

UNITED STATES OF AMERICA

DEPARTMENT OF DEFENSE

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ARMED FORCES EPIDEMIOLOGICAL BOARD

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MEETING

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Friday, April 17, 1998

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The meeting reconvened in the Randall Room, Navy Environmental Health Center, 2510 Walmer Avenue, Norfolk, Virginia, at 8:00 a.m., Dr. Gerald Fletcher, President, presiding.

PRESENT:

GERALD F. FLETCHER, M.D., President

JAMES R. ALLEN, M.D.

HENRY A. ANDERSON, M.D.

JOHN R. BAGBY, Ph.D.

ELIZABETH BARRETT-CONNOR, M.D.

JAMES CHIN, M.D.

MARY LOU CLEMENTS-MANN, M.D.

L. JULIAN HAYWOOD, M.D.

JUDITH H. LaROSE, Ph.D.

DENNIS M. PERROTTA, Ph.D.

PRESENT (Continued):

GREGORY A. POLAND, M.D.

ARTHUR L. REINGOLD, M.D.

CLADD E. STEVENS, M.D.

LCOL. RUSSELL EGGERT, PMO

LCDR. ANN FALLON, MC, USN, PMO

LCOL. FRANK SOUTER, CFMS, PMO

LCDR. MARK TEDESCO, PMO

COL. VICKY FOGELMAN, Executive

Secretary

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P R O C E E D I N G S

(7:56 a.m.)

(Call to attention.)

COL. FOGELMAN: Sir, would you like for me to introduce you?

RADM. ROWLEY: Oh, okay.

COL. FOGELMAN: Thank you.

It's really my pleasure today to introduce Rear Admiral William Rowley, who is taking time from his busy schedule to come to speak to us. He's currently the Command Surgeon of the U.S. Atlantic Command and also the Medical Advisor to the Supreme Allied Commander, Atlantic. Correct me if I'm wrong, sir.

He's previously been the Commander of the Naval Medical Center, Portsmouth, and the lead agent of Tricare Region II. He's also been assigned to the Naval Bureau of Medicine, Surgery, as the Deputy Assistant Chief for Health Care Operations and the Assistant Chief for Plans, Analysis, and Evaluation, and he was also the Commanding Officer of the Naval Hospital, Camp Pendleton, and the Deputy Commander of the National Naval Medical Center in Bethesda.

So as you can see, he's really got a wealth of experience in the topic that we're

1 going to discuss today.

2 He's a real futurist and has been
3 heading the Military Health Service 2020
4 strategic planning initiative, and he's going to
5 talk to us today about the future of military
6 health care.

7 Admiral.

8 RADM. ROWLEY: Well, good morning.

9 (Applause.)

10 RADM. ROWLEY: Anybody know how you
11 turn this on? I can't find -- I have to get out
12 my K-Mart glasses to read it. See, it's not just
13 me, right?

14 Okay. Can you hear me?

15 COL. FOGELMAN: Yes.

16 RADM. ROWLEY: Great. Now, it's
17 interesting, the other job that I have is I'm the
18 Fleet Surgeon of the U.S. Atlantic Fleet, and
19 I've been that for a couple of weeks, but I
20 haven't gotten any ships yet. I'm still going
21 through orientation at the office. So yesterday
22 you found out more about the fleet than I know.
23 You really are the experts, and you probably have
24 got the sore feet to prove that.

25 I'm going to do something a little bit
26 different today. I'm going to give you my view

1 of the future of military medicine, and I'm going
2 to focus more on sort of what are the forces
3 which are going to affect it, an effort to get us
4 to think.

5 Here it is, and one of our biggest
6 problems is we don't let go of our paradigms, and
7 I think that's the secret of the future, is to
8 see the world in a different light because I
9 don't think things are going to change so much as
10 our view of things, and our view makes all the
11 difference in the world.

12 First off, you've been around for a
13 long time and understand everything is economics
14 and politics, and that applies to medicine. It
15 applies to the military. It applies to my house.

16 This slide is a couple of years old,
17 and you say, "Well, this isn't true anymore," but
18 this is how we thought the cost of American
19 medicine was going to rise, and right now it's
20 somewhere between 14 and 15 percent of the gross
21 domestic product. So you can see it was
22 anticipated it would shoot up, and of course
23 people say, "Not a problem because we have
24 managed care. It's controlling cost." Medical
25 inflation last year was less than inflation
26 overall, but that's really a temporary fix.

1 As the next slide will show, the
2 reason it's going to get out of hand again is
3 because Americans are getting older. Looking at
4 the demographics, this is what we looked like in
5 1970, and you see this big bulge. This is us
6 Baby Boomers, and we're all young and healthy.

7 Well, this last year the first of the
8 Baby Boomers turned 50, and as you can see, this
9 large bolus or kind of like the snake that
10 swallowed something is moving up into the age
11 range where there's going to be a lot of medical
12 problems.

13 The other thing that's fascinating is
14 the fastest growing segment is right up here,
15 especially females who are over the age of 75.
16 So the demands for medical care are probably
17 going to far outstrip any of the cost savings
18 that we can come up with, and I think the cost of
19 American medicine is going to continue to plague
20 us.

21 If we look at the federal budget, this
22 is the reason that President Clinton said earlier
23 on, "I've got to do something about health care
24 reform." If you look here, this wedge is
25 Medicare and Medicaid. Eighteen years ago it was
26 about ten percent of the federal budget. Last

1 year it was 22 percent. In other words, it more
2 than doubled.

3 The other thing that's kind of
4 interesting because I believe some of you work
5 one way or another for the federal government and
6 get money from the federal government. This is
7 everything else. If you exclude Social Security,
8 Medicare, interest, and the national debt and the
9 military, this seems to be a pretty healthy piece
10 of the budget, but look at how it's gotten
11 squeezed out. That has shrunk by more than 50
12 percent.

13 So if we want to start new social
14 programs and really can't do a whole lot with
15 entitlements, either taxes get raised or we make
16 the economy better or we take it from the
17 military, and as you can see, this purple wedge
18 has shrunk fairly significantly, and it's going
19 to shrink more. That's the piece of the pie that
20 the American military gets.

21 Part of the reason is because we don't
22 -- the Americans, at least, don't see a big
23 threat to their national security. Part of it is
24 that you can only do so much with the money.
25 It's a shell game, and that's going to have a
26 tremendous impact on the Defense Department.

1 Over the last ten years, the number of
2 people in uniform has dropped around 30, 35
3 percent. The budget for the military has dropped
4 about 45 percent, but because we have a lot of
5 infrastructure to take care of, we're very busy
6 operationally, and still have a lot of expenses,
7 the part of the budget which has been cut the
8 most is the procurement budget to replace all of
9 our aging weapons systems.

10 Now, the Defense Department has about
11 a trillion dollars in the purchasing line right
12 now. In other words, we're in the process of
13 buying about a trillion dollars worth of stuff
14 from American industry, which makes us by far the
15 biggest buyer in the country or in the world.

16 So there's the dilemma. The military
17 is struggling to balance everything. It has cut
18 the budget, but guess what Boeing and McDonnell-
19 Douglas and everybody else wants us to do. They
20 want us to buy new weapons systems. So it's a
21 real dilemma.

22 If you look at the entire Defense
23 Department, which includes that giant bureaucracy
24 in Washington, 62 percent of it is
25 infrastructure. That's the part we're trying to
26 cut down so that more of the money goes into the

1 real readiness side of things.

2 Here are some bullets that show the
3 dilemma. Right now many people say we don't have
4 the money and the resources to fight two major
5 regional conflicts at the same time, like maybe
6 having to fight Iraq and North Korea.

7 We're getting to the point where we
8 can't provide all of the training for everybody,
9 and we're saying maybe those units that wouldn't
10 go to a wartime setting fast, we'll not
11 completely train them, and then we'll give them
12 "just in time" training before they go.

13 Nobody knows where the Defense
14 Department budget is going because the economy,
15 as well, right now is probably going to stay
16 stable for the next few years. It's about \$260
17 billion, but there are people that say as we get
18 into the 21st Century, maybe it'll get down to
19 the 200 billion mark, which would really put a
20 crimp on things.

21 And I'll talk a little bit about what
22 size military medicine ought to be to compete
23 with this. This is my view of military medicine.

24 They want us to be all things for all people,
25 what you'd expect.

26 In America health care is a condition

1 of employment, and I've represented it right
2 here. If you work, you expect that somebody's
3 going to provide all of the health care you need,
4 and that means all of the health care you desire.

5 So we're expected to be on the
6 wellness side, lifelong care, specialty care.
7 Anything that's needed they expect us to provide
8 it.

9 The military is unique though because
10 we have another piece of our health care system.

11 You saw part of it yesterday. That's the
12 military unique piece, which means that we've got
13 to have a medical department floating around with
14 our ships or traveling around the world with the
15 Marine Corps, with the Army. We've got to be
16 ready to go to war and have a wartime medical
17 infrastructure, too.

18 So we're expected to do all of these
19 things. The problem is we don't have enough
20 resources in uniform to do it all. So part of
21 this we provide with our active duty medical
22 department, which includes military unique and a
23 fair amount of our peacetime health care system.

24 The rest of it we have to buy in the civilian
25 community.

26 To give you an idea of some of the

1 dilemmas, that we're facing, right now there are
2 more retirees and their family members that we're
3 obligated to take care of than there are active
4 duty and their family members.

5 Could you move that slide up a little
6 bit so they can see in the back? Great.

7 In the near future, we're going to
8 have more retirees over the age of 65 receiving
9 military medicine than we have active duty, and
10 that's getting scary. You know, people live
11 longer. We've got a lot of retirees, and our
12 active duty forces are shrinking.

13 The other thing that scares some
14 people, especially the Marine Corps is that right
15 now we're spending more money on military
16 medicine than we're spending on the Marine Corps.

17 It's in about the \$16 billion a year range. So
18 we're becoming a big target for trying to figure
19 out how to control that cost.

20 So some things are happening to us.
21 We're going through right-sizing just like
22 everybody else or we're attempting to. We've got
23 a lot of small hospitals. In fact, there are
24 some hospitals that have an average daily patient
25 load of less than one, not too cost effective.
26 We're closing all of those, making them into

1 clinics.

2 We're getting closer and closer to
3 Congress accepting another Base Realignment and
4 Closure Commission because we've got to get rid
5 of some of that unnecessary infrastructure.

6 We've been slowly reducing the number
7 of training programs as the need for our
8 specialists drops in some areas.

9 There has been pressure off and on to
10 reduce the size of our medical departments to the
11 minimum necessary to fight those two major
12 conflicts, and each one of the three medical
13 departments has a significant number of personnel
14 beyond that level.

15 There's a lot of effort to privatize
16 things, to out source, to contract, and all of
17 that stuff. We are working much better between
18 the three services. For instance, in Hampton
19 Roads here, there are 425,000 people eligible for
20 military medical care. That's one-third of the
21 entire population here. We have an Army
22 hospital, an Air Force hospital, and a Navy
23 hospital. They do everything on one computer
24 system. More and more we're cooperating, sharing
25 resources, finding ways to economize. We buy
26 things in bulk as a unit. We're finding that

1 working together is much more effective, more
2 cost effective than doing everything on our own.

3 And we're finally paying attention to
4 the business. We're now capitulated. We never
5 worried about that before. Now all of a sudden
6 we've got to make it last within a certain amount
7 of money, too.

