

UNITED STATES OF AMERICA

ARMED FORCES EPIDEMIOLOGICAL BOARD

+ + + + +

MEETING

+ + + + +

WEDNESDAY

SEPTEMBER 19, 2001

+ + + + +

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

PRESENT:

STEPHEN M. OSTROFF, M.D., M.P.H., Acting President

DAVID ATKINS, M.D.

S. WILLIAM BERG, II, M.D., M.P.H.

DOUGLAS CAMPBELL, M.D.

PIERCE GARDNER, M.D.

L. JULIAN HAYWOOD, M.D.

JOHN HERBOLD, D.V.M.

PHILIP J. LANDRIGAN, M.D., M.Sc.

KEVIN M. PATRICK, M.D.

DENNIS F. SHANAHAN, M.D.

ROBERT E. SHOPE, M.D.

LTC. RICK RIDDLE, USAF

AFEB Executive Secretary

JEAN P. WARD

AFEB Staff Assistant

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS

1323 RHODE ISLAND AVE., N.W.

WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

PRESENT: (CONT.)

PREVENTIVE MEDICINE OFFICERS:

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

FLAG STAFF OFFICERS:

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

ALSO PRESENT:

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

Opening Remarks and Introductions 4

Deployment Health Clinical Center 8
 Chuck Engel

Validity of 2 Year Initial Physical Exam
 (2 versus 5 Year); ECG for Selected Officer
 Program Applicant Screening; Panographic X-Ray for
 Selected Officer Program Applicant Screening

 Presentation of Question..... 80
 Lt. Col. Corcoran

 DoD - Cpt. McKinley..... 91
 DoDMERB - Col. Weien..... 99
 MEPCOM - Col. Lee..... 109
 AMSARA - Ltc. Krauss..... 123

Post-Disaster Assessment Questionnaire

 Col. Mallon..... 195
 Discussion..... 202

Committee Discussion 232

Closing Remarks 271

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

(7:30 a.m.)

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

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

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

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

But we are going to talk to Dr. Barrett-Connor and see if we can talk her into expending for another year. But, Dr. Haywood, if you will come up here to the front. We do want to recognize your four years of service with the board.

Well, actually five years. I guess you have been on since November of 1996. So, on behalf of the AFEB, we want to give you this plaque, really just to show our appreciation for

1 your contributions as a member of the board.

2 And, you know, you can't just underestimate the
3 impact of the recommendations of the AFEB has for the Department,
4 and again the appreciation that we have for all of the efforts
5 that you go through uncompensated for the time that you serve,
6 and the contributions that you make to the Department of Defense.

7 So on behalf of the AFEB, we certainly appreciate
8 it, Dr. Haywood.

9 (Applause.)

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

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

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

21 This morning, we have with us Colonel John Powers.
22 Colonel Powers is the Acting Deputy Assistant Secretary of
23 Defense for Clinical and Program Policy. Also here today, again
24 we have Rear Admiral Robert Hufstader, with the Medical Office of
25 the Marine Corps.

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

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

9 There is a couple of agenda changes. As you know,
10 Commander Ryan could not be here. NHRC only allowed absolutely
11 mission essential travel given the circumstances.

12 But Colonel Chuck Engel, who is the Director of the
13 DoD Clinical Center for Deployment Health, is going to fill in,
14 and he is going to give us an overview of the operations of the
15 clinical center, and some of the work that DoD has been doing in
16 developing clinical practice guidelines.

17 Just for a little bit of background, a couple of
18 years ago, in response to some legislative initiatives, and
19 initiatives within the Department, we really established a triad
20 of effort, which is the surveillance effort that the Army Medical
21 Surveillance Activity, a DoD Center for Deployment Health
22 Research out at NHRC, and the DoD Center for Deployment Health
23 clinical work up at Walter Reed.

24 And so we are glad to have Chuck here, and I think
25 it is pertinent with the work that they are doing given the

1 current situation. And also in response to yesterday's
2 discussion, Dr. Mallon, from CHPPM is going to come down at 1330.

3 And he is going to give an overview of the
4 questionnaire and the work that CHPPM is doing over at the
5 Pentagon. And I think what General Peake had intended was to
6 probably have that questionnaire reviewed and validated by the
7 Board, and so I think that is what Colonel Mallon will present.

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

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

18 Chuck is a Gulf War veteran, and has been involved
19 in post-deployment health care and development of some clinical
20 practice guidelines for quite a while.

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

25 But I really appreciate the opportunity to address

1 you and tell you a little bit about the Deployment Health
2 Clinical Center, a sort of history as Rick has presented it in
3 brief terms.

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

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

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

22 And one researcher in the Gulf War situation at
23 Tulane has hypothesized finding things in the urine that other
24 people can't see. Other physiological and laboratory anomaly in
25 the veterans, et cetera, et cetera. Some people thought it was

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS

1323 RHODE ISLAND AVE., N.W.

WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1 psychiatric.

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

10 And as those got fairly big the list turned into a
11 clinical evaluation as a fairly sizeable group of those, about a
12 fifth, turned out to have medically unexplained physical
13 symptoms.

14 And it was determined that we needed to have a
15 treatment program for those with medically unexplained physical
16 symptoms that we could not do other things for.

17 And that was about mid-1995 when the treatment
18 program was initiated, and it was initiated at the Gulf War
19 Health Center, and we were also a place that was doing this CCEP
20 evaluation as it came to be known, the Comprehensive Clinical
21 Evaluation Program.

22 I am not going to belabor the point, but to just
23 sort of review the basic point that there were health issues
24 among Gulf War veterans after the Gulf War, perhaps not
25 surprisingly. There were 700,000 Gulf War veterans, about the

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

1 size of the City of San Francisco.

2 And people over time get sick, and epidemiologic
3 studies showed, and continue to show really, that Gulf War
4 veterans are not dying faster, and in some of the early studies,
5 which are difficult to continue on, suggested that they were not
6 getting hospitalized faster than their counterparts who were not
7 deployed.

8 A lot of people said, well, you know, problem-no
9 problem, I guess, but it is really not as simple as that. If you
10 look at about a dozen epidemiologic studies that have been done
11 since then, in varying degrees of rigor, and some quite good,
12 they all really show that virtually across-the-board that
13 physical symptoms are elevated among Gulf War veterans, and that
14 Gulf War veterans to a modest degree rate their health as more
15 poorer than those who didn't deploy.

16 And some have argued, right or wrong, that perhaps
17 the most healthy people are actually deployed. So you would
18 almost expect, all things equal, to see the reverse of that
19 relationship.

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

24 And there is some more recent examples of this,
25 which our group has looked at fairly carefully, and others have

1 looked at fairly carefully, and we have tried to ferret out some
2 -- let's just call them social context kinds of factors that can
3 help us maybe to understand these kinds of events.

4 And the common elements, just looking from the
5 10,000 foot level, seem to be that there is some sort of
6 instigating event, some mass violence sort of event.

7 And subsequently there are symptoms and concerns
8 that emerge in people who are around that event. There is
9 suspicion and mistrust all around, and the sources may differ
10 from situation to situation.

11 There is an ensuing debate about causes, and often
12 a fairly concerted effort to understand the causes through
13 clinical investigations, and sometimes epidemiologic studies, and
14 almost universally nothing is found.

15 To give you some fairly recent examples of this,
16 and there are many, that sort of suggest that this trend that we
17 saw after wars is, if anything, escalating. It is becoming
18 faster.

19 I had the opportunity to go to Canada and testify
20 before a Board of Inquiry, where peacekeepers there were
21 concerned about their health; and subsequent investigation found
22 nothing, but there was a lot of concern about environmental
23 exposures.

24 Certainly those that in the room are quite familiar
25 with concerns around the anthrax vaccination, and in our clinical

1 center we have taken care of people with illness after anthrax
2 vaccination that they relate to the anthrax vaccination.

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

6 We are probably all in this room quite familiar
7 with the situation involving depleted uranium in Europe. There
8 are some lesser known circumstances dating back to the '80s that
9 the Dutch have encountered, peacekeepers in Lebanon that
10 subsequently developed unexplained symptom illnesses.

11 And in the '90s, they had a group that went to
12 Cambodia that came back and complained of what came to be known
13 as "jungle disease," which essentially were similar types of
14 symptoms to the symptoms of people in World War I that I related
15 earlier.

16 And then peacekeepers in Bosnia in the middle '90s,
17 they had a large fraction of them complain of various difficult
18 to understand illnesses. This is a very interesting event,
19 particularly as it relates to the recent incidents that we have
20 suffered here in the U.S. in the last week.

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

1 And subsequent to this crash in this residential
2 area, people became ill, and conspiracy theories evolved. And up
3 here, which you can't really see, there is a blurb out of a
4 Boeing memo that says there is depleted uranium in the tail fin
5 of a 747.

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

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

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

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

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

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

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

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

22 Now, I don't mean to poke fun really. Maybe I do,
23 but this is the way that clinicians sort of feel when they are
24 encountering this sort of a patient, because they cannot diagnose
25 a disease. They are not sure what is going on, and all they know

1 is that they want to get out of there, and they want to see
2 another patient real fast.

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

8 And that there are good population epidemiologic
9 studies of symptoms that show about a fourth to a third of
10 physical symptoms, both in clinical practice and in populations,
11 in general populations, are unexplained.

12 And in medicine, we have this habit of putting or
13 developing an epidemiology. By the way, I am a epidemiologist,
14 too, and so we have this habit of developing a case definition
15 that is grounded in some sort of theoretical perspective which
16 has yet to be proven, and it's -- wow, I have got a smorgasbord
17 here. I have multiple chemicals here.

18 But they are grounded in a theoretical perspective
19 that has yet to be proven, but as you know in epidemiology, the
20 reason that you develop the case definition is so that you can
21 understand the cluster or constellation of symptoms or findings
22 better.

23 And in clinical practice, we often make the
24 diagnosis and record it in the record before we really know that
25 it is a valid syndrome, and we do that for a variety of different

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

1 reasons.

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

5 Now, there is a belief among -- I would say across
6 society, but particularly among clinicians, that medically
7 unexplained physical symptoms are not important, and unless there
8 is a disease driving them, they are really not important.

9 But there is fairly good-sized literature that
10 suggests that they are, and that they are related to mental
11 disorders, and psychosocial distress, and some of those quite
12 treatable and under-recognized.

13 There are very robust associations across a wide-
14 variety of study designs, longitudinal as well, looking at the
15 relationship of functional impairment, to medically unexplained
16 physical symptoms. Back pain is often a medically unexplained
17 physical symptom which accounts for a great deal of functional
18 impairment in our society.

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

23 And really from my perspective as a military
24 clinician/epidemiologist, I think this is -- I view this as a
25 public health problem. That is separates us from the people that

1 we are supposed to care for. It causes a lack of trust, a lack
2 of creditability.

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

9 Sometimes the answer included multiple evasive
10 procedures and medications that was sort of capitalizing on
11 desperate people looking for unlikely solutions.

12 And there has been a discussion in the academic
13 literature, increasingly moving in the direction that these
14 syndromes which we tend to label in different ways, are in a
15 phenomenologic sense are essentially medically unexplained, and
16 they are overlapping.

17 And rather than dividing them out before we really
18 know that we should, maybe we should conceptualize them as one.
19 Simon Weseley in particular has done a lot of excellent work in
20 this area, and shown that the risk factors for development of
21 medically unexplained physical symptoms, regardless of case
22 definition, are largely the same.

23 The clinical outcomes are largely the same, and the
24 treatments are largely the same that are supported by evidence in
25 the literature, and makes the argument that we should be

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS

1323 RHODE ISLAND AVE., N.W.

WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1 conceptualizing this until proven otherwise if you will as one
2 syndrome.

3 The irony is that it is essentially not one
4 syndrome. It is one heterogeneous collection of symptoms. And
5 the problem on some level is our usual high-powered tool.

6 Our problem is the medical model; that when
7 patients come in to see the clinician, and they go through a
8 history and an examination, and testing, and the exam and
9 testing come up empty, but the history is yielding of all kinds
10 of symptoms, clinicians tend to discount the symptoms.

11 So the history is on some level less important to
12 them, and this creates a sort of untenable clinical solution,
13 which is -- or clinical occurrence or context, which is amplified
14 in the military setting I think.

15 It is not unique to the military setting. Anybody
16 here who has practiced civilian primary care medicine knows that
17 it is not unique, but it certainly is amplified I believe in our
18 setting, and that is what I would describe as a contest.

19 That you have a situation with a patient feeling
20 like garbage, and trying to convince a clinician that they
21 perceive as putting barriers in the way, and sometimes clinicians
22 who because of dual obligations to organization and to patients
23 may identify with the barrier role.

24 So that both sides of this -- this is sort of a
25 caricature of a situation, of a context, that really exists in

1 military medical care. So in some fashion on a social level, one
2 can think of these as contested illnesses and contested
3 exposures, which I have attempted to operationalize here in some
4 fashion.

5 So, exposures with plausible health consequences,
6 and certainly not proven, but plausible, or illnesses that are
7 based on symptoms alone, that become a matter of public debate,
8 political controversy, or litigation.

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

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

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

24 And we can actually up front -- you know, if you
25 ask clinicians, they can -- in fact, in the U.K., they called

1 them "heart sink" patients, because usually their heart sinks
2 when they see the folder in the file.

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

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

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

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

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

23 And we compared beliefs of clinicians with regard
24 to causes and treatments of essentially Gulf War illness, and
25 what you see is that internists tend to conceptualize this as

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

1 more of a mental disorder, and that psychiatrists or
2 psychologists tend to conceptualize this as more of a medical
3 disorder.

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

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

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

18 It is because they get different messages from
19 different clinicians, and it's because we don't really know what
20 the cause is. This is a political cartoon that came out at about
21 the time that there were problems with tires.

22 It says, "We have mapped the human genome, mastered
23 artificial intelligence, and unlocked the secrets of the
24 universe. The wheel though still needs some work."

25 And really this is really what is -- well, on some

1 level, this is what our clinical center is about. That we know a
2 lot of high-powered things in medicine. We are not very good
3 where the rubber meets the road.

4 We sort of leave out some important elements of
5 care. As we know more scientifically, we seem to forget more
6 that we are not dealing nuts and bolts. We are dealing with
7 flesh and blood, essentially black boxes with huge variation from
8 person to person in their responses to various kinds of exposure
9 situations, et cetera.

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

15 We have gotten good at technology, and we have
16 gotten lousy at delivering a service. So our clinical center is
17 how can we do better at delivering a service to people who often
18 have things that are very difficult to understand and explain,
19 medically unexplained symptoms, unclear exposures that are often
20 contested and undergoing public debate, which will always be the
21 situation after deployments. Always.

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

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

4 Our goal at the clinical center is to try and
5 evolve -- and I don't pretend that this is easy, but we have a
6 DoD-wide mission. Our goal at the clinical center is to create a
7 system of collaborative care.

8 And to contrast this, I would say that in general
9 medical care that the way it works is that the lay person goes to
10 see the expert clinician scientist, and the expert clinician
11 scientist tells you what is wrong, and tells you what to do, and
12 tells you to go away.

13 In collaborative care, it is much more of a human
14 mode. You know, it recognizes human factors. It recognizes that
15 you can tell somebody what to do, but it doesn't mean that they
16 will do it.

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

21 They will just leave and do what they would have
22 done otherwise without telling you. So the goal is to
23 collaborate and to negotiate a process of care, to negotiate what
24 are the outcomes of care that you are interested in.

25 And to come up with some negotiation of those

1 things that you as a physician think are most important to
2 change, and that the clinician or that the patient is ready to
3 change, and that there is some understanding that they need to
4 change.

5 And the monitoring is often of behavioral
6 parameters, such as self-reports, and how much activity they are
7 engaged in. And in many respects maybe the fact of a planned
8 follow-up is more important than what you do during that follow-
9 up itself.

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

15 So everything that we learn in psychiatry it seems
16 like these days is oriented towards the acute initial assessment.

17 We don't know what to do after the first visit. And I am being
18 facetious, but it's true.

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

21 (Brief Pause.)

