base it on the data that we get back from the

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1 training bases.

2 And our practice of not doing it has not
3 caused a problem, at least not that they notify us
4 about. And they do notify us, trust me. Every time
5 they think there is something that we could have or
6 should have caught, I get a call.

7 Now, the other one, the recommendation
8 about the lack of an accession physical is more
9 problematic. If we make the assumption that a full
10 physical is more comprehensive than a simple inspect,
11 where we ask an interval history, if you make that
12 assumption, the 5 year validity period will possibly
13 allow more with disqualifying defects in.

14 And what do I mean by that? Well, what I
15 mean is that if you don't see a kid for 5 years, and
16 then say, hey, did anything happen in the past 5
17 years?

18 Well, if you think you lose a college kid,
19 think about the kid who typically doesn't go to
20 college, and who is typically living on the streets,
21 who is from a lower socio-economic background, and who
22 may or may not have access to medical care, things may
23 have happened to him, and that in the short period of
24 time that we have to do an inspect or an interval
25 history, we may not catch.

1 So that is why we are thinking intuitively
2 that more defects may get through us. It won't save
3 us any work at all because we will have to do a
4 history or an inspect within 35 days prior to DEPing
5 anyhow. So it won't save us any effort or any work.

6 For us, this would be logistically
7 difficult. For us to keep records on all these kids
8 for 5 years, we are talking roughly 500,000 to 800,000
9 physicals that we have to keep on file somewhere,
10 because remember that a kid can go, let's say, to
11 Butte for his physical, and then when he wants to come
12 back in, he is in New Orleans, and they do that
13 frequently.

14 So it will be problematic for us, and then
15 the computer systems that we use, this is a technical
16 problem, and I understand that. We don't keep a
17 representation of a physical. We keep selected data.

18 So for us to keep the exact physical with
19 all the parameters will require some reworking for the
20 computer systems.

21 Another unintended consequence is that we
22 currently have a waiver for HIV testing. In other
23 words, if our kid DEPs and stays in the DEPs 2 years,
24 we don't retest because we have a waiver to allow
25 that.

1 If it goes to 5 years, that probably -- we
2 will not get that waiver again, and extend it to 5
3 years, more than likely. And we will have to retest
4 that individual.

5 So it will take an extra visit to come in
6 to see us, because then they won't be able to ship
7 right away. And currently the HIV is -- and depending
8 on which service -- valid for only 6 or 12 months.
9 Are there any questions?

10 LT. COL. RIDDLE: Actually, if we could
11 hold off for --

12 DR. ATKINS: Can I ask just a process
13 question?

14 LT. COL. RIDDLE: Yes.

15 DR. ATKINS: Is the fact that there are
16 different standards for DoDMERB and MEPCOM a problem?
17 I mean, are there --

18 LT. COL. RIDDLE: Well, there aren't
19 different standards. You have the DoDD and the DoDI.

20 So I think there is probably different interpretation
21 of the existing standards.

22 COL. LEE: Actually, I think the standards
23 are identical, but how we determine whether an
24 applicant meets or doesn't meet the standard is
25 different.

1 DR. ATKINS: Different procedures, I
2 guess. So is the current status where the procedures
3 are different, is that a viable option, or are we
4 being asked to move towards more uniformity, which
5 either involves reducing?

6 LT. COL. RIDDLE: Tim, do you want to
7 address that? I think that the directive really
8 states that the standards should be uniform across the
9 board. Part of the process that got these four
10 questions to the board was the recognition that we had
11 of discrepancies.

12 And do we need to eliminate these
13 discrepancies or should they be applied universally as
14 far as interpretation and utilization of the existing
15 standard.

16 DR. OSTROFF: Can I ask Colonel Lee one
17 question. If -- or at least ask the dentists a
18 question, and this may come up in the panopeg session.

19 If one of the concerns is that family physicians are
20 inadequately able to conduct dental examinations has
21 there been thought given at any time to have dentists
22 do them?

23 COL. LEE: We have thought about it. But
24 the question was are we inadequate to do the exam for
25 the purposes of the DODI. So we have asked the

1 training bases are we letting dental pathology that
2 you think we should catch slip through, and they have
3 not come on line and said yes.

4 There are certainly dental conditions that
5 go through, but as he indicated, they are usually
6 repaired at basic training or follow-on training, and
7 that applicant or recruit is then accessed to the
8 service.

9 If they didn't get it done at that point,
10 I am not sure that we would have an accession at all,
11 because are we asking that applicant to get his dental
12 care done at his own expense on the outside if we had
13 a dentist review that problem?

14 LT. COL. RIDDLE: And that's what is
15 happening with DoDMERB.

16 COL. LEE: That is what DoDMERB does, but
17 it doesn't happen with us.

18 LT. COL. RIDDLE: And you are actually
19 forcing that individual to have cavities filled, and -

20 -

21 ADM. HUFSTADER: I'm not the DoDMERB
22 dentist for sure, but I don't think that is done any
23 longer. I think that was a historic item.

24 COL. WEIEN: That was a historic item. In
25 the past, there were strongly worded remedials that

1 went out that sort of indicated that they should get
2 their teeth fixed before they sent them back in. That
3 is not being done any more.

4 We simply inform the applicants that they
5 are either qualified or disqualified. We do not
6 prescribe dental care or medical care, or any other
7 kind of care. We simply inform them if they meet or
8 failed to meet the standard, period.

9 DR. LANDRIGAN: Do you tell them what part
10 of the standard they do not meet?

11 COL. WEIEN: Yes. We will tell them that
12 they are disqualified for impacted wisdom teeth or
13 whatever.

14 LT. COL. RIDDLE: All right. Now we have
15 Colonel Margot R. Krauss.

16 DR. OSTROFF: Let Pierce ask his question.

17 DR. GARDNER: Yes. I am Pierce Gardner.
18 I was a little disappointed that we didn't hear more
19 quantitative data.

20 DR. OSTROFF: That's coming.

21 DR. GARDNER: Thank you.

22 LT. COL. RIDDLE: Actually, it is
23 interesting if you look back at the board history, and
24 these accession questions, I think there was a
25 recommendation from the board in 1983 for DoD to

1 establish an entity, such as AMSARA, to better look at
2 evidence-based decision with accession questions.

3 So the Board really had quite an impact
4 and a role in accession questions, and then these are
5 the first questions that come to the Board in some
6 time.

7 But Colonel Krauss from the Accession
8 Medical Standards Analysis and Research Activity up at
9 Walter Reed is really the entity to apply evidence to
10 the decision making process, and that is what she is
11 going to present for us. Colonel Krauss.

12 COL. KRAUSS: That is my title slide, and
13 I have already been introduced. Today, I will be
14 presenting some data that is relevant to the screen
15 for cardiac blood and dental conditions.

16 And you have already heard that this is
17 quite a complicated process, and I will try to explain
18 the data as I go through it. But please feel free to
19 raise your hand and ask for clarification if I lose
20 you anywhere along the way.

21 Historically, you have already heard that
22 the accession standards have been based on expert
23 opinion, and not on consistently collected and
24 analyzed epidemiological data.

25 The goal of AMSARA is actually to do just

1 that, is to develop those evidence-based accession
2 standards. Clearly to do this, we need to guide the
3 improvement of the medical and the administrative
4 databases.

5 You have heard a little bit about that
6 already in the briefings just before me, and that is
7 where a lot of our emphasis has been in the last 5
8 years, particularly on the enlisted side.

9 In addition, we conduct epidemiological
10 analysis with a military relevant end point in mind,
11 and try to integrate into the policy recommendations
12 the relevant clinical, economic, and operational
13 considerations.

14 You have already heard that we were
15 established in 1996 within the Division of Preventive
16 Medicine at Walter Reed Army Institute of Research,
17 and we serve in direct support of the AMSWG, or the
18 Accession Medical Standards Working Group, which
19 Colonel Corcoran already briefed you on.

20 The first slide here is to try to orient
21 you to the enlisted accession process as I see it from
22 a data perspective. So of the over 220,000 physical
23 exams performed at MEPS across 65 MEPS stations in the
24 United States every year, approximately 14 percent
25 receive disqualifications.

1 And as you heard not all disqualifications
2 means that you cannot enter a military service. In
3 fact, you are able to ask for a waiver for any
4 disqualification that you get upon physical exam. Of
5 those individuals who ask for waivers for their
6 disqualifications, 50 percent receive the waivers.

7 And that is across all conditions, and
8 obviously it varies by the disqualification that we
9 are talking about. So individuals are waived and
10 enter active service.

11 If you look at the entire group of
12 individuals coming in as enlistees or recruits at the
13 reception stations across all of our three services or
14 four services, about two percent enter with a waiver.

15 And a majority of individuals entering
16 active service do not have a waiver. Individuals then
17 from the reception station, and basic training, and
18 through advanced individual training, can certainly
19 attrit or leave the service for a variety of reasons.

20 We are interested more in the medical
21 reasons, and that is five percent that will leave
22 because of existing prior to service discharge, or
23 what we call EPTS.

24 Now, among those individuals who EPTS --
25 and in theory, these are conditions that we hope that

1 the MEPS physicians would have detected. But the
2 reality is that over 70 percent of these individuals
3 have concealed their condition, and they acknowledge
4 that when they leave basic training.

5 The other 30 percent, perhaps these
6 individuals didn't know that they had this condition,
7 such as unrecognized asthma, and things that they
8 didn't really understand when they went to the MEPS
9 physicians.

10 So really the data that I am going to be
11 sharing on the enlisted side today will be the
12 existing prior to service discharge data. Let's try
13 to keep that in perspective.

14 Now, I have tried to create a similar
15 schematic for the officer accessions, but you can see
16 that it is a little bit confusing. Believe me, this
17 is simplistic, and I see acknowledgement from DoDMERB.

18 So I am going to try and walk you through
19 this and certainly I can be corrected by the DoDMERB
20 representatives in the room. AMSARA just recently
21 received DoDMERB data. So we don't have a lot of
22 familiarity with this data, but this is my
23 understanding.

24 We have applicants to five service
25 academies, and this is the way that I got the data

1 from DoDMERB. It is labeled academies, CSB --
 2 Candidate Service Branch, or ROTC. These two
 3 apparently are both considered ROTC programs.

4 But we have five service academies, and we
 5 have the three service ROTC programs. But we have 2
 6 year, 3 year, and 4 year scholarships for ROTC. We
 7 also have non-scholarship ROTC. So a lot of different
 8 applicants, and certainly an individual can apply to
 9 several programs.

10 Today what I have done is just look at
 11 individuals. I don't care which program they are
 12 applying to. I just count them individually. So, one
 13 individual could have five applications. I dismissed
 14 with that.

15 But I have approximately 30,000 applicants
 16 to any of these programs every year from DoDMERB.
 17 Now, you will see missing the USUHS data. Actually, I
 18 didn't ask for that data. I didn't know that I was
 19 going to be doing this briefing, and so that is
 20 missing.

21 Now, these individuals have their physical
 22 exams done all over the country, and mailed into
 23 DoDMERB. DoDMERB reviews this information, and finds
 24 that there may be adequate information to disqualify
 25 those individuals.

1 This is the data that I have available,
 2 and I will be presenting this morning. I left one
 3 little thing off this slide, which I wish was here
 4 right now, but DoDMERB has something called remedials,
 5 and which was referred to earlier.

6 That would come in right here, and the
 7 remedials is really an administrative action. They
 8 may get a physical exam and it is missing the EKG.
 9 Well, that is a remedial. It must go back and the
 10 applicant must have their EKG.

11 Likewise, the remedial might be for an
 12 abnormal EKG, but we now need a cardiology consult.
 13 So again that information goes back to the applicant,
 14 and they must get the cardiology consult, and come
 15 back to DoDMERB.

16 Once the remedial is finished, it could
 17 result in a fully qualified applicant, which then
 18 could go to the academies, the CSB, or ROTC programs,
 19 or it could then again end up in a permanent
 20 disqualification.

21 All applicants who are disqualified may
 22 ask for a waiver, and the waiver authorities are again
 23 the five academies or the three ROTC programs. So we
 24 are dealing with five waiver authorities, and they
 25 will waive different conditions depending on the

1 service, and the academy, and the program.

2 Then those individuals waived can start
3 these programs. So for the first three questions I
4 was asked, I will be relying heavily on this
5 disqualification data, and also the remedial data,
6 which is somewhere in here.

7 For the fourth question, we are really
8 looking at this other facet which you don't see in the
9 enlisted side of the house. These accession physical
10 exams are done for the program, for entry into the
11 program, but as they are facing graduation, they must
12 have a pre-commissioning physical exam.

13 These individuals again can be
14 disqualified, and those disqualifications can be
15 waived, and then they can enter active service. We
16 have essentially no data over here, and I will comment
17 on that when we get to the fourth question.

18 So to put it in perspective, these are the
19 data sources that we access to try to answer questions
20 or do epidemiological analysis. Traditionally, most
21 of our analyses have been disease specific.

22 This morning, you will not see detailed
23 analysis. You will see more raw data that is
24 available on these issues. But we have over 18 data
25 sources that we interact with.

1 And anyone who has worked with databases
2 knows that all databases have their faults, and we are
3 trying to link all these multiple databases that are
4 basically used for administrative reasons. But there
5 are certainly some medical databases that we access.

6 So for the enlisted side, we have a fairly
7 good handle on the data, and we have been working with
8 it for over five years. And this morning I will be
9 focusing on these existing prior to service discharge,
10 which should represent individuals who are unable to
11 complete basic training because they have a serious
12 medical problem.

13 On the officer side, I really have the
14 DoDMERB data. Now, I put it down as 12 different
15 programs, and it depends on how you count these
16 things. But each program has their own nuances. I
17 have over 60,000 individual applicants for the two
18 school years of '99 and 2000.

19 The disqualifications are coded by the
20 DoDMERB reviewers, which I think as you have already
21 heard, they are very consistent with their
22 disqualification coding, and they code by specific
23 disease conditions, which is very helpful,
24 particularly as we try to address the issues posed to
25 the Board this morning. There is a lot of data that

1 we don't have.

2 DR. OSTROFF: Can I interrupt?

3 COL. KRAUSS: Sure.

4 DR. OSTROFF: Is a code a single disease
5 condition or multiple disease conditions?

6 COL. KRAUSS: These are mostly single
7 disease conditions. It is ICD-9 coding, but we will
8 talk about some of the problems with that also. This
9 is all the data, and I still need really to get a
10 handle on if you are disqualified, then how likely is
11 it that you are going to get a waiver from the service
12 academy or the ROTC programs.

13 I do not know who actually started each
14 program. Remember, we have a lot of applicants, and
15 many are fully qualified, but then they decide that
16 they don't want to go to the service academy, and then
17 go to some civilian program. Well, we don't have that
18 data available.

19 So we are looking very up front at the
20 applicants and what happens on disqualifications. So
21 I will start with the evidence of the ECG, and again I
22 paraphrased this question. It actually was asked is
23 there any literature available.

24 I believe the board members all were
25 supplied with some abstracts on this very issue. As I

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1 did a separate literature search, I certainly didn't
2 see any literature supporting routine ECGs among
3 asymptomatic individuals with no history or negative
4 cardiac history.

5 Okay. The current practice for DoDMERB is
6 they do require ECGs for the majority of programs, but
7 not for their non-scholarship ROTC programs. So there
8 is some other data in there which I will not be using
9 and will not present it. MEPS, of course, does not
10 require an ECG.

11 I am first focusing on the remedials which
12 I mentioned previously as more of an administrative
13 action taken by DoDMERB. The first one up here means
14 that these individuals had an application that was
15 missing their ECG.

16 So this 379 individuals had to go back and
17 get an ECG over this two year period. These two
18 clearly -- it looks like the ECG was abnormal. I
19 don't know what the abnormality was.

20 But based on that, they had to go get an
21 additional evaluation from a cardiologist or internal
22 medicine. I am not sure what this is, but that is the
23 code that I got from DoDMERB.

24 I didn't think having a heart rate greater
25 than 80 was that bad, and so I can't really explain

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1 that one, but it is not a lot of people.

2 ADM. HUFSTADER: Beats per minute.

3 COL. KRAUSS: Yeah, but right now mine is
4 higher than that, but I don't know. So what I did
5 next was I looked at the remedials and how well did
6 they correlate with final disqualification.

7 DR. GARDNER: Well, what is the "n" here,
8 is it 60,000?

9 COL. KRAUSS: This is 60,000 applicants
10 over a two year period. So if I looked at all the
11 remedials, how many actually ended up with a
12 disqualification? I mean, was there any match.

13 And I found three individuals that did
14 match. They had a disqualification, and they were
15 coded as miscellaneous, and so I still don't know what
16 they were.

17 But there were other people who were
18 disqualified and that did not need remedials.
19 Probably their application was complete, and some
20 actually did a very good job and submitted it to
21 DoDMERB.

22 And here we see very few individuals with
23 ICD-9 coded conditions, and there are a lot of
24 miscellaneous. Again, I don't know what those are,
25 but from my analysis, I actually assumed that they

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1 were all disqualifications identified only on ECGs.

2 DR. SHANAHAN: May I interrupt for a
3 second?

4 COL. KRAUSS: Sure.

5 DR. SHANAHAN: The first line with
6 abnormal ECG, is that an "Other" there?

7 COL. KRAUSS: That is exact DoDMERB
8 coding.

9 DR. SHANAHAN: Well, am I to understand
10 that obviously the underlined ones are specific ECG
11 diagnoses?

12 COL. KRAUSS: Right.

13 DR. SHANAHAN: So, abnormal would be
14 apparently something --

15 COL. KRAUSS: Other.

16 DR. SHANAHAN: Do you know that, Bob? Is
17 that what it is?

18 COL. WEIEN: We have had -- we are
19 revising our coding system right now, but in the past
20 we had this sort of obscure coding system that sort of
21 developed on its own.

22 And, yeah, we did have codes for generic
23 abnormal ECGs, and we also had codes for specific
24 things, like WPW and right bundle branch block. And
25 the people that applied these codes in the past

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1 sometimes did so inconsistently, which of course
2 corrupted our data.

3 But that's how -- a number of people as
4 you can see, instead of searching for the right code,
5 they just went boom, miscellaneous cardiac DQ. So
6 that is the limitation of our data.

7 DR. SHANAHAN: Okay. Thanks.

8 DR. HAYWOOD: It would be very unusual to
9 have zero abnormalities if that is used as a general
10 rule.

11 COL. KRAUSS: Right. So to try to
12 estimate how many we really have disqualified by ECG
13 is really an educated guess. What I consider was a
14 high estimate of disqualifications identified by ECG
15 was .2 percent of all applicants.

16 So that is the 132 that you just saw on
17 the last slide, and that is including the
18 miscellaneous category, over the total number of
19 62,000 applicants over the two year period.

20 So I am assuming that all of these
21 miscellaneous DQs were detected by ECG alone, and that
22 all of these individuals had a negative history, which
23 I do not know. On the low end would be if I only took
24 those six with clearly identifiable conditions only
25 identified by ECG, like the right bundle branch block.

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1 This probably is a very low estimate, and
2 I am assuming that all of the miscellaneous
3 disqualifications were not related to ECG, and I don't
4 really know. But that gives a range of
5 disqualifications that would potentially be
6 identifiable by ECG.