8 Military medicine is going through
9 everything almost that civilian medicine is going
10 through. We're going to primary care, ambulatory
11 care. At the hospital across the river, 95
12 percent of our surgery goes through the
13 ambulatory surgery center. Four hundred and
14 twenty-five thousand people in this area; the
15 average census over there is about 150, and it
16 used to be a 600-bed hospital. The average
17 length of stay is about three and a half days.

18 We have gradually gone into a
19 transition where we're bringing in civilian
20 partners to help us provide health care. That's
21 called Tricare. We've divided the country up
22 into 12 regions. There is a major civilian
23 organization that we've contracted with in every
24 region. For instance, most of you have heard of
25 Humana. Humana has Regions 3 and 4. We have a
26 business called Anthem, which is a very big, Blue

1 Cross/Blue Shield industry in Ohio who are our
2 partners.

3 So we're all joining with civilian
4 partners to have managed care. This is old hat
5 for many of you. Some of you probably don't know
6 our system very well, but this looks pretty much
7 like civilian medicine.

8 We now offer our beneficiaries three
9 choices. One is a Health Maintenance
10 Organization where they get their own primary
11 care manager, and we really manage the way they
12 get their health care.

13 We have a Preferred Provider Network,
14 which offers a discount, and then we have a
15 regular plan, which is a fee-for-service type of
16 health care plan. So we're doing things very
17 much like the civilian sector.

18 But we're doing it kind of in
19 combination. If somebody enrolls in our HMO,
20 they may go to a military doctor or they may go
21 to one of our civilian network doctors. For
22 their specialty care and hospitalization, if we
23 can get them into a military facility, we will.
24 If we can't, we'll in any place put them in a
25 civilian facility, and you can see what the cost
26 is.

1 For an active duty family member,
2 there is no enrollment fee. There is no
3 deductible. If they go to a military provider,
4 it's free. If they stay in a military hospital,
5 they've got to pay \$10.20 a day, and that's the
6 meal charge.

7 If they go into the civilian sector,
8 it's \$12 a visit, and if they're hospitalized,
9 it's only \$11 a day. So that's a pretty good
10 insurance plan.

11 Remember I said we're getting to the
12 point where we're going to have more retirees
13 over 65 than active duty members? That's a real
14 challenge because when these people join the
15 military, we promise them health care for life,
16 and we've said, well, in fact, many times we've
17 promised them free health care for life. Well,
18 that was back in the '50s. We had no idea what
19 health care would cost, and what we really said
20 is we would give you space available care, but of
21 course, the recruiters didn't quite explain it
22 that way.

23 Now, we've got 1.4 million elderly
24 retirees who are very upset with us because space
25 available is not available. They are the lower
26 priority. We've been closing a lot of military

1 hospitals. They felt they had free health care
2 for life so that when they turned 65 they did not
3 sign up for Medicare Part B and discovered that
4 that was a big mistake, and there's a significant
5 penalty for joining.

6 So there's been a lot of lobbying to
7 Congress. Congress and the senior leadership in
8 the military said, "You know, we really did make
9 that promise. Maybe we'd better fix it."

10 We've just introduced something we
11 call Tricare Senior, which is a system on a
12 demonstration basis for allowing retirees over 65
13 to enroll in Tricare Prime. Right now on Capitol
14 Hill they're deciding whether we also ought to
15 allow them to use the Federal Employees Health
16 Benefits Program. Some of you probably have
17 that. The President, Congress have that
18 available, and those benefits do not stop at 65.

19 This is probably a very familiar slide
20 to you, but this is probably one of my favorite
21 slides. If you ask the question what can you do
22 to prevent premature death or unnecessary
23 illness, it ends up that about 50 percent of
24 those things are lifestyle, which you all know:
25 smoking, drinking, seat belts, having safe versus
26 unsafe sex, diet, exercise, stress. All of those

1 things. The environment has another 20 percent
2 factor.

3 In other words, our biggest problem in
4 America is that we have not convinced Americans
5 to take personal responsibility for their health.

6 They're all victims. They want to do what they
7 want to do, and then they expect us to undo it.
8 That's their right because they're Americans.

9 This is what I think the big question
10 of the next century is going to be, and these are
11 some very profound things by a guy named Leland
12 Kaiser from Colorado. No modern nation has
13 enough money to pay for the amount of disease
14 it's generating: one trillion dollars of disease
15 a year we're generating.

16 And this is the intelligent answer.
17 Rather than trying to treat all of our diseases,
18 we ought to attempt to design them out of our
19 population. If life style is a big factor, we've
20 got to convince Americans to change their life
21 style.

22 If you look at it, one of the biggest
23 factors associated with disease in America is
24 poverty, and if we want to have a healthy
25 society, we've got to start dealing with poverty.

26 With the revolution in bioengineering and

1 genetic engineering, in the future we may be able
2 to design some of these diseases out of our gene
3 pool, as crazy as it sounds.

4 Now, the real question here though,
5 and this is what I think we're going to ask in
6 the 21st Century: how much of that disease that
7 we have in America is unavoidable? When you
8 talk to a family physician and they say, what, 80
9 percent of their illnesses have something to do
10 with stress, emotional things like that.

11 We know that some disease is
12 associated to mental, psychological, community
13 factors, but my guess is there's a lot more than
14 that, and we just have never admitted it. We
15 assume that bacteria caused pneumonia, and if you
16 get enough bacteria, you're going to get
17 pneumonia. I'm not sure that's true. You assume
18 that you get a mutation or something and you're
19 going to get cancer.

20 I really wonder though how much the
21 psychological factors, the mental attitude, the
22 spiritual factors, support of the family and
23 community affect us because we know that there
24 are so many ways to resist disease. Why is it
25 that one person gets the pneumonia and another
26 person doesn't? Why is it that some people get

1 miraculous cures with cancer and others go
2 downhill so incredibly fast?

3 My guess is that there's a lot more
4 than just external agents and fate associated
5 with disease, and we may discover in the future
6 that most of the disease that we assumed was just
7 a fact of life right now is not necessary. It's
8 just that we haven't figured out how to prevent
9 it from occurring.

10 In the old days we waited for people
11 to get sick and we treated them. Most of the
12 things we dealt with were due to external agents.

13 They were infectious diseases and trauma. Well,
14 more and more we're dealing with chronic diseases
15 that have an inherited predisposition, have
16 societal factors, and with our better
17 understanding of pathophysiology, our mapping of
18 the human genome, more and more we're going to
19 predict risks and do something to prevent the
20 disease from occurring in the first place or do
21 something to control it or to stop it.

22 The other thing that goes along with
23 an information revolution is customization.
24 We've been in a system where one size fits all.
25 No matter what your size is, you take two pills
26 four times a day. I think in the future we're

1 going to tailor make treatment to that
2 individual, decide what form of therapy, what
3 dose, you name it, is best for that particular
4 individual.

5 And one last thing I think we're going
6 to do more and more of. We're a bunch of
7 scientists that like to deal with things that we
8 can easily see and understand, and so we tend to
9 focus on this stuff. We don't like to get real
10 involved with what's going on psychologically.
11 The word "spiritual" is something you're almost
12 not allowed to put in print, and yet we're
13 beginning to realize that all of these factors
14 inside the individual have a tremendous impact on
15 disease, and it's not just that, but it's what's
16 going on in the environment.

17 You cannot have a healthy individual
18 living in an unhealthy society, and so we're
19 beginning to take a much more holistic approach
20 to medicine, trying to deal with the family and
21 the community and trying to deal with the
22 spiritual, the mental, the psychological and
23 emotional, all of those factors, and I think
24 that's what we're going to be doing more of in
25 the future.

26 Now, to kind of summarize this portion

1 of it, right now we spend a trillion dollars a
2 year. You think about. We treat somebody. As
3 soon as a chest X-ray shows no more pneumonia, as
4 soon as the culture is negative, we say, "You no
5 longer have the disease. Get out of here and
6 come back when you're sick again." One trillion
7 dollars treating things after they happen.

8 We spend very little effort over here
9 trying to make people super healthy. We don't
10 even know what this looks like. We know what it
11 means to be fit, you know, to be happy, but how
12 far in this direction could we progress if we
13 really understood and focused our efforts, if we
14 put a trillion dollars a year over here?

15 I think what this means is that you
16 feel good about yourself, that you have a job
17 where you feel like it's rewarding, where you
18 take care of your body, where you're part of
19 society where you feel that you are a valued
20 member of society. That probably is a little bit
21 of what this looks like, but we haven't done a
22 good job of defining it yet.

23 Okay. Now, to shift gears to our
24 other mission, before 1990, it was kind of a no
25 brainer. We were at war against the evil empire
26 called communism. Everybody in the world was on

1 one side of the fence or the other. We knew
2 exactly what we had to defend ourselves against.

3 Well, then Russia crumbled. Now what
4 we have is a bunch of other countries, each of
5 which has its own vision of the world. They
6 don't mesh together very well. We're not quite
7 sure what we're defending against, but we're
8 discovering that we don't have to worry about a
9 couple of super powers. We really have to worry
10 about all of these things that are happening
11 within our countries.

12 And you think of Haiti, Bosnia,
13 Somalia. It's all problems of runaway population
14 growth, degradation of the environment,
15 inequalities or inequities of the global economy,
16 all of these ethnic and religious and other
17 conflicts which were kind of suppressed but never
18 resolved. Those are causing the problems these
19 days.

20 It used to be that armies fought
21 against armies. Now the victims frequently are
22 the innocent civilians who are caught in the
23 middle. So we're trying to figure out how to
24 deal with all of these new threats,
25 disintegrating countries, problems with drug
26 cartels and crime, ethnic strife, all of that. A

1 very different world than we had just a few years
2 ago.

3 And it brings up some interesting
4 things. Terrorists are a big problem. It used
5 to be that a terrorist was somebody who did
6 something in Europe. Now a terrorist is a
7 disgruntled American who does something at the
8 post office or to a federal building or you name
9 it. This has become worldwide, and we're just as
10 vulnerable as anybody else.

11 We have a severe drug problem. We
12 have to worry about crime. No nation, unless
13 somebody is a lunatic, is going to attack our
14 military front on. Saddam Hussein tried that,
15 and he got creamed, but we've got a lot of
16 vulnerabilities in our open society. If somebody
17 wants to get even with us, they can go after our
18 infrastructure, knock out our computer system for
19 air traffic control, the banking system or the
20 stock market, and we've got big problems.

21 They can affect the environment by
22 doing something to our water supply, for
23 instance. Our culture is vulnerable to things.
24 If you can get various segments of our society
25 fighting against each other, you know, we
26 disintegrate as a world power.

1 So we have to worry about our areas of
2 vulnerability rather than our areas of strength,
3 and that's a real dilemma. How many airplanes
4 should we buy at 150 to \$600 million a piece?
5 How much money should we put into low tech stuff
6 or improving our power grids or whatever because
7 of the future threats?

8 Another thing which is becoming a real
9 issue are weapons of mass destruction. We're
10 still not sure whether countries have gotten
11 nuclear material out of Russia to build atomic
12 bombs. That's going to be a worry for some time,
13 but the real weapons of mass destruction now are
14 called biological weapons, chemical weapons in
15 Ryder trucks full of fertilizer and whatever else
16 you stick in them.

17 These are very difficult to deal with.
18 With a biotechnology revolution, again, it's not
19 that difficult to build a chemical weapon or a
20 biological weapon. You know, you develop a
21 vaccine against anthrax, and somebody using
22 computer simulation in the future, they'll build
23 a strain of anthrax which is resistant. It's
24 going to be a tough challenge.