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

23 LT. COL. ENGEL: Is there?

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

25 LT. COL. ENGEL: So, in biomedicine, you know, we

1 look for this, and once we know what this is, which is usually a
2 disease of some sort, something with clinical correlates on --
3 and some structural correlate on testing or examination, and if
4 we can do something about that -- if we can make it go away, if
5 we can cut it out and we can cure it -- then this goes away.

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

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

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

23 And in most cases, of course, we can't really cure.

24 So how do we get to that point in a health care system. Well,
25 the first thing is that we have to recognize that we need to get

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

1 to that point.

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

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

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

14 So how do we get to a more collaborative health
15 care system, a system more oriented towards morbidity reduction?

16 This is sort of the road map that we have laid for ourselves,
17 and the first step is clinical experience, which we believe we
18 have gained a lot of on the heels of the Gulf War, and working
19 with patients from other deployments, and those who have received
20 the anthrax vaccination.

21 And designing and collating clinically relevant
22 research that guides our practices, and once those are collated,
23 to develop guidelines from them, and to make concerted efforts to
24 implement those guidelines.

25 And then to do what I have called pragmatic

1 studies, which other people might call effectiveness studies, or
2 studies of implementation. An efficacy study asks can this
3 therapy work under the most ideal circumstances usually.

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

8 The Institute of Medicine essentially agreed that
9 this was a good approach, and that their group that has been
10 considering force health protection fairly carefully has
11 recommended that in the Department of Defense that we implement
12 strategies to address medically unexplained physical symptoms.

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

17 And, you know, PTSD, that is what trauma does.
18 Well, trauma does lots of things. It has lots of outcomes. PTSD
19 is one slice in the salami, and it is actually the modal slice,
20 but it is a thin slice.

21 So we need to make people aware that symptoms are
22 common, and that we know things about the general outcomes of
23 unexplained symptoms, because we do. We tend not to pay
24 attention to them in medicine. They are not the most exciting
25 world-beating findings out there.

1 We need to carry out training for health care
2 providers, and how to manage them, and how to carry out clinical
3 trials to look at how guidelines work, and also essentially
4 develop a health services research program.

5 That's where we are. This is our center, the
6 Deployment Health Clinical Center, and the original
7 conceptualization was that there would be three DoD centers for
8 deployment health.

9 One would be the clinical center, and the other
10 would be the research center at NHRC, essentially a population
11 research center; and the other would be a surveillance center.
12 And the idea, which would be headquartered in CHPPM, the idea
13 would be to use data that is currently being monitored for the
14 purpose of informing clinical care.

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

19 Our mission is the delivery of services, and its
20 research around services, and education around services, and the
21 services that we are specifically talking about are post-
22 deployment services. Not all services, but post-deployment
23 services.

24 And we are very good in the military I would put
25 forward at rushing to the scene, or at battlefield casualties,

1 but when the sexiness wears off, and patients have longer term
2 problems, we are sort of not very interested anymore.

3 And that I think is where our center needs to be
4 focused, and again the reason why is because I think that this is
5 fundamentally a public health problem, and that we have to use
6 this to foster trust of the people who are using military
7 services.

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

13 So this is another way of thinking about what we
14 are doing. There are these three elements of our program;
15 services delivery, services research, and education. You know,
16 continuing medical education, and patient education.

17 And it is all centered around a clinical practice
18 guideline or a group of clinical practice guidelines. So we have
19 sort of put our eggs into some baskets, and more than this, but
20 these are some key ones.

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

25 And this guideline is currently being pilot

1 implemented at three sites; Fort Bragg, Camp Lejeune, and Maguire
2 Air Force Base. This one is nearing completion.

3 This one is a twinkle still, but we have been
4 talking about that, and actually in PTSD, the nice thing about
5 PTSD is that there is actually existing guidelines that we can
6 just modify. We don't have to recreate something.

7 Whereas, with the first two really, we have to
8 start from scratch, and unlike many disease states, where you
9 develop clinical practice guidelines, as you can imagine, there
10 is a paucity of evidence, certainly a paucity of randomized
11 control trials to help us to make decision points in the
12 guidelines.

13 So what is a guideline? It systematically develops
14 statements to assist practitioner and patient decisions about
15 appropriate health care services for specific clinical
16 circumstances. Note that it doesn't say a disease. It says
17 specific clinical circumstances like someone seeking care after
18 deployment.

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

24 These are some of the other guidelines that are
25 going on within DoD and VA. It is a collaboration between the

1 two health care systems, and so there is an opportunity to share
2 ideas about how care is delivered for various problems across our
3 two systems.

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

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

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

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

21 If you look at the different guidelines, there
22 should be some -- you should have some sense of what are our
23 priorities about health care. So it strikes me -- and especially
24 since no one else has it as their big priority, except perhaps
25 the VA -- that we should have a pos-deployment care guideline.

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

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

13 So there is a variety of VA and DoD clinicians and
14 academics who were involved with the development of these. There
15 were a variety of different disciplines, perhaps the most
16 important of which are primary care disciplines.

17 As a psychiatrist, I was also involved in the major
18 depressive disorder guideline effort, and there is always a bunch
19 of psychiatrists and psychologists around the room who think that
20 we should swoop in and do four years of psychoanalysis on every
21 patient with depression.

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

1 If we are going to have success helping depressed
2 people in primary care, we have to do it in a way that integrates
3 depression care into the process of primary care.

4 So there is a variety of disciplines involved, and
5 two that are a little different for many guidelines, or we had a
6 toxicologist involved in this, and we had more than one risk-
7 communicator involved in this, because as you will see here in a
8 minute, we agreed that an important element of this, and perhaps
9 the backbone of this, was how to communicate to patients about
10 risks that in many respects we had to acknowledge we wouldn't
11 know the answers to.

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

17 And that doesn't mean that we revamp the guideline
18 if the patients don't like it, but they have a voice at the
19 table. The evidence -- like I say, there was distinctly evidence
20 lacking in many places in this particular guideline. This was
21 sort of the priorities.

22 These were the priorities that we used.
23 It was scientific evidence first. You will notice that I am not
24 even talking about clinical trials. It is scientific evidence
25 first, and there usually wasn't a lot.

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

4 And another thing to emphasize is that this is all
5 really a starting place. It is a recursive process. Every two
6 years the guidelines get revisited and revised based on current
7 experience.

8 And places where we see that we don't have evidence
9 to guide us, we are able to formulate clinical research
10 priorities to inform future clinical care in the post-deployment
11 context.

12 Some general guideline features. One thing that we
13 have recommended in the guideline is what we are calling a
14 military-unique fifth vital sign.

15 The use of a step care approach, and the use of
16 clinically based risk-communication strategies, and web-based
17 clinician support to provide information for them about exposures
18 relevant to various deployments.

19 Some guidance on longitudinal follow-up, which is
20 what we got criticism for in the CCEP, one of the things that we
21 were criticized for was that it was a one-time evaluation, and
22 then off they go; and then some monitoring of longitudinal
23 outcomes, and a supporting center. Basically, the deployment
24 health clinical center.

25 This is the military-unique fifth vital sign; is

1 the issue causing you to seek care today related to a deployment.

2 The guideline recommends use of the vital sign for all visits,
3 except wellness care, and it is a patient based question, rather
4 than a clinician based question.

5 We are not interested here -- I mean, obviously we
6 are interested ultimately, but we are not interested at the time
7 that this question is asked and answered on what "the real answer
8 to this question is." We are interested in what the patient
9 thinks.

10 In the piloting that we have done, one of the
11 obvious concerns in the early going was, oh, my gosh, if we ask
12 this question, everybody will say everything is deployment
13 related.

14 In the pilot testing, about 1 to 2 percent of
15 patients are saying that their problems are deployment related.
16 Step care is used in the guideline, which is a generic sort of
17 clinical service organization approach, and increasingly a health
18 services research approach, and that is a way of organizing care
19 across the continuum.

20 It involves sequencing of different strategies, and
21 it involves matching the clinical strategies based on the
22 patient's identified need. And then matching the level of care
23 to the patient based on what has been used in the past, and
24 something that health services researchers have described as the
25 illness trajectory, essentially cernicity and severity.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS

1323 RHODE ISLAND AVE., N.W.

WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

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

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

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

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

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

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

1 out.

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

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

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

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

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

23 And then subsequent tiers which allows them to look
24 more deeply at something. You know, if at the end of the day
25 they decided that they want to go back and read an executive

1 summary style thing, then they can do that.

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

7 And then a section on what your patients may be
8 reading, which is relatively unfiltered media information for
9 clinicians. So, some people said, well, why do you want to just
10 put anything up there. Well, on some level, we want to put
11 anything up there because we want clinicians to read it and know
12 why their patients are coming to see them.

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

17 We are developing an on-line risk communication
18 tool for teaching clinicians how to implement this stepped care
19 risk communication approach, and it is classic health services
20 research.

21 The first step is development of the tool, and uses
22 ethnographic techniques, focus groups. The second step involves
23 a clinical trial that looks at provider behavior; and the third
24 step is a clinical trial that looks at its impact on patient
25 satisfaction.

1 So the final part of the guideline that I want to
2 emphasize is that tip of the iceberg group of patients at the
3 top, those with chronic, unexplained conditions which they relate
4 to their deployment.

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

9 These are articles, and we had a couple of front
10 page articles in the Post about 3 years ago about our program.
11 This is an article in the American Legion magazine, which is
12 about as high of a compliment as any military thing is ever going
13 to get from the American Legion. It says, "Decent Treatment."

14 So I would like you to compare that with this.
15 "The Tiny Victims of Desert Storm: Has Our Country Abandoned
16 Them?" And which do you think is going to foster more trust in
17 our beneficiaries? That is kind of a no-brainer.

18 So this is the specialized program, which is our
19 referral program, and it is based on a chronic pain treatment
20 model, and almost all of the patients that we see by the way have
21 chronic pain.

22 And we have a toll free number, which is listed
23 here, and can be accessed through our website as well. Other
24 features of the guidelines are outcomes monitoring, using some
25 tools that are -- let's just say that are more detailed and more

1 effort to use than most guidelines would recommend.

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

6 So these are validated measures of functioning
7 mental health status and medical status. population metrics have
8 been developed which I am not going to belabor here, that are the
9 nuts and bolts of these metrics are still not conceptually
10 clarified.

11 And in my experience with the depression guideline
12 is that each one of these population metrics is about a 4 or 5
13 page document that describes how it is supposed to be measured.

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

21 In our services research side, just to give you
22 some example of the kinds of things that we are doing to
23 investigate care, we published some stuff on uncontrolled
24 outcomes of our three week program.

25 We are also involved in multi-center clinical

1 trials. We formed a collaboration of sorts with the Co-op
2 Studies Program and the VA. I would like to see us down the road
3 work towards an independent multi-center clinical trial
4 capability within the Department of Defense that would pursue
5 pragmatic health policy research in recognition of the fact that
6 we can't really generalize very easily health care research done
7 in other settings.

8 We are also involved in some mechanistic studies
9 with Georgetown, a group at Georgetown, Dan Clauw's group, which
10 is about to move to Michigan. And we are looking ahead to
11 various other services' research projects involving the clinical
12 practice guidelines.

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

18 And in the risk communication literature, there is
19 a lot of talk about commitment, and what fosters trust in the
20 patient is a sense of continuity and commitment. That you are
21 going to be there.

22 And that is the central thrust of our center, is
23 the recognition that we need to try to prevent, and we need to
24 try to do primary prevention. But there will always be things
25 that happen that we can't anticipate as we have learned again in

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

1 the last two weeks.

2 And as people develop health issues subsequent to
3 that, regardless of what scientifically our rational mind tells
4 us is related or not related to these events, to step forward and
5 be there for patients who have real needs, and real reasons for
6 people to step forward on their behalf. That is my presentation.

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

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

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

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

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

5 You know, they are chronic characteristics; things
6 learned about in childhood, and reactions to injury and illness.

7 Again, I am not saying necessarily that these are
8 psychologically caused, but psychological factors mediate how
9 people respond to various injuries and illnesses.

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

16 In short, there is probably a good bit of evidence
17 that is emerging, although it doesn't apply directly to medically
18 unexplained physical symptoms. It is more towards post-traumatic
19 stress disorder, and that prior to these events, and in the
20 immediate aftermath of these events, we have to be careful
21 because a lot of -- because good intentions aren't enough.

22 That on some level that strategies that we may jump
23 in with, such as to name one that has gotten a lot of attention
24 recently, critical incident stress debriefing, that there is
25 evolving randomized trial evidence that these strategies don't

1 work very well.

2 They don't on a grand scale make patients feel
3 better, and if one looks at the evidence carefully, there is
4 probably more evidence that they make people worse than that they
5 make people better. And there is some theory and speculation
6 about why that would be.

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

11 And essentially strongly recommends that compulsory
12 critical incident stress debriefing should stop, which I think is
13 probably a stronger recommendation than is justified.

14 But I think it highlights the point that on some
15 level our -- you know, that when something happens, like what has
16 happened in the last couple of weeks, everyone's impulse is to go
17 there and do something.

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

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

1 And in my experience around -- you know, I have had
2 opportunities to interface with the folks after Oklahoma City, as
3 well as after the Gulf and other events, and it has been my --
4 one of the things that I have seen is that lots of people collect
5 after these events.

6 That if anything that one of the major challenges
7 is controlling the area, and trying to keep interested, well-
8 intentioned parties away so that the work can get done. So the
9 short summary of all of that is that I think -- that I would like
10 to be optimistic about our ability to prevent.

11 And the epidemiologist in me would like to be about
12 prevention, but the clinician in me says this is an area where no
13 matter what we do, we will see consequences.

14 And that what we have to get good at is secondary
15 prevention, and tertiary prevention, and perhaps the best
16 population prevention is through the images of reaching out to
17 our own beneficiaries advertising those images so that on a
18 grandeur scale, on a population-communication scale, our
19 beneficiaries see us taking care of our own.

20 And then that fosters trust. I mean, as I see it,
21 that is the best prevention. One-on-one -- and I know that I am
22 jumping around here a little bit, but to go back to the critical
23 incident stress debriefing, I think it is a well-intentioned
24 application of a clinical intervention to a population problem.

25 You know, you are doing face-to-face intervention

1 for what is a population problem and that is distress after this
2 sort of event. And you have to apply population based
3 interventions, which as I see it is advertising the good that you
4 are doing for people.

5 LT. COL. RIDDLE: I had Dave pull this slide up
6 right here to kind of give an idea of how we are building a
7 program to be able to answer just that question; is how do we in
8 essence predict and intervene.

9 And really a lot of the things that we put in place
10 subsequent to the Gulf War is Chuck Center, the research center,
11 the Millennium Cohort Study, which is in your slide, working on
12 the recruit assessment program.

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

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

23 And the Millennium Cohort Study, which is the
24 largest prospective cohort study ever implemented in the
25 Department of Defense, that is designed to follow 140,000

1 individuals over a period of 21 years, focusing on deployment
2 health and health outcomes, all of this built in with the
3 clinical program with Chuck.

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

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

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

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

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

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

1 organization in Atlanta that found that it was flea collars.

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

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

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

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

19 LT. COL. ENGEL: Right. Well, those are important
20 questions. We do have data on three month outcomes of our
21 program, again uncontrolled. However, what we have done is as
22 part of this collaboration with the VA Co-Op Studies Program, we
23 have developed a 20-site clinical trial that takes the elements
24 of care that are inherent in the specialized care program, and
25 sort of boils it down to two fundamental elements, physical

1 reactivation and what essentially many people now are calling
2 cognitive behavioral therapy.

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

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

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

15 And in the multi-center trial -- and let's put it
16 this way. I have listened to a lot of sessions, because part of
17 what we have to do is evaluate the fidelity of the session, and
18 how well therapists are delivering it. And some of the fidelity
19 is pretty awful, I think.