7 So what is the impact of screening ECG?

8 The best that I can determine is that about .9 percent
9 of all applicants had to do additional work because of
10 this requirement.

11 Some of this means that they just had to
12 go get an ECG, and some of them had to go see a
13 cardiologist or an internal medicine physician for
14 further evaluation.

15 Clearly, 126 did have an abnormal ECG, and
16 it could have been more, but we don't have the data.
17 The data is not available for that. So the range that
18 I found was somewhere between .01 percent and .2
19 percent had or potentially had an ECG related
20 disqualification.

21 What we don't know is how many had a
22 negative cardiac history, and how many of those with
23 disqualifications could actually receive a waiver and
24 still come into a program. Yes?

25 DR. ZIMBLE: There is one other thing that

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1 you don't know. Of those that had a disqualification,
2 how many of them might have served a full term without
3 any problems.

4 COL. KRAUSS: Correct.

5 DR. ZIMBLE: So you don't have any health
6 -- you don't know what the potential attrition is
7 going to be for those people who were disqualified.

8 COL. KRAUSS: Yes. Correct. All the
9 officer data that I have is very up front, and is in
10 the application process when they first come to
11 DoDMERB.

12 And as you saw, the whole schematic, there
13 is a lot more afterwards; how they do during their
14 service academy; and how they do in the ROTC program;
15 and how do they do in their precommissioning exam; and
16 what happens when they actually get on active duty.
17 That is at least four years past the data that I am
18 presenting. Yes?

19 DR. OSTROFF: Can I interrupt for a
20 second. I wonder if Colonel Weien could speak to the
21 fact if he has any concept at all of these 126 that
22 were disqualified based on some cardiac problem, and
23 if you have any idea how many of them were based
24 solely on a EKG or ECG.

25 COL. WEIEN: We did a -- we looked at a

1 subset of that miscellaneous DQ category. Larry, what
2 was it, about 80 that we reviewed? And out of that
3 group, as I remember it, about 90 percent were
4 actually cardiac.

5 And I am not certain what percentage of
6 those were solely detected on the EKG, and how many
7 were detected on history. A couple of those
8 psychiatric diagnoses. So, clearly that code had been
9 misapplied to these. So clearly the DoDMERB data had
10 some problems.

11 MR. MULLEN: To answer your question
12 specifically, there has rarely been a case when
13 someone gets an abnormal EKG and it is disqualified,
14 period.

15 They are normally going to ask for medical
16 records or cardiac consult, or whatever, to confirm
17 it. So I suspect going back to that original slide,
18 where it said zero for abnormal EKG, that is what it
19 actually referred to. No one was disqualified just
20 because they presented with that.

21 COL. WEIEN: And in fact in the year that
22 I have been at DoDMERB, I have never disqualified
23 someone solely on the basis of the EKG. I have always
24 asked for a further work up if that is the intent of
25 your question.

1 DR. LANDRIGAN: Are those 126 applicants
2 available to your folks so they could be reexamined
3 and recoded at this point?

4 COL. WEIEN: Yes. If they are year 1999
5 or 2000, yes, they are.

6 DR. LANDRIGAN: Thanks.

7 COL. KRAUSS: Remember that of those 126,
8 only three actually came up with a final
9 disqualification. So after further consultation or a
10 review of medical records, it was felt not to be a
11 disqualifying condition.

12 So this is not a cost benefit analysis,
13 and nothing close to it. I used the cost performing
14 of the ECG based I think on data from Health Affairs,
15 or maybe it was DoDMERB. I am not sure of the source
16 of this number, but it wasn't my number.

17 And depending on which disqualification
18 rate you want to use, it costs anywhere from \$34,000
19 to \$750,000 to identify one disqualifying condition
20 among these applicants.

21 And again we don't know if these
22 individuals could have had this disqualifying
23 condition waived and still entered active service. I
24 think another cost that needs to be considered, which
25 I couldn't even take a stab at, was all these

1 remedials.

2 An applicant may well have not completed
3 their application because of the ECG or remedial
4 requirement. Other things could have happened in the
5 meanwhile because it is a lot of work to communicate
6 with the applicants.

7 And they may have just dropped the whole
8 process. There is also the cost of additional
9 consults that should be considered.

10 DR. HAYWOOD: And your cost estimates for
11 EKG is about at least three times too large.

12 COL. KRAUSS: Yes. This is provided by
13 Health Affairs. I took it off the tasker.

14 COL. CORCORAN: It was actually DoDMERB
15 data.

16 COL. KRAUSS: Oh, DoDMERB data. Okay. So
17 this may be the cost to DoDMERB, because of course
18 they are going out to the civilian sector.

19 MR. MULLEN: And that would be a
20 discounted rate because we have high volume with our
21 contract. So that is what we went for, as opposed to
22 an individual going downtown and getting an EKG would
23 obviously be a lot higher. We get a discounted rate.

24 DR. HAYWOOD: That is not a discounted
25 rate. HCFA is not going to give you that kind of

1 rate.

2 COL. CORCORAN: That's what they pay.

3 COL. KRAUSS: So that is what DoDMERB
4 pays, and we are probably being charged too much. But
5 that would be a real change wouldn't it? All right.

6 So what I did from here was to ask the question what
7 happens if you -- to a cohort of unscreened young
8 individuals, and about the same age as the applicants
9 to the officer programs.

10 These individuals -- well, the worst thing
11 that could happen is that they could drop dead. That
12 was mentioned, but it is not on this slide. But we
13 are always concerned that at recruit training that
14 people would drop over from a cardiac reason.

15 This is a little difficult to look at
16 because we don't do EKGs in this recruit population.
17 We do have sudden deaths during basic training. I
18 looked at the data from the mortality registry, and
19 the range of this occurrence -- all deaths -- in basic
20 training ranges from 1 to 4.9 per hundred-thousand
21 accessions every year.

22 And that depends on the service and the
23 gender that you are looking at. Among all those
24 deaths, which actually is a relatively few deaths, a
25 very few have been attributed solely to cardiac

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1 reasons.

2 So the major -- I mean, mortality
3 obviously is a very serious issue. But a lot of those
4 are suicides, and MVAs, other issues. Dr. Gardner
5 could probably give you more data.

6 But very few appeared to be solely coded
7 cardiac, and there is on data to suggest that a
8 screening ECG would have detected the cause of that
9 sudden death.

10 But other things that could happen more
11 likely is that an individual could be hospitalized for
12 a cardiac related condition. Again, it would be
13 difficult to determine whether the condition would
14 have been identified by a screening ECG.

15 but if they have preexisting cardiac
16 conditions, they should have received it prior to
17 discharge within the first six months of service. So
18 that's why I chose to look at EPTS conditions among
19 active duty enlisted personnel.

20 I have used a 3 year time period, and we
21 are looking at -- and again enlisted accessions is --
22 the magnitude is greater than officer accessions.
23 There are approximately 120,000 enlisted accessions
24 into active duty service every year.

25 So of that, we have -- and these are ICD-9

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1 codes, and which we now code in AMSARA for all
2 existing prior to service discharges. And I decided
3 that these were all potentially detectable by a
4 screening ECG.

5 And what you would see is that some of
6 these may not be detected, but I am assuming that all
7 of them would have been detected. So looking at this
8 over a three year period, we found that .05 percent of
9 all enlisted active duty recruits were discharged with
10 a cardiac diagnosis that may have been detectable by a
11 screening ECG.

12 It is very likely that these recruits were
13 symptomatic at the time of diagnosis, or they had been
14 hospitalized for their cardiac condition, and that is
15 why they were discharged from military service.

16 This particular estimate is actually
17 intermediate to the estimate that I came up with
18 looking at officer data. Now, certainly if we
19 screened all the enlisted personnel with ECG, we would
20 have found a lot more abnormalities.

21 But there is no data that really suggests
22 that that would have precluded entry on to active
23 service. Now I am going to jump to the next question,
24 which --

25 DR. OSTROFF: And before you do that, are

1 there any questions?

2 DR. CAMPBELL: I have a question. Have
3 you figured out the cost that was incurred to the
4 military of those people who were discharged that
5 would have been saved if they had not been admitted
6 into the military?

7 COL. KRAUSS: Well, there is no real data
8 that it would have saved them or would have prevented
9 them from entry. We could use the GAO report on how
10 much it costs to get someone to do a physical exam,
11 screen them, and get them to basic training.

12 And the GAO estimate that Colonel Corcoran
13 used was about \$35,000. But that actually includes
14 costs all the way through to the end of basic
15 training. But in the scale of things -- let's see how
16 many people I had.

17 For over 205 people over three years was a
18 relatively smaller number of people to lose. EPTS
19 conditions are much more common for a preexisting
20 mental health conditions, orthopedic conditions, and
21 asthma.

22 And cardiac conditions really don't reach
23 the level of concern for existing prior to service
24 discharges. So, relatively, a very small number of
25 individuals are leaving.

1 That is less than about seven people a
2 year, and again I am not quite clear whether a
3 screening ECG would have detected it in the first
4 place. So I will go on to hemoglobin.

5 We are know that under current practice
6 DoDMERB screens and MEPS does not. And I would
7 present that kind of in the same framework. In the
8 remedials generated by the requirement for hemoglobin
9 and hematocrit, it appears that a certain number of
10 applicants I guess never received the screening test.

11 So there is a remedial generated for
12 getting this blood test, and then some of these blood
13 tests probably were low, and the physician asked for a
14 repeat. And those are the only remedial codes that I
15 have from DoDMERB.

16 Then we look at disqualifications for
17 blood related conditions. We have anemia, and then
18 hematocrit below standards, and then that
19 miscellaneous category, just for a total of 86
20 disqualifications for potentially related to the
21 screening hemoglobin requirement.

22 So this requirement actually generates
23 about 1.2 percent of all applicants that have
24 remedials for this requirement, resulting in only one
25 miscellaneous DQ for a blood disease, unspecified.

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1 Overall, .1 percent of applicants are DQ'd
2 for some kind of hematocrit related finding. Again, I
3 do not know how many were waived for this
4 disqualifying condition. Likely, most of these are
5 iron deficiency anemia, which is easily treatable.
6 And these individuals may well have come on active
7 service afterwards.

8 The cost is probably almost a hundred-
9 thousand per disqualification identified. Again, I am
10 basing this on DoDMERB costs of a hemoglobin and
11 hematocrit of \$24. That is DoDMERB costs. I didn't
12 make those up.

13 Some of the remedials generated. Again, I
14 have no idea how much impact these remedials are.
15 Certainly having a hemoglobin is not a major cost in
16 my mind, but certainly remedials delay the application
17 process, and could cause some applicants to be lost in
18 the entire process. We could be losing quality
19 applicants because of this requirement.

20 So again I ask the question what happens
21 if we don't screen and we look on the enlisted side of
22 the house. You can be hospitalized certainly for some
23 anemia type condition, and if this is identified in
24 the first six months of service, you would receive an
25 existing prior to service discharge if the anemia

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1 cannot be corrected.

2 So you will not see discharges for iron
3 deficiency anemia because that is certainly easily
4 correctable. We have any hereditary anemias being the
5 most likely cause of early discharge from among
6 enlisted personnel.

7 And then we have mostly then unspecified
8 anemia. The majority of this hereditary anemia is
9 sickle cell anemia, and we do not screen for sickle
10 cell.

11 COL. DINIEGA: You don't?

12 COL. KRAUSS: So we have 0.5 percent. The
13 sickle cell screening is done at basic training and
14 not at the accession process. Sorry. Remember that
15 this is at the MEPS level.

16 At the MEPS station, there is no screening
17 for sickle cell. Once they go to the Navy, the Coast
18 Guard, Air Force, and I think now the Army, they will
19 be screening for sickle cell. But that is not done at
20 the MEPS.

21 So these individuals, 190 individuals have
22 been discharged over the three year period with a
23 diagnosis that may be detectable with a screened
24 hemoglobin. Not necessarily so. Most of this is
25 sickle cell as I already mentioned.

1 Certainly if we screened all enlisted
2 applicants, we would find a lot of iron deficiency
3 anemia, since that is extremely common among women,
4 and probably sickle cell anemia is a larger issue than
5 iron deficiency anemia.

6 Now I will take on --are you ready for the
7 next one? Okay.

8 DR. OSTROFF: Any questions about the
9 hemoglobin issue?

10 DR. HAYWOOD: Just a comment. Hemoglobin
11 traits does not produce anemia. So it would not be
12 detected at the screening anyway.

13 COL. KRAUSS: Right. But those discharges
14 were sickle cell anemia. They were not sickle cell
15 traits.

16 DR. HAYWOOD: Right.

17 COL. KRAUSS: I reviewed all EPTS
18 conditions for the code for sickle cell trait and
19 sickle cell anemia, and I found all of them to be
20 sickle cell anemia. Trait is a different issue. Each
21 service handles trait in a different manner. Yes?

22 DR. CAMPBELL: If sickle cell anemia were
23 picked up at screening prior to accession would that
24 be a disqualifying factor?

25 COL. KRAUSS: That would be permanently

1 disqualifying.

2 DR. GARDNER: Was there any attempt to
3 grade the level of anemia? If these are marginal
4 hemoglobins, there is technical reasons that can
5 happen, and there is a big difference between a
6 marginal one and one that is half-normal, or something
7 like that.

8 COL. KRAUSS: Well, on the enlisted side,
9 those individuals receiving existing prior to service
10 discharge would have had significant anemia, because
11 certainly we would not let someone out of their
12 obligation for a marginally low hematocrit.

13 That certainly does not interfere with
14 your ability to do our job. On the enlisted side, I
15 can't interpret the data any more than the codes that
16 were provided to me, and I would assume there also
17 since we have physicians reviewing all of those
18 applications that they would not disqualify someone
19 for a marginally hematocrit.

20 DR. GARDNER: What were your definitions
21 of what was the acceptable hemoglobin/Hematocrit?

22 COL. KRAUSS: That would be the DoDMERB
23 standard. It would not be my standard.

24 DR. GARDNER: What is it? Do you know?

25 COL. WEIEN: I believe that the male

1 standard is 11.7 and the female standard is 10.4 lower
2 limit of normal for hemoglobin.

3 COL. KRAUSS: The question as I understand
4 it was really the discrepancy of the scholarship
5 applicant meeting the dental professional using bite
6 wings or panographs to accomplish the screening.

7 Whereas, those certainly -- certainly the
8 enlisted applicants do not get those similar type
9 screens, and certainly the non-scholarship ROTC
10 applicants, and the HPSP also do not get the same
11 dental screen.

12 Colonel Corcoran highlights that there
13 were many issues revolving around this question and I
14 will try to focus on the data that I have available.
15 So the current practice, I think you already have a
16 good understanding of that.

17 And here are the remedials that I have
18 received. This is the DoDMERB data for these two
19 years. The first several appear that the applicants
20 needed the panographs or the bite wings, or they had
21 not had the dental officer review that was a
22 requirement.

23 And that is by far the majority of the
24 remedials generated due to this screening requirement.

25 I felt that perhaps a physician would be able to tell

1 if someone had braces on, and could request -- well, I
2 don't want to go too far.

3 So what I did was that I voted for the
4 ones that I felt that only a dentist could really
5 address and could truly provide the disqualifications.

6 And certainly our standards are a little bit
7 different, but the quality of the non-restorable
8 teeth, or the periodontal disease, the caries, the
9 oral surgeon evaluation, and all miscellaneous,
10 probably would -- that these would have been remedials
11 that might have resulted in DQ.

12 I have heard in the past that these
13 disqualifications were fixed prior to the final
14 determination and disqualification, if that makes any
15 sense.

16 I have heard that the process has now
17 changed, and that DoDMERB is now keeping track of
18 these disqualifications, rather than fixing them prior
19 to telling the applicant whether they are
20 disqualified.

21 So for this analysis, I have actually
22 considered that all these individuals would have
23 received disqualifications.

24 DR. OSTROFF: Can I just comment, and not
25 to offend my dental colleagues at all, but I think I

1 as a physician probably would have noticed missing
2 teeth.

3 COL. KRAUSS: I guess the problem is how
4 many are allowed to be missing, and how many teeth do
5 you really need.

6 CPT. MCKINLEY: I can take a shot at that.
7 Two things. Sure you can see an orthodontic
8 appliance. That is not the issue. Anybody can see
9 that.

10 The issue is the extent of treatment, and
11 how long it is going to take, and how complicated it
12 is, can it be discontinued or put in retention, on
13 hold through boot camp, et cetera.

14 And is there an orthodontist at the
15 receiving site to carry on the treatment. I can tell
16 you that at most places there aren't. So it is more
17 complicated than just are there braces there.

18 On the missing teeth issue, prosthodontics
19 is an mechanical/biological replacement of these
20 teeth, and it can be complicated. And it is not the
21 number of teeth.

22 But rather it's how difficult and how
23 possible it is to replace those teeth, including
24 implants. And so these are the issues that are
25 evaluated, and not just the number of teeth.

1 COL. LEE: Margot?

2 COL. KRAUSS: Yes.

3 COL. LEE: Just from our point of view,
4 the MEPS point of view, when we look at whether or not
5 they have had braces or not, if they have braces, it
6 is disqualifying.

7 If they have had orthopedic appliances, we
8 require a note from their dentist that treatment has
9 been terminated and they should be able to go through
10 basic training. I wanted to point that out.

11 In terms of the number of teeth, quite
12 frankly what we look at is whether the kid is robust,
13 as opposed to malnourished. Can he chew. I mean, we
14 try and do it from a practical point of view.

15 So notwithstanding that all these points
16 are valid, we try and take the practical point of view
17 and say has he been eating, and is he eating, and will
18 he eat, and can he eat an MRE. And if the answer is
19 yes, then we process them on.

20 COL. KRAUSS: This is a little bit
21 challenging. On this, I think you just heard Colonel
22 Lee say that these would automatically be
23 disqualifications. So a separate dental review is
24 probably not needed to disqualify an applicant just
25 based on this alone.

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1 But in my opinion a dentist was required
2 to make these disqualifications, and that's how I
3 chose to say that these are the amount of
4 disqualifications generated because of this
5 requirement for dental review.

6 Now, this is the actual data that I
7 received on dental disqualifications from DoDMERB.
8 Again, I felt that these were the ones that a dentist
9 would really have to determine, and this was the final
10 permanent disqualifications that I received in the
11 DoDMERB data.

12 Now, I have talked to the DoDMERB dentist,
13 and he said that there was actually 40 here instead of
14 24.

15 COL. DUNN: Yes. I wanted to point out
16 that that was the period of time in which we were
17 actually prescribing dental care.

18 COL. KRAUSS: Right.

19 COL. DUNN: And many of the cases during
20 that period were placed in remedial status tog et
21 their teeth fixed, and then they would come back
22 fixed, and show up as qualifications.

23 And only the people that sort of said, no,
24 I'm sorry, I refuse to get my teeth fixed ended up as
25 dental Dqs. So I think your numbers, in terms of

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1 potential Dqs, is artificially low because of a
2 previous policy that is no longer enforced.

3 COL. KRAUSS: Well, correct me if I am
4 wrong, but that's why I am using this number as
5 disqualifications. I am counting all remedials
6 requested from whoever, because I can't necessarily
7 say.