25 This stands for operations other than
26 war. What have we been involved in? It's

1 peacemaking, nation building, humanitarian
2 assistance, disaster relief. Very different
3 worlds.

4 For the medical department that is
5 involved here, all of a sudden we've got to worry
6 about weird tropical diseases and pregnant
7 females and keeping our own troops healthy in
8 foreign lands. Very different than battling war
9 wounds.

10 For the military as a whole, the
11 Information Age is making smart weapons which are
12 very difficult to defend against. Depending upon
13 your service, these are the crown jewels. Well,
14 it's amazing how difficult it is to protect one
15 of these things against low tech -- well, they're
16 high tech -- weapons. I mean right now you could
17 take a Cessna airplane, put a global positioning
18 device on it, and tell it to go fly into the
19 Capitol. So those are the challenges that we
20 have.

21 These things which are so important to
22 us may well someday soon become too vulnerable to
23 have anymore.

24 We're in a world of jointness. This
25 probably doesn't mean a lot to you. It started
26 with the Goldwater-Nichols Act, but the military

1 services don't have a lot of power anymore. The
2 unified commands have the power and Joint Chiefs
3 of Staff. The services work together now.

4 There's probably two parts to that.
5 We're learning to become interoperable, meaning
6 we're learning to have communications systems
7 that talk to each other, but we're slowly
8 learning also to become joint, which means that
9 each service brings certain capabilities to the
10 battle, and we have to work together rather than
11 each service acting independently.

12 This gives you an idea of what a high
13 tech battlefield may look like, and actually it's
14 getting pretty close to that now. There's a lot
15 of ways that we can assess what's going on. What
16 have I got here? We've got radar planes to keep
17 track of what's going on in the skies. We've
18 also got to keep track of what's going on on the
19 ground. Satellites, we now have unmanned aerial
20 vehicles that can fly around the battlefield for
21 hours looking down. We can plant remote sensors
22 that sort of sense what's going on in the
23 environment, and of course we now stick a team in
24 to snoop around and see what's going on.

25 With rapid communications, we can take
26 all of this information, send it to a command

1 ship somewhere, and turn it into useful
2 knowledge. That's the trick, is to take an
3 incredible amount of data and turn it into
4 something that a commander can use for decision
5 making very rapidly.

6 Our goal is within about two minutes
7 of the time we sense something going on on the
8 battlefield to gather the information,
9 assimilate it, make a decision, and send some
10 kind of weapon against that target.

11 So we see the Scud missile hopefully
12 not launching, but, you know, going out in the
13 desert, and the ideal thing would be a couple of
14 minutes later either telling this tank to send a
15 round in or having this guy drop a smart bomb on
16 it or something like that.

17 As you can see, this is a very rapidly
18 moving, dispersed, highly lethal battlefield if
19 everything goes as planned.

20 In the old days we would land on
21 shore. We'd build up -- well, the Desert Storm
22 war is a good example. We spent six months
23 building up, had all of this huge infrastructure
24 in the country, all of the supplies we needed,
25 and then we went to war.

26 Well, you can't do that in the future,

1 and probably what we'll see in many cases is
2 we'll have to keep all of that infrastructure out
3 at sea, fly in the combat troops not to the
4 beach, but fly over the beach to an objective
5 somewhere inland where there's an important
6 target, but not a lot of enemy there to protect
7 it.

8 The anti-missile, anti-aircraft
9 defense will probably come from these ships.
10 Command and control will probably be on the
11 ships. Logistics, rather than being on shore,
12 will be just in time. You say, "I've got to have
13 this," and they'll bring it in right from the
14 ship. So it's another way of looking at the
15 world very differently.

16 It makes for a mobile battle force
17 that doesn't kind of en masse go rolling across a
18 country. It means there's little teams that go
19 out to these essential elements, a communications
20 center, a bridge, a concentration of elite
21 troops, whatever it is.

22 This is sort of the Star Wars soldier
23 of the future: Storm Ship Trooper, Aliens, Star
24 Trek, the Next Generation. They've all got some
25 of this stuff.

26 We're developing -- in fact, we have

1 some of it now -- clothing which offers
2 protection. Well, we have clothing that offers
3 biological and chemical protection. We're
4 developing small sensors that maybe we'd carry on
5 the individual that could detect a chemical or
6 biological exposure, something of that nature.

7 We can have small television systems
8 mounted in the helmet so that the commander in
9 the rear can see exactly what's going on through
10 the eyes of the soldiers in the front, and with
11 communications systems and computers, we can
12 communicate back and forth, and maybe tell a
13 small squad that this is where the enemy is or
14 this is what the target is, or when you get back
15 to base camp, this is what your meal ready to eat
16 is going to be at lunch. I don't know, but we're
17 going to bring all of that stuff to the
18 battlefield.

19 Now to get really crazy, what we could
20 do if we wanted to in the near future is this guy
21 is out by himself, and he gets exposed to a
22 chemical weapon. The sensor in his clothing
23 says, hey, you know, it's a nerve gas. Well,
24 what we could do also is have something in his
25 clothing or equipment automatically administer an
26 antidote to that nerve gas, or let's say he's

1 shot, and maybe in the future we're going to
2 administer something to stabilize him
3 hemodynamically, something else to provide pain
4 relief, something else to improve his resistance
5 against infection.

6 So when you can buy computer chips for
7 less than \$1 a piece, which is coming, you can
8 put computers in everything and do all kinds of
9 amazing stuff with them.

10 Now I told you about all of the high
11 tech stuff. Now I've got to look at it from a
12 slightly different viewpoint. In my world,
13 there's two kinds of campers. There's car
14 campers, and there's backpackers. Car campers
15 have vans. They have big tents with floors and
16 flies and multiple rooms, cots, stoves,
17 refrigerators, TV sets with VCRs, picnic tables,
18 chairs. You know, they go out to have a great
19 weekend. If it rains or it's miserable, they
20 throw everything back in the van and go home.

21 The backpacker has to carry everything
22 on his back. It means it has got to be light,
23 and it's got to fit in the backpack. They go off
24 for a week or two at a time. They can be 50
25 miles away from civilization. Everything that's
26 essential has got to be carried, and so they

1 carefully plan, and some of it's high tech,
2 Goretex, carbon fiber, titanium. Some of it's
3 low tech, surplus store, number ten tin cans,
4 whatever it takes.

5 But the backpacker can survive in
6 anything. Our medical system used to have the
7 car camper mentality. Everything that was in a
8 civilian trauma center we wanted to have in a
9 tent out in the field.

10 One of the big flails during Desert
11 Storm was they said, "Where's my CAT scanner in
12 my tent?" And we got them. And what did we try
13 to do? We tried to do everything known to
14 American medicine out in the battlefield to an
15 individual who was injured.

16 I think we've got to change our
17 paradigm and ask the question: what is the
18 minimum amount that we have to do to keep
19 somebody alive and get them out of there rather
20 than what's the most we can do for them?

21 Because of Desert Storm, we now have a
22 new concept called Force Medical Protection, and
23 this is a big deal. We're saying, well, a little
24 bit more. Americans don't mind sending soldiers
25 to war as long as nobody gets killed. What was
26 it, 140 or 50 that got killed in the whole Desert

1 Storm war? We had that one street fight in
2 Somalia and we got out of there after 40 people
3 got killed or so.

4 Force Medical Protection has three
5 parts to it, and this is where we're focusing our
6 energy now. First off is somebody is going to do
7 far better in battle if they're healthy and fit
8 in the first place. So we're putting a lot of
9 energy into having not only fit soldiers, but how
10 about super fit soldiers or super healthy
11 soldiers so that they can resist the stresses of
12 the battlefield or they can get injured and keep
13 fighting longer because they can handle it?

14 The next thing we've got to do is
15 prevent casualties, and I guess I'll go into this
16 a little bit further, and obviously the third
17 part is if somebody's injured, we've got to be
18 able to take care of them.

19 When I came in the Navy I had a
20 physical. It was the worst physical I've ever
21 seen in my life. The guy stood in the middle of
22 the room with an ophthalmoscope, and he went like
23 this with about 50 guys around the room.

24 (Laughter.)

25 RADM. ROWLEY: He couldn't even see
26 our bodies through that thing. When he checked

1 for hernias, he'd check one side in every
2 individual. I mean what do they do? This was
3 Vietnam, and if you were alive you were going.

4 Hey, we bring somebody in the Navy --
5 this is more the Navy of the past -- a nice kid
6 from a farm in Iowa. Within a few months we've
7 taught him how to smoke, drink, have unsafe sex,
8 eat an unhealthy diet, not get enough exercise,
9 and live in a stressful environment. You do that
10 for ten or 20 years, and people start getting
11 sick.

12 What we need to do in the future is
13 give everybody who comes in a comprehensive risk
14 appraisal, figure out what their health status
15 is, and then develop a tailor made plan of how to
16 maintain their health, how to deal early with
17 potential problems in the future.

18 We probably need to do this once a
19 year so that we have a longitudinal view of
20 what's happening to their strength and their
21 weight, blood pressure, cholesterol, and things
22 like that.

23 We never thought about that kind of
24 stuff before, but it's easy to do. We've got to
25 come up with a computer system that's going to
26 track this stuff, and we've got to have the

1 willpower, but my guess is that if we
2 conscientiously really coach people along about
3 their health, we would have a much healthier
4 force than we have right now.

5 To give you another example, this
6 happened down here in the Tidewater area. The
7 SEALs are one of these special forces groups of
8 nutty people that are very physically fit, and
9 they do crazy things like jump out of airplanes
10 and swim out of submarines and all kinds of stuff
11 like that.

12 Well, they were discovering they were
13 getting a lot of injuries because what does a
14 SEAL do? He gets up at six o'clock in the
15 morning. Maybe he runs 20 miles on the beach and
16 then goes with the guy with the best upper body
17 strength and they see how many push-ups they can
18 do before they all drop. I mean that's their
19 days.

20 The problem is they were getting
21 injuries, and because their rotation is for three
22 months they're ready to go, three months they
23 kind of stand down and recovery, they hired a
24 sports trainer to help them recover faster.

25 This lady looked and said, "I can't
26 believe this. You guys are destroying

1 yourselves. You're creating your own injuries
2 because you're training wrong and you're training
3 far too much. You know, you're stressing
4 yourselves too much."

5 So she took a look at the training and
6 said if you want to have lower body endurance and
7 upper body strength, these are the things you
8 need to do, and this is the frequency you need to
9 do it; changed the whole way that they train
10 because, you know, somebody knew what they were
11 doing.

12 Now, stuff like this is hard to sell
13 because an athletic trainer costs money, but when
14 they thought about it they realized that at the
15 ten year mark the Navy has invested two and a
16 half million dollars per SEAL in their training
17 and, you know, salaries and all, and they said,
18 you know, these guys are as valuable to us as
19 professional athletes. It's worthwhile for us to
20 hire trainers to work with them so that we can
21 keep them healthy longer and keep them as SEALs.

22 So that's the "oha" we're going
23 through. We're realizing that this isn't just
24 good stuff. It saves money.

25 Now what have we got here?

26 In November President Clinton made

1 this statement about Force Medical Protection.
2 You can see the challenge that we have. "I'm
3 directing the Departments of Defense and
4 Veterans' Affairs to create a new force health
5 protection program. Every soldier, sailor,
6 airman, and Marine will have a comprehensive life
7 long medical record of all diseases and injuries
8 they suffer, the care and inoculations they
9 receive, and exposure to different hazards.
10 These records will help prevent disease and
11 identify and cure those that occur."