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

24 There have been -- I won't say lots of randomized
25 controlled trials, but there has been on the order of approaching

1 10 randomized controlled trials, and if you pool studies across
2 different symptom based conditions, like chronic fatigue
3 syndrome, and fibromyalgia, irritable bowel, and look in that
4 way, that there is on the order of about 20 different randomized
5 controlled trials that Kurt Kroenke has recently pooled.

6 And not in a systematic meta-analysis, because they
7 are different enough that it is hard to do that, but comes to
8 some conclusions about its overall effectiveness for medically
9 unexplained physical symptoms.

10 But those are -- and he essentially concludes that
11 it is effective for several different outcomes, but the -- and I
12 think that those are all single site trials, and it will be very
13 interesting I think to see whether in a multi-site trial we are
14 able to demonstrate benefit.

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

20 So that will give us some sense of how much gets
21 poured into doing this for a unit of benefit. But I think it is
22 --

23 DR. LANDRIGAN: It probably won't be cost effective
24 in a narrow econometric sense because the costs are going to fall
25 to either the DoD or the VA, depending on whether the person is

1 active or retired.

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

5 LT. COL. ENGEL: Right.

6 DR. LANDRIGAN: -- the bean counters and the
7 Congress are going to require them at some level. But I think
8 that you are absolutely right in saying that the underlying issue
9 is not one of cost accounting, but rather fulfilling the
10 commitment.

11 LT. COL. ENGEL: Right. The public health issue as
12 I see it.

13 DR. LANDRIGAN: That, but I mean -- and you said it
14 yourself, the deep commitment of the nation to the people who
15 serve.

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

19 DR. OSTROFF: Colonel Bradshaw.

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

25 Part of my MPH project and actually some things

1 that I did even prior to that time involved health utilization
2 research, and issues of traumatization and violence, particularly
3 domestic violence, but other related things.

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

9 And that some of these same individuals may be more
10 likely to develop a post-traumatic stress disorder after being
11 exposed to combat situations. And interestingly enough, there is
12 Deborah Bostock here at USUHS and some others who have done
13 studies that have suggested that there is an increased number of
14 people, for instance, that have been sexually victimized that
15 come into the military for whatever reason, for whatever
16 selective factors there are that that happens.

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

21 And there is even some studies that have shown
22 people that have been exposed to that, for instance, will have
23 decreased pain tolerance and thresholds for pain. And that may
24 relate to things like fibromyalgia and many of the other things
25 that we see in these kinds of populations.

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

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

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

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

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

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

24 And an adage that I have thrown around, which is
25 wherever there is two psychiatrists, there is three opinions. So

1 it is very difficult to come to some agreement about a set of
2 questions.

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

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

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

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

23 DR. GARDNER: I am focusing much more on the intake
24 side of things.

25 LT. COL. ENGEL: I understand.

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

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

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

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

12 The second thing that was very impressive to this
13 committee was how little the field data, how poor the quality
14 was, even in terms of any kind of dose response. How many days
15 you were there, and did you visit or did you need medical
16 attention while you were there.

17 And somebody who flew over at 30,000 feet was
18 considered the same as somebody who spent six months on the
19 ground, and there wasn't the kind of dose response that you would
20 like for an epidemiologic study.

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

25 LT. COL. ENGEL: Then I will say that on some level

1 I am criticizing myself by saying or speaking to this struggle,
2 because as Rick knows, you know, since the Gulf War, we have
3 worked with Dr. Hyams, and others to develop the RAP, the Recruit
4 Accession Program, which is a fairly detailed questionnaire.

5 There is quite a lot of mental health stuff that
6 has been built into that, and it takes us a frustratingly long
7 time to get to the places where it needs to be implemented, and
8 to build it into the process of recruit accession. Now, these
9 are key efforts, and it just takes a long time.

10 LT. COL. RIDDLE: If you look at the accession
11 standards on mental health, you know, they are fairly obvious
12 mental conditions that individuals have suffered.

13 And that is one of the things with the Recruit
14 Assessment Program, and the Millennium Cohort Study, and others,
15 is to better build a body of evidence so that you can develop the
16 kinds of questions that can be administered from an accessions
17 standpoint, or even early on, because if you look at the leading
18 causes of in-patient and out-patient care in DoD, mental health
19 is the second leading cause of hospitalization, and I think in
20 the top 3 of 10.

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

23 LT. COL. RIDDLE: So there is tremendous focus
24 there, and we are not there yet, but at least we think we have
25 recognized that and are working on the issues, especially with

1 the Millennium Cohort Study. Our questionnaire is quite focused
2 on a psychosocial assessment, because those are where the
3 deficiencies are.

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

9 LT. COL. ENGEL: I think actually the Millennium
10 Cohort Study, too, as I was just looking at that last night as we
11 were developing questions for this, but as I see it, it is a
12 model for the kinds of mental health questions that can be asked,
13 because it has been very well designed.

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

19 Allegedly, CDC and the Mayo Clinic are in on this,
20 and has this been presented at this group before?

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

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

25 LT. COL. RIDDLE: Yes. We will get her before the

1 board, hopefully at the next meeting.

2 DR. GARDNER: I would like to hear about that.

3 LT. COL. RIDDLE: Yes, sir.

4 DR. OSTROFF: Colonel Gardner.

5 COL. GARDNER: Colonel Gardner, Fort Bragg and
6 USUHS Faculty. Just to begin with, I have been involved in these
7 issues since the very first committee, where we tried to define a
8 case definition for Gulf War illnesses.

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

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

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

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

1 going on with our people.

2 Either we don't care or we are incompetent, either
3 of which means there is no credibility, and I think that ability
4 to track what is going on with our people, in terms of deaths,
5 hospitalizations, disability, and clinical outcomes, is
6 critically important to establish the credibility and trust that
7 our government cares about its soldiers.

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

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

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

21 And the medical side of it has been in large part
22 ignored, and that's why we really need to get from this group a
23 focus to say that this medical side of it has to be resourced to
24 establish the clinical outcomes follow-up.

25 LT. COL. RIDDLE: Actually, I think it really is

1 based on clinical outcomes, because we are unable virtually to
2 relate the exposure to the individual. I mean, we do not have
3 the biomonitor on the individual soldier on the battlefield.

4 We are doing a lot of work looking at biomarkers,
5 utilization of the serum repository, and others, but like the
6 Millennium Cohort Study was designed or at least to have the
7 power to look at rare outcomes, and then to collect the data that
8 we have deficiencies on, really focusing a lot on clinical
9 outcomes.

10 The exposure piece is a very difficult piece, and
11 they are working extremely hard on that, with CHPPM. They have
12 just recently promulgated some additional guidance, and they are
13 doing a better job, but it is difficult to relate, you know,
14 other than generically the battlefield exposure to the individual
15 on the battlefield.

16 DR. BERG: Bill Berg. I would like to comment on a
17 part of your presentation that I think has a significant
18 potential in the preventive spirit, the stepped response.

19 As a local health director, I get questions like
20 this all the time, and in the past couple of weeks, I have gotten
21 questions and calls from a woman who thinks there is an excess of
22 cancer in her college class, because she went to what is called a
23 historically black college, and thinks that this represents some
24 sort of biological experiment.

25 I have gotten a call from a woman who rents a

1 house, and the owner is not keeping it up, and there is rain
2 leaking, and it is musty, and she thinks that her ulcerative
3 colitis is due to stachyose batris.

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

9 So I don't need to cite chapter and verse from
10 medical journals to convince someone who just wants a simple
11 reassurance and vice versa. Somebody will take a simple
12 reassurance as being dismissive; and then teasing out those who
13 are just convinced and you are not going to change their minds.

14 So I think that this has significant preventive
15 potential in helping to deal with matching the response to the
16 level of concern.

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

21 In fact, the message that I was trying to get at is
22 exactly captured by your comments; that the stepped approach is
23 the way to match the interventions that we have in our
24 armamentarium if you will to the specific needs of subgroups
25 within the population.

1 And we have to plan it, you know, or otherwise some
2 patients with modest needs will get very intensive treatment that
3 they didn't need; and then likewise, some people will go
4 unrecognized and not receive a higher level of intensity of care
5 that they really could have been identified fairly early as
6 needing.

7 DR. OSTROFF: Colonel Engler.

8 COL. ENGLER: Dr. Engler from Walter Reed, and part
9 of the vaccine health care center initiative. I just wanted to
10 thank Chuck, because in the course of the challenges that arose
11 with anthrax, adverse events management, he was a beacon to the
12 allergy and immunology community because we were frustrated with
13 the fact that the larger part of the health care delivery system
14 didn't understand the basic principles of adverse drug reaction
15 management.

16 And the issues, and the questions, and the validity
17 of the questions about continued immunizations in the face of
18 adverse events, and the fact that individuals -- and our
19 specialty deals a lot with multiple chemical sensitivity, and
20 chronic fatigue syndrome, and also known as chronic immune
21 disfunction syndrome.

22 And the fact that a single patient, the advocacy
23 and the need to build an infrastructure that supports, and that
24 has competency, and supports both the providers and the patients,
25 and a single patient, who was eloquent, and a reservist, who was

1 badly treated through the VA system.

2 The acknowledgement of his illness, and people
3 being more focused on saying it is not anthrax, as opposed to
4 providing the care. You know, his eloquence was partly
5 responsible for the legislation in the States in New England to
6 try to shut the program down.

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

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

21 And I know that I have made a commitment that
22 anything we do in the vaccine health care center network will
23 build on and collaborate with Chuck's efforts, because there is a
24 lot of overlapping issues. There are also unique issues.

25 But if we are going to build trust, and we are

1 going to have creditability, we have got to deal honestly with
2 those things that we don't know. We have clinical guidelines
3 that we put together purely on clinical experience, and there
4 isn't outcomes evidenced for continued immunization and certain
5 adverse events settings.

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

10 DR. OSTROFF: Colonel.

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

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

20 He has been the impetus behind this, and there has
21 been Congressional interest, as well as the VA interest. He has
22 been the impetus behind this. There has been Congressional
23 interest, as well as the VA interest, and they are converting
24 some of their Gulf War referral centers to these centers.

25 There is one here in D.C., and there is one in East

1 Orange, New Jersey, and the Military and Veterans Health
2 Coordinating Board will be working to establish collaboration
3 between these centers.

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

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

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

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

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

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

1 Walter Reed.

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

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

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

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

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

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

23 ADM. HUFSTADER: Yes, he is going to be here this
24 afternoon.

25 LT. COL. ENGEL: I did hear earlier that they were

1 going to be presenting the work that they have been doing.

2 DR. OSTROFF: Dr. Zimble.

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

8 We need to, of course, study it and learn, but at
9 the same time we take care of the folks that put the uniform on.

10 It really should be the cost and the obligation that this
11 government takes to gain the type of volunteers that we want to
12 come into the service.

13 And whether they are in for a month or for a year,
14 or a career, they should be entitled to care, period. And they
15 should know that going in. I think that it will pay great
16 dividends.

17 It is just hard for those with the green eye-shades
18 to be able to measure that, and most of the folks that are
19 budgeteers in this business -- and in your business as well --
20 are rewarded for saving money and don't understand investment.

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

25 His presentation is in Tab A in your notebooks, and

1 I think it relates to the two outstanding recommendations that we
2 have on the medical threat assessments, and the DoD
3 immunizations, and reinforces I think in my mind the
4 recommendations that the Board has on the table.

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

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

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

13 COL. CORCORAN: I have been advised to start my
14 clock now, and hopefully you can all hear me. I am Tim Corcoran,
15 and I am from the Office of the Secretary of Defense and Health
16 Affairs, and Program Policy. I am a family physician.

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

20 The issues that are before the Board actually
21 predate any of the DoD directives and the instruction that
22 presently exist. In fact, they are very longstanding issues.

23 A lot of them deal with DoDMERB practices, and
24 DoDMERB has utilized these types of things, in terms of the basis
25 for the questions, and have utilized the procedures and tests

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

1 actually starting in the early '70s.

2 And so the directives, the Department of Defense
3 directives, came after that. Actually, the first were published
4 in 1986, and before then, they were actually Army regulations.

5 Okay. There are two Department of Defense level
6 directive instructions that actually guide physical standards for
7 accessioning into the military, and it is the DoD Directive
8 6130.3, and the DoDI 6130.4.

9 The DoD Directive 6130.3 is about three pages long,
10 and so it just provides the broad overview as the directive does,
11 and the Instruction is really the meat of how to make this
12 happen. It is about 41 pages long. So it is actually a quite
13 detailed document.

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

18 We want to screen out unqualified candidates to
19 reduce early attrition. Obviously, we want them to get through
20 basic trainings and the other types of things that we ask them to
21 do.

22 And we want to decrease failure to existing medical
23 conditions. The GAO actually released a report some years back,
24 and they estimate that the total cost, for example, of just
25 recruiting, and then screening and getting through a recruit

1 through basic training is about \$35,000 each.

2 And so it is not a trivial cost when we lose these
3 people based upon their medical condition. We want to exclude
4 conditions leading to excessive time lost from duty. This seems
5 almost obvious. We want them to spend more time doing their job
6 than we want them to be in medical clinics and in hospitals.

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

12 So the bottom line here is this, and this is really
13 brought into light given the recent events. It is fine to have
14 people in the military, but unless they can deploy, and unless
15 they can do the mission, that it doesn't do us any good.

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

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

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

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

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

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

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

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

23 And apparently in the past there was a tendency for
24 the medical community more to drive that train, and so this was
25 put into place to allow the personnel community to also weigh in

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

1 on those decisions.

2 The Accession Medical Standards Working Group,
3 called the AMSWG, which I co-chair, along with Mawhee Edmondson,
4 who represents Force Management Policy actually, she and I co-
5 chaired this meeting.

6 And our members of this group are basically
7 representatives for the members of this higher level committee.
8 And so Reserve Affairs is represented, and the Service Surgeon
9 Generals are represented.

10 You also have DoDMERB represented, and USMEPCOM
11 representatives, and you have the Deputy Chiefs of Staff of
12 Personnel represented. So, you see, you have a large group of
13 people that represent both the Personnel and Medical community on
14 this group.

15 And essentially we are charged with -- the actual
16 words are receives and reviews issues pertinent to effect good
17 policy, at least at the AMSWG level. And then we have the
18 Accession Medical Standards Analysis and Research Activity, which
19 also stood up in 1996. All of these were.

20 And they are a division of preventive medicine from
21 WRAIR, and what they are is the group that helps us, in terms of
22 providing evidence-based feedback from analysis of data that
23 exists presently.

24 And also another little salient point here is that
25 the present standards primarily that you see are based upon

1 expert opinion, and not necessarily on epidemiologic data linked
2 to military performance.

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

7 We have the U.S. Military Entrance Processing
8 Command, U.S. MEPCOM, which is responsible for conducting all
9 enlisted exams, including the reserve components and the Coast
10 Guard. They do the great majority of the physical examinations,
11 and I won't say too much about that, because Colonel Lee is going
12 to present two today.

13 And then also they conduct exams of individuals not
14 included in the Military Entrance Processing Station workload.
15 And it actually opens up sort of a broad category here. So, for
16 example, they do all non-scholarship officers as an example of
17 what they can do here.

18 Oh, and just backing up here, there are 65 of the
19 MEPS stations, and they are all across the country. And DoDMERB
20 is the DoD Medical Examination Review Board, and they are
21 responsible for these categories.

22 The U.S. Service Academies and the Reserve Officer
23 Training Corps Scholarship Program specifically, and not non-
24 scholarship. And the Uniform Services University of the Health
25 Sciences, USUHS.

1 Okay. The first question put to the Board, and I
2 sort of paraphrased it. The exact language is -- you all have
3 that, but the exact language from Dr. Clinton is if any evidence-
4 based literature supports utilization of the ECG as a predictor
5 of cardiovascular problems among asymptomatic individuals between
6 the ages of 17 and 35.

7 And DoDMERB screens all applicants with an ECG, and
8 the MEPS do not screen applicants with an ECG. And when I
9 present this question, I struggled with a lot of these questions
10 because actually they are a little bit more complex than they
11 first appear.