8 But I would think that these were all
9 remedials requested by the dentist, and I am saying
10 that they would all be disqualifications, okay? This
11 is actually is what is in the database. So this is
12 really the low number.

13 So I think this is probably a little bit
14 high, because I am not sure that all the dental
15 remedials would have been disqualified. But I am
16 saying that they all would have been, because I would
17 want to give a fair estimate.

18 So, 726 individuals would have been
19 disqualified for some dental reason based either on
20 panographs, bite wings, or the dental review. So that
21 is 1.2 percent of all applicants to officer programs.

22 The low estimate, I already think that
23 this is incorrect. We have already been told by
24 DoDMERB that many of these Dqs are fixed prior to the
25 disqualification coding. So this we know is

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1 artificially low. I think this is a better number.

2 So the impact of screening. A large
3 number of remedials are generated. Actually, 3
4 percent of all applicants with a final
5 disqualification really apply to 1.2 percent of
6 applicants being on the high side.

7 I think a major issue to consider is how
8 many of these applicants stop the application process
9 because of the dental remedials, or the need to fix
10 dental problems.

11 My concern here is that some of these
12 applicants are trying to get into the academies or the
13 ROTC programs may not be from socially advantaged
14 families, and may not be able to afford getting their
15 teeth fixed.

16 So this may actually be a discriminatory
17 practice to have this requirement for these young
18 kids. We don't know anything about the waivers for
19 certain dental conditions, and whether these
20 individuals could have started the program for which
21 they applied.

22 So it is very crude costs of identifying
23 these disqualifications, and it is probably closer to
24 about \$8,000, but maybe up to \$237,000 for every
25 disqualification found. This is a DoDMERB cost for

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1 getting a dental review, panograph, and bite wings on
2 these applicants.

3 And back to these remedials that were
4 generated, and to worry about the real costs of lost
5 applicants, and how many really had significant dental
6 problems, and what kind of repair costs do these
7 applicants face.

8 So what happens if we don't screen, which
9 is what we have been doing on the enlisted side for
10 years. They can certainly get existing prior to
11 service discharges, and this would only happen if the
12 condition was felt to be not fixable, or interfering
13 to such a great extent with their ability to perform
14 their duties that they had to be let go.

15 These numbers are actually -- I found out
16 last night that these are all actually high. Some of
17 my people are double-counted, and this true number is
18 half of what you see.

19 That aside, this I felt was something that
20 you would only identify through panograph or bite
21 wings. This also I think probably requires a dentist,
22 because we have various approaches to how many teeth
23 we think we need to have, and certainly also
24 malocclusion.

25 Actually, I considered all of these

1 requiring dentists to determine these conditions and
2 the seriousness of these conditions, but my number is
3 artificially high here.

4 So over the three year period, I felt that
5 probably .02 percent were discharged with a dental
6 diagnosis that may have been detectable by a dental
7 review.

8 Most of these recruits were likely
9 symptomatic at diagnosis. I will take that away
10 because I figured that maybe the dentist would have
11 identified all TMJs if they were able to see the
12 individuals.

13 But this number actually stands, and that
14 is based on my not getting the data quite right in the
15 last slide. Certainly if we had looked at all
16 enlisted accessions that we would have found a lot
17 more dental conditions, but it looks certainly from
18 the enlisted side that most of these dental conditions
19 are fixed at basic training and the recruit is able to
20 finish basic and go on to active duty.

21 The last question is dealing with physical
22 exams, and the period, the interim period required
23 from inspection versus a full physical exam.
24 Unfortunately, we really don't have data available on
25 this.

1 This is my only slide addressing this
2 question, and I got this data from Colonel Dunn based
3 on the 2001 Army ROTC camp at Fort Lewis. During that
4 ROTC camp, we had 246 disqualifications. So, 6.2
5 percent of all these cadets were disqualified.

6 The fact is that most of these were
7 waived. Only 20 individuals had a permanent
8 disqualification, meaning that they had to leave the
9 program. They were not commissioned. And 17 of these
10 were identified by history and three by physical exam.

11 But that is all the data that I have. I
12 don't have their initial accession physical exam. I
13 can't compare what was found on the initial to this
14 second pre-commissioning exam.

15 We have 2 to 4 year ROTC scholarships
16 involved in this camp. So I am dealing with accession
17 exams that could be 1 to 4 years prior to this exam
18 right here. So the data is really not too clear on
19 this issue.

20 DR. BERG: What is the denominator for
21 that last slide?

22 COL. KRAUSS: There were 4,000 cadets.

23 DR. BERG: Okay. Thank you.

24 DR. ATKINS: Do you have any information
25 on what those diagnoses were by exam?

1 COL. KRAUSS: Actually, I do know that for
2 these 20 permanent -- let's see if I can remember.

3 COL. DUNN: On the three -- good morning.

4 I am Colonel Dunn, the Cadet Command Surgeon at Fort
5 Monroe. On the three that were permanently
6 disqualified based on exam, two were heart murmurs,
7 which were evaluated by cardiologists for bicuspid
8 valve; and one was for keratitis, which is an eye
9 condition which was not previously identified on the
10 initial accession exam.

11 COL. KRAUSS: Colonel Dunn is the one who
12 gave me the data. And I really don't think I should
13 even go this far. I would rather just ignore this,
14 but certainly I think we need more data to really look
15 at the interval for physical exams, and what was found
16 on the pre-accession physical exam, versus the pre-
17 commissioning exam.

18 Certainly the data that I am using today
19 has limitations, and I think you have already heard
20 several of them, particularly from DoDMERB. Their
21 databases seem to be lacking some of the information,
22 particularly on the dental questions, that they would
23 like to see.

24 This is mostly administrative data, with
25 some medical data available to us. The assumptions

1 that I have used this morning may not hold true. I
 2 have tried to assume on the side of disqualifications
 3 being the result of a screening test, but as you all
 4 know, that may not be true.

5 A lot of these disqualifications may be
 6 based on history alone or physical findings. I do not
 7 have that data available. And the bottom line here is
 8 disqualification does not mean that an applicant
 9 cannot come into a program.

10 Many disqualifications are waived and the
 11 applicant comes on the program, and really need to
 12 look further at that to evaluate the outcome of
 13 letting these individuals into officer programs, as
 14 well as on to active duty.

15 So summarizing really crudely, ECG
 16 screening does not seem to be supported in the
 17 literature for asymptomatic adults with a negative
 18 cardiac history.

19 It actually costs DoDMERB approximately
 20 \$2.2 million to do ECG screening, and somewhere
 21 between \$34,000 and \$750,000 for every
 22 disqualification identified.

23 Haemoglobin/hematocrit screening. I could
 24 not find recommendations for or against this. It is
 25 considered low cost, but it is also low yield for a

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1 condition that is generally readily treatmentable if
 2 it is iron deficiency anemia. But I don't really have
 3 the data to make a comment one way or the other.

4 Dental panograph screening. I did find
 5 some data in the dental literature that says panograph
 6 screening of asymptomatic individuals is really not
 7 cost effective, but the question to this board is
 8 really the whole package of dental and panograph
 9 screening.

10 Again, the DoDMERB data seems to be not
 11 quite complete on this issue. But if we look at the
 12 enlisted side, it does not seem to be causing a major
 13 problem in our basic recruit training or basic
 14 training.

15 And the physical exam. I felt that the
 16 data is really not available to address the utility of
 17 screen versus a full physical exam, and what time
 18 frame would be most beneficial. I think the officer
 19 side has different issues since they have accession
 20 physicals and a pre-commissioning physical.

21 Whereas, the enlisted side really has only
 22 the accession physical, which I think Colonel Lee was
 23 able to express far better than I. And I think I will
 24 stop there unless you would like to review the three
 25 papers that I found in the dental literature which are

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1 appended to this.

2 DR. OSTROFF: Thank you very much. Before
3 you go, I think there are a couple of questions.

4 DR. HERBOLD: Yes. John Herbold. I would
5 like to commend you, Colonel Krauss, for an excellent
6 presentation. But I would just like to make an
7 observation for the record. We are being asked to
8 look at or to make a point in time decision, and I
9 think we really need to look at life-cycle costs.

10 And I am going to use the dental question
11 as an example. Over the last 10 years, there have
12 been several excellent reviews on the impact of dental
13 disease on military preparedness and military
14 readiness.

15 And dental disease can have a significant
16 impact on military operations. Two that come readily
17 to mind is if you are going to deploy shipboard or
18 under the sea for six months, the onset of dental
19 disease can be disruptive or break a mission.

20 If you are involved in air operations,
21 going up to 40,000 feet and coming down, and going up
22 40,000 feet, you all know that if you fly frequently
23 that can cause significant problems.

24 It is my understanding antidotal that in
25 the past -- and I am ready to be corrected, but

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1 several decades ago it was one Service's policy that
2 on the enlisted side that if the troop could get
3 through the first enlistment and not have to have any
4 attention to dental disease, that that was a service
5 policy.

6 And that any corrective or remedial action
7 would be addressed to career enlisted. The issue of
8 how much time has to be directed towards dental
9 remitation at basic training and/or at advanced
10 individual training can have a significant impact I
11 think on recycling, and/or which career fields
12 individuals can go to.

13 Now, I am not making any observations on
14 whether the panorex or the screening tools, or the
15 process used at this point in time answers the
16 question that I am putting forward to you.

17 But I do not think we should use any
18 levity in discounting the impact of dental disease on
19 the performance of our military people.

20 DR. OSTROFF: Dr. Ludwig.

21 CDR. LUDWIG: Sharon Ludwig, Coast Guard.

22 I just would like to add to that, and partly along
23 those same lines that I was thinking. Actually, our
24 people, when they leave basic training -- and this may
25 be true in the other sea services, but they have to be

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1 medically, including dentally, deployable by the time
2 that they leave basic training.

3 And we have had a lot of discussion on
4 this, because we receive many, many people at basic
5 training who need extensive dental work. And we are
6 talking about almost every tooth in their mouth.

7 We do a lot of waivers, and we don't very
8 often send people home because we have had some
9 trouble with recruiting like the other services,
10 although we do send some home that just need so much
11 work that it is not reasonable.

12 But the outcome of it has been that we
13 have had to hold a substantial number of people over
14 at basic training at our expense, and sometimes having
15 to put them up in motels and so on to finish their
16 dental work.

17 Or in other cases they have actually been
18 sent out to their units and not been dentally ready,
19 and we have had a number of complaints from the field.

20 So this is a huge problem for us.

21 And in terms of somebody at MEPS -- and I
22 am talking about MEPS now -- looking into somebody's
23 mouth and saying this person should not go into the
24 service because they are not dentally ready, they are
25 the kind of mouths that anybody -- not a physician,

1 but anybody -- could look in their mouth and say that
2 this person is going to have some dental problems.

3 And I think that before any decision is
4 made -- and I am saying the same thing. I don't know
5 the utility. I am not a dentist. I don't know the
6 utility of the panograph.

7 But the other point that has been made
8 strongly in our headquarters is that people with
9 dental problems like this -- and not even or maybe
10 half the teeth in their mouth even or whatever -- are
11 not just you fix them and you send them out and they
12 are okay.

13 These are people who need life long dental
14 work. The prosthodontics don't last forever. They go
15 back to their old habits and they have periodontal
16 disease and more caries, and the caries wear out or
17 come out, break, crack, and so on, these are life long
18 problems. And it is a chronic problem when someone
19 comes in with bad dentistry.

20 DR. OSTROFF: Dr. Zimble.

21 DR. ZIMBLE: I'm going to jump into the
22 same pool. This is not addressing the question that
23 was asked, which is a very specific question on
24 panograph.

25 But I would think that this may be a place

1 for the Board to make a recommendation and not ask the
2 question. But as far as dental is concerned, I was
3 the commander of a hospital in Orlando, Florida, which
4 was a recruit training center when I was there.

5 And I remember seeing the very harassed
6 head of the dental clinic, and harassed recruit
7 training commanders, because they had lost so much
8 time from basic training in order to get their
9 remediation done in order to be Class Two when they
10 finally go to the fleet.

11 And this is a significant issue as far as
12 mission grading is concerned, is to make sure that
13 your soldier/sailor is equipped to not have these
14 dental problems, and we are really pushing for Class
15 One across the board.

16 These enlisted people come in with
17 horrible mouths, and need a great deal of care, and it
18 seems to me that with the delayed entry programs,
19 recognizing that we are going to have to pay for it,
20 that at least we don't have to pay the cost of lost
21 training time.

22 And we ought to probably be doing
23 something to support good dental remediation during
24 the delayed entry programs of the services.

25 COL. LEE: I agree with you that dental

1 care is incredibly important, but just what you said,
2 that these people are in the delayed entry program.
3 They are in a status that at this moment is not
4 covered by dental care, medical care, or anything
5 else.

6 And the costs would be enormous, and the
7 point made by the Coast Guard is exactly right. They
8 have complained in the past about their people having
9 to go directly out to the fleet, and the training
10 schedule being so tight that they can't get the dental
11 people to fix all the dental problems.

12 But the flip of it is also what she said.

13 They would rather have those people than not have
14 them at all, and that's the recruiting side of it.
15 That if we require these people to have a dental exam,
16 and then get disqualified at this moment under the
17 current rules, they will have to pay for it
18 themselves. And we know across the population that
19 dental care is not optimal in the civilian population.

20 DR. ZIMBLE: But it is a great recruiting
21 tool though, is to be able to give them the dental
22 care that they need when they come in.

23 COL. LEE: That's fine.

24 CPT. SCHOR: Just a couple of comments.

25 One is that with the EKG issue, I wonder if it would

1 be better to reframe that in terms of a pre-
2 participation sports physical sort of construct.

3 You are bringing these folks in, and it is
4 not just about EKGs. It is about whether their
5 cardiovascular system is capable of going through the
6 physical exertion demands of basic training and future
7 service.

8 So that broadens the issue a little bit,
9 but I wonder if looking at it from that lens may be a
10 little bit more helpful, and to approach it with the
11 kind of thought that the sports medicine docs guide
12 pre-participation physicals, which have changed
13 recently in the last couple of years.

14 And I think you usually don't include
15 EKGs. But somebody may correct me if I am wrong on
16 that point.

17 LT. COL. RIDDLE: That's correct. In that
18 literature, the American College of Cardiologists and
19 AMA, those guidelines are in the background material,
20 and Captain Schor is right. They don't recommend ECG.

21 CPT. SCHOR: Just two other questions.
22 One for Captain McKinley, and that is if he knows what
23 the proportion of the dental readiness categories, and
24 how that breaks out on your initial dental exams. So,
25 how many Class Fours, and Class Threes, Class Twos,

1 and that sort of thing do you get.

2 And to estimate the work burden that this
3 brings in, I suspect that it is fairly significant.
4 And the other issue is as implied by Colonel Lee, I
5 believe or wonder what it is that -- well, there may
6 be a very large difference in these socio-economic
7 background of individuals between the two programs,
8 and how does that impact the pre-test probability of
9 what you are going to find.

10 CPT. MCKINLEY: This is Captain McKinley,
11 and I can answer the dental readiness question.
12 Dental readiness of the incoming recruits is roughly
13 around -- between 20 and 30 percent ordinarily.

14 Again, the Navy is the only service that
15 front loads dental treatment in the recruit depot. So
16 the Navy and Marine Corps have consistently graduated
17 all their companies at 95 percent or better dental
18 readiness over the last 2 or 3 years as a result of
19 what we call phased dentistry.

20 The Army and Air Force pass on those
21 recruits. They essentially do an examination and form
22 a dental record, and move those recruits through, and
23 that dental care is absorbed further on down the line
24 at subsequent duty stations.

25 Because of the MEPS screening exam, which

1 we are not here to discuss, and I am not here to take
2 that way or the other, I was here to discuss the
3 DoDMERB end of this.

4 Because of the MEPS lack of a general
5 screening the services do absorb this care. They
6 absolutely do. I was the Dental Commander in Orlanda
7 for two years, and I have been through the whole mill.

8 These candidates are not washed out
9 because of dental. Almost never. We fix them. We
10 keep them after their recruit training, and we keep
11 them during the work week, and do it on weekends,
12 nights, and we fix them.

13 And their availability is limited, and it
14 is an extremely intense time for them, as well as for
15 us, and it is a very tough place to work for
16 everybody, including the dentists. But we fix them.

17 So we absorb that care, and it gets done.

18 And so I guess the question is do we want to do that
19 at the Service Academies? Do we want to take that
20 same burden and put it on these students who are going
21 into the Service Academies.

22 That's basically the decision here, and
23 are we willing to put that burden on the Service
24 Academies, and then are we willing to finance that.

25 COL. KRAUSS: If I may offer an

1 alternative, which I wasn't asked to do, but when we
2 look at the officer accession programs, you are
3 dealing with 30,000 applicants every year.

4 And I think we have about 18,000 actually
5 enter the programs. So it is 12,000 kids that are
6 required to get dental exams that will never make it
7 into our programs.

8 Some of them are not academically suited,
9 and they are disqualified for other -- you know, non-
10 medical reasons. Rather than screen everyone and
11 making kids that may not be able to pay for it have to
12 go out and get these remediations, perhaps they should
13 go ahead and be able to apply to the programs, and
14 once accepted, get a provisional acceptance letter,
15 stating now you have been accepted to the Naval
16 Academy, and you need to have X, Y, and Z fixed, or
17 you must have a dental exam or whatever.

18 MR. MULLEN: That would be a good
19 suggestion, but it is not realistic because of the
20 window of opportunity to go into the programs, and the
21 basic point that Captain McKinley addresses is basic
22 training for all the services is obviously a tight
23 schedule.

24 But once you go into a service academy,
25 you have 16 hours or 17 hours from then forward, and

1 so the Service Academies are extremely opposed to it
2 because they don't want to set people up to fail.

3 You can't be sitting in a dental chair for
4 a prolonged period of time or a treatment plan during
5 your first year in the Academy. Otherwise, you are
6 going to basically bail out.

7 LT. COL. RIDDLE: If we can hold just one
8 second. Colonel Dunn actually can provide some
9 information on several issues that may answer some
10 questions that the Board. He is the ROTC Command
11 Surgeon, and has done the waiver and requested the
12 waiver on the physical exam to get it to here. So,
13 Colonel Dunn.

14 COL. DUNN: We are the largest customer
15 for DoDMERB. I am also the wavier authority for Army
16 ROTC, and two of the issues that are addressed this
17 morning were raised by Cadet Command originally.

18 So if I get a little emotional at times,
19 it is because it is an emotional topic for my
20 Commanding General, and therefore, it is an emotional
21 topic for me.

22 Talking with regards to the validity
23 period of the DoDMERB physical. Our issue is
24 different from MEPS. MEPS has made a very good
25 argument as to why the standard needs to remain the

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1 same for them, and I support that.

2 But ROTC is a different animal compared to
3 enlisted accessions. Most of you don't know, but Army
4 ROTC has not met mission for seven years in a row.
5 This coming October, we will access commission roughly
6 3,300 officers.

7 That is 650 to 700 short of what the Army
8 requires. We have a major recruiting problem, and so
9 my new Commanding General, who has been on board for
10 the past year, has been told to fix the problem.
11 Easier said than done, because the problem didn't
12 develop over night.

13 And there are many reasons why recruiting
14 is poor. We all know it has been tough on the
15 enlisted side, but what is not known is that it is
16 also real tough on the officer side as well.