12 See, the problem after Desert Storm
13 when people started getting ill is we couldn't
14 figure out who had immunizations against anthrax
15 and stuff like that. We didn't know what the
16 health status was when they went to Saudi Arabia.

17 We didn't know what the health status was when
18 they got back from Saudi Arabia. We didn't know
19 what they'd been exposed to, what they'd been
20 treated with, and it became a nightmare.

21 So they're saying, "Wait a minute.
22 You've got to record that stuff." Now, as you
23 can imagine, this is where the challenge comes.
24 They want us when we send 500,000 people to a
25 country to somehow track all of this stuff in a
26 centralized computer system so that we can in

1 real time find out what's going on and intervene.

2 The challenge is that there's people
3 scattered all over the place with all of these
4 little medical departments. We're trying to
5 figure out portable computers and information
6 systems to track this, ways to download it into a
7 central system.

8 The other thing we're looking at, and
9 I don't know if you've heard about this before,
10 but it's something called a Personal
11 Identification Carrier, PIC. That's a typical
12 military acronym. It's a computer chip or smart
13 card that's going to keep basic information.

14 They're still arguing whether it
15 should look like a credit card or whether it
16 should be a computer chip. Here is a computer
17 chip which is hard, and it's got two megabytes of
18 memory. You can put a lot of medical information
19 in this. If somebody got injured on the
20 battlefield, you could slip it into some little
21 hand held device, dictate or punch and click some
22 information in while you're treating the patient.

23 This goes with the patient, and when they get to
24 the next echelon of care somewhere, they could
25 find out what happened early on.

26 So that's our challenge now, is how in

1 the world are we going to keep track of all of
2 these things and have documentation.

3 Well, what is prevention? It's a lot
4 of things. As you can imagine, you send somebody
5 to an undeveloped tropical country somewhere, and
6 you've got to worry about waterborne disease.
7 You've got to worry about them eating unhealthy
8 foods in the local economy. You've got to worry
9 about insect vectors and things like that. These
10 days we've got to worry about chemical and
11 biological exposure, give them immunizations
12 ahead of time to try to defend against the
13 threats that we see.

14 But there are a couple of other
15 things. We've got to know what's going on in the
16 environment. One of our biggest problems is
17 force injuries. See, in most wars these days, 80
18 percent or so of the problems are non-battle
19 injuries. It's not people getting shot. It's
20 people breaking their leg playing touch football
21 or going into town and eating the wrong things
22 and getting schistosomiasis or something.

23 So we as a medical department are
24 responsible for doing all of these things and
25 then somehow keeping track of it to prevent our
26 people from getting illnesses while they're

1 deployed.

2 And to take a look at the next piece
3 of this, this is the way we did casualty care in
4 the past. We had five echelons of care. It was
5 pretty formal. It was one of these things where
6 you went to Point A. You got stable and you went
7 to Point B. You kind of go through the system.

8 Frequently we'd have an evacuation
9 policy of 15 to 30 days, which meant if you could
10 get somebody healthy and back to duty, you kept
11 them there, and you'd only send them back home if
12 they were not going to recover, we'll say, in 30
13 days.

14 But as you can see, this is kind of a
15 big, complicated process. Some of these things
16 were big systems, too, like field hospitals. A
17 field hospital could be a tent city with 500
18 beds, let's say. Well, that tent city of 500
19 beds could take 350 tractor trailers full of
20 supplies to set up and maintain, you know, with
21 water supplies, generators, air conditioning, you
22 name it, all of the stuff you put in a modern
23 hospital.

24 It doesn't fit that modern battlefield
25 very well, does it? Rapidly evolving, highly
26 lethal, very dispersed; how are you going to move

1 that 500 bed hospital around as the battle moves
2 along? How are you going to prevent it from
3 being a target? How are you going to get the
4 patient to one central area?

5 So we've kind of thrown all of this
6 stuff out, and we're looking a little bit more
7 like this. Somebody gets injured, and the first
8 thing is the first responder is going to take
9 care of him, and in many cases it's going to be
10 self-aid or buddy aid.

11 The other thing though is that we've
12 got to do as much as we can to really educate
13 this corpsman or medic to provide fairly
14 comprehensive care at the site of injury. It may
15 be done with two-way radio communications so that
16 we can coach them along as they're providing
17 that.

18 From there we want to get him to some
19 kind of forward resuscitative surgery where we do
20 the minimum amount of stuff to keep him alive:
21 stabilize fractures, control bleeding, treat
22 shock, things of that nature. But that can't be
23 a big hospital. It may be mobile. You know, a
24 couple of school buses or a couple of armored
25 vehicles or in some cases something that four or
26 five guys can carry on their back.

1 From there, we would like to get them
2 out to a theater hospital somewhere and it may be
3 a more comprehensive hospital in the back. It
4 may be a hospital ship. One way to do that may
5 be to put him in a trauma pod. This would be a
6 stretcher that has the equipment to measure vital
7 signs, to self-administer at least IV fluids and
8 oxygen, provide some climate control, you know,
9 sort of an ICU like environment in a stretcher
10 until we could get him to the more definitive
11 treatment site.

12 If we can't get somebody well and back
13 to the battle fairly quickly, we're going to get
14 them out of there, and while doing that, we're
15 going to have to have the capability of providing
16 some care en route, which sounds simple but gets
17 really hard to do when you've got patients
18 stacked three high in an airplane that could be
19 40 degrees inside or 120 and is noisy and
20 vibrates and everything else.

21 But we're looking at how we can take
22 people who need a fair amount of care en route
23 and do that and then get them back home.

24 As I said, remember they want to know
25 what's happened to everybody all of the time. If
26 you want to know where your package is, you call

1 American Express and they tell you. If you want
2 to know where your son is, they say, "Well, let's
3 see. He was in Saudi Arabia, and I think he's
4 somewhere else now, but I don't know where."

5 We're trying to track casualties like
6 American Express. That's another challenge, this
7 is what we're trying to evolve into.

8 Now, you know about ship board medical
9 care. There's a couple of things from my
10 perspective. Number one is we're going to smart
11 ships, which means that the crew is getting
12 smaller and smaller. A small crew means you
13 can't have a big medical department. A small
14 crew means there's not a lot of redundancy. So
15 if somebody runs the communications or radar or
16 understands the power plant, you can't afford to
17 lose them.

18 And so with fewer people, we've got to
19 use technology to provide more medical capability
20 on our ships. Coaching systems with computer,
21 you know, where you go through protocols and get
22 information from CD-ROMs or through the Internet
23 are one way to do it. Video teleconferencing so
24 you can consult with a specialist; more and more
25 equipment that can do things automatically for
26 laboratory values or managing patients. Those

1 are the things that we've got to look at.

2 Training and education are going to
3 change, too. How do you learn to become a
4 surgeon? You operate on a lot of veterans.
5 That's the old days, right? In the future how
6 are you going to become a surgeon? You're going
7 to go to virtual reality, and after you've done
8 it in cyberspace enough times, then we'll let you
9 get close to a human being.

10 That's going to be how we do all of
11 our training. Lots of opportunities there.

12 Okay. So what have I done? These are
13 some of the things I think we're going to face in
14 the 21st Century on the wartime side. It's going
15 to be a joint environment where we all have to
16 work together. Each service brings selective
17 capabilities.

18 We're going to have interoperability
19 of our equipment and our communications systems.
20 We're going to have to be light, flexible,
21 mobile. The hospital at one time may be
22 configured as a 50 bed hospital. It's going to
23 deliver babies and take care of kids in a
24 disaster, humanitarian assistance kind of thing.

25 The next day we may reconfigure it to
26 be a 100 bed hospital to take care of casualties

1 for a very intense battle, and we've got to have
2 that kind of flexibility.

3 We've got to be prepared for laser
4 injuries, biochemical injuries, funny tropical
5 diseases, stress, you name it, everything. More
6 and more we're going to find ways to use
7 technology to help us, expert computer system
8 sensors, you know, all that kind of stuff.

9 We're going to have to streamline and
10 try to figure out what's the minimum amount to do
11 rather than the maximum amount we could do.
12 We're going to have to find ways to do it with a
13 minimum amount of equipment and bring in those
14 essential elements just in time as we need them.

15 We've got to train people, and
16 probably most important, all of the technology is
17 wonderful, but if you don't have caring,
18 innovative people that can work together in
19 stressful environments, none of it works. The
20 most important thing always is the people.

21 So with those challenges, I think
22 we're going to do a lot with self-aid and buddy
23 aid. We may do some things in the future where
24 the clothing or the backpack automatically treats
25 the soldier when they become injured. We're
26 going to have to figure out what's the minimum

1 amount to do. We're going to have to see if we
2 can develop things which can extend the golden
3 hour of trauma because maybe we're not going to
4 get to them for six or 12 hours.

5 Bioengineering will probably produce
6 sensors to detect biological and chemical
7 weapons, diseases in the environment. We will
8 probably have rapidly produced, multiple agent
9 vaccines, things of that nature. Biotechnology
10 has got a tremendous future.

11 We've got to figure out safe ways to
12 get people out of the battle field. I've
13 mentioned that. In fact, I've mentioned all of
14 that stuff, but those are the things that I think
15 we've got to work on, and that's why it's kind of
16 exciting right now because we're reinventing
17 everything that we're doing.

18 And one last thing. The buzz word is
19 readiness. You know, are we really ready to go
20 into harm's way?

21 The way we view it from a medical
22 perspective, readiness means, number one, is we
23 include healthy, good people. We train them
24 well, but throughout this continuum, we really
25 focus on maintaining their health. So they go
26 through a military career, and several times they

1 go into some of these loops and deployment, and
2 we've now been ordered to do an assessment before
3 they deploy. We got some blood samples, a
4 comprehensive evaluation, get it in the computer
5 system, and make sure we protect their health
6 during deployment, assess them when they come
7 back from deployment. So Force Medical
8 Protection.

9 If we don't take care of the entire
10 family, two things happen. Number one, the
11 soldier worries about his wife and kids when he
12 should be worrying about the battle. The second
13 thing, they all leave. So providing health care
14 that's good for everybody is a retention tool.

15 The same thing happens when they
16 retire because if we break our promises, people
17 leave also. You know, they're looking at this
18 whole continuum. As long as we have a health
19 care system that supports all of this, we're
20 going to have a good military.

21 If we try to cut corners and cut out
22 pieces, then we find unexpected consequences
23 elsewhere.

24 Okay. Sort of just in time, hopefully
25 I got you to see a little bit that the future
26 fundamentally is a mind change. It's not so much

1 that the world is going to change. It's our view
2 of the world is going to change, and our view of
3 what the threat is is changing.

4 American medicine has gone through so
5 much change in the last ten years. It used to be
6 a specialty based in hospital, high tech system,
7 and now what have we done? It's become an
8 ambulatory care, primary care, low -- well, semi-
9 low tech system. It's not because medicine
10 technology has changed. It's because of our view
11 of what medicine is all about has changed, and
12 that applies to everything in our society.

13 Hopefully I've given you some
14 understanding of the challenges that we face as
15 we go into the 21st Century, some of the things
16 that we're thinking about doing.

17 There is about five minutes, I guess.
18 You've got two choices. You either ask
19 questions or you can take a break.

20 DR. FLETCHER: Let's ask a few
21 questions.

22 Thank you very much.

23 (Applause.)