12 There are multiple facets to each question. This
13 is one facet of the ECG question, where we are asking for a
14 predictor. Is it a good predictor of disease.

15 The other parts of the question is whether it is
16 cost effective, and AMSARA is going to address part of that issue
17 today. And also there is an aspect of the question that concerns
18 policy. Do the standards as they are published presently require
19 this be done.

20 And then the other aspect of the question is
21 specific customer needs, and that's why Colonel Lee is going to
22 present, and Colonel Weien is going to present, to give the Board
23 a perspective of what the customers are requesting.

24 So when we consider these questions, there is
25 layers of the question actually, and the AFEB can certainly help

1 us with providing help in terms of answering some of this.

2 Now, the standard from the DoD Instruction states
3 that, and so as it relates to ECG, it says that the cause for
4 rejection for appointment, enlistment, or induction are
5 symptomatic arrhythmia, a history of such condition.

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

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

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

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

23 Okay. Now the hemoglobin question, and again I
24 paraphrased Dr. Clinton's specific question to the Board. "Does
25 screening asymptomatic individuals with no history of anemia with

1 hemoglobin have utility."

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

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

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

16 In the Instruction, it states that the physical
17 experience and closure don't apply to the following, and then it
18 lists these different categories. Applicants for appointment as
19 commissioned or warrant officers; applicants for enlistment in
20 the Armed Forces; applicants for scholarship or Advanced Course
21 Reserved Officer Training Corps, and so forth and so on, and
22 retention of cadets and midshipman.

23 So these are the groups that this actually applies
24 to. The DoD instruction does not directly address the issue of
25 physical exam validity periods, but rather it states who the

1 standards apply to.

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

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

16 And they have used that, and in fact their
17 experience has been good with this. They have reduced the number
18 of physicals by about a thousand, and again, Colonel Krauss, from
19 AMSARA, will sort of present more information that sort of goes
20 through that.

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

25 LT. COL. RIDDLE: Thanks, Dr. Corcoran. In your

1 books, in the tabs, you have the DoDD, the DoDI, that Tim was
2 talking about, the backup slides, and you also have the Service
3 Implementing Instruction for all of the accession standards.

4 And we have provided the abstracts on the
5 literature reviews, and we will have the full text articles for
6 the members considering the review. So, Captain McKinley is from
7 the Office of the Assistant Secretary of Defense, the TRICARE
8 Management Activity, and he is going to present the fourth
9 question, which is the utilization of the dental examination and
10 panoramic x-ray for screening.

11 CPT. MCKINLEY: Thanks very much. The question for
12 dentistry, and I think I misunderstood my mission slightly today,
13 as I am going to give you both the question, and from the dental
14 communities' perspective the desire to answer, and we will move
15 on.

16 The question really is, is a professional dental
17 examination necessary for service academy and ROTC scholarship
18 applicants.

19 The DoDMERB, which is the screening board to select
20 applicants, requires a professional dental examination by a
21 dentist, and a panoramic radiograph for service academy and ROTC
22 applicants.

23 That is opposed to the MEPS dental screening, which
24 is essentially a look through with a dental mirror, and just a
25 quick visual examination. The answer is -- and I bounced this

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

1 question off the Tri-Service dental chiefs -- General Sculley,
2 General Murray, Admiral Johnson, and now Admiral Woofter, and
3 also the service academy dental commanders, and to get their take
4 on this.

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

8 If we are going to take the dental standards that
9 our dental communities take on this, is that if we are going to
10 take the dental standards seriously, we need to have a dental
11 examination. A visual look-and-see with a mirror just will not
12 do the job.

13 And the standards are four; essentially one of
14 pathology and dental, general oral disease, and the most
15 significant of which in this case is myofacial pain dysfunction
16 syndrome, seen very commonly in folks under stress, both on your
17 recruit and the officer side.

18 But there are many other diseases and entities of
19 the heart structures that require a radiograph. The best
20 radiograph for a general look in the oral cavity is the panorex.

21 Another standard is severe malocclusions.
22 Malocclusions can cause a number of problems, either immediate or
23 down the road, over a period of time; and an imbalance between
24 the maxilla and mandible, and the potential or the future
25 prosthodontic replacement is a key issue here.

1 If these malocclusions are to be corrected down the
2 road and usually they have to be, a satisfactory prosthodontic
3 replacement has to be in place, and the complexity and ability to
4 do this is a very costly and time consuming endeavor for
5 dentistry.

6 Insufficient natural healthy teeth, or the lack of
7 serviceable prosthesis, again it is a prosthodontic issue, and
8 the ability of the candidate to undergo the preparation for a
9 full-mouth rehabilitation that would be necessary, and the time
10 involved with that, as well as the expense, would not jeopardize
11 the success of that candidate in the service academy or in the
12 ROTC program.

13 We think that dentists are probably the best folks
14 to evaluate these conditions and the standards. Also, dental
15 implants and osteo-integration is a key issue here, and it
16 requires a radiograph.

17 Lastly, orthodontic appliances, and active
18 orthodontic appliances and their presence, is a high cost, high
19 maintenance issue, and is the fourth and last disqualifying
20 factor for service academy and ROTC applicants.

21 The contention are three; that the professional
22 dental examination is not necessary based on the statistics, and
23 the remedials and the disqualifications. My discussions with
24 DoDMERB seemed to indicate that some of the statistics, the
25 recovery statistics -- the documentation is not very good, and

1 that we don't have a real solid database upon which to make a
2 database decision.

3 And so although we would like to make -- I think
4 that this board would be tasked with making as much as possible a
5 database decision, and the data are not collected very
6 consistently across the Services, and the outcomes are not
7 particularly well documented.

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

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

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

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

1 better than I.

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

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

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

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

19 The MEPS type dental screening of recruits and
20 officers costs MHS dearly in subsequent corrective dental
21 treatment. I don't have the statistics for the Army and Air
22 Force, but in terms of the Navy and Marine Corps, a significant
23 amount of money is spent on the dental treatment of recruits.

24 The Navy jump starts up front, and frontloads
25 general care in boot camp because of the nature of the follow-on

1 service of the recruits. The Army and Air Force are more in
2 garrison organizations, and can afford to pass these patients on
3 through to the system down the road and down the stream.

4 So the Navy and Marine Corps numbers average
5 somewhere between \$300 and a thousand dollars per recruit of
6 dental care delivered in the Navy and Marine Corps dental
7 treatment facilities.

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

11 So, in conclusion, this continuation of the
12 professional dental examination and associated panoramic
13 radiographs we don't believe are justified by the available data.

14 We would like to propose to you that we collect the data.

15 The Dental Corps are -- well, we may seem parochial
16 in this. We don't want to be. We want to give you the correct
17 scoop. We want to collect the data and we would like to look at
18 this and give you a good recommendation downstream as to which
19 way to go.

20 We are not so sure that the standards are all that
21 appropriate, particularly in the orthodontic section. I know or
22 I think the standards need to be revisited, and I would recommend
23 that.

24 But in the meantime I would not recommend taking a
25 step backwards and eliminating the dental exam for these recruits

1 or these select officers. I think that's probably enough said.

2 LT. COL. RIDDLE: And what we would like to do is
3 hold off on the questions until we get the DoDMERB and MEDCOM,
4 and AMSWG presentations. So, what has been presented is really
5 the DoD standards, and now Colonel Weien, the Director of the DoD
6 Medical Examination Review Board, is going to give you his
7 perspective from where the rubber meets the road really for his
8 select group of applicants, which are the service academies and
9 ROTC.

10 And then Colonel Lee will follow up from the U.S.
11 Military Entrance Processing Command, which does the enlisted
12 applicants and direct commission officers. Colonel Weien.

13 COL. WEIEN: Okay. I am Bob Weien, and I am the
14 Director of DoDMERB, and a little bit about the background of
15 DoDMERB for you, just in case you don't know who we are.

16 We were established in 1972 to do physicals for
17 basically the funded officer accession programs. Initially the
18 five service academies, and later the three ROTC scholarships,
19 and later still, USUHS was added. So we have nine total customer
20 programs, and that is on a later slide actually.

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

25 And General Murray over at the Air Force Medical

1 Operations Agency is tasked as the executive agent providing
2 administrative and logistic support for us.

3 We have a joint staff -- Army, Navy, Air Force,
4 Coast Guard -- and as you can see, we have a large staff of
5 civilians that work with me as well. The directorship rotates
6 among the services, and the last one was Navy, and I'm Army, and
7 the next one will be Air Force.

8 And here are our customers, and I have already been
9 over that, and so did Colonel Corcoran cover that. Now, our
10 examinations -- and there is going to be quite a contrast between
11 the way we do these exams and the way that Colonel Lee does his
12 exams for MEPCOM.

13 Ours, as you can see, 60 percent by a civilian
14 contractor, and 40 percent at military MTFs. That was prior to
15 last Tuesday. That may have to change because a lot of our
16 applicants -- we are getting lots of reports that our applicants
17 are having a difficulty getting on military bases in order to get
18 their exams performed.

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

23 Our contractor is a company called Concord. They
24 do a very good job for us. These exams -- and there are hundreds
25 of examiners. I think we have 400 Concord examining sites alone,

1 and of course you know how many MTFs there are.

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

7 And I have my staff of enlisted reviewers and the
8 three docs -- Army, Navy, and Air Force, and the dentists and
9 optometrists review the physicals and determine if these people
10 meet or fail to meet the standards listed in the DoD Directive
11 and DoDI.

12 Colonel Corcoran has already covered what those
13 are, and you have seen some of the excerpts from them, but those
14 are the source documents that we use. They are intended to be
15 revised every four years.

16 We use different forms. We don't use the standard
17 forms, and that was because in the beginning the physical that we
18 use -- when the standards came out, of course, the standards
19 don't direct what kind of examination you perform in order to
20 determine if someone meets the standard.

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

24 For instance, we don't use a cycloplegic eye exam.
25 We use a manifest exam. There are a number of changes, but that

1 was where we started. That's why the EKG is there, and the
2 hemoglobin/hematocrit, and lots of different things. If you look
3 at our starting point, it was the Air Force Class One Flight
4 Physical.

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

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

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

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

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

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

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

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

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

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

22 One thing we do is for the two year period is that
23 we have a statement of present health that we send out to all our
24 applicants. If someone gets a physical, and say we are
25 qualifying people right now for next summer's academy classes, in

1 the spring we will send them a statement of present health, and
2 also send them an instruction sheet saying that if anything
3 significant changes in your medical history, you have to tell us
4 about it. I am not sure that they all do, but we do ask them
5 that question at least.

6 DR. OSTROFF: Can I ask you one question? After
7 they get the physical, how long is that physical good for before
8 they access?

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

14 The question of screening ECGs. We favor ECGs, and
15 we favor that because we asked our customers -- and particularly
16 the Air Force Academy and the Naval Academy came on very strongly
17 and said we like the fact that DoDMERB does ECGs.

18 The reason? A significant number of their grads
19 have to get flight physicals down the road in order to go on
20 flight status, and they want us to do that initial screen to
21 determine if those people are going to make it or not make it.

22 One additional wrinkle that we do for the Air Force
23 Academy alone is instead of just determining if someone is
24 qualified or disqualified, we additionally say they are PPQ,
25 Potentially Pilot Qualified, or PNQ, Potentially Navigator

1 Qualified.

2 And if they are either one of those, but they are
3 otherwise qualified, they are commission qualified. And the Air
4 Force likes us to do that, and this impacts on the PPQ and PNQ
5 decision for the Air Force Academy and Air Force ROTC.

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

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

16 The perception is that it is preventable, and the
17 perception on the line is that it is preventable by EKGs, even
18 though we all know that that is probably not true.

19 Hemoglobin. We are neutral on hemoglobin. The
20 vast majority of the ones that we see, or the anemias that we
21 see, are the iron deficiency anemia, thus correctable. It is a
22 relatively low cost test, but again it is a low benefit test. So
23 we are neutral on that.

24 The dental exam and panograph. We strongly support
25 continuing this. If you want us to enforce the DoD instruction

1 as written, and if you want us to enforce the standards, we need
2 the tools to do so.

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

7 And we need the panographs for standards, and not
8 for identification. Every time we raise the panorex issue,
9 everyone says, oh, we aren't using those for identification
10 anymore.

11 We know that and we need it to determine whether
12 someone meets or fails to meet the standard. So, a summary of
13 the recommendations. We are neutral on the validity period, and
14 we recommend retention of the ECGs, and neutral on the
15 hemoglobin.

16 And we want to retain dentists and panograph
17 requirements for our population because of the way in which we
18 acquire these physicals, and then have to make a determination of
19 qualification or not.

20 LT. COL. RIDDLE: Thank you, Colonel Weien. And we
21 have now Colonel Lee, who is the Command Surgeon, who is the
22 Command Surgeon for the U.S. Military Entrance Processing
23 Command.

24 DR. OSTROFF: Pierce.

25 DR. GARDNER: I just had a question about the iron

1 deficiency anemias that you identified as the most common. What
2 sort of workup does that lead to, in terms of finding the cause?

3 Do they end up with GI studies, or do you just treat the iron
4 deficiency with some iron tablets?

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

8 We say that you have an anemia, and your hemoglobin
9 and hematocrit are too low, and you should go see your physician
10 about that. And usually what happens is not very long after that
11 we get a new report in that is within standards.

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

17 DR. OSTROFF: One more question.

18 DR. ZIMBLE: Colonel, it is obvious from the
19 presentation that the people that you are examining are people in
20 whom the government, the DoD, is making a considerable
21 investment; the Academy, the scholarship programs, et cetera.

22 But I am curious as to why you are doing
23 -- when you say ROTC scholarships, do you include the HPSP
24 program?

25 COL. WEIEN: No, sir. Our mission includes the

1 nine programs that are listed up there.

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

6 And 85 percent of the annual accessions for
7 physicians are coming from the HPSP program, and to me I think
8 one question that we ought to ask is how come. I hate to give
9 you more work, but it seems to me that the HPSP program is one
10 program that ought to be under the interests of DoDMERB.

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

13 UNIDENTIFIED ATTENDEE: The subject was brought
14 forward about four years ago, and it was basically a budgetary
15 decision that didn't get made. but the same point that you
16 brought up, Dr. Mazuki brought up, and it just never was
17 executed.

18 DR. OSTROFF: Okay.

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

24 I never had to go through a MEPS, and I didn't know
25 what they did. What they do is all the enlisted physicals, the

1 non-scholarship officer physicals, and sometimes the HPSP
2 physicals.

3 Now, in addition to the medical piece, they do a
4 lot of other things, and this is part of what I wanted to make
5 sure that everyone here understood. They do the vocational
6 aptitude battery, which basically sees if these people are
7 qualified for service.

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

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

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

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

1 want to try and do this at an affordable price.

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

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

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

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

20 Plus, I have 65 docs roughly, one at each MEPS, who
21 is a full-time Federal employee. And then I have a cadre of
22 about 400 docs in addition that we use on a recurring basis.

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

1 day.

2 So, they get their student testing, and then
3 assuming they pass, they go through medical, and then they get
4 their job, their contract here, and again their background
5 screening, and then they are enlisted in the Delayed Enlistment
6 Program.

7 Unless they are in that program, they can be in
8 that program for up to two years, okay? This is the
9 qualification phase. This is the first time that they ever come
10 to the MEPS. Ideally, it is done in one day.

11 Now, then it comes time for them to actually go to
12 basic. Well, they come back to us, and we talk to them again,
13 and we do an inspect on them. We check to see that nothing has
14 changed since we did the physical, and then we ship them off to
15 basic training.

16 And what you need to know is that we do these two
17 processes every day concurrently. So there will be some guys who
18 are DEPing in, and some guys who are shipping on the same day.

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

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

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

5 Now, let's talk a few numbers. As you can see,
6 MEPCOMs workload, we start with a number close to half-a-million.

7 Now, not all of those people get through the ISVAP because we
8 only do about 372,000 physicals a year, and then fewer than that
9 actually get to basic training.

10 That is the number to get to basic training,
11 because there are people who just don't choose to continue the
12 process for whatever reason, even though they are qualified.