17 There is many reasons; propensity to
18 serve. Not a lot of folks want their sons and
19 daughters in the military. That needs to be addressed
20 in a different forum.

21 Issues regarding adequacy of the
22 scholarship benefits and stipend. That is a different
23 issue for this forum here. But there is one issue
24 that my Commanding General hears frequently from the
25 field, and that is that the medical system is just too

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1 complex, and it takes too much time, and too many
2 people walk away because they were not willing to go
3 through the entire process.

4 Now, the physical exam has to be done for
5 accessions, but the question has to do with the scope
6 of that exam, and whether or not there is ways to make
7 the whole process a little easier for the applicants.

8 One of the problems that my Commanding
9 General is facing right now is that he realizes that
10 there is an awful lot of applicants that apply to West
11 Point, the U.S. Military Academy, who do not get
12 accepted because there is not enough positions for
13 them.

14 Right now three percent of everybody who
15 is rejected by West Point is ultimately signed up by
16 ROTC. These are folks who indicated an interest in a
17 military career, but have been disillusioned because
18 they weren't accepted, and who have walked away.

19 And what my Commanding General is saying
20 is, well, we need to see if we can bring them back
21 into ROTC, because these are folks who are oriented
22 towards the military rather than some Joe Blow on the
23 street who doesn't know what the military is all
24 about.

25 A problem is starting to come up. Many of

1 these folks applied to West Point out of high school,
2 and so that clock is ticking on the date of their
3 physical exam, which currently the validity period is
4 only two years.

5 Many of these folks really lose interest
6 in the military for the first year after being
7 rejected by West Point, and they enter a college, and
8 now we are trying to recruit them just to find out
9 that their physical has expired or is about to.

10 And now we are going to tell them that
11 they need another physical to apply to ROTC, and I'm
12 saying why. And my Commanding General is saying why
13 also.

14 When I can have an ROTC Cadet jump out of
15 planes at the airborne school for a five year period
16 after being originally qualified by DoDMERB, why can't
17 that same physical be at least good for a couple of
18 more years, when the airborne school will allow that
19 physical with a statement that they are still in good
20 health be good for five.

21 So I am asking for a little bit of common
22 sense here. Last week, I had a student -- I was
23 called up by an ROTC program, where a student had
24 applied to West Point, and been rejected, and is in
25 ROTC.

1 And West Point has now realized the error
2 of their ways, and didn't realize that he was such a
3 great athlete, and they want this kid back in West
4 Point.

5 Even though this kid does PT three times a
6 week, and is in better fitness or shape than probably
7 most of us here, he needs to get a new physical.
8 Well, he is not going to do it. He is not going to
9 start the whole physical exam process again.

10 So what the Cadet Command is asking for
11 ROTC is to extend the validity period for certain
12 additional years, provided that the student has
13 indicated that there has been no change in his health
14 status.

15 These are young, healthy Americans going
16 to college, and involved in football, lacrosse, and a
17 whole bunch of other sports that we now currently say
18 they may need another physical.

19 I would like to take that disincentive to
20 recruitment away from the ROTC cadre who are having a
21 real tough job. So that is the perspective on the
22 validity period. We are separate from MEPCOM. We are
23 a different animal.

24 Now, in terms of the dental exam, I raised
25 that issue a few months ago because the question we

1 are asking is if enlisted sliders or applicants do not
2 need a dental exam by a dentist, and non-scholarship
3 officer applicants do not need a dental exam by a
4 dentist, then why do scholarship officer applicants
5 need a dental exam by a dentist when it is all based
6 on the same DoD instruction in the first place.

7 So Cadet Command's position is either do a
8 dental exam by dentists for everybody, or nobody if
9 you continue to use the same original DoD instruction.

10 Now, in terms of -- there has been some very viable
11 and legitimate arguments raised by the general
12 community and some other folks regarding the costs and
13 so forth, and they are legitimate.

14 But ultimately it comes down to are these
15 folks going to be waived or not, and I will tell you
16 that if a kid can chew food, even MRE, the guidance to
17 me by the Army Surgeon General's Office, and my Dental
18 Consultant, is to waive it.

19 And I am going to waive every single one
20 of them if they can chew food. Now, if you want to
21 require a dental exam before that, all you have done
22 is put a road block into the recruiters out there.

23 But the net effect ultimately is that I am
24 going to waive it, because as maybe the Coast Guard
25 has noticed, you are not going to turn those folks

1 home, and send them back home.

2 CDR. LUDWIG: Not after they get there,
3 once they have made the trip there. But if we knew
4 about it ahead of time, we would probably send them
5 back home.

6 COL. LEE: Actually, no, because we paid
7 for the trip there. We paid for all of it and so that
8 is transparent to you. When they get to the Coast
9 Guard training base -- Cape May, I guess it is -- so
10 far it has cost the Coast Guard nothing, and you
11 process on from there.

12 CDR. LUDWIG: We are looking at the total
13 cost and not just what comes to the Coast Guard.

14 COL. LEE: But my point would be that you
15 would rather have them show up there with bad teeth
16 than not show up at all.

17 CDR. LUDWIG: Some would.

18 DR. BERG: Bill Berg. It seems to me what
19 we are being asked to do is to eliminate some of the
20 screening for a select group of officers. Now, I
21 agree that bad teeth are a horrible manpower problem
22 for the Navy, and the Coast Guard, and everyone else.

23 But I have not heard anything that says
24 that problem is going to be prevented. What we have
25 are lower standards because we are desperate to take

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1 people in, and we are with a certain amount of
2 sweating and grumbling willing to pay the price of
3 fixing all these bad teeth.

4 I have not heard anything that says people
5 are coming in with really subtle dental problems that
6 require an MRI to diagnose. What I am hearing are
7 people coming in with mouths full of rotting teeth
8 that a corpsman could diagnose.

9 And I think the question for us, and that
10 we are being asked here, is eliminating these
11 screenings for a select group of officers likely to
12 result in an increased burden on the dentals.

13 COL. DUNN: That has already been
14 eliminated for non-scholarship applicants. It is not
15 required. So why should your scholarship status make
16 a difference in terms of who looks in your mouth?

17 COL. POWERS: Could I address that one
18 issue since I am from clinical program policy. I
19 think the question you are being asked is please look
20 at what the standard is that is on the books, and look
21 at what you need to make that determination.

22 And the question is are the screening
23 procedures necessary to make that call given the
24 standards that you are given. Now, we are having a
25 lot of discussion over what I think a lot of people

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1 think the standard may need to be. That is a
2 different issue.

3 If you think we need to have different
4 policy, then that is a different and separate
5 recommendation. But the question that you are being
6 asked to answer right now is given what the standard
7 presently is in place, what do you need to do to make
8 the determination on whether a candidate meets that
9 standard or does not meet that standard.

10 And I think the other issue that we have
11 is that we have different processes for making that
12 determination, and having those different processes,
13 are we really having two de facto standards.

14 CPT. MCKINLEY: This is Captain McKinley.

15 That was a very succinct and well stated, and that's
16 exactly what we are talking about. If we are going to
17 maintain the standards that we have now, then we need
18 a certain level of examination.

19 If we are not going to maintain the
20 standards, then we are going to absorb all this dental
21 care, and that is an enterprise decision which dental
22 communities certainly are willing to take on also with
23 additional resources. But that's a decision that you
24 are being asked to make and that was well stated.

25 DR. OSTROFF: Dr. Campbell.

1 DR. CAMPBELL: The problem we are facing
2 is that we are hearing different targets from these
3 different services. Some parts of the services are
4 willing to accept certain costs and some aren't.

5 So to make a policy that is going to meet
6 different standards is difficult. We need to hear
7 what is the military willing to accept as far as costs
8 to fix all these things, and given that, we should
9 make a determination of who is allowed into the
10 service given that it is going to cost X-amount of
11 money to fix the problems.

12 COL. DUNN: The problem you have is that
13 you already have the standard, which is being
14 implemented differently, depending on whether you are
15 an enlisted applicant, who by the way should have
16 worst teeth than an officer applicant, when 86 percent
17 of all Army ROTC folks come from a military family,
18 and who have had access to dental care for most of
19 their life.

20 DR. CAMPBELL: Well, my point is what is
21 the military willing to pay to correct all these
22 problems, and to make a determination on that.

23 COL. DUNN: We are paying it right now

24 LT. COL. RIDDLE: What we have tried to do
25 is

1 -- and again if you go back to Colonel Powers, is the
 2 question was asked here is the standard. What
 3 evidence is there based upon the existing data from
 4 DoD and AMSARA, and in the literature, to make an
 5 evidence-based decision on what is needed from a
 6 screening and an exam process to accomplish the
 7 standard.

8 And that is what we focus the literature
 9 reviews on, and the material, and for a lot of these
 10 there is actually a significant amount of evidence,
 11 even on the physical exam.

12 When the Board addressed this issue
 13 originally in 1976, the question was brought to the
 14 Board on the validity period for the physical exam,
 15 and the Board made a recommendation for reserve forces
 16 to move it from a year to five years.

17 There was subsequent legislative changes
 18 and we have got all of that background material, and
 19 so there really is quite a bit of material to take a
 20 look at to provide some evidence for the
 21 interpretation of those standards and the question
 22 asked.

23 DR. OSTROFF: Let me -- I mean, I tend to
 24 look at things based on where I work, and from an
 25 epidemiologic societal point of view. And some of

1 what is being done here with the differential
 2 requirements for MEPS versus the Academies, et cetera,
 3 is to some degree value judgment based on what the
 4 value of those individuals is, and what the cost of
 5 training those individuals happens to be.

6 And the problem is that when you look
 7 epidemiologically, the ones that are much more likely
 8 to have some of these conditions that you are talking
 9 about are the ones that aren't being screened.

10 The ones that are being screened are the
 11 ones that are probably much -- I mean, college kids
 12 are kids that are good enough in terms of their
 13 academics to be qualified to enter the U.S. Military
 14 Academy, and are far less likely to have dental
 15 disease problems than some kid who is living out on
 16 the street.

17 And so the difficulty that I have with all
 18 of these arguments is that we are not screening the
 19 ones who probably most need the screening, and we are
 20 screening the ones that probably don't.

21 COL. LEE: Actually, we are screening. I
 22 would like to clarify a point in case it was not
 23 clear. What we did from all of the Services is ask
 24 them what standard do you want our physicians to use.
 25 They said can they masticate, and that is the

1 standard that they wanted us to use for dental.

2 Now, any time one of the physicians has a
3 question, he can get a dental consult if there is a
4 question about whether the kid can masticate and
5 whether or not he is taking sufficient nourishment.

6 So we can get a dental consult, but based
7 on what the Services have told us, they said that if
8 he can chew, that's good to go, you know. They would
9 rather us do that than disqualify the kid or get a
10 consult.

11 DR. HERBOLD: Could you clarify that,
12 because we had a briefing earlier that said that the
13 three dental chiefs supported the panorex and the
14 examination by a dental professional.

15 But you are saying that if the standard is
16 -- and I understand this, too, because I went through
17 it with blood borne diseases 15 years ago, but if the
18 standard is can you chew, I don't think you need to
19 bring this question to the AFEB to answer. The answer
20 is there and so what are you drilling us for on it.

21 DR. ZIMBLE: The question to the AFEB is
22 are these four very specific screening tools relevant,
23 and I think if attrition is the end point -- you have
24 seen the data from AMSARA that says it is irrelevant.

25 You don't need these four. These four

1 tools are not making or breaking the whole process,
2 and are costing money, and they are interfering with
3 recruitment, and they are cutting back on manpower,
4 and they have no real value in terms of screening for
5 a standard. They have a great deal of value for other
6 applications, but not for screening.

7 DR. OSTROFF: But it is even more than
8 that because if they are of value, basically you are
9 screening the wrong ones.

10 DR. ZIMBLE: True, but they are not.

11 COL. WEIEN: There are a couple of
12 different questions here.

13 DR. ATKINS: Go ahead.

14 COL. WEIEN: There is the standard as
15 written in the DoDI. DoDMERB's position is that in
16 order to enforce that standard as written that we need
17 certain tools. I think I have explained that before.

18 When Colonel Lee talks about mastication
19 is a test for whether or not someone should come in.
20 That is really a de facto waiver standard. They are
21 saying, okay, here is the standard, and they don't
22 need that standard. Can they still eat? Okay. We
23 will let them in.

24 And so waiver decisions are a service
25 level decision; whereas, the standard, the question is

1 what tools do you need to determine whether someone
2 meets or fails to meet the standard.

3 Then whether or not you want to let them
4 in as an aid to recruitment is a waiver decision that
5 ought to be service level specific.

6 COL. DUNN: And that's why I say have the
7 same tool for everybody or don't use that tool.

8 DR. OSTROFF: Dr. Atkins.

9 DR. ATKINS: Well, I have worked for the
10 U.S. Preventive Services Task Force, which puts out
11 recommendations about common screening tests, and I
12 noticed that those weren't here in partly because I
13 think they are on websites rather than on
14 publications.

15 But it seems that there are three levels
16 of issues. One is are these screening tests medically
17 appropriate with these, and that is not even in the
18 standards. But that is probably sort of a lower bar.

19 Would you expect the average person in the
20 population to get these, and from our position and
21 most other groups, none of these are things that if
22 you were Joe Civilian that you would be expecting to
23 get.

24 The second is whether there is anything
25 particular about military service which would make

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1 them appropriate for people, such as the rigors of
2 military training or other aspects. And again I don't
3 think those are sufficiently differently to justify
4 EKG screening or hemoglobin screening.

5 But the third thing that I think is making
6 it so difficult is that we are being asked to deal
7 with policy issues, and so the real question is if you
8 change the policy either by making the MEPCOM
9 screening stricter or by relaxing the other policies,
10 what would the overall impact be.

11 And so those are -- well, the data that I
12 have heard about is would it change attrition rates.
13 So if the outcome is attrition, we didn't hear good
14 data that that should be justifying a stricter
15 standard.

16 But then there are other sorts of policy
17 issues that maybe if the investment in Academy folks
18 is substantially higher, maybe we are willing to
19 screen for a much lower yield.

20 So I don't know that having uniform
21 standards on both sides is essential from a policy
22 standpoint, but that may be a political question on
23 whether we can say we are implementing the same
24 standard, but with slightly different measures because
25 we are dealing with a different population, and

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1 different needs, and different investments.

2 I think we all agree that the standard
3 ought to be the same, but there may be some policy
4 justifications for implementing it slightly
5 differently.

6 I mean, the EKG is a typical example, and
7 the yield of EKG screening for preventable sudden
8 cardiac events is extremely low, but if you were
9 screening pilots, you would tolerate a very low yield
10 of screening because the impact of that one
11 preventable event might be huge.

12 And certainly on the commercial side we do
13 that, but you would be crazy to invest that money on
14 EKG screening on the MEPCOM side. But I guess I am
15 feeling at a loss of knowing whether the thing that
16 drove this is discomfort over the appearance of
17 unequal policies, and feeling that was not tolerable
18 from sort of an equity standpoint.

19 Or whether as I was hearing that there are
20 actual obstacles being imposed by the fact that
21 standards may be too strict for your needs.

22 LT. COL. RIDDLE: If we could, maybe a
23 couple of more questions, and then with the
24 subcommittee sessions this afternoon, we will
25 specifically appoint groups to address the questions,

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1 and then maybe we can get into a little bit more
2 detail.

3 And maybe Tim could hang around with the
4 individuals to discuss just that. I mean, from the
5 money savings. If you eliminate these discrepancies,
6 and you save \$10 million a year, that will buy quite a
7 few more dentists to provide care to maybe get these
8 people in better shape.

9 So an application of resources
10 differently, and maybe we can tease some of those out
11 this afternoon.

12 DR. HERBOLD: And can we suggest that all
13 the subject matter experts that are here are welcome
14 to participate in all the subcommittee meetings.

15 DR. OSTROFF: Absolutely. Particularly
16 the dentists.

17 LT. COL. RIDDLE: Any more questions?

18 DR. GARDNER: I would think the -- we have
19 heard some strong defenses for each of the screening
20 tests, but the thing that we have not spent very much
21 time on is the duration of the validity on once you
22 have passed these tests, and how long are you good
23 for.

24 And I think there is the one that we can
25 probably come to a consensus on most easily. I think

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1 the person who is applying to West Point and wants to
2 get into ROTC -- and I have not heard any data
3 presented today about the interval to support a short
4 interval.

5 If your EKG, which is Wolf--Parkinson-
6 White, is normal, it is not going to pick it up 2 or 3
7 years later. The things that you are going to drop
8 dead on are cardiac issues primarily, and an EKG is
9 good for a very long time, and if you have one, you
10 certainly don't need to come back and do that very
11 well.

12 I have not heard from the dentists that if
13 you have normal teeth on Day X, and is it really worth
14 coming back and doing the whole thing over again 2 or
15 3, or 4, or 5 years later. We have not fixed the
16 interval.

17 And certainly for the hemoglobin
18 screening, you are not going to get in too much
19 trouble over that. So I would think we could quickly
20 come to some decision to lengthen the interval for
21 rescreening, and then go back to talking about the
22 rest of it.

23 I think it mostly turns out to be cost
24 figures, and that is the issue for dentists. They are
25 not going to drop dead over bad teeth, but there is

1 military preparedness.

2 And you are probably not going to drop
3 dead over hemoglobin issues, but you might drop dead
4 over cardiac issues, and I guess that is an issue that
5 you have to take into consideration.

6 COL. LEE: But I think the other ones also
7 cost for the length of physical, because for the
8 officer -- unless you are speaking just of officers.

9 DR. GARDNER: The officers get examined
10 twice, right? That is the exact same exam twice?

11 COL. DUNN: Not completely. The
12 commissioning physical is done at advanced camp, and
13 for students between the junior and senior years.

14 DR. GARDNER: But they get in essence the
15 same set of criteria applied to them in two intervals.
16 Whereas, the enlisted folks get it once.

17 LT. COL. RIDDLE: It may be three or more
18 intervals. I mean, if you go to the academy and you
19 go to prep school, you get an exam. If you are
20 accepted into the Academy, do you get another one, and
21 then when you are commissioned, you get another one?

22 MR. MULLEN: The worst case is you apply
23 to a four year program, and you don't get in. You
24 then go to a college and you apply for a scholarship,
25 and while you are applying for the scholarship you

1 have to take a quick training exam so you can go to
2 camp.

3 Then you get the scholarship exam, and
4 then you get the pre-commissioning exam. And if you
5 are flight, a flight exam. So conceivably during a
6 or 6 year window, you might be required by policy to
7 get upwards of five exams.

8 COL. GARDNER: So we certainly could go
9 after that with great gusto I think, but I think we
10 are still left with arguing what is an efficient thing
11 to do at least once.

12 DR. OSTROFF: Okay. I am going to take
13 the President's prerogative of closing this session,
14 and let me just say that I am really pleased that
15 these questions were brought to the Board.

16 This is certainly one of the liveliest
17 discussions that we have had in a number of years, and
18 I think they are very thought provoking, and these are
19 things that we could potentially help you with.

20 And certainly from the standpoint of
21 potential cost savings, I think they are not
22 insignificant. I am assuming that all of you can
23 still chew, and so why don't we go ahead and have
24 lunch. When do we need to be back?