24 DR. FLETCHER: Admiral, thank you.

25 Are there comments?

26 Dr. Bagby.

1 DR. BAGBY: Admiral, first I'd like to
2 say that that's the best and most comprehensive
3 statement of problems and a view of the future
4 that I've ever seen, and I appreciate what you've
5 brought to us.

6 At this major installation and at
7 others, we have been told that one of the main
8 technological problems of bringing all of this
9 together with a comprehensive following of each
10 person is brought about because of a competition
11 for satellite time because of the other uses of
12 the satellite.

13 Do you see that as a major problem,
14 and is there a solution to that? How do we go
15 about solving the problem of getting the
16 technology to the individual?

17 RADM. ROWLEY: I think the satellite
18 time has two parts to it. Number one is
19 communications capacity is doubling about every
20 18 months. So sooner or later there's going to
21 be so much, you know band width that that's not
22 going to be an issue.

23 But I think the other thing is that
24 our concept is too much that we want to take the
25 old ways of doing business and send it all over
26 satellite. If we come up with something like

1 this, we don't have to download that information
2 in a satellite right away because we're going to
3 have the data carried on the individual. We'll
4 have the data in some kind of a laptop that the
5 medic is carrying around, and during times of
6 opportunity we'll download that information.

7 When I look at the aircraft carriers,
8 and I'm kind of talking out of school because I
9 haven't been out there yet, but one concept is to
10 have real time communication. So if you've got
11 somebody with a mental health problem, let's give
12 them three hours of therapy a week real time over
13 satellite with a psychiatrist at Bethesda.

14 That's a pretty expensive way to take
15 care of somebody. If you've got to do that,
16 maybe it's more intelligent to get somebody off
17 the ship, but if it's a matter of getting your X-
18 rays read, you can send that packet of
19 information any time during the day, you know, in
20 the middle of the night. You can condense so
21 that it doesn't take up too much space on the
22 airwaves.

23 If you've got questions about what
24 this skin lesion is or is this -- you know,
25 things of that nature, it doesn't have to be a
26 high band width, real time discussion with

1 somebody. It can be let's send the information
2 and then get the answer back in the next 24
3 hours.

4 So my guess is that in many cases it's
5 a matter of saying we don't need all of that real
6 time stuff. Let's figure out simple ways to pass
7 the information back and forth of what we have
8 available now.

9 DR. FLETCHER: Other questions or
10 comments?

11 I, too, enjoyed your slides. The life
12 style, 50 percent of our problems in the future
13 and in the civilian population, it's obviously
14 even worse. So how do you propose we make people
15 comply, comply with this? Give us an idea.

16 RADM. ROWLEY: Well, you know, that's
17 a toughie. The question is do we want them to
18 comply or can we figure out ways to make them so
19 that they do it automatically?

20 DR. FLETCHER: Yes, whatever.

21 RADM. ROWLEY: See, one of the things
22 that's interesting is we're Baby Boomers. We're
23 beginning to pay attention to our health now.
24 It's a little late, but you know, better late
25 than never.

26 I think as people start realizing that

1 they can't live forever, that they can't keep
2 running three miles a day if they don't take care
3 of their body, some of that's going to be done on
4 their own.

5 Obviously there's a lot of incentives
6 we could put in society, too. Some of it's
7 probably education. Some of it's seeing what our
8 peers do. I mean, why do so many people run?
9 Why are we so conscious about how we look? It's
10 because of peer pressure, and maybe there's ways
11 that we can use that.

12 Obviously we've got to rig some of the
13 incentives. That's the dilemma with the tobacco
14 industry. How do we make it so that cigarettes
15 don't seem appealing to young kids, because
16 that's when they get hooked?

17 There's probably a lot of things. I
18 guess from my perspective the biggest challenge
19 though is we in the medical profession have got
20 to change our minds. Now, we don't spend a whole
21 lot of time worrying about prevention, you know.

22 If you want to ask a doctor how to take care of
23 your life, you're crazy because they don't have a
24 clue. I mean, look at the way they live.

25 (Laughter.)

26 RADM. ROWLEY: So we as a profession

1 have probably got to take the lead by becoming
2 much more expert in this stuff, communicating it
3 not only in what we say, but probably how we live
4 our lives and make it so that people try to
5 emulate good health.

6 There's ways to try to order it. You
7 know, you're going to pay a higher insurance
8 premium or we're only going to limit your care if
9 you don't do certain things. I don't think
10 that's going to work well in America. I think
11 it's got to be more about people wanting to go
12 somewhere rather than us trying to drag them
13 somewhere that they don't want to go.

14 DR. FLETCHER: Other comments,
15 questions?

16 DR. HAYWOOD: We were looking at the
17 menu on the ship the other day. When are you
18 going to get started with the diet?

19 RADM. ROWLEY: Actually we're
20 beginning to do that. You know, it looks
21 horrible to you, but, man, it's a lot better than
22 it used to be. We have sent dieticians out to
23 ships. Every couple of years we ratchet down
24 another notch in the physical fitness, weight
25 control program, and we're not there yet, but
26 we're coming a long ways.

1 You may have gone to the wrong ship.

2 There's some ships where --

3 (Laughter.)

4 RADM. ROWLEY: -- they're very
5 conscious about it. Every item has got a little
6 placard in front of the tray that says what the
7 fat content and the calories are.

8 I think people are becoming more and
9 more serious about that, too.

10 DR. FLETCHER: Colonel Eggert.

11 LCOL. EGGERT: I just have to add to
12 your comments. I don't think it's hopeless in
13 terms of prevention. We all know about the
14 reduction in cardiovascular mortality we've seen
15 over the years, but recently the NCI released
16 data that showed the incidence of mortality of
17 cancer is declining for the first time, and they
18 attribute that primarily to primary and secondary
19 prevention efforts. So I think there's hope out
20 there.

21 RADM. ROWLEY: I've got to give you
22 one more answer. You remember the slide I showed
23 about the SEALs? That's easy to sell to the
24 senior leadership because it's a money issue.
25 That's what we've got to do with the diet on the
26 ship and with everything else we've got to do.

1 See, I think the Navy throws out about
2 3,500 people a year because they don't meet the
3 physical readiness standards. To recruit
4 somebody and send them through basic training can
5 be 20 or \$30,000, and as you saw in those ships,
6 we're a very highly technical Navy, which means
7 by the time you've got a real technician, maybe
8 we've spent \$100,000 on them.

9 With that kind of expenditure on these
10 people, you can't afford to lose 3,000 a year or
11 whatever the number is because they don't meet
12 our fitness standards, and that's what we've got
13 to keep selling to our line, that it's not just
14 Mom and apple pie. These are sound business
15 decisions.

16 If you focus on health on your ship,
17 you're ship's going to work a lot better. It's
18 going to be more effective, and you're going to
19 save money. So that's the approach we've got to
20 take.

21 Now, the line is not stupid. If they
22 don't like all of this nice "whoopie" stuff, they
23 say, "Show me the data," and that's one of the
24 things we're gradually getting, is we're
25 computerizing this stuff that's real data of what
26 is cost effective and what isn't cost effective.

1 DR. FLETCHER: Other questions,
2 comments?

3 (No response.)

4 DR. FLETCHER: If not, Admiral, thanks
5 very much.

6 RADM. ROWLEY: Thank you.

7 (applause.)

8 COL. FOGELMAN: Thank you, again, sir.
9 We really appreciate it.

10 We're going to take about a ten minute
11 break.

12 (Whereupon, the foregoing matter went
13 off the record at 9:01 a.m. and went
14 back on the record at 9:18 a.m.)

15 COL. FOGELMAN: In a few minutes we're
16 going to break into our groups, and we're going
17 to combine the Environmental Occupational Health
18 group and the Health Maintenance subcommittee
19 today, and you should be getting two briefings,
20 although one of our briefers isn't here,
21 Commander Cassano, and hopefully she'll be here,
22 but if she isn't, it may be that we'll be able to
23 end a little bit early. So we'll play it by ear.

24

25 One of the things I wanted to say is
26 the way we'll break out, like I said, is that the

1 Infectious Disease subcommittee will meet in the
2 break room, and the other two committees will
3 meet in here because you'll have some Power
4 Point demos.

5 So if it turns out that our second
6 briefer doesn't show, we'll plan on taking about
7 an hour for each subcommittee or maybe just a
8 little bit longer if the Infectious Disease
9 subcommittee needs it, and then we'll go ahead
10 and break into the executive committee.

11 DR. FLETCHER: I think we can be back
12 maybe by 10:30 or so, 11.

13 COL. FOGELMAN: Yeah, 10:30 or quarter
14 till 11, something like that.

15 DR. FLETCHER: Quarter till 11.

16 COL. FOGELMAN: I think Major Fisher
17 has an announcement.

18 MAJ. FISHER: If anybody had a
19 temporary vehicle pass and you didn't turn it in
20 on base, you're actually supposed to take this
21 back to the base, but we can take them here. So
22 you can give it to me, and then I'll make sure
23 that --

24 There's some propaganda over here on
25 the table, textbooks of military medicine.
26 There's how you can order these, and the ones

1 that are available here, and please, I don't want
2 to carry any of these brochures back. This is on
3 the Global Emerging Infections Program. So there
4 are little brochures that we have, little Web
5 site cards.

6 COL. FOGELMAN: If anyone wants to
7 order lunch and has not done so, you need to fill
8 out that little sheet for Friday that we gave you
9 yesterday and turn it in to Ms. Ward as we break
10 into subcommittees.

11 I would also like the combined group
12 that meets in here today after Captain Brawley
13 briefs to maybe have a little discussion of how
14 you think that your subcommittees can maybe
15 interweave with the military objectives from the
16 DOD prevention plan and start, you know, maybe
17 have a discussion between the military and the
18 AFEB members on sorts of projects that you may
19 want to take on for the future or they may want
20 to have you take on. So it's a good time to do a
21 little bit of strategic planning as well.

22 Do we have any issues from the Board
23 members before we break up? Any questions,
24 issues?

25 (No response.)

26 COL. FOGELMAN: Okay. I would like

1 some military folks, specifically Dr. Eggert and
2 anyone who's been working prevention issues a lot
3 within the military to stay with this group on
4 Occupational Health Issues, and then the
5 Infectious Disease people or people who have a
6 specific interest in the infectious disease issue
7 can meet in the other room.

8 So let's go ahead and split up now.

9 (Whereupon, at 9:21 a.m., the meeting
10 adjourned for subcommittee meetings, to reconvene
11 in executive session at 10:56 a.m..)

12 DR. FLETCHER: Executive session.

13 COL. FOGELMAN: If I could just make a
14 quick announcement, for those who may need rides
15 to the airport, first, there are some Board
16 members with cars who may be willing to take you.

17 So if there are Board members with cars, would
18 you raise your hand?

19 Fine. Also, NEHC has offered the use
20 of their van, and they can carry up to eight
21 people. So after we finish the executive
22 meeting, if anybody would like to use the van, we
23 can do that, as well. So we will have available
24 transportation.

25 Just to let you know, it's possible
26 there may be some weather delays today. So just

1 keep that in mind. I'm not sure.

2 DR. PERROTTA: What are we going to do
3 about that?

4 COL. FOGELMAN: I'm not sure.

5 PARTICIPANT: I thought you were going
6 to handle that.

7 COL. FOGELMAN: I'm going to try.

8 PARTICIPANT: Who do we call about
9 that?

10 COL. FOGELMAN: So real quickly, we've
11 basically got three items to cover. The first is
12 a look at the recommendations. That'll go real
13 quickly.