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

17 Well, the services have set each set a different
18 standard that is higher than that. They have raised the bar a
19 little bit. So each service has a specific standard. So we will
20 drop out a few more with different standards.

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

24 Now, this is where we send them to. There are 10
25 training bases; one for the Air Force, one for the Navy, two for

1 the Marines, and then five for the Army. So we are shipping kids
2 every day all over the United States.

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

6 We are doing the HIV/DAT testing based on statutory
7 requirement. We turn negatives in 24 hours. We have to use a
8 DoD controlled lab, and we do that. We FedEx it and get negative
9 results back, and we usually have confirmation back on positives
10 within 72 hours usually. So once again we are doing this every
11 day.

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

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

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

23 If you want to break it down further, we have done
24 it by category, and this is all in your handouts. But again I
25 wanted to point out that the big rocks, as we indicated earlier,

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS

1323 RHODE ISLAND AVE., N.W.

WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1 and they really weren't or didn't affect the questions posed to
2 this group.

3 In other words, dental was not a big disqualifier.

4 EKG and cardiovascular was not a big disqualifier.

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

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

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

20 We recommend that there is no change to the current
21 practice, and not routinely doing either, and we base it on the
22 data that we get back from the training bases.

23 And our practice of not doing it has not caused a
24 problem, at least not that they notify us about. And they do
25 notify us, trust me. Every time they think there is something

1 that we could have or should have caught, I get a call.

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

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

11 Well, if you think you lose a college kid, think
12 about the kid who typically doesn't go to college, and who is
13 typically living on the streets, who is from a lower socio-
14 economic background, and who may or may not have access to
15 medical care, things may have happened to him, and that in the
16 short period of time that we have to do an inspect or an interval
17 history, we may not catch.

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

23 For us, this would be logistically difficult. For
24 us to keep records on all these kids for 5 years, we are talking
25 roughly 500,000 to 800,000 physicals that we have to keep on file

1 somewhere, because remember that a kid can go, let's say, to
2 Butte for his physical, and then when he wants to come back in,
3 he is in New Orleans, and they do that frequently.

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

8 So for us to keep the exact physical with all the
9 parameters will require some reworking for the computer systems.

10 Another unintended consequence is that we currently
11 have a waiver for HIV testing. In other words, if our kid DEPs
12 and stays in the DEPs 2 years, we don't retest because we have a
13 waiver to allow that.

14 If it goes to 5 years, that probably -- we will not
15 get that waiver again, and extend it to 5 years, more than
16 likely. And we will have to retest that individual.

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

21 LT. COL. RIDDLE: Actually, if we could hold off
22 for --

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

24 LT. COL. RIDDLE: Yes.

25 DR. ATKINS: Is the fact that there are different

1 standards for DoDMERB and MEPCOM a problem? I mean, are there --

2 LT. COL. RIDDLE: Well, there aren't different
3 standards. You have the DoDD and the DoDI. So I think there is
4 probably different interpretation of the existing standards.

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

8 DR. ATKINS: Different procedures, I guess. So is
9 the current status where the procedures are different, is that a
10 viable option, or are we being asked to move towards more
11 uniformity, which either involves reducing?

12 LT. COL. RIDDLE: Tim, do you want to address that?
13 I think that the directive really states that the standards
14 should be uniform across the board. Part of the process that got
15 these four questions to the board was the recognition that we had
16 of discrepancies.

17 And do we need to eliminate these discrepancies or
18 should they be applied universally as far as interpretation and
19 utilization of the existing standard.

20 DR. OSTROFF: Can I ask Colonel Lee one question.
21 If -- or at least ask the dentists a question, and this may come
22 up in the panopeg session. If one of the concerns is that family
23 physicians are inadequately able to conduct dental examinations
24 has there been thought given at any time to have dentists do
25 them?

1 COL. LEE: We have thought about it. But the
2 question was are we inadequate to do the exam for the purposes of
3 the DODI. So we have asked the training bases are we letting
4 dental pathology that you think we should catch slip through, and
5 they have not come on line and said yes.

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

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

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

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

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

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

23 COL. WEIEN: That was a historic item. In the
24 past, there were strongly worded remedials that went out that
25 sort of indicated that they should get their teeth fixed before

1 they sent them back in. That is not being done any more.

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

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

8 COL. WEIEN: Yes. We will tell them that they are
9 disqualified for impacted wisdom teeth or whatever.

10 LT. COL. RIDDLE: All right. Now we have Colonel
11 Margot R. Krauss.

12 DR. OSTROFF: Let Pierce ask his question.

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

15 DR. OSTROFF: That's coming.

16 DR. GARDNER: Thank you.

17 LT. COL. RIDDLE: Actually, it is interesting if
18 you look back at the board history, and these accession
19 questions, I think there was a recommendation from the board in
20 1983 for DoD to establish an entity, such as AMSARA, to better
21 look at evidence-based decision with accession questions.

22 So the Board really had quite an impact and a role
23 in accession questions, and then these are the first questions
24 that come to the Board in some time.

25 But Colonel Krauss from the Accession Medical

1 Standards Analysis and Research Activity up at Walter Reed is
2 really the entity to apply evidence to the decision making
3 process, and that is what she is going to present for us.
4 Colonel Krauss.

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

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

13 Historically, you have already heard that the
14 accession standards have been based on expert opinion, and not on
15 consistently collected and analyzed epidemiological data.

16 The goal of AMSARA is actually to do just that, is
17 to develop those evidence-based accession standards. Clearly to
18 do this, we need to guide the improvement of the medical and the
19 administrative databases.

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

24 In addition, we conduct epidemiological analysis
25 with a military relevant end point in mind, and try to integrate

1 into the policy recommendations the relevant clinical, economic,
2 and operational considerations.

3 You have already heard that we were established in
4 1996 within the Division of Preventive Medicine at Walter Reed
5 Army Institute of Research, and we serve in direct support of the
6 AMSWG, or the Accession Medical Standards Working Group, which
7 Colonel Corcoran already briefed you on.

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

13 And as you heard not all disqualifications means
14 that you cannot enter a military service. In fact, you are able
15 to ask for a waiver for any disqualification that you get upon
16 physical exam. Of those individuals who ask for waivers for
17 their disqualifications, 50 percent receive the waivers.

18 And that is across all conditions, and obviously it
19 varies by the disqualification that we are talking about. So
20 individuals are waived and enter active service.

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

25 And a majority of individuals entering active

1 service do not have a waiver. Individuals then from the
2 reception station, and basic training, and through advanced
3 individual training, can certainly attrit or leave the service
4 for a variety of reasons.

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

8 Now, among those individuals who EPTS -- and in
9 theory, these are conditions that we hope that the MEPS
10 physicians would have detected. But the reality is that over 70
11 percent of these individuals have concealed their condition, and
12 they acknowledge that when they leave basic training.

13 The other 30 percent, perhaps these individuals
14 didn't know that they had this condition, such as unrecognized
15 asthma, and things that they didn't really understand when they
16 went to the MEPS physicians.

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

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

24 So I am going to try and walk you through this and
25 certainly I can be corrected by the DoDMERB representatives in

1 the room. AMSARA just recently received DoDMERB data. So we
2 don't have a lot of familiarity with this data, but this is my
3 understanding.

4 We have applicants to five service academies, and
5 this is the way that I got the data from DoDMERB. It is labeled
6 academies, CSB -- Candidate Service Branch, or ROTC. These two
7 apparently are both considered ROTC programs.

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

13 Today what I have done is just look at individuals.

14 I don't care which program they are applying to. I just count
15 them individually. So, one individual could have five
16 applications. I dismissed with that.

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

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

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

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

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

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

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

17 All applicants who are disqualified may ask for a
18 waiver, and the waiver authorities are again the five academies
19 or the three ROTC programs. So we are dealing with five waiver
20 authorities, and they will waive different conditions depending
21 on the service, and the academy, and the program.

22 Then those individuals waived can start these
23 programs. So for the first three questions I was asked, I will
24 be relying heavily on this disqualification data, and also the
25 remedial data, which is somewhere in here.

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

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

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

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

17 And anyone who has worked with databases knows that
18 all databases have their faults, and we are trying to link all
19 these multiple databases that are basically used for
20 administrative reasons. But there are certainly some medical
21 databases that we access.

22 So for the enlisted side, we have a fairly good
23 handle on the data, and we have been working with it for over
24 five years. And this morning I will be focusing on these
25 existing prior to service discharge, which should represent

1 individuals who are unable to complete basic training because
2 they have a serious medical problem.

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

8 The disqualifications are coded by the DoDMERB
9 reviewers, which I think as you have already heard, they are very
10 consistent with their disqualification coding, and they code by
11 specific disease conditions, which is very helpful, particularly
12 as we try to address the issues posed to the Board this morning.

13 There is a lot of data that we don't have.

14 DR. OSTROFF: Can I interrupt?

15 COL. KRAUSS: Sure.

16 DR. OSTROFF: Is a code a single disease condition
17 or multiple disease conditions?

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

24 I do not know who actually started each program.
25 Remember, we have a lot of applicants, and many are fully

1 qualified, but then they decide that they don't want to go to the
2 service academy, and then go to some civilian program. Well, we
3 don't have that data available.

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

8 I believe the board members all were supplied with
9 some abstracts on this very issue. As I did a separate
10 literature search, I certainly didn't see any literature
11 supporting routine ECGs among asymptomatic individuals with no
12 history or negative cardiac history.

13 Okay. The current practice for DoDMERB is they do
14 require ECGs for the majority of programs, but not for their non-
15 scholarship ROTC programs. So there is some other data in there
16 which I will not be using and will not present it. MEPS, of
17 course, does not require an ECG.

18 I am first focusing on the remedials which I
19 mentioned previously as more of an administrative action taken by
20 DoDMERB. The first one up here means that these individuals had
21 an application that was missing their ECG.

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

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

4 I didn't think having a heart rate greater than 80
5 was that bad, and so I can't really explain that one, but it is
6 not a lot of people.

7 ADM. HUFSTADER: Beats per minute.

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

12 DR. GARDNER: Well, what is the "n" here, is it
13 60,000?

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

18 And I found three individuals that did match. They
19 had a disqualification, and they were coded as miscellaneous, and
20 so I still don't know what they were.

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

25 And here we see very few individuals with ICD-9

1 coded conditions, and there are a lot of miscellaneous. Again, I
2 don't know what those are, but from my analysis, I actually
3 assumed that they were all disqualifications identified only on
4 ECGs.

5 DR. SHANAHAN: May I interrupt for a second?

6 COL. KRAUSS: Sure.

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

9 COL. KRAUSS: That is exact DoDMERB coding.

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

12 COL. KRAUSS: Right.

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

15 COL. KRAUSS: Other.

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

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

21 And, yeah, we did have codes for generic abnormal
22 ECGs, and we also had codes for specific things, like WPW and
23 right bundle branch block. And the people that applied these
24 codes in the past sometimes did so inconsistently, which of
25 course corrupted our data.

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

5 DR. SHANAHAN: Okay. Thanks.

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

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

12 So that is the 132 that you just saw on the last
13 slide, and that is including the miscellaneous category, over the
14 total number of 62,000 applicants over the two year period.

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

21 This probably is a very low estimate, and I am
22 assuming that all of the miscellaneous disqualifications were not
23 related to ECG, and I don't really know. But that gives a range
24 of disqualifications that would potentially be identifiable by
25 ECG.

1 So what is the impact of screening ECG? The best
2 that I can determine is that about .9 percent of all applicants
3 had to do additional work because of this requirement.

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

7 Clearly, 126 did have an abnormal ECG, and it could
8 have been more, but we don't have the data. The data is not
9 available for that. So the range that I found was somewhere
10 between .01 percent and .2 percent had or potentially had an ECG
11 related disqualification.

12 What we don't know is how many had a negative
13 cardiac history, and how many of those with disqualifications
14 could actually receive a waiver and still come into a program.
15 Yes?

16 DR. ZIMBLE: There is one other thing that you
17 don't know. Of those that had a disqualification, how many of
18 them might have served a full term without any problems.

19 COL. KRAUSS: Correct.

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

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

1 And as you saw, the whole schematic, there is a lot
2 more afterwards; how they do during their service academy; and
3 how they do in the ROTC program; and how do they do in their
4 precommissioning exam; and what happens when they actually get on
5 active duty. That is at least four years past the data that I am
6 presenting. Yes?

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

12 COL. WEIEN: We did a -- we looked at a subset of
13 that miscellaneous DQ category. Larry, what was it, about 80
14 that we reviewed? And out of that group, as I remember it, about
15 90 percent were actually cardiac.

16 And I am not certain what percentage of those were
17 solely detected on the EKG, and how many were detected on
18 history. A couple of those psychiatric diagnoses. So, clearly
19 that code had been misapplied to these. So clearly the DoDMERB
20 data had some problems.

21 MR. MULLEN: To answer your question specifically,
22 there has rarely been a case when someone gets an abnormal EKG
23 and it is disqualified, period.

24 They are normally going to ask for medical records
25 or cardiac consult, or whatever, to confirm it. So I suspect

1 going back to that original slide, where it said zero for
2 abnormal EKG, that is what it actually referred to. No one was
3 disqualified just because they presented with that.

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

8 DR. LANDRIGAN: Are those 126 applicants available
9 to your folks so they could be reexamined and recoded at this
10 point?

11 COL. WEIEN: Yes. If they are year 1999 or 2000,
12 yes, they are.

13 DR. LANDRIGAN: Thanks.

14 COL. KRAUSS: Remember that of those 126, only
15 three actually came up with a final disqualification. So after
16 further consultation or a review of medical records, it was felt
17 not to be a disqualifying condition.

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

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

25 And again we don't know if these individuals could

1 have had this disqualifying condition waived and still entered
2 active service. I think another cost that needs to be
3 considered, which I couldn't even take a stab at, was all these
4 remedials.

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

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

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

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

16 COL. CORCORAN: It was actually DoDMERB data.

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

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

25 DR. HAYWOOD: That is not a discounted rate. HCFA

1 is not going to give you that kind of rate.

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

3 COL. KRAUSS: So that is what DoDMERB pays, and we
4 are probably being charged too much. But that would be a real
5 change wouldn't it? All right. So what I did from here was to
6 ask the question what happens if you -- to a cohort of unscreened
7 young individuals, and about the same age as the applicants to
8 the officer programs.

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

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

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

24 So the major -- I mean, mortality obviously is a
25 very serious issue. But a lot of those are suicides, and MVAs,

1 other issues. Dr. Gardner could probably give you more data.

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

5 But other things that could happen more likely is
6 that an individual could be hospitalized for a cardiac related
7 condition. Again, it would be difficult to determine whether the
8 condition would have been identified by a screening ECG.

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

13 I have used a 3 year time period, and we are
14 looking at -- and again enlisted accessions is -- the magnitude
15 is greater than officer accessions. There are approximately
16 120,000 enlisted accessions into active duty service every year.

17 So of that, we have -- and these are ICD-9 codes,
18 and which we now code in AMSARA for all existing prior to service
19 discharges. And I decided that these were all potentially
20 detectable by a screening ECG.

21 And what you would see is that some of these may
22 not be detected, but I am assuming that all of them would have
23 been detected. So looking at this over a three year period, we
24 found that .05 percent of all enlisted active duty recruits were
25 discharged with a cardiac diagnosis that may have been detectable

1 by a screening ECG.

2 It is very likely that these recruits were
3 symptomatic at the time of diagnosis, or they had been
4 hospitalized for their cardiac condition, and that is why they
5 were discharged from military service.

6 This particular estimate is actually intermediate
7 to the estimate that I came up with looking at officer data.
8 Now, certainly if we screened all the enlisted personnel with
9 ECG, we would have found a lot more abnormalities.

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

13 DR. OSTROFF: And before you do that, are there any
14 questions?

15 DR. CAMPBELL: I have a question. Have you figured
16 out the cost that was incurred to the military of those people
17 who were discharged that would have been saved if they had not
18 been admitted into the military?