25 COL. RIDDLE: At 1:30.

1 DR. OSTROFF: So let's be back at 1:30.

2 (Whereupon, at 12:16 p.m., a luncheon
3 recess was taken.)

A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

(1:35 p.m.)

LT. COL. RIDDLE: Yesterday at General Peake's request, he had asked that Colonel Mallon come down and present to the board a questionnaire that has been developed and that they are proposing to use to follow up at the Pentagon post-disaster.

So we changed the agenda to have Colonel Mallon come down and discuss that with the Board.

COL. MALLON: Thank you for the opportunity to come down and talk about the questionnaire. General Peake was very excited to hear that Dr. Landrigan and the New York City group were going to go in and do a post-disaster assessment survey.

I think the survey instrument that we started with was the Kobar Towers and Oklahoma City Post-Disaster Assessment. Our original thoughts were to look at the opportunity for assessing the impact and the injuries, and the kinds of things that would prevent injury in buildings and in situations in the future.

Since we started with that, the questionnaire process, we have really evolved. I think that our focus has come around to where I think

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it really needs to be, and that is focusing on our people, and assessing the impact of the incident on the individuals involved at the Pentagon.

And to look at how many people were affected, and to document the experience for the future. I think when you look at the questionnaire, it is kind of broken down into three areas.

There is some general background demographics, and a section on exposure assessments. You know, odors, smoke, fumes, vapors, that kind of thing. And then a section on psychological impact or assessment.

Now, we recognize that the psychological questions that were provided were an initial set of questions, the focus of which was to try and establish a base line of where they are now, and do a quick assessment of do they need to see or get psychological help at this point in time.

Also, to assess any acute immediate pulmonary or subacute problems that people were having so that we could get them into medical care. Now, the third component of this is what I was referring to earlier, and that is the potential use of this for the future, in terms of building design and how to protect people like at the Pentagon when we reconstruct it.

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1 And how can we design it better so that if
2 an event like this occurred again, we would have fewer
3 casualties and fewer problems.

4 So the task that I was asked to come down
5 and talk about was to present the questionnaire, and
6 ask you as a group to see if the instrument that we
7 prepared is going to provide the answers to the
8 questions that we are looking for.

9 And we are looking for feedback in terms
10 of -- and we realize in a very short turnaround. It
11 is not traditionally what the AFEB is designed to do,
12 in terms of giving rapid turnaround feedback.

13 But we would appreciate if you had the
14 opportunity to look this over in the next few days to
15 give us feedback on any questions or comments that you
16 might have. I think it would be very constructive for
17 us as we put this out.

18 Our current plan is to administer this and
19 start administering it in the next week or so. I
20 mean, that is a deal that we realize is very
21 aggressive. We have an execution plan that is going
22 to involve -- it is going to be executed through
23 NARMC.

24 They are planning a pretty major effort to
25 put this on the website so that people have web access

1 to it, and they can complete it that way. We have a
2 stand alone server that we are standing up that will
3 provide 128 byte or even higher encryption so that we
4 will provide some security for the web.

5 And as well as hard copy questionnaires,
6 and will be walking and almost developing a grid map,
7 corridor by corridor, and section by section, to hand
8 it out, distribute it, and make sure everybody who is
9 there, or has been relocated, has an opportunity to
10 complete the questionnaire.

11 Some of our challenges I think are going
12 to be to come up with a complete list of everybody who
13 was at the Pentagon at the time, and to track to see
14 where they have been relocated to.

15 There are some significant challenges, in
16 terms of managing the database. We anticipate that if
17 everybody completed the questionnaire, there would be
18 over 24,000 questionnaires turned in. That's a
19 monumental task in terms of analysis.

20 We have had offers of a lot of help, and I
21 think as this evolves that we -- and depending on what
22 the future of our military is in terms of other
23 interventions, we may accept some of those offers of
24 help.

25 And we may be contracting some of this

1 work out, and a lot of it depends on where we go from
2 here. That is really all the prepared comments that I
3 had.

4 I guess one additional thought, and that
5 would be that we have been working with -- we have
6 invited the psychiatric consultant and some of the
7 people in the psychiatric community to look at the
8 questions that were here, and offered an opportunity
9 to provide better questions, perhaps a better subset
10 of questions that might more accurately be more
11 useful, in terms of collecting a background
12 psychological assessment.

13 And I know that our psychological and
14 psychiatric community would like us to do this in a
15 longitudinal fashion, and I think the questionnaire
16 alludes to it on the cover sheet.

17 The cover sheet provides an introduction
18 that is designed to be handed out to every individual.

19 So one of the questions is, is the cover sheet
20 sufficient in terms of defining the purpose, of
21 defining what it is that we are trying to capture.

22 And getting back to the longitudinal
23 component, we would envision that there would be a
24 subsequent questionnaire to assess the psychological
25 morbidity over time, where thinking depends on the

1 psychological community.

2 But I think a six month and perhaps even a
3 one year follow-up, I think they would believe that
4 would be necessary.

5 DR. LANDRIGAN: Could I ask you to speak
6 to two other issues, and whoever is the relevant
7 person. Number One is environmental sampling, air
8 sampling, and other forms of environmental sampling.

9 And, number two, what plans -- I realize
10 that it is early, and I am not trying to embarrass
11 you, but I am just trying to get the information.

12 What plans are you formulating for
13 monitoring the health of the people who are going to
14 be in there in the days and weeks ahead doing the
15 demolition, and the clearing of rubble, and all the
16 rest of those dirty horrible tasks?

17 COL. MALLON: I think those are excellent
18 questions. I think that I would suggest that an
19 environmental sampling is being done by the
20 Environmental Protection Agency, in conjunction with
21 the State Health Department, and the State
22 Environmental Quality people.

23 This is a separate operation. Anything
24 outside the Pentagon is considered environmental, and
25 has to do with environmental waste, and environment

1 remediation.

2 The inside work in the Pentagon is being
3 looked at as an occupational health work place. The
4 standards that are being applied are OSHA standards
5 and that sampling, and that work is being done by our
6 industrial hygiene people at the Center for Health
7 Promotion and Preventive Medicine through Walter Reed
8 Army Medical Center.

9 As well as the industrial hygienist from
10 the Air Force and the Navy participating in the
11 sampling effort. Now, that started essentially the
12 evening of the first day, and then has continued over
13 time. We have been sampling and doing personal
14 dosimetry on workers, as well as going into and doing
15 individual office indoor air quality assessments,
16 where we get complaints from workers who are going
17 back in and doing reentry.

18 If we are getting complaints from workers,
19 we are having an industrial hygienist go in and do a
20 direct reading and instrumentation to assess the
21 problems in the immediate space.

22 DR. LANDRIGAN: And monitoring the future
23 workers?

24 COL. MALLON: Well, we have both a
25 Pentagon health clinic, a military health clinic, as

1 well as a civilian occupational health clinic. We
2 intend to use the surveys as a way to monitor,
3 particularly if people indicate that they had been
4 involved in the recovery, or in the remediation effort
5 at the Pentagon, that that will give us a good
6 starting point to sample that particular cohort over
7 time.

8 DR. LANDRIGAN: If you would like, let me
9 take a few minutes --

10 DR. OSTROFF: Can I just ask one question
11 first? How many people among the injured are still
12 hospitalized in relatively severe -- I mean, I am
13 thinking in terms of administering the questionnaire,
14 and how you are going to do that with individuals who
15 have the more severe injuries.

16 COL. MALLON: Let me say that the
17 execution plan for administration of the questionnaire
18 is still in the formulation stages. The latest
19 information that I have heard is there were
20 approximately a hundred people still hospitalized,
21 some in varying degrees of severity.

22 PARTICIPANT: That is not correct.

23 COL. DINIEGA: It was down to 20 something
24 yesterday.

25 PARTICIPANT: It is actually less than

1 that, and I think it is less than 20, but I don't know
2 that we need to say exactly what the number is.

3 COL. MALLON: It's nice to have updated
4 information. Thank you.

5 COL. ENG: It is less than 20, because the
6 Walter Reed command has been tracking and going around
7 and it is really very few.

8 COL. MALLON: And for the people who were
9 hospitalized, we were planning to track them
10 separately, and to actually go out and do essentially
11 a supplemental questionnaire to get more detailed
12 information for those who were actually injured and
13 hospitalized.

14 COL. DINIEGA: Phil, before you answer,
15 this was brought up when General Peake was here
16 yesterday, and I think there are two different efforts
17 here. One is for the regular employees of the
18 Pentagon, which is what they want to do.

19 And I think in our discussion and in the
20 discussion yesterday, you were talking about the
21 recovery operation, and the workers in the recovery
22 operations.

23 DR. LANDRIGAN: That's absolutely correct,
24 and we are making really that same distinction up in
25 New York between people who were nearby, and when I

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1 say nearby, I include people who might have been in
2 the buildings, but got out.

3 And versus the folks who are going to be
4 involved in the recovery demolition operation, which
5 up there is probably going to last 6 to 12 months. So
6 they are going to be exactly as you said, Colonel, a
7 real occupational cohort who needs to be surrounded
8 with the OSHA type protections, which are very
9 different from what is going to apply to the people
10 who were transiently exposed.

11 COL. DINIEGA: But I think Tim said that -
12 -and if I am not mistaken, but that when you are doing
13 the sampling in the Pentagon, in the offices close to
14 the impact area, you are using OSHA standards as the
15 levels to follow?

16 COL. MALLON: That's correct.

17 COL. DINIEGA: So it is not for the
18 recovery personnel, but it is for people who might go
19 back to the offices near the recovery area.

20 COL. MALLON: Now, it is my understanding
21 that EPA and OSHA were actually monitoring those
22 people who were actually in the immediate crash site
23 and monitoring those individuals, and collecting data.

24 DR. LANDRIGAN: And that's what happened
25 up there. So I am sure that the people are cross-

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1 talking. So that makes sense. The one point that I
2 had made to General Peake when we spoke yesterday was
3 that I was urging that some attention be paid, in
4 addition to the air sampling, which is quite correct
5 and absolutely necessary.

6 But I argued that in addition to that that
7 there is a case to be made for taking other kinds of
8 sample to compliment your sampling. One kind of
9 sampling which I did not mention to General Peake,
10 because I didn't think of it at the time, is the
11 notion of doing like samples of surfaces, especially
12 surfaces that might have black soot on them,
13 combustion products.

14 And, of course, you are going to find
15 polysilacarum or hydrocarbons, and that is a given,
16 but the real question is whether or not there is any
17 dioxin, any furan, any other more complex combustion
18 products that may have been generated by the burning
19 of plastics.

20 And if they are there, that's okay, as
21 that is not a show stopper, but it does mean that
22 attention needs to be paid to properly clean those up
23 before you let either military or civilian personnel
24 go back into those particular areas.

25 And my guess is that if that stuff is

1 there at all that it is going to be geographically
2 pretty delimited. It is going to be in the areas
3 where there was black smoke, but probably not much
4 beyond that. But it will not show up on an air
5 sample.

6 COL. MALLON: I understand, and I am
7 pressed to reassure you that I think or I know that
8 wipe samples have been taken.

9 DR. LANDRIGAN: Good. Good.

10 COL. MALLON: We requested a complete
11 analysis, to include the dioxins, the pHs, and also
12 lead, and the things that you would expect to find in
13 an old building.

14 DR. LANDRIGAN: Then the other thing --
15 and we have seen this up in New York -- is we know --
16 I don't know specifically about the Pentagon, but we
17 know that quite a bit of asbestos was used in the
18 construction of the World Trade Center.

19 Basically, they sprayed asbestos on the
20 steel beams up to about the 40th story of the first
21 tower, at which point in 1971 the spraying of asbestos
22 became illegal. So thereafter they used vermiculite
23 and other insulating materials.

24 But there is a lot of asbestos, and of
25 course it has been liberated. Now, the air samples

1 that have been taken to my understanding up there have
 2 all been within OSHA standings, and that is really not
 3 surprising because those of you who don't know how air
 4 sampling works, you take a little bit of air through a
 5 filter, and you collect the solid material on the
 6 filter, and you express it in terms of the number of
 7 fibers per -- over the number of cubic meters of air
 8 that you bring through in eight hours.

9 So it averages, and that's good because
 10 the OSHA standards for the most part are set as what
 11 is called an eight hour time weighted average, and you
 12 measure a person's average exposure over the eight
 13 hours.

14 And either they are above the standard or
 15 they are below it, and so far they have been below it.

16 But the trouble in a very uncontrolled work place
 17 like this is that you have got asbestos in the dust,
 18 and it is very unevenly distributed.

19 There is cold spots and there is hot
 20 spots, and up at the World Trade Center, they found
 21 some dust containing as much as 4.5 percent asbestos.

22 That is the upper limit, and some have been 1 or 2
 23 percent, and a number have been below the limit of
 24 detection, which is a perfectly expected sort of right
 25 skewed distribution, and that is what you would expect

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1 to see in this kind of environment.

2 But it says to me that there is a threat
 3 of asbestos there, and even though the 8 hour time
 4 weighted averages are probably going to be below the
 5 standard, almost always it is still going to be
 6 necessary to fit those workers who are in there doing
 7 the heavy duty work with proper respirators.

8 And that fortunately is the solution of
 9 the problem. It is an unpleasant solution because
 10 people don't like to wear respirators, but it will do
 11 the job, and it will keep them from getting exposure,
 12 and I am sure that you are doing the same thing here.

13 I just wanted to run through the logic.

14 DR. LANDRIGAN: Who would have the
 15 sampling results?

16 COL. MALLON: EPA. It has been a great
 17 cooperative effort between the Feds, the State, the
 18 City, and people like myself in the academic arena,
 19 and the Federal EPA have been the lead agency for the
 20 environmental sampling up there.

21 DR. LANDRIGAN: Do you have a point of
 22 contact up there that you would refer us to?

23 COL. BRADSHAW: This is Colonel Bradshaw.
 24 Our environmental folks are in touch, and have been
 25 up to New York and visited, and have talked with OSHA,

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1 and EPA, and the Coast Guard has actually been there
2 since -- some of the best respirators that they had
3 were from the Coast Guard HAZMAT team.

4 So I think that all of the proper
5 connections have been made, and our folks are talking
6 on this.

7 COL. MALLON: So, Colonel Bradshaw, the
8 Air Force point of contact for the sampling?

9 COL. BRADSHAW: Colonel Sprester, and then
10 Tom Neal, a doctor of patient medicine and physician,
11 who has been up there; and also one of our public
12 health people went up. Those are some of the specific
13 issues that they were looking at.

14 COL. MALLON: Understood. One of the
15 concerns that we had -- and we were touching base with
16 the National Guard and the reserve folks -- was that
17 on the news and in the New York Times, you see people
18 walking around without wearing their respirators.

19 And I think that we had enforced with the
20 State Surgeon from New York just a couple of days ago
21 when I spoke to him personally, and I said and
22 basically reiterated what Dr. Landrigan had said, that
23 the asbestos levels were in fact high.

24 And that they were required to wear
25 respirators but in fact as the pictures represent --

1 COL. BRADSHAW: Our folks noticed when
2 they went up there that a lot of the rescue workers
3 were just wearing the little particulate masks, and
4 our people, as soon as they got there, the Coast Guard
5 gave them the respirators.

6 So our people were in respirators, but
7 they did notice that was a problem in New York. So we
8 had --

9 DR. LANDRIGAN: It is sort of an anartic
10 city.

11 COL. DINIEGA: There is a group of
12 military personnel that have been very involved with
13 the recovery effort, and you see them on t.v. all the
14 time now, the Old Guard Soldiers, who are on rotations
15 who help with the recovery effort, and they are in the
16 crash site.

17 DR. LANDRIGAN: Are they wearing --

18 COL. DINIEGA: I'm not sure.

19 COL. MALLON: It was our intent to work
20 through the chain-of-command to ensure that people
21 were following the recommended respirator protection
22 requirements to make sure that the command enforced
23 the wear.

24 DR. OSTROFF: Can I try to shift the
25 conversation back to the questionnaire, and to the

1 major issue that we were asked to deal with? I do
2 have a couple -- first of all, let me commend you.

3 I am sure that the situation is very
4 stressful. It is very difficult to think about doing
5 something like this in the context of this situation.

6 So I think the Board strongly supports this being
7 done, and it will be an interesting exercise to see
8 what the response rate will end up being.

9 My guess is that it will be quite good,
10 but you never know. One issue that when I look at
11 this -- and, you know, I work for CDC. We have 71
12 people up in New York, many of them doing
13 epidemiologic work. And we have been very sensitive
14 to this issue of we are not doing research.

15 And that we are doing essential public
16 health things, and this particular questionnaire is a
17 questionnaire that is designed to protect people's
18 health, and I think that is very, very important.

19 And that in circumstances in the future
20 that you would want the best information that is
21 available so that you can to the maximum degree
22 possible protect our health and safety.

23 The second thing when I look at this that
24 I have some questions about is the choice of the term
25 "registry." And I am wondering what the logic behind

1 using that particular term is since it has certain
2 connotations in the military setting, particularly
3 around Gulf War registries and things of that nature.

4 And I am wondering if you considered using
5 a different title.

6 COL. MALLON: Let me share with you what
7 the thought processes were. I think that when we
8 originally came up with the word registry the thought
9 was that we could actually motivate participation,
10 with the idea that people would be more interested in
11 getting their name on to the registry and be part of
12 the group.

13 So that if something were to happen down
14 the road, perhaps just like in the Gulf War situation,
15 people would be particularly motivated to participate.

16 And I think that we have had some subsequent
17 discussions that would encourage us to rethink the use
18 of the term registry.

19 But then we looked at the psychological
20 component and the intent of our psychiatric community,
21 which is to follow this group longitudinally over time
22 to see if there is any morbidity in this worker
23 population.

24 So perhaps it really is appropriate to
25 call it what it is, and a registry that we intend to

1 follow people over time.

2 DR. OSTROFF: I'm not sure I know the
3 answer.

4 DR. BERG: Bill Berg. I think the -- now
5 this first page is intended to be the introductory
6 letter?

7 COL. MALLON: Yes.

8 DR. BERG: Okay. I think you could
9 rewrite it so it is more inviting and user friendly.
10 It comes across to me as a bit bureaucratic. You
11 start out, "It is important that we look after our
12 people."

13 And then you sort of drop that line to the
14 second paragraph, where you say, "go see your doctor."

15 You use the word survey, and we want to know
16 information, and there is going to be more
17 questionnaires.

18 And I would read that and say what does
19 this have to do with me, and then you have the
20 opportunity to help others. It is important. And
21 that comes across to me -- and again looking at some
22 of the questions, we want a whole bunch of engineering
23 information so that we know next time whether to make
24 the wall 10 inches thick or 12 inches thick.

25 And I think you could benefit from setting

1 out a more straightforward and open manner, or a more
2 clear cut manner, what benefit is going to come to
3 people who fill out this questionnaire.

4 You may want to think in terms of whether
5 these are issues that people want to talk about, and
6 this is a chance to give us some feedback. The word
7 registry is problematic, but you may want to address
8 the issue that there may be long term psychological or
9 other health effects, and this allows us to follow you
10 and let you know of information.

11 In other words, address the question of
12 what is in it for me if I fill this thing out. I have
13 been through a horrible experience, and I may be
14 injured, and now I have got 14 pages of incredibly
15 detailed questions. Why should I fill it out. So I
16 think shifting it that way may help your response
17 rate.