14 Second is a report from the services
15 on what action that they may have or be willing
16 to take in the future on the recommendations that
17 we gave last time.

18 And then last is a short business
19 meeting. So hopefully we can cover that within
20 about an hour.

21 DR. FLETCHER: Okay. Dr. Poland?

22 DR. POLAND: Well, the Infectious
23 Diseases Control Subcommittee met all day
24 Wednesday and then this morning, and I guess
25 before I do anything else, a number of the
26 committee members will be rotating off, and I did

1 sincerely want to say thank you to Cladd Stevens,
2 Jim Allen, Art Reingold. I don't know if you're
3 rotating off or not, Ashley. Bill Schaffner, who
4 couldn't be here, and Jim Chin.

5 For those of you who don't know, you
6 really can't go into a lot of the epidemiology
7 and infectious disease literature without having
8 seen some of the seminal articles written by
9 these individuals, and genuinely it was my
10 pleasure to work with you, and I think we did
11 some good in our own way. So thank you very
12 much, each of you.

13 The work's not quite over yet, and
14 before we let them out the door, we are writing a
15 DOD wide immunization review that will look a lot
16 like the injury report of a few years ago that
17 you saw.

18 The primary issues that we dealt with
19 today and will circulate recommendations to you
20 about are really twofold. One is looking at the
21 jet injector issue and basically recommending
22 that Health Affairs facilitate the development of
23 the next generation of needleless injection
24 technology, and the other was the anthrax issue,
25 and in particular, what to do about deviations
26 from the current recommended schedule.

1 So the committee has agreed upon some
2 wording and some recommendations. I need to fine
3 tune that a little bit rather than stumble around
4 with my chicken scratching, but we'll circulate
5 those electronically or hard copy for the full
6 committee to see.

7 So pending any questions, that's all I
8 have to say.

9 COL. FOGELMAN: Great.

10 DR. FLETCHER: Have you got any
11 proposals for the Board to vote on?

12 COL. FOGELMAN: I think they're still
13 sort of in development.

14 DR. FLETCHER: They're not ready?

15 DR. POLAND: No, sir.

16 DR. HAYWOOD: That's something that
17 will be circulated before the next meeting?

18 COL. FOGELMAN: Right, right.

19 DR. POLAND: It's like a fine wine.
20 We don't want to give it to you before its time.

21 (Laughter.)

22 DR. FLETCHER: Very sensitive, very
23 sensitive.

24 COL. FOGELMAN: I will make sure that
25 they get out to you, and if you have any
26 comments, you can get back to Greg on them.

1 PARTICIPANT: Well, didn't we
2 recommend that everybody who was on the committee
3 should get the anthrax vaccine?

4 DR. POLAND: That's outside our
5 committee.

6 DR. ALLEN: Greg, you have to be
7 careful with that wine analogy because, you know,
8 a good red wine that's exposed to the open air
9 for a period of time turns to vinegar.

10 COL. FOGELMAN: Okay. Now I'd like to
11 ask the service reps. if they would each give a
12 short report on what you may be doing or may plan
13 to do on the recommendations that we had last
14 time.

15 Could I start with the Army? Is
16 Colonel Karwacki here? Did he disappear on us?

17 PARTICIPANT: I think he's in the
18 break room.

19 COL. FOGELMAN: Okay. How about the
20 Navy? Do we have anybody from the Navy?
21 Commander McBride was actually supposed to brief,
22 but apparently was unable to make it, and I
23 didn't get a copy of his.

24 Okay. Air Force? Anybody from the
25 Air Force?

26 PARTICIPANT: He is in conference

1 across the hall.

2 COL. FOGELMAN: Okay. He's on a phone
3 call. Okay. Well, let's proceed on.

4 Are you ready to talk about the Army's
5 response to the recommendations? Army's response
6 to the recommendations from last time.

7 COL. KARWACKI: Let me go grab that.
8 I've got it all written out. I'll have it in
9 five seconds. You can go on with the Coast
10 Guard.

11 (Laughter.)

12 COL. FOGELMAN: I did ask, honest, and
13 the Army actually gave me a response in writing,
14 but I preferred that they talk about it.

15 COL. KARWACKI: Sorry about that. Do
16 you want to go through them by number?

17 COL. FOGELMAN: Yeah, just talk about
18 what the topic was.

19 COL. KARWACKI: Okay, yeah. In
20 general, we're going to concur with all of them
21 in terms of the statements. However, there are
22 going to be some issues with implementation as
23 you might expect, and I think we've discussed
24 most of the issues in the topics.

25 The Hep-B, we've been doing that for a
26 number of years, since 1991 actually, the reduced

1 dose of Hep-B.

2 We were questioning, as it came up in
3 the other issue, the question of obesity in terms
4 of what the definition of that is. It would be
5 my general contention that we don't have any
6 obese people, depending on what the cutoff was
7 going to be in the military.

8 It turns out that if you use the
9 preventive task force guidelines, the blue book
10 definition of obesity, it's 198 pounds in a 65
11 inch tall male. The military cutoff for being
12 acceptably tall is 195 pound at 65 inches. So
13 that's very close, 195, 198.

14 For women, it's 141 acceptable table,
15 159 according to the blue book defined as obese
16 for a five foot, three inch, five foot, four or
17 whatever the table gave.

18 So in terms of screening, implementing
19 the policy, it would be a question of do you have
20 to ask are you obese or do you have to weigh
21 them. What do you have to do? It might just be
22 easier to say are you a smoker or nonsmoker and
23 not deal with the question of weight or
24 overweight.

25 so we probably do not have any obese
26 individuals if those are the two parameters in

1 implementing a half dose.

2 DR. HAYWOOD: Well, how about an
3 opinion on whether those parameters are
4 appropriate?

5 COL. KARWACKI: Well, you know, what
6 your recommendation said, if you are obese or a
7 smoker, you cannot get the half dose. That's why
8 I came back and said, "Tell me what obese is."
9 Is it 400 pounds and we're not worried about it?

10 The other issue I wanted to get a
11 clarification on was in the adenovirus vaccine
12 recommendation, which again we totally concur
13 with, but the question has always come up again
14 and again -- the studies were done in males --
15 giving it to women.

16 I read the recommendation. It says
17 "recruits," and our joint instruction says
18 "recruits." We have assumed that that is an
19 approval in both instances of giving it to women.

20 I just wanted to clarify that there was no
21 contentiousness there, that that was the intended
22 purpose of that.

23 The others were sort of mundane.
24 Within the typhoid, number five recommendation,
25 taking the acetone killed product off of the
26 market, taking it out of the NSN is fine. Nobody

1 has any real problems with that.

2 However, that does not solve the
3 problem. As long as it is an FDA approved,
4 marketed product, our pharmacists can go to the
5 prime vendor and purchase whatever it is they
6 want at the price that is appropriate. So moving
7 it from an NSN does not make any difference.
8 They can still get to it as long as it's out
9 there on the market, and if it's price
10 competitive, they may go to that.

11 So that's not the simple solution.
12 Saying absolutely you can't use it becomes a
13 different issue perhaps, but that was not
14 necessarily your recommendation. It was --

15 DR. POLAND: The intent of it was to
16 not use it.

17 COL. KARWACKI: Well, but it still is
18 available. It still can be purchased, and it
19 wasn't --

20 COL. FOGELMAN: Right, but we were
21 trying to imply that each service should develop
22 a policy that it should not be used based on this
23 recommendation.

24 COL. KARWACKI: I'm just saying that
25 approach will not do away with the problem. It
26 has to be an implementation issue of you will not

1 use.

2 COL. FOGELMAN: And I don't think you
3 were here at the last meeting, but we said that.

4 COL. KARWACKI: I was not able to make
5 that.

6 Jet injectors we've beaten to death,
7 and the others were really no problem. I don't
8 see any major issues.

9 The pneumococcal vaccine, I'm not
10 sure. Was the recommendation to use it
11 throughout? Let me see. Yeah, use it in
12 recruits. Again, that's going to be problematic
13 because, as I was saying, the concept of
14 implementing that as opposed to making a one-on-
15 one decision, provider to patient in terms of
16 meeting --

17 DR. POLAND: You're talking about
18 pneumococcal immunization of recruits?

19 COL. KARWACKI: That's what you said.
20 Recommendation 3.

21 DR. POLAND: That would have been
22 limited to --

23 COL. KARWACKI: You're recommending
24 more studies, is what you were recommending.

25 COL. FOGELMAN: Yeah, I don't think it
26 said that's all recruits.

1 DR. POLAND: We had not recommended
2 recruits, the one exception being -- actually,
3 does NCRD give them the pneumococcal vaccine?
4 They do. Okay.

5 LCDR. FALLON: Yes, they do, and that
6 was based on the recommendation.

7 DR. POLAND: But in terms of general
8 recruiting utilization, no.

9 COL. KARWACKI: You started out in
10 Paragraph 1 discussing to assess whether the
11 recommendation should be made for routine use in
12 military recruits, and then the recommendation
13 was not to do that, but to do more studies.

14 COL. FOGELMAN: Okay. Anything else?

15 Russ, do you have any comment on the
16 Air Force's response to the recommendations?

17 LCOL. EGGERT: All the
18 recommendations, yeah. Maybe I'll just kind of
19 go through these. The first one I have on my
20 list has to do with Hepatitis B vaccine in
21 recruits, and we would certainly concur with
22 using the reduced dose in that setting.
23 Certainly that would be a cost savings.

24 However, I would have to point out
25 that at this point in time, we are not doing
26 force-wide immunization of Hepatitis B. It's

1 limited to medical care workers. We have
2 expanded that somewhat to include more medical
3 health care workers than what had been previously
4 done.

5 Budget shortfalls have really plagued
6 us this past year. Trying to get the Hepatitis A
7 immunizations accomplished has been the priority.

8 We're looking at expanding varicella vaccination
9 as well.

10 So I think the Air Education and
11 Training Command is looking at that issue as to
12 whether they want to, if they have the budget to
13 support that or not. We have to mull that over
14 some more.

15 PARTICIPANT: We'll get all of our
16 money from the air staff, so not to worry.

17 (Laughter.)

18 DR. POLAND: That's correct. We'll
19 look at that some more.

20 LCOL. EGGERT: Secondly, I have here
21 the Japanese encephalitis vaccine, and again, we
22 would concur with that, and we can certainly put
23 out some guidance instructions for insuring that
24 administration of the vaccine is done
25 appropriately.

26 Let's see. Third, the proposed study

1 on pneumococcal vaccine, we would concur with
2 that.

3 There was some question about it's
4 really not defined who the OPR would be, I mean,
5 who would be the agency responsible for carrying
6 out this study, and that needs to be defined.

7 PARTICIPANT: For pneumococcal?

8 LCOL. EGGERT: For the pneumococcal
9 vaccine.

10 DR. POLAND: No, that's being done.
11 Greg Gray is.

12 LCOL. EGGERT: Oh, it's already?
13 Excuse me.

14 COL. FOGELMAN: Yeah, Greg Gray
15 presented a proposal.

16 LCOL. EGGERT: Maybe this was at the
17 last AFEB meeting I didn't attend.

18 COL. FOGELMAN: Yes, right.

19 LCOL. EGGERT: I'm sorry. Okay.

20 Adenovirus vaccine, we have already
21 ongoing adenovirus vaccine surveillance in
22 conjunction with Project Gargle and certain
23 concur with all of the recommendations there.