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

24 And the GAO estimate that Colonel Corcoran used was
25 about \$35,000. But that actually includes costs all the way

1 through to the end of basic training. But in the scale of things
2 -- let's see how many people I had.

3 For over 205 people over three years was a
4 relatively smaller number of people to lose. EPTS conditions are
5 much more common for a preexisting mental health conditions,
6 orthopedic conditions, and asthma.

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

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

13 We are know that under current practice DoDMERB
14 screens and MEPS does not. And I would present that kind of in
15 the same framework. In the remedials generated by the
16 requirement for hemoglobin and hematocrit, it appears that a
17 certain number of applicants I guess never received the screening
18 test.

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

23 Then we look at disqualifications for blood related
24 conditions. We have anemia, and then hematocrit below standards,
25 and then that miscellaneous category, just for a total of 86

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

1 disqualifications for potentially related to the screening
2 hemoglobin requirement.

3 So this requirement actually generates about 1.2
4 percent of all applicants that have remedials for this
5 requirement, resulting in only one miscellaneous DQ for a blood
6 disease, unspecified.

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

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

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

23 So again I ask the question what happens if we
24 don't screen and we look on the enlisted side of the house. You
25 can be hospitalized certainly for some anemia type condition, and

1 if this is identified in the first six months of service, you
2 would receive an existing prior to service discharge if the
3 anemia cannot be corrected.

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

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

11 COL. DINIEGA: You don't?

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

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

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

23 Certainly if we screened all enlisted applicants,
24 we would find a lot of iron deficiency anemia, since that is
25 extremely common among women, and probably sickle cell anemia is

1 a larger issue than iron deficiency anemia.

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

4 DR. OSTROFF: Any questions about the hemoglobin
5 issue?

6 DR. HAYWOOD: Just a comment. Hemoglobin traits
7 does not produce anemia. So it would not be detected at the
8 screening anyway.

9 COL. KRAUSS: Right. But those discharges were
10 sickle cell anemia. They were not sickle cell traits.

11 DR. HAYWOOD: Right.

12 COL. KRAUSS: I reviewed all EPTS conditions for
13 the code for sickle cell trait and sickle cell anemia, and I
14 found all of them to be sickle cell anemia. Trait is a different
15 issue. Each service handles trait in a different manner. Yes?

16 DR. CAMPBELL: If sickle cell anemia were picked up
17 at screening prior to accession would that be a disqualifying
18 factor?

19 COL. KRAUSS: That would be permanently
20 disqualifying.

21 DR. GARDNER: Was there any attempt to grade the
22 level of anemia? If these are marginal hemoglobins, there is
23 technical reasons that can happen, and there is a big difference
24 between a marginal one and one that is half-normal, or something
25 like that.

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

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

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

13 COL. KRAUSS: That would be the DoDMERB standard.
14 It would not be my standard.

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

16 COL. WEIEN: I believe that the male standard is
17 11.7 and the female standard is 10.4 lower limit of normal for
18 hemoglobin.

19 COL. KRAUSS: The question as I understand it was
20 really the discrepancy of the scholarship applicant meeting the
21 dental professional using bite wings or panographs to accomplish
22 the screening.

23 Whereas, those certainly -- certainly the enlisted
24 applicants do not get those similar type screens, and certainly
25 the non-scholarship ROTC applicants, and the HPSP also do not get

1 the same dental screen.

2 Colonel Corcoran highlights that there were many
3 issues revolving around this question and I will try to focus on
4 the data that I have available. So the current practice, I think
5 you already have a good understanding of that.

6 And here are the remedials that I have received.
7 This is the DoDMERB data for these two years. The first several
8 appear that the applicants needed the panographs or the bite
9 wings, or they had not had the dental officer review that was a
10 requirement.

11 And that is by far the majority of the remedials
12 generated due to this screening requirement. I felt that perhaps
13 a physician would be able to tell if someone had braces on, and
14 could request -- well, I don't want to go too far.

15 So what I did was that I voted for the ones that I
16 felt that only a dentist could really address and could truly
17 provide the disqualifications. And certainly our standards are a
18 little bit different, but the quality of the non-restorable
19 teeth, or the periodontal disease, the caries, the oral surgeon
20 evaluation, and all miscellaneous, probably would -- that these
21 would have been remedials that might have resulted in DQ.

22 I have heard in the past that these
23 disqualifications were fixed prior to the final determination and
24 disqualification, if that makes any sense.

25 I have heard that the process has now changed, and

1 that DoDMERB is now keeping track of these disqualifications,
2 rather than fixing them prior to telling the applicant whether
3 they are disqualified.

4 So for this analysis, I have actually considered
5 that all these individuals would have received disqualifications.

6 DR. OSTROFF: Can I just comment, and not to offend
7 my dental colleagues at all, but I think I as a physician
8 probably would have noticed missing teeth.

9 COL. KRAUSS: I guess the problem is how many are
10 allowed to be missing, and how many teeth do you really need.

11 CPT. MCKINLEY: I can take a shot at that. Two
12 things. Sure you can see an orthodontic appliance. That is not
13 the issue. Anybody can see that.

14 The issue is the extent of treatment, and how long
15 it is going to take, and how complicated it is, can it be
16 discontinued or put in retention, on hold through boot camp, et
17 cetera.

18 And is there an orthodontist at the receiving site
19 to carry on the treatment. I can tell you that at most places
20 there aren't. So it is more complicated than just are there
21 braces there.

22 On the missing teeth issue, prosthodontics is an
23 mechanical/biological replacement of these teeth, and it can be
24 complicated. And it is not the number of teeth.

25 But rather it's how difficult and how possible it

1 is to replace those teeth, including implants. And so these are
2 the issues that are evaluated, and not just the number of teeth.

3 COL. LEE: Margot?

4 COL. KRAUSS: Yes.

5 COL. LEE: Just from our point of view, the MEPS
6 point of view, when we look at whether or not they have had
7 braces or not, if they have braces, it is disqualifying.

8 If they have had orthopedic appliances, we require
9 a note from their dentist that treatment has been terminated and
10 they should be able to go through basic training. I wanted to
11 point that out.

12 In terms of the number of teeth, quite frankly what
13 we look at is whether the kid is robust, as opposed to
14 malnourished. Can he chew. I mean, we try and do it from a
15 practical point of view.

16 So notwithstanding that all these points are valid,
17 we try and take the practical point of view and say has he been
18 eating, and is he eating, and will he eat, and can he eat an MRE.
19 And if the answer is yes, then we process them on.

20 COL. KRAUSS: This is a little bit challenging. On
21 this, I think you just heard Colonel Lee say that these would
22 automatically be disqualifications. So a separate dental review
23 is probably not needed to disqualify an applicant just based on
24 this alone.

25 But in my opinion a dentist was required to make

1 these disqualifications, and that's how I chose to say that these
2 are the amount of disqualifications generated because of this
3 requirement for dental review.

4 Now, this is the actual data that I received on
5 dental disqualifications from DoDMERB. Again, I felt that these
6 were the ones that a dentist would really have to determine, and
7 this was the final permanent disqualifications that I received in
8 the DoDMERB data.

9 Now, I have talked to the DoDMERB dentist, and he
10 said that there was actually 40 here instead of 24.

11 COL. DUNN: Yes. I wanted to point out that that
12 was the period of time in which we were actually prescribing
13 dental care.

14 COL. KRAUSS: Right.

15 COL. DUNN: And many of the cases during that
16 period were placed in remedial status to get their teeth fixed,
17 and then they would come back fixed, and show up as
18 disqualifications.

19 And only the people that sort of said, no, I'm
20 sorry, I refuse to get my teeth fixed ended up as dental Dqs. So
21 I think your numbers, in terms of potential Dqs, is artificially
22 low because of a previous policy that is no longer enforced.

23 COL. KRAUSS: Well, correct me if I am wrong, but
24 that's why I am using this number as disqualifications. I am
25 counting all remedials requested from whoever, because I can't

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

1 necessarily say.

2 But I would think that these were all remedials
3 requested by the dentist, and I am saying that they would all be
4 disqualifications, okay? This is actually is what is in the
5 database. So this is really the low number.

6 So I think this is probably a little bit high,
7 because I am not sure that all the dental remedials would have
8 been disqualified. But I am saying that they all would have
9 been, because I would want to give a fair estimate.

10 So, 726 individuals would have been disqualified
11 for some dental reason based either on panographs, bite wings, or
12 the dental review. So that is 1.2 percent of all applicants to
13 officer programs.

14 The low estimate, I already think that this is
15 incorrect. We have already been told by DoDMERB that many of
16 these Dqs are fixed prior to the disqualification coding. So
17 this we know is artificially low. I think this is a better
18 number.

19 So the impact of screening. A large number of
20 remedials are generated. Actually, 3 percent of all applicants
21 with a final disqualification really apply to 1.2 percent of
22 applicants being on the high side.

23 I think a major issue to consider is how many of
24 these applicants stop the application process because of the
25 dental remedials, or the need to fix dental problems.

1 My concern here is that some of these applicants
2 are trying to get into the academies or the ROTC programs may not
3 be from socially advantaged families, and may not be able to
4 afford getting their teeth fixed.

5 So this may actually be a discriminatory practice
6 to have this requirement for these young kids. We don't know
7 anything about the waivers for certain dental conditions, and
8 whether these individuals could have started the program for
9 which they applied.

10 So it is very crude costs of identifying these
11 disqualifications, and it is probably closer to about \$8,000, but
12 maybe up to \$237,000 for every disqualification found. This is a
13 DoDMERB cost for getting a dental review, panograph, and bite
14 wings on these applicants.

15 And back to these remedials that were generated,
16 and to worry about the real costs of lost applicants, and how
17 many really had significant dental problems, and what kind of
18 repair costs do these applicants face.

19 So what happens if we don't screen, which is what
20 we have been doing on the enlisted side for years. They can
21 certainly get existing prior to service discharges, and this
22 would only happen if the condition was felt to be not fixable, or
23 interfering to such a great extent with their ability to perform
24 their duties that they had to be let go.

25 These numbers are actually -- I found out last

1 night that these are all actually high. Some of my people are
2 double-counted, and this true number is half of what you see.

3 That aside, this I felt was something that you
4 would only identify through panograph or bite wings. This also I
5 think probably requires a dentist, because we have various
6 approaches to how many teeth we think we need to have, and
7 certainly also malocclusion.

8 Actually, I considered all of these requiring
9 dentists to determine these conditions and the seriousness of
10 these conditions, but my number is artificially high here.

11 So over the three year period, I felt that probably
12 .02 percent were discharged with a dental diagnosis that may have
13 been detectable by a dental review.

14 Most of these recruits were likely symptomatic at
15 diagnosis. I will take that away because I figured that maybe
16 the dentist would have identified all TMJs if they were able to
17 see the individuals.

18 But this number actually stands, and that is based
19 on my not getting the data quite right in the last slide.
20 Certainly if we had looked at all enlisted accessions that we
21 would have found a lot more dental conditions, but it looks
22 certainly from the enlisted side that most of these dental
23 conditions are fixed at basic training and the recruit is able to
24 finish basic and go on to active duty.

25 The last question is dealing with physical exams,

1 and the period, the interim period required from inspection
2 versus a full physical exam. Unfortunately, we really don't have
3 data available on this.

4 This is my only slide addressing this question, and
5 I got this data from Colonel Dunn based on the 2001 Army ROTC
6 camp at Fort Lewis. During that ROTC camp, we had 246
7 disqualifications. So, 6.2 percent of all these cadets were
8 disqualified.

9 The fact is that most of these were waived. Only
10 20 individuals had a permanent disqualification, meaning that
11 they had to leave the program. They were not commissioned. And
12 17 of these were identified by history and three by physical
13 exam.

14 But that is all the data that I have. I don't have
15 their initial accession physical exam. I can't compare what was
16 found on the initial to this second pre-commissioning exam.

17 We have 2 to 4 year ROTC scholarships involved in
18 this camp. So I am dealing with accession exams that could be 1
19 to 4 years prior to this exam right here. So the data is really
20 not too clear on this issue.

21 DR. BERG: What is the denominator for that last
22 slide?

23 COL. KRAUSS: There were 4,000 cadets.

24 DR. BERG: Okay. Thank you.

25 DR. ATKINS: Do you have any information on what

1 those diagnoses were by exam?

2 COL. KRAUSS: Actually, I do know that for these 20
3 permanent -- let's see if I can remember.

4 COL. DUNN: On the three -- good morning. I am
5 Colonel Dunn, the Cadet Command Surgeon at Fort Monroe. On the
6 three that were permanently disqualified based on exam, two were
7 heart murmurs, which were evaluated by cardiologists for
8 bicuspid valve; and one was for keratitis, which is an eye
9 condition which was not previously identified on the initial
10 accession exam.

11 COL. KRAUSS: Colonel Dunn is the one who gave me
12 the data. And I really don't think I should even go this far. I
13 would rather just ignore this, but certainly I think we need more
14 data to really look at the interval for physical exams, and what
15 was found on the pre-accession physical exam, versus the pre-
16 commissioning exam.

17 Certainly the data that I am using today has
18 limitations, and I think you have already heard several of them,
19 particularly from DoDMERB. Their databases seem to be lacking
20 some of the information, particularly on the dental questions,
21 that they would like to see.

22 This is mostly administrative data, with some
23 medical data available to us. The assumptions that I have used
24 this morning may not hold true. I have tried to assume on the
25 side of disqualifications being the result of a screening test,

1 but as you all know, that may not be true.

2 A lot of these disqualifications may be based on
3 history alone or physical findings. I do not have that data
4 available. And the bottom line here is disqualification does not
5 mean that an applicant cannot come into a program.

6 Many disqualifications are waived and the applicant
7 comes on the program, and really need to look further at that to
8 evaluate the outcome of letting these individuals into officer
9 programs, as well as on to active duty.

10 So summarizing really crudely, ECG screening does
11 not seem to be supported in the literature for asymptomatic
12 adults with a negative cardiac history.

13 It actually costs DoDMERB approximately \$2.2
14 million to do ECG screening, and somewhere between \$34,000 and
15 \$750,000 for every disqualification identified.

16 Haemoglobin/hematocrit screening. I could not find
17 recommendations for or against this. It is considered low cost,
18 but it is also low yield for a condition that is generally
19 readily treatable if it is iron deficiency anemia. But I
20 don't really have the data to make a comment one way or the
21 other.

22 Dental panograph screening. I did find some data
23 in the dental literature that says panograph screening of
24 asymptomatic individuals is really not cost effective, but the
25 question to this board is really the whole package of dental and

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

1 panograph screening.

2 Again, the DoDMERB data seems to be not quite
3 complete on this issue. But if we look at the enlisted side, it
4 does not seem to be causing a major problem in our basic recruit
5 training or basic training.

6 And the physical exam. I felt that the data is
7 really not available to address the utility of screen versus a
8 full physical exam, and what time frame would be most beneficial.

9 I think the officer side has different issues since they have
10 accession physicals and a pre-commissioning physical.

11 Whereas, the enlisted side really has only the
12 accession physical, which I think Colonel Lee was able to express
13 far better than I. And I think I will stop there unless you
14 would like to review the three papers that I found in the dental
15 literature which are appended to this.

16 DR. OSTROFF: Thank you very much. Before you go,
17 I think there are a couple of questions.

18 DR. HERBOLD: Yes. John Herbold. I would like to
19 commend you, Colonel Krauss, for an excellent presentation. But
20 I would just like to make an observation for the record. We are
21 being asked to look at or to make a point in time decision, and I
22 think we really need to look at life-cycle costs.

23 And I am going to use the dental question as an
24 example. Over the last 10 years, there have been several
25 excellent reviews on the impact of dental disease on military

1 preparedness and military readiness.

2 And dental disease can have a significant impact on
3 military operations. Two that come readily to mind is if you are
4 going to deploy shipboard or under the sea for six months, the
5 onset of dental disease can be disruptive or break a mission.

6 If you are involved in air operations, going up to
7 40,000 feet and coming down, and going up 40,000 feet, you all
8 know that if you fly frequently that can cause significant
9 problems.