18 COL. MALLON: Thank you. Understood.

19 DR. OSTROFF: Dr. Haywood.

20 DR. HAYWOOD: Is it contemplated that a
21 similar or identical questionnaire will be given to
22 both civilians and military?

23 COL. MALLON: Yes.

24 COL. GUNZENHAUSER: Tim, maybe I am not
25 seeing it, but there is probably going to need to be

1 an explicit statement of the privacy of this
2 information, and it won't be released to any
3 supervisors, any personal information.

4 And I think we have got to make sure that
5 our chain understands that clearly.

6 DR. OSTROFF: I think that is very
7 important. I mean, what if you put down that your
8 last name is Rumsfeld or something like that. There
9 will be a lot of interest in the particular responses
10 that you would get in a situation like that.

11 COL. DINIEGA: How are we going to control
12 that?

13 COL. MALLON: I beg your pardon?

14 COL. DINIEGA: How are you going to
15 control access to the questionnaire?

16 COL. MALLON: The questionnaire will be
17 handed out to the person who is going to complete it,
18 and collected back at the health clinic.

19 COL. DINIEGA: I thought you were saying
20 something about access on the web page. That's why.

21 COL. MALLON: There will be an information
22 sheet distributed to Pentagon employees addressing how
23 they can access the questionnaire on the Pentagon web
24 page.

25 So if you have dot-mil address, or a DoD

1 e-mail address, our server will screen to permit only
2 access to the dot-mil addresses, and that is one way
3 to restrict access.

4 The other is that we are limiting our
5 distribution of who we are providing the information
6 to.

7 LT. COL. RIDDLE: Dr. Atkins.

8 DR. ATKINS: I was thinking of Dr.
9 Ostroff's comments about research. If one of the aims
10 is to look at sort of long term psychological
11 consequences, as well as other medical consequences,
12 it would seem that there is more information that one
13 would like to look at the things that might be
14 important effect modifiers of that.

15 But I am imagining that some of that might
16 get into sensitive areas, and I was just thinking like
17 looking at marital status and other sort of social
18 connections, and things that might make people more or
19 less vulnerable to the psychological consequences.

20 And I don't have a suggestion. I am just
21 sort of wondering what your approach is, in terms of
22 whether you can capture more information about the
23 things that we could predict might may somebody more
24 vulnerable.

25 And whether you want to capture it at this

1 point, or whether it be something that you might
2 capture down the road and follow up with surveys.

3 COL. MALLON: Well, I think that one of
4 the unasked questions should be does the questionnaire
5 strike the appropriate balance between the kinds of
6 effect modifier questions assessing the appropriate
7 psychological baseline, as compared to the other
8 questions that we are asking in regards to injury and
9 to exposure assessment.

10 LT. COL. FENSOM: Lieutenant Colonel
11 Fensom. One thing that we found a real effective
12 motivator with these kinds of questionnaires was a
13 guarantee up front that anyone who fills it out is
14 going to be informed as to the results of the survey,
15 or at least made knowledgeable about any helpful
16 product of the inquiry.

17 DR. OSTROFF: Yes. And the other
18 requirement is -- I mean, looking at the elements of
19 informed consent when you are talking about informed
20 consent is that there has to be some contact
21 identified that they can call to ask questions if they
22 have particular questions about the questionnaire
23 itself.

24 Or the use of the questionnaire, and any
25 of those types of things, or again how information

1 will be provided back about the findings.

2 DR. BERG: Bill Berg. Speaking to
3 elaborate a little bit on the confidentiality. You
4 may want to consider whether this is releasable or
5 obtainable under the Freedom of Information Act.

6 It is kind of a medical record, but it's
7 really not, and it may be worth at the least running
8 this by the Judge Advocate to see whether it would be
9 protected or not; and if not, what might be done to
10 protect it.

11 DR. OSTROFF: Thank you.

12 COL. ENGLER: Dr. Engler. In regards to
13 that, when questionnaires are done in a clinic
14 setting, if you put on every page that this is
15 protected under quality assurance, and there is a fine
16 if you use this for anything else.

17 It is a standard disclaimer that a lot of
18 us are putting on our e-mail also to protect it from
19 exposure. And if you don't have that -- you know, we
20 all use it regularly.

21 The other thing, just at the end of your
22 questionnaire, the civilians aren't going to have a
23 primary care doctor. Frankly, a lot of active duty
24 don't either. They don't go see them.

25 And the Walter Reed command has made a

1 great effort during this to -- there has been training
2 of the non-psychiatry staff to raise awareness about
3 approaches within regular clinics.

4 And I think you should rather say please
5 contact whoever -- you know, if somebody is coming to
6 the allergy clinic, or to the internal medicine
7 clinic, or whatever, and that is their home. What
8 people identify as their home may not be the primary
9 care, the DeLorenzo Clinic.

10 And we are all prepared to provide that
11 support, and probably getting information out about
12 the questionnaire to the clinics throughout the Walter
13 Reed health care system, and I would think the Navy
14 and Air Force as well, would make you partners in
15 that.

16 Otherwise, the patient will go to the
17 person that they trust, or the individual, and if they
18 don't know anything about it, that will raise distrust
19 of the processes to really be effective.

20 And I think stressing that you provide
21 some kind of nurturing support through this, because
22 this reads very cold, and if you are really struggling
23 with something -- the people who you probably want to
24 hear from the most will be the least likely to fill it
25 out.

1 COL. MALLON: Understood. I should say
2 that we were planning to do information sheets that
3 providers could give to the patients, and some of the
4 information that we talked about could be rolled up
5 into that information sheet, and that the patient
6 could actually take away with them.

7 For example, the uses of the
8 questionnaire, and the restrictions on how it is going
9 to be disseminated, and all of that. I think the
10 other thing that we are going to provide is an
11 information sheet to health care providers so that if
12 a patient comes in and they know nothing -- the health
13 care provider knows nothing of the questionnaire, they
14 can call one of us, and we can provide some
15 background, and give them some insight.

16 And to try and lay it out on the
17 information sheets, but we will also have points of
18 contact and phone numbers.

19 COL. GUNZENHAUSER: Colonel Gunzenhauser.
20 I had a question about the sort of delivery and your
21 oversight of obtaining as complete a response as
22 possible.

23 I don't know how you are planning on doing
24 that exactly. I know that is something that you will
25 have to give some thought to. Normally if this is a

1 survey and you get a 20 percent response rate, there
2 is going to be some concern about what that really
3 means.

4 And obviously it is not a non-administered
5 tracking, and who is responding and who isn't. And
6 there are going to be some questions about do you need
7 to contact these people, or resubmit a survey, or how
8 you are going to do that.

9 And whether you are using command
10 channels, or whether you are using some off-line way
11 of delivering this to them. Have you given any
12 thought to that?

13 For example, in here, if you are going to
14 resurvey them -- I know that you said later that we
15 may resurvey you, but you may send this instrument
16 again if you don't get a response, and you probably
17 should have a statement about that in here.

18 COL. MALLON: Well, what kind of thing did
19 you have in mind?

20 COL. GUNZENHAUSER: Well, for example, if
21 you intend -- let's say you find a 10 percent response
22 rate when you send this out to 20,000 employees. If
23 your intention is, well, we will send it again to
24 those that didn't respond, you should say if you don't
25 -- you might make a comment in here that you will send

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1 another survey later.

2 CPT. SCHOR: Just a question. I think
3 this follows up with Colonel Diniega's and Colonel
4 Gunzenhauser's questions, and that is the use of the
5 word we. I think that occurs maybe 3 or 4 times in
6 the cover sheet.

7 Perhaps it was intended that we is the
8 DeLorenzo Clinic, but it doesn't seem to come across
9 very clearly here. Is we CHPPM? Is we -- that's bad
10 English isn't it? And strike that from the tape,
11 please.

12 But some idea of who is actually sending
13 it out, because I think it then gets into how does it
14 -- will it get tied back into the health record for
15 civilians or active duty.

16 And if it does get tied into the health
17 record, I am not sure that you are going to
18 necessarily be able to do it with just a last name and
19 a date of birth.

20 COL. DINIEGA: The first name is on these.

21 CPT. SCHOR: Okay. But it is still kind
22 of shaky though.

23 COL. BRADSHAW: This is Colonel Bradshaw.
24 I am going to jump in since I have been preempted
25 twice if you don't mind. I wanted to follow up on a

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1 couple of things, but I have several things actually.

2 I did want to be sensitive to what Dr.
3 Ostroff mentioned about the registry, and the CCEP
4 registry in particular, because for one thing, I think
5 we want to make sure that people don't think that I
6 need to have to answer to this questionnaire, or
7 otherwise I am not going to get compensated for what
8 has happened to me.

9 We discussed this earlier and it was
10 raised by Dr. Zimble, I think; but that we are going
11 to take care of our people no matter what, you know.
12 So that is going to happen, whether or not you answer
13 this questionnaire or not.

14 But there is a lot of things that we may
15 get and you may benefit from you yourself, and that
16 needs to be stressed, and I agree with that. But also
17 that we may post-hoc be able to gain knowledge from by
18 doing this, and that all needs to be put in context I
19 think with the questionnaire.

20 So I agree with those comments, and I just
21 wanted to mention that. The other thing is that you
22 have to consider is that if you were thinking by
23 saying registry that you were going to ensure that you
24 increased your participation, you also may have
25 ensured your selection bias if those are the only

1 people that respond are the ones that want to make
2 sure that they get the compensation.

3 I mean, these are just all sorts of issues
4 that we have learned the hard way I think from the
5 Gulf War sort of experience. The other thing is that
6 -- just a few things about the questionnaire itself.

7 We were contacted I think by CHPPM and had
8 an opportunity to look at some earlier versions of
9 this, although I noticed that there were some things
10 missing from the earlier versions that I have seen,
11 and I am sure that reflects a continuing kind of
12 massaging of the whole thing.

13 But the question that I had was on Section
14 B, the mental health or emotional questions that you
15 have. What is underneath that? What were you
16 actually trying to establish from the mental health?
17 Is this the mental health baseline; and if so, what
18 was or what instrument did you draw those from?

19 COL. MALLON: The first question first.
20 It was intended to be the mental health baseline.
21 Now, since those questions were prepared, the
22 psychiatric consultant and a number of other
23 psychiatric professionals within the Army have gotten
24 together, and they are also looking at that same set
25 of questions to make sure that those are the set of

1 questions that they want to have included in here. So
2 those questions are being relooked.

3 COL. DINIEGA: Are they being relooked by
4 them as a single person? I mean, a group of people
5 that are going to come up with one answer? Colonel
6 Engel had stated that he was involved with some of the
7 questions, and he was not very happy with the earlier
8 versions of the questions.

9 And he thought that quantity wise that it
10 was not enough, and he had made some comments this
11 morning about that.

12 COL. BRADSHAW: Yes. I know that you have
13 been talking with Dr. Ursano at USUHS, who is probably
14 one of the preeminent people, at least in PTSD, but it
15 also has worked at the Oklahoma City group, and many
16 others in this area. So I didn't know how much you
17 were considering or if this reflected their input.

18 COL. MALLON: At this point, it does not
19 reflect their input.

20 COL. BRADSHAW: Okay. Because I would
21 caution that you not go out with the mental health
22 until you have incorporated Dr. Engel, and Dr. Ursano.
23 And I think we also in the Air Force provided
24 questionnaires that were used in the Kobar Towers
25 bombing.

1 And we worked with the Oklahoma City group
2 that did the bombing of the Murrah Federal Building.
3 So there is a number of validated instruments on the
4 mental health, and it is a quite extensive list.

5 You can't obviously use it all, but that's
6 where I would say that Dr. Ursano and Dr. Engel, and
7 some others, might help you comb that list down. But
8 if you can use instruments that have been validated
9 elsewhere -- and some of them may be copyrighted, but
10 I think it would be preferable that we use those for
11 comparability and other purposes.

12 So that is just my comments on the mental
13 health section briefly. Other minor comments --

14 DR. OSTROFF: Be quick.

15 COL. BRADSHAW: Yes. The other one was
16 simply on the health status. I noticed that you only
17 mentioned new health problems, and we had wondered
18 about the context of old health problems made worse.
19 And just one editorial. Malcolm Grow is G-R-O-W and
20 not G-R-O-V-E.

21 DR. OSTROFF: We are going to have to
22 break it off or otherwise we are not going to get into
23 our subcommittees. Let me make a proposal here. I
24 think the Board strongly supports what you are doing.

25 We think that it is very important and if

1 you can give us your time frame for getting this thing
 2 finalized, what we could do or what I could suggest,
 3 is that if you provide us an e-mail address or some
 4 way to get in contact with you, each of the individual
 5 members can take this, and take a look at it, and
 6 provide you back specific suggestions about what we
 7 think could be potentially improved to make this
 8 maximally beneficial to the people in the Pentagon.

9 COL. DINIEGA: Should there be a tie-in --
 10 there is nothing in here about previous knowledge or
 11 heightened awareness already of the New York incident.
 12 And psychologically I would think that if people were
 13 aware that they would have reacted a little
 14 differently than the others.

15 DR. OSTROFF: I don't know. I am just --
 16 well, were there time sequences such that everyone was
 17 aware?

18 COL. DINIEGA: Yes, everyone was aware.
 19 It was on t.v.

20 DR. OSTROFF: Then that might be a very
 21 good question then. So what is your time frame to
 22 finalize?

23 COL. MALLON: We would ask for input by
 24 the close of business on Friday. I realize --

25 DR. OSTROFF: That's pushing it, but

1 that's fine.

2 COL. MALLON: -- that is pushing it and
 3 asking people for a lot.

4 DR. OSTROFF: Well, we are again very
 5 committed to helping you develop the best instrument
 6 you possibly can and that's fine. I think speaking
 7 for the Board, that is fine.

8 COL. GUNZENHAUSER: Can you read that e-
 9 mail address?

10 LT. COL. RIDDLE: I will get it out to you
 11 today.

12 COL. BRADSHAW: This is Colonel Bradshaw.
 13 I think we can also make available if people are
 14 interested the Kobar Towers investigation if you want
 15 to look at that for a comparison.

16 LT. COL. RIDDLE: What we would like to do
 17 because of the issues is to have the environmental and
 18 occupational health subcommittee meet in here, along
 19 with the health promotion and maintenance
 20 subcommittee, to discuss the four accession questions.

21 And then I was going to try and get with
 22 Dr. Shope and Dr. Berg, and Dr. Campbell, and we are
 23 going to meet with some folks, and look at the draft
 24 recommendations that we have from the last meeting on
 25 the DoD Immunization Program and the Medical Risk

1 Assessment.

2 And we will move over to next door and
3 then we can just have the break, and then we will have
4 the refreshments around 2:30, and then meet back in
5 here at 2:45. And then if you can record the session
6 in here, and I will take notes next door.

7 COL. MALLON: The thing that I would ask
8 is that time is really of the essence. So if people
9 had the opportunity to look at the questionnaires
10 today, the earlier on that we get the feedback, then
11 the easier it is to incorporate and make changes.

12 We are doing the web-based issue, and we
13 are doing this by teleform so we can scan the results
14 in. So I would just ask that the sooner we get the
15 comments, then the more useful they are going to be.

16 LT. COL. RIDDLE: And I will mail out the
17 contact information to Colonel Mallon today.

18 DR. OSTROFF: Let me just ask before we
19 break. Are there any board members that are opposed
20 to this going forward?

21 DR. HAYWOOD: Not in principle

22 COL. MALLON: Did I hear a consensus in
23 terms of calling it a registry or just a
24 questionnaire?

25 DR. OSTROFF: My gut instinct is not to

1 call it a registry, but I understand why there may be
2 reasons for and against it. I think it is not the
3 Board's decision.

4 COL. MALLON: I will pass along the
5 recommendations of the Board.

6 DR. OSTROFF: Right. I think that is a
7 word that connotes things, and I appreciate what
8 Colonel Bradshaw said, in terms of not wanting people
9 to assume that this is the only way they could get
10 compensation and other issues.

11 And that as long as the -- and again my
12 perspective is that the narrative statement at the
13 beginning needs to be a bit more nurturing. I think
14 that would be very helpful.

15 But if you clearly indicate to people that
16 there will be follow-up, I think that you should be
17 able to get around that particular issue of the fact
18 that there is going to be -- well, I mean, I would be
19 very open about the fact that you think that their
20 health and safety is important. That you are our most
21 value asset.

22 And that their health and safety is so
23 important to you that you think it is very important
24 to continue following along their health and well-
25 being.

1 DR. LANDRIGAN: Would you even go so far
2 as to call it a health and safety questionnaire to
3 make it plain that that was the thrust?

4 DR. OSTROFF: Health and Safety
5 Assessment. I might use a term such as that. But I
6 do think that the narrative has to be a bit more
7 nurturing.

8 CPT. SCHOR: Gary and I were talking and
9 would the Board suggest that the cover letter be
10 signed by the Secretary of Defense?

11 COL. DINIEGA: Wait a minute now. Who is
12 sponsoring the questionnaire? If it is the commander
13 of DeLorenzo, that clinic commander already has a tie
14 with the --

15 CPT. SCHOR: With the Secretary of
16 Defense.

17 COL. DINIEGA: Well, he runs the clinic
18 for the Pentagon. If you want it to be the Secretary
19 of Defense, that is a whole different ball game guys.

20 CPT. SCHOR: But the point is that the
21 Navy and Marine Corps knew nothing about this effort
22 until today.

23 COL. DINIEGA: That's right. The question
24 is who is the sponsor of this questionnaire. Who is
25 pushing it, and who is testing it.

1 COL. MALLON: Admiral Clinton. It has
2 going up to his level, and he has endorsed it.

3 COL. DINIEGA: No, but did he ask for it?

4 COL. MALLON: That's a good question.

5 COL. DINIEGA: That's the question.

6 DR. OSTROFF: I would think that -- I
7 mean, at least from my perspective -- and again I work
8 in a very different atmosphere than you do -- that
9 certainly if it is a product of the clinic, the clinic
10 director should be the primary signatory.

11 But I think in terms of demonstrating the
12 importance of this particular effort, having a co-
13 signatory that is at a relatively high level will
14 demonstrate the commitment to peoples' health and
15 safety. And I would support somebody at a fairly high
16 level endorsing this effort.

17 COL. MALLON: Thank you very much. I
18 appreciate your comments and if you could e-mail me
19 more detailed comments that would be great.

20 DR. OSTROFF: Thanks. We appreciate you
21 coming down.

22 (Whereupon, the meeting was recessed at
23 2:22 p.m., and was resumed at 2:29 p.m.)

24 DR. OSTROFF: David, why don't you start
25 the discussion.

1 DR. ATKINS: Okay. Well, my understanding
2 is that we have four individual questions, and this is
3 a little different than what was written. The other
4 group is looking at immunizations, and so we are
5 responsible for all four questions.

6 DR. OSTROFF: Yes, accession questions.

7 DR. ATKINS: All right. So my proposal is
8 that we go in order to just discuss whether people
9 have specific comments about any of the individual
10 issues that didn't get aired in the previous
11 discussion.

12 And then we will come back to sort of the
13 overall question, in terms of how our response should
14 be addressed, because I think we need an overall
15 response that that incorporates specific answers on
16 their questions.