24 We don't at this time provide
25 adenovirus vaccine to our recruits. So we
26 haven't seen a problem, and at this time we don't

1 anticipate implementing adenovirus vaccine in our
2 recruit setting unless surveillance indicates
3 otherwise.

4 At this point with the limited supply
5 --

6 PARTICIPANT: That's more for us.
7 (Laughter.)

8 LCOL. EGGERT: There's more for the
9 Army.

10 DR. ALLEN: Are you getting serotypes
11 of the isolates?

12 LCOL. EGGERT: Yes, they are, yes.

13 Typhoid vaccine. About a year ago Air
14 Force Medical Logistics Office put out a
15 memorandum that says to discontinue use of the
16 heat phenol inactivated vaccines. We currently
17 only use the two recommended types.

18 Jet injectors, I guess there was some
19 discussion some more on that. We at this point
20 in time are not using jet injectors, waiting for
21 more evidence and recommendations to be
22 forthcoming.

23 Mortality surveillance, I think this
24 is a big issue for all of the services. There's
25 a lot of work going on in terms of developing
26 standardized DOD and joint instructions, Air

1 Force instructions to do comprehensive health
2 surveillance, both environmental and personal
3 medical surveillance. So we certainly concur
4 with the recommendations there.

5 COL. FOGELMAN: Did you want to talk
6 about at all the Air Force initiative on the
7 mortality registry?

8 LCOL. EGGERT: I guess we could have
9 Don speak to that, but we've been trying to
10 establish a mortality registry in the Air Force.

11 It's in conjunction with the ranch hand study,
12 the Agent Orange study that's been going on where
13 they have been collecting death certificates of
14 all active duty -- is that right, Don, for how
15 many years now?

16 PARTICIPANT: Since '69.

17 LCOL. EGGERT: Right. So now there's
18 some effort. They've hired a nosologist to go
19 ahead and provide the documentation off the death
20 certificates to begin to build this registry.
21 Why don't you give more details on that?

22 PARTICIPANT: Sure. It's just a
23 contractor actually in the final stages of
24 negotiation and are negotiating a statement of
25 work.

26 PARTICIPANT: Would you speak up,

1 please?

2 PARTICIPANT: We're negotiating a
3 statement of work with a contractor that supports
4 the Air Force health study, the ranch hand
5 effort, and they are going to be expanding,
6 through this contract, be expanding their death
7 certificate collection and electronic recording
8 of all death certificate data on all retirees
9 from the Air Force and then all active duty
10 Guard, Reserve, and Air Force civilians
11 prospectively.

12 We're going to go back to 1969 and
13 take a lot of the data that they've already
14 collected as part of the ranch hand study and
15 incorporate it into this database, and then go
16 proactively with all people who are on active
17 duty and the Reserve and civilian.

18 We're starting off with a piece that
19 we can grab. We're starting off with just death
20 certificates. We have not gone after the full
21 measure of the mortality registry that was
22 proposed at the last meeting that included
23 autopsy reports and medical records and
24 investigative reports.

25 We're going to start with death
26 certificates. We'll get a process in place that

1 works and then that can be expanded in the
2 future.

3 DR. BARRETT-CONNOR: Are you getting
4 the whole death certificate or just the so-called
5 cause of death?

6 PARTICIPANT: We get a hard copy, a
7 photocopy usually, of the death certificate, and
8 we're coding everything.

9 DR. BARRETT-CONNOR: Everything on it,
10 right.

11 PARTICIPANT: And then anything that's
12 inaccurate, our nosologist goes back and verifies
13 while the body is still warm, if you will, to get
14 better data.

15 DR. BARRETT-CONNOR: Since 1969,
16 that's good.

17 (Laughter.)

18 COL. FOGELMAN: Anything else, Russ?

19 LCOL. EGGERT: The next item was the
20 environmental medical surveillance for
21 deployments again. That ties into the previous
22 issue.

23 There is an environmental health
24 working group that's been established and is to
25 report periodically to the joint preventive
26 medicine policy group, and so --

1 PARTICIPANT: Tri-service or just --

2 LCOL. EGGERT: Yes, tri-service.

3 And then there are quite a few
4 recommendations in regards to the alcohol misuse,
5 prevention, and we have a fairly detailed reply
6 that one of our subject matter experts,
7 Lieutenant Colonel Talcott, provided, and I would
8 just present those for the record.

9 COL. FOGELMAN: Right, and actually
10 I'll send a copy out also to the members who
11 participated in that function.

12 I did want to say that DOD, and maybe
13 you discussed this in your subcommittee meeting,
14 but DOD is greatly appreciative of the efforts
15 that went into that report, and it sounds like,
16 from what I heard of the DOD prevention plan that
17 AFEB has actually addressed two of the three
18 major issues that are going to be pushed here in
19 the recent future, the upcoming future, short
20 term.

21 I don't think -- Commander McBride is
22 not here, and he's the person who was supposed to
23 pull all of this together. So is there another
24 Navy rep. that is prepared to talk about the
25 previous recommendations? Because he had told me
26 he was going to try to be here, but I guess he

1 was unable to attend.

2 LCDR. FALLON: The only two that I
3 could address would be the Hepatitis B. Yes, we
4 do have a policy using the reduced dose.
5 However, we have not implemented it force wide
6 and that becomes as part of a resource issue.

7 The typhoid, we have put that in a
8 policy statement that you only use the two
9 approved.

10 COL. FOGELMAN: Okay. Great.

11 DR. FLETCHER: Let me ask one. A
12 special request we had about the clinical
13 preventive services, that was from Dr. Joseph's
14 office, has that been out to the services or
15 anything on that?

16 LCOL. EGGERT: Well, was there
17 something that came from Health Affairs? Yes, I
18 believe we responded to that.

19 The Air Force has over the last
20 several years implemented the Put Prevention into
21 Practice campaign, which as you are well aware is
22 a comprehensive approach to delivering or
23 improving the delivery of clinical preventive
24 services.

25 We have policy on that. We've
26 resourced that. You know, that's being

1 implemented at all of our medical treatment
2 facilities, and we are going to just continue to
3 press ahead.

4 We've been working with the Army and
5 Navy in this model site effort to now try to
6 implement this throughout DOD and not just the
7 Air Force.

8 DR. FLETCHER: Anything from the Army?
9 Anything specific?

10 COL. KARWACKI: Nothing more. I mean
11 the policy is out there. The implementation is
12 obviously manpower dependent. We're hoping that
13 -- there was a recent change to our physical
14 examination regulation just published which,
15 after many, many years of discussion, it was
16 decided that there's no reason to do every five
17 year physicals on 20 year olds or 25 year olds.

18 We are hoping that that will release
19 some personnel who are consumed, but that's the
20 majority of the standing force, is less than 25
21 almost by definition. That will release some
22 practitioner time to make them available for
23 implementing clinical preventive services. So we
24 hope to divert some folks into that with this
25 recent change.

26 DR. FLETCHER: It would be good, I

1 think, if we have a follow-up on that because
2 that's very important.

3 LCOL. EGGERT: Yeah, the Air Force has
4 already implemented an annual preventive health
5 assessment that replaces the periodic physical
6 exam. So it's basically a health risk
7 assessment, and including occupational risk
8 factors, and then any further intervention or
9 provider time is based on what's found in the
10 health risk assessment.

11 COL. FOGELMAN: Any comments for that?

12 (No response.)

13 COL. FOGELMAN: All right. Then we'll
14 go on to the business meeting then unless anybody
15 has anything else.

16 (No response.)

17 COL. FOGELMAN: Okay. One of the
18 things we wanted to do today is we do have three
19 members who their last official meeting will be
20 this one. However, we're going to try to bring
21 you back for the next meeting to follow up on
22 this immunization project that we're working on.

23 (Laughter.)

24 COL. FOGELMAN: Especially those that
25 have volunteered to help write a portion of the
26 report.

1 You know, I want you to know from the
2 DOD perspective and speaking for Dr. Mazzuchi and
3 now General Claypool, who's going to be the
4 overarching guide for the AFEB, how much we have
5 appreciated your volunteerism, which is what it
6 really is. You don't get paid for doing this,
7 and we greatly appreciate your coming to us three
8 times a year and often more on the telephone and
9 sometimes additional meetings to help us solve
10 problems and give an objective, outside expert
11 view on a lot of these issues.

12 So as a token of our appreciation, we
13 want to -- could we have Dr. Stevens, Dr. Chin,
14 and Dr. Allen come to the front?

15 DR. FLETCHER: This means you'll
16 always be a consultant. You may not be a regular
17 member.

18 (Whereupon photographs were taken.)

19 COL. FOGELMAN: As a token of our
20 appreciation from DOD, we wanted to present each
21 of you with a plaque and a letter from Dr.
22 Mazzuchi showing how much we appreciate your
23 support.

24 DR. FLETCHER: Dr. Stevens. Thank you
25 very much.

26 DR. STEVENS: Thank you.

1 DR. FLETCHER: And, Dr. Chin, thank
2 you very much.

3 Last, but not least, Dr. Allen. Thank
4 you very much.

5 COL. FOGELMAN: I think we ought to
6 give all of these folks --

7 (Applause.)

8 DR. FLETCHER: We're going to take up
9 one more thing before we adjourn. We would like,
10 Dr. Allen and I, specifically to offer that this
11 is a more temporary plaque, you might say, to
12 Colonel Fogelman.

13 COL. FOGELMAN: Thank you.

14 (Applause.)

15 DR. FLETCHER: For her very special
16 attention.

17 COL. FOGELMAN: Thank you. That's
18 very nice.

19 DR. STEVENS: I don't know if we're
20 supposed to make speeches, but --

21 DR. FLETCHER: Certainly.

22 DR. STEVENS: -- I would just like to
23 say it's been a privilege to be a part of this
24 group, and particularly under Colonel Fogelman.

25 COL. FOGELMAN: Thanks.

26 DR. STEVENS: The Board has really

1 turned around and become very active, and it's
2 been really a pleasure to be part of it.

3 COL. FOGELMAN: Thank you.

4 I wanted to tell you also that we will
5 also be sending plaques and letters to the people
6 that weren't able to be here for whom this was
7 their last meeting, as well. So don't think that
8 we've forgotten them, including a few of the
9 members who had left the Board last year.

10 It took me a while to be able to get
11 permission to prepare plaques. You know how DOD
12 is.

13 (Laughter.)

14 COL. FOGELMAN: It took a year to get
15 permission to do that.

16 DR. ALLEN: It's just like
17 cardiovascular disease. It takes you two years
18 for the plaques to develop.

19 COL. FOGELMAN: Right. Anyway, thank
20 you again.

21 (Applause.)

22 DR. FLETCHER: One last item now. We
23 are going to transfer the gavel to our new
24 President, and let me tell you a few things about
25 him. We have come a long ways, I think, in
26 preparation to talking a bit about Dennis.

1 As you know, AFEB was developed just
2 after World War II, and many giants such as
3 Maxwell Finland of Harvard and Randell, Camp,
4 Wanimaker, Sabin of the polio vaccine were
5 actually intimately involved with the AFEB,
6 studies, collaborative studies, and all of these
7 developments.