10 It is my understanding antidotal that in the past -
11 - and I am ready to be corrected, but several decades ago it was
12 one Service's policy that on the enlisted side that if the troop
13 could get through the first enlistment and not have to have any
14 attention to dental disease, that that was a service policy.

15 And that any corrective or remedial action would be
16 addressed to career enlisted. The issue of how much time has to
17 be directed towards dental remitation at basic training and/or at
18 advanced individual training can have a significant impact I
19 think on recycling, and/or which career fields individuals can go
20 to.

21 Now, I am not making any observations on whether
22 the panorex or the screening tools, or the process used at this
23 point in time answers the question that I am putting forward to
24 you.

25 But I do not think we should use any levity in

1 discounting the impact of dental disease on the performance of
2 our military people.

3 DR. OSTROFF: Dr. Ludwig.

4 CDR. LUDWIG: Sharon Ludwig, Coast Guard. I just
5 would like to add to that, and partly along those same lines that
6 I was thinking. Actually, our people, when they leave basic
7 training -- and this may be true in the other sea services, but
8 they have to be medically, including dentally, deployable by the
9 time that they leave basic training.

10 And we have had a lot of discussion on this,
11 because we receive many, many people at basic training who need
12 extensive dental work. And we are talking about almost every
13 tooth in their mouth.

14 We do a lot of waivers, and we don't very often
15 send people home because we have had some trouble with recruiting
16 like the other services, although we do send some home that just
17 need so much work that it is not reasonable.

18 But the outcome of it has been that we have had to
19 hold a substantial number of people over at basic training at our
20 expense, and sometimes having to put them up in motels and so on
21 to finish their dental work.

22 Or in other cases they have actually been sent out
23 to their units and not been dentally ready, and we have had a
24 number of complaints from the field. So this is a huge problem
25 for us.

1 And in terms of somebody at MEPS -- and I am
2 talking about MEPS now -- looking into somebody's mouth and
3 saying this person should not go into the service because they
4 are not dentally ready, they are the kind of mouths that anybody
5 -- not a physician, but anybody -- could look in their mouth and
6 say that this person is going to have some dental problems.

7 And I think that before any decision is made -- and
8 I am saying the same thing. I don't know the utility. I am not
9 a dentist. I don't know the utility of the panograph.

10 But the other point that has been made strongly in
11 our headquarters is that people with dental problems like this --
12 and not even or maybe half the teeth in their mouth even or
13 whatever -- are not just you fix them and you send them out and
14 they are okay.

15 These are people who need life long dental work.
16 The prosthodontics don't last forever. They go back to their old
17 habits and they have periodontal disease and more caries, and the
18 caries wear out or come out, break, crack, and so on, these are
19 life long problems. And it is a chronic problem when someone
20 comes in with bad dentistry.

21 DR. OSTROFF: Dr. Zimble.

22 DR. ZIMBLE: I'm going to jump into the same pool.

23 This is not addressing the question that was asked, which is a
24 very specific question on panograph.

25 But I would think that this may be a place for the

1 Board to make a recommendation and not ask the question. But as
2 far as dental is concerned, I was the commander of a hospital in
3 Orlando, Florida, which was a recruit training center when I was
4 there.

5 And I remember seeing the very harassed head of the
6 dental clinic, and harassed recruit training commanders, because
7 they had lost so much time from basic training in order to get
8 their remediation done in order to be Class Two when they finally
9 go to the fleet.

10 And this is a significant issue as far as mission
11 grading is concerned, is to make sure that your soldier/sailor is
12 equipped to not have these dental problems, and we are really
13 pushing for Class One across the board.

14 These enlisted people come in with horrible mouths,
15 and need a great deal of care, and it seems to me that with the
16 delayed entry programs, recognizing that we are going to have to
17 pay for it, that at least we don't have to pay the cost of lost
18 training time.

19 And we ought to probably be doing something to
20 support good dental remediation during the delayed entry programs
21 of the services.

22 COL. LEE: I agree with you that dental care is
23 incredibly important, but just what you said, that these people
24 are in the delayed entry program. They are in a status that at
25 this moment is not covered by dental care, medical care, or

1 anything else.

2 And the costs would be enormous, and the point made
3 by the Coast Guard is exactly right. They have complained in the
4 past about their people having to go directly out to the fleet,
5 and the training schedule being so tight that they can't get the
6 dental people to fix all the dental problems.

7 But the flip of it is also what she said. They
8 would rather have those people than not have them at all, and
9 that's the recruiting side of it. That if we require these
10 people to have a dental exam, and then get disqualified at this
11 moment under the current rules, they will have to pay for it
12 themselves. And we know across the population that dental care
13 is not optimal in the civilian population.

14 DR. ZIMBLE: But it is a great recruiting tool
15 though, is to be able to give them the dental care that they need
16 when they come in.

17 COL. LEE: That's fine.

18 CPT. SCHOR: Just a couple of comments. One is
19 that with the EKG issue, I wonder if it would be better to
20 reframe that in terms of a pre-participation sports physical sort
21 of construct.

22 You are bringing these folks in, and it is not just
23 about EKGs. It is about whether their cardiovascular system is
24 capable of going through the physical exertion demands of basic
25 training and future service.

1 So that broadens the issue a little bit, but I
2 wonder if looking at it from that lens may be a little bit more
3 helpful, and to approach it with the kind of thought that the
4 sports medicine docs guide pre-participation physicals, which
5 have changed recently in the last couple of years.

6 And I think you usually don't include EKGs. But
7 somebody may correct me if I am wrong on that point.

8 LT. COL. RIDDLE: That's correct. In that
9 literature, the American College of Cardiologists and AMA, those
10 guidelines are in the background material, and Captain Schor is
11 right. They don't recommend ECG.

12 CPT. SCHOR: Just two other questions. One for
13 Captain McKinley, and that is if he knows what the proportion of
14 the dental readiness categories, and how that breaks out on your
15 initial dental exams. So, how many Class Fours, and Class
16 Threes, Class Twos, and that sort of thing do you get.

17 And to estimate the work burden that this brings
18 in, I suspect that it is fairly significant. And the other issue
19 is as implied by Colonel Lee, I believe or wonder what it is that
20 -- well, there may be a very large difference in these socio-
21 economic background of individuals between the two programs, and
22 how does that impact the pre-test probability of what you are
23 going to find.

24 CPT. MCKINLEY: This is Captain McKinley, and I can
25 answer the dental readiness question. Dental readiness of the

1 incoming recruits is roughly around -- between 20 and 30 percent
2 ordinarily.

3 Again, the Navy is the only service that front
4 loads dental treatment in the recruit depot. So the Navy and
5 Marine Corps have consistently graduated all their companies at
6 95 percent or better dental readiness over the last 2 or 3 years
7 as a result of what we call phased dentistry.

8 The Army and Air Force pass on those recruits.
9 They essentially do an examination and form a dental record, and
10 move those recruits through, and that dental care is absorbed
11 further on down the line at subsequent duty stations.

12 Because of the MEPS screening exam, which we are
13 not here to discuss, and I am not here to take that way or the
14 other, I was here to discuss the DoDMERB end of this.

15 Because of the MEPS lack of a general screening the
16 services do absorb this care. They absolutely do. I was the
17 Dental Commander in Orlando for two years, and I have been
18 through the whole mill.

19 These candidates are not washed out because of
20 dental. Almost never. We fix them. We keep them after their
21 recruit training, and we keep them during the work week, and do
22 it on weekends, nights, and we fix them.

23 And their availability is limited, and it is an
24 extremely intense time for them, as well as for us, and it is a
25 very tough place to work for everybody, including the dentists.

1 But we fix them.

2 So we absorb that care, and it gets done. And so I
3 guess the question is do we want to do that at the Service
4 Academies? Do we want to take that same burden and put it on
5 these students who are going into the Service Academies.

6 That's basically the decision here, and are we
7 willing to put that burden on the Service Academies, and then are
8 we willing to finance that.

9 COL. KRAUSS: If I may offer an alternative, which
10 I wasn't asked to do, but when we look at the officer accession
11 programs, you are dealing with 30,000 applicants every year.

12 And I think we have about 18,000 actually enter the
13 programs. So it is 12,000 kids that are required to get dental
14 exams that will never make it into our programs.

15 Some of them are not academically suited, and they
16 are disqualified for other -- you know, non-medical reasons.
17 Rather than screen everyone and making kids that may not be able
18 to pay for it have to go out and get these remediations, perhaps
19 they should go ahead and be able to apply to the programs, and
20 once accepted, get a provisional acceptance letter, stating now
21 you have been accepted to the Naval Academy, and you need to have
22 X, Y, and Z fixed, or you must have a dental exam or whatever.

23 MR. MULLEN: That would be a good suggestion, but
24 it is not realistic because of the window of opportunity to go
25 into the programs, and the basic point that Captain McKinley

1 addresses is basic training for all the services is obviously a
2 tight schedule.

3 But once you go into a service academy, you have 16
4 hours or 17 hours from then forward, and so the Service Academies
5 are extremely opposed to it because they don't want to set people
6 up to fail.

7 You can't be sitting in a dental chair for a
8 prolonged period of time or a treatment plan during your first
9 year in the Academy. Otherwise, you are going to basically bail
10 out.

11 LT. COL. RIDDLE: If we can hold just one second.
12 Colonel Dunn actually can provide some information on several
13 issues that may answer some questions that the Board. He is the
14 ROTC Command Surgeon, and has done the waiver and requested the
15 waiver on the physical exam to get it to here. So, Colonel Dunn.

16 COL. DUNN: We are the largest customer for
17 DoDMERB. I am also the wavier authority for Army ROTC, and two
18 of the issues that are addressed this morning were raised by
19 Cadet Command originally.

20 So if I get a little emotional at times, it is
21 because it is an emotional topic for my Commanding General, and
22 therefore, it is an emotional topic for me.

23 Talking with regards to the validity period of the
24 DoDMERB physical. Our issue is different from MEPS. MEPS has
25 made a very good argument as to why the standard needs to remain

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS

1323 RHODE ISLAND AVE., N.W.

WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1 the same for them, and I support that.

2 But ROTC is a different animal compared to enlisted
3 accessions. Most of you don't know, but Army ROTC has not met
4 mission for seven years in a row. This coming October, we will
5 access commission roughly 3,300 officers.

6 That is 650 to 700 short of what the Army requires.

7 We have a major recruiting problem, and so my new Commanding
8 General, who has been on board for the past year, has been told
9 to fix the problem. Easier said than done, because the problem
10 didn't develop over night.

11 And there are many reasons why recruiting is poor.

12 We all know it has been tough on the enlisted side, but what is
13 not known is that it is also real tough on the officer side as
14 well.

15 There is many reasons; propensity to serve. Not a
16 lot of folks want their sons and daughters in the military. That
17 needs to be addressed in a different forum.

18 Issues regarding adequacy of the scholarship
19 benefits and stipend. That is a different issue for this forum
20 here. But there is one issue that my Commanding General hears
21 frequently from the field, and that is that the medical system is
22 just too complex, and it takes too much time, and too many people
23 walk away because they were not willing to go through the entire
24 process.

25 Now, the physical exam has to be done for

1 accessions, but the question has to do with the scope of that
2 exam, and whether or not there is ways to make the whole process
3 a little easier for the applicants.

4 One of the problems that my Commanding General is
5 facing right now is that he realizes that there is an awful lot
6 of applicants that apply to West Point, the U.S. Military
7 Academy, who do not get accepted because there is not enough
8 positions for them.

9 Right now three percent of everybody who is
10 rejected by West Point is ultimately signed up by ROTC. These
11 are folks who indicated an interest in a military career, but
12 have been disillusioned because they weren't accepted, and who
13 have walked away.

14 And what my Commanding General is saying is, well,
15 we need to see if we can bring them back into ROTC, because these
16 are folks who are oriented towards the military rather than some
17 Joe Blow on the street who doesn't know what the military is all
18 about.

19 A problem is starting to come up. Many of these
20 folks applied to West Point out of high school, and so that clock
21 is ticking on the date of their physical exam, which currently
22 the validity period is only two years.

23 Many of these folks really lose interest in the
24 military for the first year after being rejected by West Point,
25 and they enter a college, and now we are trying to recruit them

1 just to find out that their physical has expired or is about to.

2 And now we are going to tell them that they need
3 another physical to apply to ROTC, and I'm saying why. And my
4 Commanding General is saying why also.

5 When I can have an ROTC Cadet jump out of planes at
6 the airborne school for a five year period after being originally
7 qualified by DoDMERB, why can't that same physical be at least
8 good for a couple of more years, when the airborne school will
9 allow that physical with a statement that they are still in good
10 health be good for five.

11 So I am asking for a little bit of common sense
12 here. Last week, I had a student -- I was called up by an ROTC
13 program, where a student had applied to West Point, and been
14 rejected, and is in ROTC.

15 And West Point has now realized the error of their
16 ways, and didn't realize that he was such a great athlete, and
17 they want this kid back in West Point.

18 Even though this kid does PT three times a week,
19 and is in better fitness or shape than probably most of us here,
20 he needs to get a new physical. Well, he is not going to do it.
21 He is not going to start the whole physical exam process again.

22 So what the Cadet Command is asking for ROTC is to
23 extend the validity period for certain additional years, provided
24 that the student has indicated that there has been no change in
25 his health status.

1 These are young, healthy Americans going to
2 college, and involved in football, lacrosse, and a whole bunch of
3 other sports that we now currently say they may need another
4 physical.

5 I would like to take that disincentive to
6 recruitment away from the ROTC cadre who are having a real tough
7 job. So that is the perspective on the validity period. We are
8 separate from MEPCOM. We are a different animal.

9 Now, in terms of the dental exam, I raised that
10 issue a few months ago because the question we are asking is if
11 enlisted sliders or applicants do not need a dental exam by a
12 dentist, and non-scholarship officer applicants do not need a
13 dental exam by a dentist, then why do scholarship officer
14 applicants need a dental exam by a dentist when it is all based
15 on the same DoD instruction in the first place.

16 So Cadet Command's position is either do a dental
17 exam by dentists for everybody, or nobody if you continue to use
18 the same original DoD instruction. Now, in terms of -- there has
19 been some very viable and legitimate arguments raised by the
20 general community and some other folks regarding the costs and so
21 forth, and they are legitimate.

22 But ultimately it comes down to are these folks
23 going to be waived or not, and I will tell you that if a kid can
24 chew food, even MRE, the guidance to me by the Army Surgeon
25 General's Office, and my Dental Consultant, is to waive it.

1 And I am going to waive every single one of them if
2 they can chew food. Now, if you want to require a dental exam
3 before that, all you have done is put a road block into the
4 recruiters out there.

5 But the net effect ultimately is that I am going to
6 waive it, because as maybe the Coast Guard has noticed, you are
7 not going to turn those folks home, and send them back home.

8 CDR. LUDWIG: Not after they get there, once they
9 have made the trip there. But if we knew about it ahead of time,
10 we would probably send them back home.

11 COL. LEE: Actually, no, because we paid for the
12 trip there. We paid for all of it and so that is transparent to
13 you. When they get to the Coast Guard training base -- Cape May,
14 I guess it is -- so far it has cost the Coast Guard nothing, and
15 you process on from there.

16 CDR. LUDWIG: We are looking at the total cost and
17 not just what comes to the Coast Guard.

18 COL. LEE: But my point would be that you would
19 rather have them show up there with bad teeth than not show up at
20 all.

21 CDR. LUDWIG: Some would.

22 DR. BERG: Bill Berg. It seems to me what we are
23 being asked to do is to eliminate some of the screening for a
24 select group of officers. Now, I agree that bad teeth are a
25 horrible manpower problem for the Navy, and the Coast Guard, and

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

1 everyone else.

2 But I have not heard anything that says that
3 problem is going to be prevented. What we have are lower
4 standards because we are desperate to take people in, and we are
5 with a certain amount of sweating and grumbling willing to pay
6 the price of fixing all these bad teeth.