17 DR. OSTROFF: Right. And then the other
18 thing that has to be decided -- and again time is
19 relatively critical -- we don't have much discussion
20 time -- is that either someone takes the primary
21 responsibility for drafting these specific responses
22 to each of the questions, or you dole them out
23 individually.

24 I would argue that since many of these
25 issues are so similar to each other that maybe we

1 could give the assignment to possibly two of the
2 subcommittee members to draft the responses, in terms
3 of what the recommendations would be. But that is an
4 essential thing that the subcommittee has to do before
5 we break.

6 DR. ATKINS: Okay. So we were asked in
7 order of accession, the first issue was the
8 lengthening of the interval for the physical exam.
9 Does anyone have any questions? I stand corrected.
10 Let's go in order of the questions.

11 The first one is about the use of the EKG,
12 and we heard that there are different implementations
13 of the policy on two sides, and we heard quite strong
14 feelings from each side arguing to retain the current
15 policy.

16 And I forget the acronyms -- but on the
17 MEPCOM side, and on the DoDMERB. So does anyone want
18 to make specific comments about the effectiveness or
19 appropriateness of EKG and on issues that did not come
20 up previously?

21 DR. HERBOLD: Just a clarification on the
22 processes so we can streamline this. Could you
23 clarify? The first two questions start with, "Is
24 there any evidence-based literature that supports this
25 tool for screening."

1 And then the last two don't use that; is
2 there any evidence-based literature for -- and I am
3 paraphrasing -- dental screening, or for this or that.

4 Should we approach it in one way, on what is the
5 evidence?

6 DR. OSTROFF: I would try to make it as
7 standardized as possible.

8 DR. HERBOLD: And then that takes us out
9 of the realm determining sub-OSD policy. I think if
10 we answer, if we can -- and this is just a suggestion
11 open for discussion.

12 But if we can say is there good evidence
13 that says that EKGs are good screening tools to
14 baseline your medical record for accession, and then
15 can we do it for all four, and that's my suggestion
16 and it makes it parallel.

17 DR. OSTROFF: And Dr. Haywood?

18 DR. HAYWOOD: That wasn't quite the
19 question. The question was as a screening tool, and
20 there is no medical record until the screening is
21 finished as I understand it. Is that right?

22 DR. HERBOLD: Well, two comments. We
23 probably both should go back to what Dr. Clinton's
24 exact phrasing is, but the records generated at MEPS,
25 or at DoDMERB, do become a part of your health record

1 if you are accessed.

2 So, your paragraph, your Standard Form 88,
3 and all those things, become part of your record, and
4 I still have mine.

5 DR. OSTROFF: And I can say that the
6 statement here is very concise, asking us to evaluate
7 if any evidence-based literature supports utilization
8 of the ECG as a predictor of cardiovascular problems
9 among asymptomatic individuals between the ages of 17
10 and 35, with a negative cardiac history.

11 I think that is a pretty clear and concise
12 question, and I don't know if you want to address that
13 specifically.

14 DR. HAYWOOD: I think the answer is no if
15 you put it in those terms.

16 DR. OSTROFF: That's the way the question
17 is phrased.

18 DR. HAYWOOD: Well, if you have already
19 assumed that the population is healthy --

20 DR. SHANAHAN: Well, I find this a little
21 bothersome.

22 DR. OSTROFF: That is the question before
23 us.

24 DR. SHANAHAN: There is no question about
25 that. Tim, I think you answered that question one

1 way, and if you looked at it in a strict isolated
2 sense in which it is presented in this particular
3 written question.

4 However, today, we have seen that there
5 are many other sides to that story, and I can at least
6 see the way that I am perceiving this question is that
7 it leads us into an area that I wouldn't exactly call
8 it a set-up.

9 But if you answer under these strict
10 terms, it will then be expanded to cover other areas
11 which are issued between DoDMERB and MEPS, and other
12 people that are involved in this issue. It is a much
13 broader issue clearly than what is specified here.

14 DR. OSTROFF: Well, Dr. Haywood could
15 comment, and again this is not my area of expertise.
16 So I am in a little bit of a disadvantage.

17 But I don't know of any national
18 organization that would recommend using an
19 electrocardiogram as a screening tool in asymptomatic
20 individuals. And we could make some sort of a caveat
21 recognizing the fact that there may be some special
22 circumstances which might warrant the use of the
23 electrocardiogram.

24 But I don't think there is any evidence-
25 based knowledge, and certainly I think we could say

1 that based on AMSARA data that there certainly is very
2 little information to suggest that it is particularly
3 cost beneficial.

4 DR. SHANAHAN: That's why I think that
5 when you answer the question as written, you get one
6 answer, but there are other issues to consider. For
7 instance, the Air Force is concerned that some 60 to
8 70 percent of the accessions have to meet flight
9 status, and flight status requires passing an ECG.

10 There are other issues related to that in
11 terms of the quality of physical diagnosis that goes
12 on during a physical exam, and whether it really is
13 adequate to cover what an ECG might do, which is a
14 very objective assessment.

15 I know in my case that no one ever
16 accessed my pulse in any of my physician examinations
17 to the point where it would have done the same thing
18 as an ECG.

19 Now, we have seen that they are very low
20 numbers, but if you eliminate the ECG altogether, what
21 you have done basically is created a problem in
22 aviation, and probably in the submarine service, and
23 probably in some other areas.

24 Now, those areas I think we should be
25 knowledgeable of, but I am a little confused as to

1 whether we should put such considerations into our
2 deliberations.

3 If we look at this directly, it answers
4 the question one way, and if we look at peripheral
5 issues, we may answer it another.

6 DR. OSTROFF: I think that there are
7 probably set policies regarding what type of screening
8 needs to be done, for instance, for people who are
9 going to be pilots, and people who are going to be
10 riding on submarines, and doing things like that,
11 which are totally separate from getting an EKG at
12 accession.

13 DR. SHANAHAN: So, under special duty
14 status, and you could be -- well, a very simple way to
15 clarify this is if you are hospitalized, you can be
16 returned to full duty is what the discharge line says.

17 However, you are not returned to special
18 duty. You have to go to see a diving medical officer,
19 or a flight surgeon to get put returned to special
20 duty, and flight surgeons and diving medical officers
21 use a different set of standards for return to special
22 duty. So that is very clear and within service
23 bounds. Those are service specific issues.

24 DR. ATKINS: I think the problem that
25 people are grappling with is -- and what we run into

1 all the time on guidelines, is that there are issues
2 of evidence, and there is evidence of other
3 considerations, which sometimes go beyond the
4 evidence.

5 So my proposal is for each of these four
6 issues, we have a response that summarizes what we
7 know about the evidence, and then we have a place to
8 comment on whether we think there are other
9 considerations which would be important in the absence
10 of evidence, or even to override what existing
11 evidence we have.

12 And I am not sure whether we can resolve
13 all those disparate opinions on those other
14 considerations. But I guess maybe what we can do is
15 go through it and see how much of an agreement there
16 is on sort of the evidence as it stands.

17 And then air the places where people think
18 we can agree that the evidence isn't compelling, but
19 we think there are other issues that somehow need to
20 be addressed in our response. Is that --

21 DR. OSTROFF: That seems perfectly
22 reasonable to me.

23 DR. HERBOLD: Can I suggest a two-sentence
24 approach to this? For example, it looks like on
25 question one is that we would suggest that no body of

1 literature that supports utilization of the ECG as a
2 predictor of cardiovascular problems among
3 asymptomatic individuals between the ages of 17 to 35
4 with a negative cardiac history.

5 And then the second sentence would be that
6 this assumption, that this means -- that the foregoing
7 statement assumes that there is an adequate cardiac
8 history obtained, and then also that it is the Board's
9 understanding that there really is not just one
10 accession standard.

11 It's not like that everybody is taking it
12 at age 16 and lined up, and then you attrite into one
13 area or another of a national military service. You
14 see, there are different accession standards.

15 The assumption in Dr. Clinton's opening
16 sentence is that there is only one accession standard.

17 COL. POSTLEWAITE: Could I address that?
18 There is only one standard, but because the Services
19 have the capability of waiving, that gives them the
20 opportunity -- well, the whole idea of a standard is
21 are you qualified or disqualified. If you are
22 disqualified, then that requires further evaluation.

23 DR. HERBOLD: But just to follow this for
24 a second. You cannot waive something that has not
25 been accomplished. So you cannot waive an EKG, an

1 aberrant EKG, that you think is just a technical
2 application issue if the EKG has not been applied.

3 So how can you waive something where the
4 standard says that either DoDMERB or the standard says
5 this should be done, and so DoDMERB and MEPS
6 independently make the decision to waive it off
7 priority?

8 COL. POWERS: What they do is they gather
9 further information, and they gather all the medical
10 evidence from the candidate's medical records. They
11 evaluate that and then they make an opinion as to
12 whether or not to waive that standard.

13 So it is not done at the point in time at
14 the evaluation station.

15 COL. LEE: I would like to clarify a
16 little bit. I think you are talking several different
17 things, and I am not sure that you understand it. You
18 are each talking several different things.

19 DR. HERBOLD: I think I do. I think I can
20 -- I ran this and I put the HIV surveillance policy
21 into place for the Department of Defense at the pre-
22 accession level in 1986.

23 I understand DoDMERB, and I understand
24 MEPS, and I understand the complexity of the
25 situation.

1 COL. LEE: Okay. Because a flying
2 physical is not an accession physical.

3 DR. HERBOLD: I understand that.

4 DR. ATKINS: I'm sorry that I am doing a
5 very poor job sharing this.

6 LT. COL. FENSOM: Well, if it is any help,
7 this is a debate that has gone on in the Canadian side
8 a few years ago, and we did take away the ECG as a
9 universal screening tool for all the reasons that you
10 are talking about, and maintaining the requirement for
11 special circumstances for air crew potential
12 candidates.

13 And in terms of preserving the base line
14 aspect of things, we obtain that at age 35 as per the
15 Canadian Medical Association guidelines for periodic
16 health.

17 But we have recruits at 35 and over, and
18 of course they get an ECG if they are going through
19 the recruiting process.

20 DR. OSTROFF: It sounds reasonable to me.

21 DR. ATKINS: Julian.

22 DR. HAYWOOD: The question presented here
23 though is fairly straightforward; evidence as a
24 predictor, and I think evidence as a predictor is that
25 it is not cost effective.

1 DR. ATKINS: Does anyone from -- well,
2 DoDMERB said they strongly support retaining it? Does
3 anyone want to speak on behalf of what the issues
4 would be if we basically put out a statement saying we
5 don't think it is indicated?

6 COL. WEIEN: Sure. The DoDMERB position
7 is that two of our major customers, the Air Force
8 Academy and the Naval Academy, favor this because of
9 the flight physical aspect later on.

10 The danger would be that we would admit
11 some people into those two institutions, and they
12 would get three years of expensive education under
13 their belt, and then not be eligible to go into an
14 aviation career, which is for the Air Force Academy in
15 particular something they want a high percentage of
16 their graduates to be qualified to do.

17 And which is why they tell me that they
18 favor the use of the screening ECG.

19 DR. OSTROFF: Well, let me just say that
20 with the amount of medical screening that you do on
21 the people that come to these academies, the number of
22 instances that you will have where you will be faced
23 with that situation after 3 years of training, and you
24 are suddenly going to discover that somebody has an
25 abnormal electrocardiogram given these particular

1 parameters, is so banishing low that I can't believe
 2 that is a particularly serious -- I mean, just from
 3 the epidemiologic point of view, it is so remote that
 4 that is going to happen in justifying its
 5 continuation, and the cost of that continuation, just
 6 isn't fair.

7 DR. ATKINS: Does anyone feel -- Phil,
 8 before he left, raised the question about we had those
 9 126 records, and we weren't sure whether it was 3 or
 10 126 --

11 COL. WEIEN: Miscellaneous.

12 DR. ATKINS: -- who might slip through the
 13 cracks and end up --

14 DR. ATKINS: Or 126.

15 COL. KRAUSS: I tried to give you a high
 16 estimate, and I used all remedials that had an
 17 abnormal ECG code. But the fact is that only three of
 18 them ended up as permanent disqualification, and they
 19 were all listed under miscellaneous.

20 So the reality is that if you put on all
 21 the disqualifications related to cardiac, but even
 22 that miscellaneous, it was less than .01 percent.

23 COL. WEIEN: I think perhaps -- and, Tim,
 24 please correct me if I misstate this, but the question
 25 was is there any evidence, epidemiologic evidence, for

1 the use of this as a screening tool.

2 And I think the intent is to take the
 3 answer back and then overlay that with the policy and
 4 other considerations to come to a final decision.

5 COL. CORCORAN: That is correct.

6 COL. WEIEN: I don't think this Board is
 7 being asked to make the final decision about screening
 8 EKGs; is that correct?

9 COL. CORCORAN: That is correct.

10 COL. WEIEN: So the Air Force Academy can
 11 weigh in and say for our people we still want it if
 12 they choose to do so.

13 COL. CORCORAN: That is correct. There
 14 have been historical questions on that. In fact, the
 15 sickle cell trait screening that this Board
 16 considered, there was a policy that was put out by, I
 17 think, Dr. Martin in like '96 or '95 perhaps, and that
 18 basically said that given the results from the AFEB
 19 Board and so forth, and so on, there is no requirement
 20 to do sickle cell screening at the accession level.

21 Well, one service basically at that point
 22 said thank you very much for that opinion, but we are
 23 going to go ahead and still screen for sickle cell.
 24 Fine. But that was decision made by that service
 25 given their circumstances.

1 But at our level, at the DoD level, the
2 accession policy level, the thing was essentially
3 stopped.

4 DR. ATKINS: Would they be able to -- I
5 mean, if the Air Force says we still need to do it,
6 given the politics of it, are they then going to have
7 to apply it back to your side, or can they just
8 selectively apply it?

9 COL. LEE: No, it can just be applied to
10 the Air Force Academy alone, in and of itself.

11 CPT. SCHOR: Just a question. Especially
12 with EKGs, if the -- and I think Colonel Powers raised
13 a question about the standards, and does a test allow
14 you to support the standards for that given an
15 individual. That is not quite the right way to say
16 that perhaps.

17 But the standard talks about conduction
18 abnormalities and rhythm abnormalities that are in the
19 DoDI. If the DoDI includes those as disqualifying
20 conditions, how can you possibly make a diagnosis of
21 those without --

22 COL. POWERS: That's the whole thing.
23 Would any of these individuals come to your attention
24 through any other means other than the ECG?

25 DR. OSTROFF: Well, my guess is that if

1 somebody did a systematic review of those 126 records,
2 where individuals got disqualified, you would realize
3 that very few of them --

4 COL. POWERS: Absolutely.

5 DR. OSTROFF: -- were disqualified solely
6 based on an electrocardiogram. That there is some
7 medical history there that knows that these
8 individuals have had cardiac arrhythmias or
9 tacharrhythmias, or Wolff-Parkinson-White, or whatever
10 it happens to be.

11 COL. POWER: Right.

12 COL. WEIEN: If it would be useful to the
13 Board, DoDMERB will review those 126 cases for you.

14 DR. OSTROFF: Excuse me?

15 COL. WEIEN: If it would be useful to the
16 Board, we can review those cases, and if Margo can
17 identify them by social security number.

18 DR. ATKINS: The point is that no
19 screening process is going to be a hundred percent.
20 Otherwise, we would be doing CAT scans on everybody.
21 And it is really sort of a debate as to whether is it
22 a prevalent enough condition to be worth screening,
23 and the logistical implications of screening
24 everybody.

25 DR. OSTROFF: The answer is no.

1 DR. SHANAHAN: That's why I was talking
2 about if you answer the question directly, because I
3 think Ken has got an extremely valid point. You argue
4 that you can pick this up on history and physical
5 examination.

6 But I think that history is often hidden
7 in physical examinations for the military. All of us
8 who have done physicals for aviation and other special
9 activities know that as well as just general
10 experience.

11 The other issue is the adequacy of the
12 physical exam to pick up these things. So you have
13 got different things going on, but the fact of the
14 matter is that the best way to screen for the
15 particular issues that are brought up within the DoDI
16 is with an ECG. But that is not the question that is
17 being asked.

18 DR. OSTROFF: Exactly.

19 DR. SHANAHAN: And that's where I am
20 having problems.

21 DR. ATKINS: I think the issue is the
22 conditions that are listed in the DODI, or the
23 interpretation of what conditions would not make one
24 able to complete one's duties.

25 So people put in specific conduction

1 disorders. The data that we have from your side
2 suggests that not a lot of people are getting through.

3 The process is clearly imperfect, but because it is
4 an uncommon condition, without screening not a lot of
5 people get through --

6 DR. LEE: Who are being attrited.

7 DR. ATKINS: Right. If the measure is
8 completing training and not having to be attrited, the
9 current process is working pretty well. Sure. There
10 is some people who are slipping by with conditions
11 that they would have gotten excluded from.

12 But the fact is that they actually were
13 still able to complete training.

14 DR. SHANAHAN: Well, that is a third issue
15 the way I see it. If the question was put to us what
16 is the best way to ensure that all applicants meet the
17 requirements in DoDI, the answer would probably be
18 getting an ECG, all right?

19 If the question is as it is presented, is
20 there any evidence to show or to support the
21 utilization, the answer is no.

22 DR. OSTROFF: But the best way to do it
23 might be to do a electrophysiologic studies. Are you
24 going to recommend that if you want to go to the endth
25 degree to make sure that nobody has a cardiac

1 arrhythmia that you don't have to take the EKG at the
2 time that they have a tachyrythmia?

3 I mean, there are ways to definitively
4 diagnose these conditions that nobody in their right
5 mind is going to recommend be a normal screening
6 procedure.

7 DR. HAYWOOD: But you are not going to do
8 an EPS without an EKG.

9 DR. OSTROFF: Well, I understand that, but
10 I mean an EKG is not going to guarantee that you are
11 going to diagnose a condition.

12 DR. SHANAHAN: Well, I wasn't saying that.

13 I am trying to point out that there are a bunch of
14 different issues here besides the question as posed to
15 us.

16 And in fact when we go to other questions,
17 and if we go back to what Colonel Powers has said, you
18 know, does it meet the intent of the DoDI, you brought
19 that up several times.

20 Well, that's not what question one is
21 asking. It is not asking whether it meets the intent
22 of the DoDI.

23 DR. ATKINS: Since I'm probably going to
24 be tasked with taking a first draft at this, here is
25 what I would probably say. I would say that current

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1 evidence doesn't support the use of an EKG as a useful
2 screening test in this population, in an asymptomatic
3 population of these grounds.

4 That some cases who would otherwise be
5 excluded under current DoDI may be or might be
6 detected, but that the yield of that does not appear
7 sufficient to justify it as a routine policy.

8 That this does not abrogate the need to do
9 a careful screening for symptoms for evidence of
10 symptomatic cardiac disease, and that there may be
11 other conditions, other issues, including specific
12 service needs that would justify screening on a more
13 selective basis. Does that capture the general --

14 COL. GARDNER: There is one more piece in
15 there. I think the point here is that MEPS and
16 DoDMERB are simply not medical care. They do
17 screening to rule out people who are ineligible for
18 military service.