8 And up until the 1970s, it was sort of
9 a dormant time. Then the AFEB was sort of looked
10 at again, and then since then we have sort of
11 gotten under a new regime, and it's been very
12 good, I think, but in the last few years, we've
13 been able to come back again with more
14 recommendations that we've seen response to
15 today, things that people like Greg Poland are
16 doing collaboratively with industry, academics,
17 to have more things back sort of as it was
18 originally.

19 So I think this is another era where
20 we're moving up and really having things done
21 that are good from the civilian standpoint to our
22 colleagues in the military.

23 And I've enjoyed very much being in
24 this position, just sort of working with you
25 people. I'm a cardiologist, as Julian Haywood
26 is. We don't know a lot about viruses and injury

1 and heat and that type thing, but we have learned
2 a lot, and I think what we're doing in clinical
3 preventive services, wellness, health
4 enhancement, I think, is something that, as the
5 admiral said this morning, is a major problem.
6 Fifty percent of our problem in the future is
7 lifestyle.

8 I think our readiness in the military
9 must look more at that, and I think our health
10 maintenance committee will continue on with this.

11 But our new President is a friend of
12 mine and colleague since I got to know him at
13 Fort Bragg some time ago and when I learned some
14 of his talents, but he is a native of San
15 Antonio. Much of his education in San Antonio,
16 but he got his Ph.D. in epidemiology at Houston,
17 and over the years has generated about two and a
18 half million dollars worth of funds that he has
19 been utilizing and still does, I believe, in his
20 work as head of the Bureau of Epidemiology of the
21 Texas Department of Health.

22 And Dennis comes with a tremendous
23 background. Of course, what he did for us here
24 with the sarin mustard gas and the document that
25 Dr. Joseph was after him to get quickly and with
26 a lot of work, and Dennis did not get a

1 the wings working with you, and let me pass the
2 gavel to you know.

3 (Applause.)

4 DR. PERROTTA: I appreciate the honor.

5 It truly is an honor to be part of the Board and
6 then to, after about five years, be asked to help
7 facilitate some of the things.

8 The way that I think I'd like to do it
9 is consensus building. I'm going to rely on the
10 Board members an awful lot, invite the service
11 representatives to visit electronically and
12 otherwise. I've got a lot to learn, but I'm
13 really tickled that I've got Vicky in the office
14 and then saddened that she's going to be moving
15 on and we have to break in somebody new, but
16 rumors are that the replacement will be a good
17 person as well, and so I'll be looking forward to
18 that.

19 So you've got my E-mail and my
20 telephone number. Let's start talking about
21 things that we can be doing in between the
22 meetings. We only get to meet three times during
23 the year, and it's just really hard to get
24 everything accomplished just at a day and a half
25 worth of meetings.

26 I can tell you that Vicky works very

1 hard on getting these meetings to be productive,
2 as productive as possible for everybody involved,
3 and so maybe we can expand some of that on some
4 of the interim stuff. I know we have plenty of
5 time to do that.

6 But perhaps I could ask Vicky to do
7 one piece more of business before we adjourn.

8 COL. FOGELMAN: Would you come and
9 help me do this?

10 DR. PERROTTA: I would.

11 COL. FOGELMAN: We have to have one
12 more presentation. Dr. Fletcher.

13 DR. PERROTTA: You didn't think you
14 were going to get off.

15 COL. FOGELMAN: We want to thank you
16 very much from DOD and from me and from all of
17 the Board members for your outstanding leadership
18 and service to the AFEB, and as such we want to
19 present you with a small token.

20 DR. FLETCHER: Oh, me, that's neat.

21 DR. PERROTTA: He's got his own gavel.

22 COL. FOGELMAN: As the outgoing
23 President.

24 DR. PERROTTA: "To Gerald F. Fletcher,
25 with deepest appreciation for your outstanding
26 service as President of the Armed Forces

1 Epidemiologic Board, July 1996 through July
2 1998."

3 DR. FLETCHER: Thank you very much.

4 (Applause.)

5 COL. FOGELMAN: I have to tell you
6 that it's not easy to be the President. This is
7 the guy I end up bugging most of the time.

8 DR. FLETCHER: We make a lot of
9 telephone calls, but it works out very well.

10 COL. FOGELMAN: As subcommittee
11 chairman you may get bugged, but if you're
12 President, you really get bugged.

13 PARTICIPANT: There's another picture
14 coming up here.

15 DR. FLETCHER: Oh, another picture?

16 PARTICIPANT: Shake his hand or
17 something.

18 (Laughter.)

19 COL. FOGELMAN: Thanks again.

20 (Applause.)

21 COL. FOGELMAN: The only other thing I
22 have to say is I will be leaving in July, but I'm
23 going to try to come back to the next meeting to
24 help finish up the business that we still have
25 pending and also to help the new AFEB Executive
26 Secretary get his or her feet on the ground.

1 We're not sure who it's going to be
2 yet, although it's likely that it will be Colonel
3 Ben Diniega from the Army, and I think some of
4 you know him.

5 DR. FLETCHER: He's good.

6 COL. FOGELMAN: And he's very eager
7 and enthusiastic about coming. So it isn't a
8 done deal yet, but we think that that's who it
9 should be, and he should be -- no, he's calling
10 me every day. He won't be reporting until
11 beginning of August some time. So that's why
12 the transition will be a little difficult, but I
13 think we'll work it out.

14 I just want to say how much I've
15 enjoyed working with all of you, all of the Board
16 members. It's just amazing. I know how
17 difficult it is to volunteer your time for
18 something like this, but the amount of effort
19 I've seen put into it is just tremendous, and I
20 just want to thank you.

21 PARTICIPANTS: Thank you.

22 COL. FOGELMAN: Thank you.

23 DR. FLETCHER: It's been a pleasure.

24 COL. FOGELMAN: Yeah. Also I want to
25 thank Captain Buck. I don't know if you've had a
26 formal introduction here. The Commanding Officer

1 of the Naval Environmental Health Center, for
2 helping us.

3 DR. FLETCHER: Thank you so much.

4 (Applause.)

5 DR. FLETCHER: Any comments you'd like
6 to make?

7 CAPT. BUCK: I've had fine feedback
8 during the breaks, and I'll certainly pass it on
9 to the staff.

10 COL. FOGELMAN: And, Commander Rendin,
11 would you please stand up?

12 He's really been one of the linchpins
13 behind helping getting this meeting going.

14 (Applause.)

15 COL. FOGELMAN: Is Pat here today?

16 PARTICIPANT: He's not.

17 COL. FOGELMAN: Okay. A special
18 thanks to Ms. Pat DiBiacio (phonetic), and to my
19 staff also, Ms. Jean Ward, who's been working
20 behind the scenes to help make this a very
21 productive and effective conference, and Major
22 Carol Fisher, who also helps part time, helps me
23 get things together for this meeting.

24 (Applause.)

25 COL. FOGELMAN: So I think that pretty
26 much wraps it up.

1 DR. BAGBY: I'm not going to make any
2 long speeches, but as a long time member of the
3 Board and consultant to the Board, I want to
4 thank you two for making this a very effective
5 and active group because five years ago we were
6 struggling. We had some problems in just
7 reacting to things that were brought to our
8 attention, and you two have had a lot to do with
9 getting us on the track, I think, of being
10 proactive, and I think that's what we should be,
11 and I think the services appreciate that. I
12 think they really would like for us to be
13 proactive.

14 Thank you, the two of you.

15 DR. FLETCHER: Thank you, John.

16 COL. FOGELMAN: Thanks very much.

17 I think that's it.

18 DR. FLETCHER: Mr. President.

19 DR. PERROTTA: Board members, do you
20 have anything else?

21 COL. FOGELMAN: Our next meeting --
22 I'm sorry?

23 PARTICIPANT: New Board members?

24 COL. FOGELMAN: We haven't gotten
25 approval. I have a number of nominations which
26 actually I'll pass on to you. We have about

1 seven or eight nominations right now.

2 The one thing I would ask is if any
3 Board member or any military member has
4 nominations for the Board that you have not
5 submitted to me, if you'd please E-mail me within
6 the next week or so so that I can give them a
7 call and try to get CVs because what we'll then
8 do is go out to the services and try to get
9 approval from them.

10 So, please --

11 DR. FLETCHER: Please keep in mind,
12 geography, gender, ethnicity, and all of this. I
13 think this is very important. We're doing pretty
14 well with that, but the more nominations you can
15 bring in, it will be more for the system to
16 select from.

17 COL. FOGELMAN: Right. We need at
18 least one new member for the health maintenance
19 subcommittee, and at least one for the
20 environmental/occupational health subcommittee,
21 one or two for that committee really.

22 We have plenty of nominations for the
23 infectious disease subcommittee, but we don't for
24 the other two. So if you have people that you'd
25 like to recommend.

26 DR. PERROTTA: Yes. Thanks, Art, for

1 bringing it up because it's critical. I mean the
2 environment committee ends up being Andy and I
3 and John, and while these are some of my favorite
4 people, we know what we're thinking. We need
5 some help.

6 And so I'm going to be working real
7 hard with Vicky to see if we can't push and I can
8 do whatever I can and whoever of you that are out
9 there that has any influence on the process, if
10 there is any influence, that we move this as
11 quickly as possible because I'd really like to
12 have some of these new folks up and running and
13 on board for the August meeting.

14 COL. FOGELMAN: Right. For our
15 military folks here, I'd really like to have you
16 go back and talk to your services about the kinds
17 of things that the AFEB may be able to do for
18 you. The more proactive we can be, as Dr. Bagby
19 says, and the more further in advance we can get
20 questions so that, you know, I can help you, tell
21 you what data you need to bring to the table and
22 things like that, the better it's going to be for
23 all of us.

24 So, please, I implore you to try to
25 work things through your systems. Get approval
26 from your various service staffs certainly before

1 you try to come to the AFEB, and that takes maybe
2 a little bit of time, but we've got until
3 probably, you know, early July or so to get some
4 things on the plate here.

5 So please do that. Come to me, give
6 me a call if you think you have an item that you
7 think should come in front of the AFEB, and we'll
8 talk about it and see if we can't get it worked
9 out.

10 Yes.

11 DR. ALLEN: Just in responding to that
12 request to the services, I would just like to
13 comment that over the five years that I've been
14 on the Board, what I've seen is a marked
15 difference in presentations from just kind of
16 information only items that you'd be left with,
17 "Well, that's interesting, but what do we do with
18 it?" to very focused kinds of presentations that
19 even if they are not complete, clearly are
20 targeted towards moving into recommendations and
21 action that the Board might take and change of
22 practice on into the Armed Forces.

23 I just really would like to applaud
24 that change and encourage you to continue in that
25 direction.

26 COL. FOGELMAN: Thank you.

1 We really have a lot of expertise on
2 the Board, and they want to help, but it's not
3 easy to help if you don't have all the background
4 and all of the data that you need to help in
5 decision making. So please try and help us make
6 better decisions or help make better
7 recommendations for you by bringing good data to
8 the table. We'd appreciate it.

9 Anything else?

10 DR. PERROTTA: Anything else?

11 COL. FOGELMAN: Yes.

12 PARTICIPANT: For those of you who
13 attended Captain Rowley's presentation, he wanted
14 to make sure you had an opportunity to pick up
15 one of the personal training plans that the Navy
16 has. So those of you that were there or anyone
17 else, I'll leave them on the table.

18 COL. FOGELMAN: Well, I think we can
19 adjourn the meeting.

20 DR. PERROTTA: We're adjourned.

21 (Whereupon, at 11:35 a.m., the meeting
22 was concluded.)

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