19 And when they have abnormal findings,
20 either they qualify or they don't qualify, but there
21 is no medical care involved in terms of following them
22 up to make sure that things got taken care of.

23 And that is a totally different concept
24 than what the preventive health task force has been
25 dealing with. There you are talking about a medical

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1 care setting, and when you find something, you follow
2 up on it, and you lower the risk.

3 And I think that is the problem here, is
4 that if you simply look at do the meet standards or
5 not, then obviously that's a cost effectiveness issue
6 as to how hard you look.

7 But when you look at the medical care
8 issue, and are these people going to get the medical
9 care that they need if they do have problems, and the
10 EKG is a good example, I think that everybody needs a
11 baseline EKG in their chart at some point, because it
12 helps you so much later on when things happen and fail
13 to go back to that.

14 But the dental situation relates in the
15 same way. There are recruits who are arriving at
16 training in what they call Dental Cat 4, which means
17 that you are not deployable or not available to move
18 forward until you get examined by a dentist, and
19 problems either taken care of or defined as not
20 needing to be taken care of.

21 And we don't have that same for medical,
22 and they may have problems that may need to be looked
23 at and developed, and evaluated, and taken care of,
24 and counseling given, and so on. That does not happen
25 at MEPS.

1 And so you have to take that into
2 consideration, and so the medical care issue is the
3 part that is missing from these questions.

4 DR. ATKINS: So what I am hearing you
5 saying is that just using attrition rates may not be a
6 sufficient standard if there is a lot of undetected
7 disease that we should be treating differently.

8 I would argue that I don't think the data
9 would support that, but I would agree that attrition
10 data may not be enough. I mean, I don't -- I am not
11 sure that you would find a lot of treatable cardiac
12 disease with an EKG.

13 COL. GARDNER: I guess my point is that
14 everybody needs a health maintenance exam at the onset
15 of military service, just like they do a dental exam.
16 We don't have a medical Cat 4 that says that you are
17 not eligible to move forward until we have reviewed
18 your history and physical and determined -- and given
19 you the counseling and immunizations, and everything
20 else that we think you need before you can move
21 forward.

22 That MEPS exam in the Army is your first
23 physical exam. Your next one is not for five years,
24 and there is no enforcement process to ensure that
25 even the five year one happens. And that is a

1 question that might need to be addressed separately.

2 But I think it should be addressed by the
3 AFEB as a way to get an enforced health maintenance
4 program into the medical side the way they do the
5 dental side.

6 DR. ATKINS: But that is not the
7 responsibility of the accession process.

8 COL. GARDNER: Absolutely not. Absolutely
9 not.

10 DR. ATKINS: All right.

11 DR. OSTROFF: Keep going.

12 DR. ATKINS: I am going to propose that we
13 skip over to the dental one, because I think that is
14 the one where there is again more -- I heard more
15 disagreement about.

16 And I think we heard competing data. So I
17 just want to invite it for any comments. We heard
18 data from the MEPCOM side that their current screening
19 process, which does not involve dentists or
20 panographs, has not led to major problems in terms of
21 attrition due to dental disease.

22 And so I would say that we don't have good
23 evidence in front of us to support that and them
24 changing their policy. The question is are we asking
25 DoDMERB to change their policy and give up something

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1 that has been now standard, in terms of dental exams
2 by dentists, including panographs. Any comments in
3 terms of general direction of that?

4 DR. SHANAHAN: Well, I think once again we
5 are faced with some of the same issues. If you read
6 the question, it is asking whether if the need for
7 service academy and ROTC applicants to be examined by
8 dental professionals using panographic.

9 Now, that is a somewhat more open question
10 than question one was, but the way I kind of boiled
11 down the discussion was that I saw it coming from two
12 ways. One was the services are saying that what they
13 are getting now is adequate in many ways.

14 But the other issue was are we meeting the
15 DoDI, and we heard a dentist tell us that you can't
16 meet the DoDI without having a dentist do an
17 examination. I am not sure how specific he was about
18 whether he needed panographic studies. So again there
19 are two issues here.

20 DR. ATKINS: Again, I think if you asked a
21 cardiologist could you meet a DoDI, or if you asked a
22 neurologist, I think you would get a different
23 response.

24 DR. SHANAHAN: Well, the critical piece of
25 evidence that I would really like to see is what is

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1 the percentage of Cat-3s and 4s who are being accessed
 2 into our training centers, because to my knowledge no
 3 one has ever really -- that is a good way of looking
 4 at the cost and the burden of getting people at the
 5 Class Two, which is what you need to deploy them.

6 COL. DUNN: But if the circumstance is
 7 that they are willing to accept that cost, should that
 8 be a major consideration then?

9 DR. SHANAHAN: Then again it gets back to
 10 are we answering the question in terms of meeting the
 11 DoDI or meeting the needs of the service.

12 COL. DUNN: Right now for non-scholarship
 13 applicants, they do not see a dentist, and while
 14 officers will be accessed as officers as well. It is
 15 the scholarship applicants that have to see a dentist.

16 And from Cadet Command's perspective that
 17 just does not make a whole lot of sense. Do it for
 18 everybody, or don't do it for anybody.

19 DR. OSTROFF: Well, let me just make a
 20 comment. I mean, I think with this particular issue,
 21 this one I think you are indeed correct is the most
 22 difficult I think to negotiate our way through,
 23 especially since most of us are not particularly
 24 expert in this area.

25 You know, the bottom line for me is

1 whether it meets the DoDI or not, and I understand the
 2 importance of that. But ultimately what we are trying
 3 to do is to maximize accession, while at the same time
 4 assuring that we have healthy soldiers, healthy
 5 airmen, healthy sailors, and healthy marines.

6 And if indeed there is a commitment that
 7 the dental work can and will be done -- I mean, my
 8 concern is not that some are getting panography, but
 9 that others aren't quite frankly. That is my bigger
 10 concern.

11 I think that the current policy is not
 12 justifiable epidemiologically to do it on scholarship
 13 recipient ROTCs, and not to do it on non-scholarship
 14 recipient ROTCs. I mean, what is the logic behind
 15 that. It doesn't make any sense to me.

16 There is almost the same amount of
 17 investment, with the exception of the scholarship, in
 18 those two groups. And the current policy doesn't make
 19 any sense to me.

20 I understand that there might be very good
 21 rationales behind it, but if the intent is to ensure
 22 that these people have healthy mouths, I think that
 23 this is the one area where I would like to see more
 24 rather than less personally.

25 LT. COL. RIDDLE: And if you have not had

1 time to look at the evidence in the abstracts, in the
2 articles, for the people who have identified to work
3 these issues, we have them, and we have them
4 available.

5 And there is pretty good evidence on these
6 issues, and I think that is what you need to look at,
7 at what is the published literature, and how does this
8 support. And I think you will get an idea of is this
9 a necessary screening tool for these conditions.
10 There is some pretty good literature out there.

11 And I did get a chance to review that
12 literature, and I share Steve's concerns about it as
13 well. But I think there are two ways of answering
14 this particular question, and we have to decide on
15 which way we are going to answer it.

16 DR. SHANAHAN: And I would suggest that it
17 looks now like there are three ways. We can answer
18 each question directly.

19 DR. HERBOLD: Rick, I --

20 DR. OSTROFF: You must be psychiatrists.

21 DR. HERBOLD: We can answer the question
22 in the context of what the current accession standard
23 statement is in the DoDI, or we can answer the
24 question in the context of do you really think that
25 this should be your accession standard, which I have

1 heard several folks say.

2 And I think we could answer it three ways,
3 and that might -- I don't think that triples the work.

4 I think it will send a message. It will answer Dr.
5 Clinton's question, and it will also send a message
6 that we recognize that there is a depth to this, and
7 that there are different levels.

8 And so we could find three different ways
9 to answer your questions, which must mean that we all
10 are psychiatrists. But at least we have answered
11 them, and we have answered it in the context of the
12 concerns that we have heard around the table today.

13 And I would be happy, Dave, to help you work through
14 that.

15 DR. OSTROFF: Okay. Let's work on the
16 fourth one very quickly.

17 DR. EDWARDS: May I make a quick comment?

18 May I have a chance to make a comment? I am Dr.
19 Edwards, and I am one of the dentists in TRICARE
20 management activity.

21 Let me just say that I like your approach.

22 I think Dr. Clinton -- and I hate to speak for Dr.
23 Clinton. I really shouldn't be trying to do that.
24 But I think he would very much appreciate your
25 comments and your exploration of the issue in depth.

1 And maybe not just addressing the question
2 that he initially posed to you, because as you can
3 see, this is a very difficult issue. On the surface,
4 it looks very simple, but it's not really.

5 I would also suggest that you not
6 concentrate so much on the panograph issue. I think
7 there has been a lot of discussion about panographs,
8 and we are talking about abstract articles about
9 panographs, and how ineffective they are as a
10 screening tool.

11 And I would suggest that we not
12 concentrate so much on panographs, but concentrate on
13 the dental professional exam. And does it in fact
14 require a dentist to make a judgment on some of the
15 standards within the DoDI.

16 Now, I think we would agree -- Captain
17 McKinley and I both would agree that we should look at
18 revising the standards. I mean, I have learned a lot
19 from this discussion today and that maybe we don't
20 have the standards in place that we need to have.

21 And I think we should look at the revision
22 of those standards, and we have already been doing
23 that with the AMSWG. I would also suggest to you that
24 if you give us a tasker to go out and collect more
25 data for you, where you can make a business case

1 decision here, with additional data that USUHS
2 suggested maybe getting some data from the recruit
3 training centers, we would be happy to do that for
4 you.

5 I would also suggest that if the DoDMERB
6 standards are eliminated, and the dental requirement
7 for DoDMERB is eliminated, that the dental services
8 will need additional resources to manage and treat
9 those patients in the Service Academies of all the
10 dental disease that we are going to find within the
11 academies that we are not finding now.

12 Also, for ROTC students, somehow we will
13 have to get those folks out into the civilian world
14 and get their dental care done at civilian prices. So
15 we will need additional resources.

16 So if you do decide to eliminate the
17 dental professional exam and the radiograph as a
18 screening tool for DoDMERB and ROTC scholarship
19 applicants, please also suggest that Dr. Clinton give
20 us more money. Thank you.

21 DR. ATKINS: So as a process issue, who
22 else would like to help craft this position on dental
23 stuff? Okay.

24 DR. OSTROFF: Physical exams.

25 DR. ATKINS: Physician exams. What I

1 heard was a neutral position from DoDMERB about
 2 extending the interval. Our task force does not have
 3 a position statement on the frequency of periodic
 4 health exams, though I would say that in this age
 5 group nothing we say would argue against extending it,
 6 people with a normal baseline exam, and extending that
 7 to a longer interval than two years.

8 We heard comments that from a logistical
 9 standpoint that might raise issues on the MEPCOM side.

10 So any comments on that? Does anyone want to weigh
 11 in on whether extending it to five years would be a
 12 problem?

13 Let me break it down. >From an evidence
 14 standpoint, does anyone here have evidence that says
 15 that we should retain a two year standard for physical
 16 exams?

17 DR. OSTROFF: No.

18 DR. SHANAHAN: Let me get one point of
 19 clarification though. I guess Colonel Lee --if it is
 20 four years or something like that for deferred status,
 21 you are going to have some kind of medical assessment
 22 before you process. Am I correct?

23 COL. LEE: Yes, we will. We will do an
 24 interval history. From a medical point of view, our
 25 concern is -- well, you already heard Dr. Krauss talk

1 about a fair number will lie to us. That will
 2 continue.

3 And if we make the assumption that a full
 4 physical is better than an interval history, if that
 5 assumption is valid, that's our primary concern,
 6 because we have applicants at a high risk behavior, a
 7 high risk activity that we don't see for a while.

8 DR. OSTROFF: Let me just add the caveat
 9 that -- I mean, I think things are a little bit
 10 backwards here as I do with many things that happen,
 11 which is that I think that the people who get the
 12 better screening should have a longer interval than
 13 people who don't get as good a screening.

14 And it is obvious that the DoDMERB gets
 15 much better -- I always get it all wrong. That your
 16 people get better screening than your people.

17 COL. LEE: Let's say they get different
 18 screening.

19 DR. OSTROFF: Different screening, but not
 20 as intensive screening as your people get. And so I
 21 think that there may be some rationale behind
 22 accepting the initial screening examinations that are
 23 done for the candidates to the service academies, et
 24 cetera, than for those that come in under the MEPS
 25 system.

1 DR. ATKINS: Yes. My understanding of
2 where this came from was actually from that side, who
3 cared more about the interval, than on the enlisted
4 side.

5 DR. OSTROFF: And I could perfectly well
6 see the justification for retaining the current MEPS
7 requirements, while extending the requirements on the
8 other side.

9 DR. ATKINS: Well, I guess my proposal
10 would be that we have a statement that says based on
11 the current evidence we think it would be acceptable
12 to extend the interval for officer accession exams
13 beyond two years.

14 That due to a higher risk and logistical
15 issues on the MEPCOM side there may be arguments for
16 retaining a two year standard and leaving it like
17 that, and that there is not definitive evidence either
18 way. Does anyone want to take issue with that?

19 DR. SHANAHAN: Not entirely, except that I
20 think that Colonel Dunn made an extremely good point
21 about the problem with ROTC, and ROTC is getting
22 acquisitions as I understand it through both DoDMERB
23 and MEPS.

24 So by doing that I don't think we are
25 necessarily addressing his issue, or we may be solving

1 one side of the prong, but not the other side of the
2 prong.

3 COL. LEE: Actually, I think you are
4 solving the waive issue from his issue for both of
5 them if you say officer accessions, because both of us
6 do officers.

7 DR. SHANAHAN: Right.

8 COL. LEE: Now, the other issue, Jim, you
9 can address if they are meeting your intent.

10 COL. DUNN: Their extending the validity
11 period for officer accessions would be my intent,
12 because I am assuming that would apply to scholarship
13 and non-scholarship.

14 DR. SHANAHAN: Okay. Because I think we
15 do have to recognize that we are dealing with two
16 distinct populations. There are very great
17 differences demographically between those two
18 populations.

19 DR. ATKINS: And I was hearing logistical
20 concerns from your side, in terms of what it would
21 mean --

22 COL. LEE: Absolutely, because kids go
23 from MEPS to MEPS and I am talking about 500,000 to
24 800,000 records that I would have to keep on. Yeah,
25 there is a lot of logistical problems for me. Plus,

1 we do HIV/DAT, which we would have to do more, because
2 our waiver is only for two years.

3 And if we extend that to five, DoD will
4 probably not give us that waiver. So we would have to
5 do a repeat.

6 LT. COL. RIDDLE: But direct commissions
7 come from MEPS. So if you were to word it strictly
8 officer, you have direct commissions that come through
9 MEPS.

10 COL. LEE: Right, but we do officer and
11 enlisted physicals. So yours would still be good for
12 five years.

13 LT. COL. RIDDLE: But you would not have
14 my record for five years. I would be an officer
15 coming through MEPS --

16 COL. LEE: But you would move on and you
17 would be in the service, and your record would be in
18 your medical record.

19 COL. BRADSHAW: I don't see where there is
20 a problem with saying that they could be valid for
21 five years, and then by policy MEPS wants to do it
22 more often, then that's MEPS policy, because most of
23 their concerns are logistical and not really evidence-
24 based that I hear.

25 DR. HERBOLD: Yes. So the question is you

1 could have stricter standards, depending upon which
2 hoop you want people to jump through. Here it is the
3 relaxation of standards.

4 So if we relax it to 5 years, and you
5 still need it for 2 years, you can do that. The
6 barrier right now is that the DoD says 2 years, and so
7 we need to relax it to 5 years if the evidence
8 supports that.

9 COL. LEE: We, MEPCOM, couldn't change the
10 policy, and perhaps accession policy, and I will tell
11 you it is going to be a food fight because the
12 recruiters will say, hey, look, the AFEB says it is
13 good for 5 years, and so we don't want to bring them
14 back for another time.

15 It will be problematic if that is the way
16 it is put, although accession policy, which is OSD
17 level stuff, could say we are going to make a policy
18 that we do it for two, but then they are put in kind
19 of a trick, too, then because officers and enlisted --

20 COL. DUNN: You require a medical history
21 right now which is not directed by DoD.

22 COL. LEE: Actually, it is.

23 DR. OSTROFF: I think it is.

24 LT. COL. EDMONDSON: But as far as this
25 specific issue -- and you bring up a good point, but

1 if it gets to that, and when it gets to that, that
2 will follow to me, and we will resolve it at that
3 time.

4 But for the sake of this meeting and the
5 task that you all have, I like the discussion and
6 where you are going with it, and I think it is
7 appropriate for the issue that was brought up earlier.

8 The way you worded it, and you will have to work on
9 it.

10 DR. ATKINS: And does our response have to
11 say something that if the physical is being considered
12 valid for a longer period that there has to be an
13 interval screening question about health status, or is
14 that something that is just an implementation piece
15 that would be assumed?

16 Because the assumption was that if you had
17 not had a physical, there would still be some process
18 of saying --

19 DR. OSTROFF: Yes, I would think it is
20 pretty critical to ask them if they had been in a
21 motorcycle accident or something like that.

22 CPT. SCHOR: I would recommend including a
23 comment as to how frequently you should reassess their
24 interval history. I don't think there is any other
25 DoDI that would cover that period of time.

1 So unless it is stated explicitly, it is
2 not going to get done. So a recommendation that
3 shapes that would be helpful.

4 COL. CORCORAN: In Title 10 law, U.S.
5 Code, Title 10, and in Section 10.206, they talk about
6 ready reserve, because I asked the question is there a
7 law there that actually dictates the length of time
8 for physical exams or for medical histories, and
9 actually there is, at least for the ready reserves.

10 And it says here to be examined as to his
11 physical fitness every five years, or more often, as
12 the Secretary considers necessary. So it gives the
13 latitude of every five years.

14 And then it says number two, and this is
15 again the law, to execute and submit annually to the
16 Secretary concerning a certificate of physical
17 condition. So I don't know if physicians wrote this,
18 but to me that sounds like an interval history.

19 CPT. SCHOR: I happen to have seen some of
20 this on the JPMPG and some of the tools that are used
21 by the reserves for assessing interval history, and
22 they look really good. So that may be particularly
23 helpful to suggest some of those tools.

24 COL. DUNN: But in terms of what we are
25 doing with the Airborne School, which allows the

1 DoDMERB physical to be valid for 5 years to jump out
2 of planes, is that within 4 months of attending
3 airborne school the student submits a statement saying
4 there has been no significant change in his health
5 status since the original physical.

6 And if there has been a significant
7 change, then he is required to get another physical.
8 So that statement is on a DA Form and is sufficient --

9 DR. OSTROFF: I have to exert the Chair's
10 prerogative and we are over time unfortunately. I
11 think we have sufficient information for you to craft
12 responses to the specific questions raised by Admiral
13 Clinton, and let's go ahead and end the subcommittee
14 meeting.

15 We need to go into the Executive Session
16 for I think the last 15 minutes that we have, and if
17 memory serves me correctly, the executive session is
18 only for board members and for Dr. Riddle.

19 So we thank the rest of you for your
20 participation.

21 (Whereupon, at 3:19 p.m. the meeting was
22 concluded.)
23
24