7 I have not heard anything that says people are
8 coming in with really subtle dental problems that require an MRI
9 to diagnose. What I am hearing are people coming in with mouths
10 full of rotting teeth that a corpsman could diagnose.

11 And I think the question for us, and that we are
12 being asked here, is eliminating these screenings for a select
13 group of officers likely to result in an increased burden on the
14 dentals.

15 COL. DUNN: That has already been eliminated for
16 non-scholarship applicants. It is not required. So why should
17 your scholarship status make a difference in terms of who looks
18 in your mouth?

19 COL. POWERS: Could I address that one issue since
20 I am from clinical program policy. I think the question you are
21 being asked is please look at what the standard is that is on the
22 books, and look at what you need to make that determination.

23 And the question is are the screening procedures
24 necessary to make that call given the standards that you are
25 given. Now, we are having a lot of discussion over what I think

1 a lot of people think the standard may need to be. That is a
2 different issue.

3 If you think we need to have different policy, then
4 that is a different and separate recommendation. But the
5 question that you are being asked to answer right now is given
6 what the standard presently is in place, what do you need to do
7 to make the determination on whether a candidate meets that
8 standard or does not meet that standard.

9 And I think the other issue that we have is that we
10 have different processes for making that determination, and
11 having those different processes, are we really having two de
12 facto standards.

13 CPT. MCKINLEY: This is Captain McKinley. That was
14 a very succinct and well stated, and that's exactly what we are
15 talking about. If we are going to maintain the standards that we
16 have now, then we need a certain level of examination.

17 If we are not going to maintain the standards, then
18 we are going to absorb all this dental care, and that is an
19 enterprise decision which dental communities certainly are
20 willing to take on also with additional resources. But that's a
21 decision that you are being asked to make and that was well
22 stated.

23 DR. OSTROFF: Dr. Campbell.

24 DR. CAMPBELL: The problem we are facing is that we
25 are hearing different targets from these different services.

1 Some parts of the services are willing to accept certain costs
2 and some aren't.

3 So to make a policy that is going to meet different
4 standards is difficult. We need to hear what is the military
5 willing to accept as far as costs to fix all these things, and
6 given that, we should make a determination of who is allowed into
7 the service given that it is going to cost X-amount of money to
8 fix the problems.

9 COL. DUNN: The problem you have is that you
10 already have the standard, which is being implemented
11 differently, depending on whether you are an enlisted applicant,
12 who by the way should have worst teeth than an officer applicant,
13 when 86 percent of all Army ROTC folks come from a military
14 family, and who have had access to dental care for most of their
15 life.

16 DR. CAMPBELL: Well, my point is what is the
17 military willing to pay to correct all these problems, and to
18 make a determination on that.

19 COL. DUNN: We are paying it right now

20 LT. COL. RIDDLE: What we have tried to do is
21 -- and again if you go back to Colonel Powers, is the question
22 was asked here is the standard. What evidence is there based
23 upon the existing data from DoD and AMSARA, and in the
24 literature, to make an evidence-based decision on what is needed
25 from a screening and an exam process to accomplish the standard.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

1 And that is what we focus the literature reviews
2 on, and the material, and for a lot of these there is actually a
3 significant amount of evidence, even on the physical exam.

4 When the Board addressed this issue originally in
5 1976, the question was brought to the Board on the validity
6 period for the physical exam, and the Board made a recommendation
7 for reserve forces to move it from a year to five years.

8 There was subsequent legislative changes and we
9 have got all of that background material, and so there really is
10 quite a bit of material to take a look at to provide some
11 evidence for the interpretation of those standards and the
12 question asked.

13 DR. OSTROFF: Let me -- I mean, I tend to look at
14 things based on where I work, and from an epidemiologic societal
15 point of view. And some of what is being done here with the
16 differential requirements for MEPS versus the Academies, et
17 cetera, is to some degree value judgment based on what the value
18 of those individuals is, and what the cost of training those
19 individuals happens to be.

20 And the problem is that when you look
21 epidemiologically, the ones that are much more likely to have
22 some of these conditions that you are talking about are the ones
23 that aren't being screened.

24 The ones that are being screened are the ones that
25 are probably much -- I mean, college kids are kids that are good

1 enough in terms of their academics to be qualified to enter the
2 U.S. Military Academy, and are far less likely to have dental
3 disease problems than some kid who is living out on the street.

4 And so the difficulty that I have with all of these
5 arguments is that we are not screening the ones who probably most
6 need the screening, and we are screening the ones that probably
7 don't.

8 COL. LEE: Actually, we are screening. I would
9 like to clarify a point in case it was not clear. What we did
10 from all of the Services is ask them what standard do you want
11 our physicians to use. They said can they masticate, and that is
12 the standard that they wanted us to use for dental.

13 Now, any time one of the physicians has a question,
14 he can get a dental consult if there is a question about whether
15 the kid can masticate and whether or not he is taking sufficient
16 nourishment.

17 So we can get a dental consult, but based on what
18 the Services have told us, they said that if he can chew, that's
19 good to go, you know. They would rather us do that than
20 disqualify the kid or get a consult.

21 DR. HERBOLD: Could you clarify that, because we
22 had a briefing earlier that said that the three dental chiefs
23 supported the panorex and the examination by a dental
24 professional.

25 But you are saying that if the standard is -- and I

1 understand this, too, because I went through it with blood borne
2 diseases 15 years ago, but if the standard is can you chew, I
3 don't think you need to bring this question to the AFEB to
4 answer. The answer is there and so what are you drilling us for
5 on it.

6 DR. ZIMBLE: The question to the AFEB is are these
7 four very specific screening tools relevant, and I think if
8 attrition is the end point -- you have seen the data from AMSARA
9 that says it is irrelevant.

10 You don't need these four. These four tools are
11 not making or breaking the whole process, and are costing money,
12 and they are interfering with recruitment, and they are cutting
13 back on manpower, and they have no real value in terms of
14 screening for a standard. They have a great deal of value for
15 other applications, but not for screening.

16 DR. OSTROFF: But it is even more than that because
17 if they are of value, basically you are screening the wrong ones.

18 DR. ZIMBLE: True, but they are not.

19 COL. WEIEN: There are a couple of different
20 questions here.

21 DR. ATKINS: Go ahead.

22 COL. WEIEN: There is the standard as written in
23 the DoDI. DoDMERB's position is that in order to enforce that
24 standard as written that we need certain tools. I think I have
25 explained that before.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

1 When Colonel Lee talks about mastication is a test
2 for whether or not someone should come in. That is really a de
3 facto waiver standard. They are saying, okay, here is the
4 standard, and they don't need that standard. Can they still eat?
5 Okay. We will let them in.

6 And so waiver decisions are a service level
7 decision; whereas, the standard, the question is what tools do
8 you need to determine whether someone meets or fails to meet the
9 standard.

10 Then whether or not you want to let them in as an
11 aid to recruitment is a waiver decision that ought to be service
12 level specific.

13 COL. DUNN: And that's why I say have the same tool
14 for everybody or don't use that tool.

15 DR. OSTROFF: Dr. Atkins.

16 DR. ATKINS: Well, I have worked for the U.S.
17 Preventive Services Task Force, which puts out recommendations
18 about common screening tests, and I noticed that those weren't
19 here in partly because I think they are on websites rather than
20 on publications.

21 But it seems that there are three levels of issues.
22 One is are these screening tests medically appropriate with
23 these, and that is not even in the standards. But that is
24 probably sort of a lower bar.

25 Would you expect the average person in the

1 population to get these, and from our position and most other
2 groups, none of these are things that if you were Joe Civilian
3 that you would be expecting to get.

4 The second is whether there is anything particular
5 about military service which would make them appropriate for
6 people, such as the rigors of military training or other aspects.

7 And again I don't think those are sufficiently differently to
8 justify EKG screening or hemoglobin screening.

9 But the third thing that I think is making it so
10 difficult is that we are being asked to deal with policy issues,
11 and so the real question is if you change the policy either by
12 making the MEPCOM screening stricter or by relaxing the other
13 policies, what would the overall impact be.

14 And so those are -- well, the data that I have
15 heard about is would it change attrition rates. So if the
16 outcome is attrition, we didn't hear good data that that should
17 be justifying a stricter standard.

18 But then there are other sorts of policy issues
19 that maybe if the investment in Academy folks is substantially
20 higher, maybe we are willing to screen for a much lower yield.

21 So I don't know that having uniform standards on
22 both sides is essential from a policy standpoint, but that may be
23 a political question on whether we can say we are implementing
24 the same standard, but with slightly different measures because
25 we are dealing with a different population, and different needs,

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

1 and different investments.

2 I think we all agree that the standard ought to be
3 the same, but there may be some policy justifications for
4 implementing it slightly differently.

5 I mean, the EKG is a typical example, and the yield
6 of EKG screening for preventable sudden cardiac events is
7 extremely low, but if you were screening pilots, you would
8 tolerate a very low yield of screening because the impact of that
9 one preventable event might be huge.

10 And certainly on the commercial side we do that,
11 but you would be crazy to invest that money on EKG screening on
12 the MEPCOM side. But I guess I am feeling at a loss of knowing
13 whether the thing that drove this is discomfort over the
14 appearance of unequal policies, and feeling that was not
15 tolerable from sort of an equity standpoint.

16 Or whether as I was hearing that there are actual
17 obstacles being imposed by the fact that standards may be too
18 strict for your needs.

19 LT. COL. RIDDLE: If we could, maybe a couple of
20 more questions, and then with the subcommittee sessions this
21 afternoon, we will specifically appoint groups to address the
22 questions, and then maybe we can get into a little bit more
23 detail.

24 And maybe Tim could hang around with the
25 individuals to discuss just that. I mean, from the money

1 savings. If you eliminate these discrepancies, and you save \$10
2 million a year, that will buy quite a few more dentists to
3 provide care to maybe get these people in better shape.

4 So an application of resources differently, and
5 maybe we can tease some of those out this afternoon.

6 DR. HERBOLD: And can we suggest that all the
7 subject matter experts that are here are welcome to participate
8 in all the subcommittee meetings.

9 DR. OSTROFF: Absolutely. Particularly the
10 dentists.

11 LT. COL. RIDDLE: Any more questions?

12 DR. GARDNER: I would think the -- we have heard
13 some strong defenses for each of the screening tests, but the
14 thing that we have not spent very much time on is the duration of
15 the validity on once you have passed these tests, and how long
16 are you good for.

17 And I think there is the one that we can probably
18 come to a consensus on most easily. I think the person who is
19 applying to West Point and wants to get into ROTC -- and I have
20 not heard any data presented today about the interval to support
21 a short interval.

22 If your EKG, which is Wolf--Parkinson-White, is
23 normal, it is not going to pick it up 2 or 3 years later. The
24 things that you are going to drop dead on are cardiac issues
25 primarily, and an EKG is good for a very long time, and if you

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

1 have one, you certainly don't need to come back and do that very
2 well.

3 I have not heard from the dentists that if you have
4 normal teeth on Day X, and is it really worth coming back and
5 doing the whole thing over again 2 or 3, or 4, or 5 years later.

6 We have not fixed the interval.

7 And certainly for the hemoglobin screening, you are
8 not going to get in too much trouble over that. So I would think
9 we could quickly come to some decision to lengthen the interval
10 for rescreening, and then go back to talking about the rest of
11 it.

12 I think it mostly turns out to be cost figures, and
13 that is the issue for dentists. They are not going to drop dead
14 over bad teeth, but there is military preparedness.

15 And you are probably not going to drop dead over
16 hemoglobin issues, but you might drop dead over cardiac issues,
17 and I guess that is an issue that you have to take into
18 consideration.

19 COL. LEE: But I think the other ones also cost for
20 the length of physical, because for the officer -- unless you are
21 speaking just of officers.

22 DR. GARDNER: The officers get examined twice,
23 right? That is the exact same exam twice?

24 COL. DUNN: Not completely. The commissioning
25 physical is done at advanced camp, and for students between the

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

1 junior and senior years.

2 DR. GARDNER: But they get in essence the same set
3 of criteria applied to them in two intervals. Whereas, the
4 enlisted folks get it once.

5 LT. COL. RIDDLE: It may be three or more
6 intervals. I mean, if you go to the academy and you go to prep
7 school, you get an exam. If you are accepted into the Academy,
8 do you get another one, and then when you are commissioned, you
9 get another one?

10 MR. MULLEN: The worst case is you apply to a four
11 year program, and you don't get in. You then go to a college and
12 you apply for a scholarship, and while you are applying for the
13 scholarship you have to take a quick training exam so you can go
14 to camp.

15 Then you get the scholarship exam, and then you get
16 the pre-commissioning exam. And if you are flight, a flight
17 exam. So conceivably during a 5 or 6 year window, you might be
18 required by policy to get upwards of five exams.

19 COL. GARDNER: So we certainly could go after that
20 with great gusto I think, but I think we are still left with
21 arguing what is an efficient thing to do at least once.

22 DR. OSTROFF: Okay. I am going to take the
23 President's prerogative of closing this session, and let me just
24 say that I am really pleased that these questions were brought to
25 the Board.

1 This is certainly one of the liveliest discussions
2 that we have had in a number of years, and I think they are very
3 thought provoking, and these are things that we could potentially
4 help you with.

5 And certainly from the standpoint of potential cost
6 savings, I think they are not insignificant. I am assuming that
7 all of you can still chew, and so why don't we go ahead and have
8 lunch. When do we need to be back?

9 COL. RIDDLE: At 1:30.

10 DR. OSTROFF: So let's be back at 1:30.

11 (Whereupon, at 12:16 p.m., a luncheon recess was
12 taken.)

13

14

15

16

17

18

19

20

21

22

23

24

25

1

2

3

4

5

6

A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

(1:35 p.m.)

1
2
3 LT. COL. RIDDLE: Yesterday at General Peake's
4 request, he had asked that Colonel Mallon come down and present
5 to the board a questionnaire that has been developed and that
6 they are proposing to use to follow up at the Pentagon post-
7 disaster.

8 So we changed the agenda to have Colonel Mallon
9 come down and discuss that with the Board.

10 COL. MALLON: Thank you for the opportunity to come
11 down and talk about the questionnaire. General Peake was very
12 excited to hear that Dr. Landrigan and the New York City group
13 were going to go in and do a post-disaster assessment survey.

14 I think the survey instrument that we started with
15 was the Kobar Towers and Oklahoma City Post-Disaster Assessment.
16 Our original thoughts were to look at the opportunity for
17 assessing the impact and the injuries, and the kinds of things
18 that would prevent injury in buildings and in situations in the
19 future.

20 Since we started with that, the questionnaire
21 process, we have really evolved. I think that our focus has come
22 around to where I think it really needs to be, and that is
23 focusing on our people, and assessing the impact of the incident
24 on the individuals involved at the Pentagon.

25 And to look at how many people were affected, and

1 to document the experience for the future. I think when you look
2 at the questionnaire, it is kind of broken down into three areas.

3 There is some general background demographics, and
4 a section on exposure assessments. You know, odors, smoke,
5 fumes, vapors, that kind of thing. And then a section on
6 psychological impact or assessment.

7 Now, we recognize that the psychological questions
8 that were provided were an initial set of questions, the focus of
9 which was to try and establish a base line of where they are now,
10 and do a quick assessment of do they need to see or get
11 psychological help at this point in time.

12 Also, to assess any acute immediate pulmonary or
13 subacute problems that people were having so that we could get
14 them into medical care. Now, the third component of this is what
15 I was referring to earlier, and that is the potential use of this
16 for the future, in terms of building design and how to protect
17 people like at the Pentagon when we reconstruct it.

18 And how can we design it better so that if an event
19 like this occurred again, we would have fewer casualties and
20 fewer problems.

21 So the task that I was asked to come down and talk
22 about was to present the questionnaire, and ask you as a group to
23 see if the instrument that we prepared is going to provide the
24 answers to the questions that we are looking for.

25 And we are looking for feedback in terms of -- and

1 we realize in a very short turnaround. It is not traditionally
2 what the AFEB is designed to do, in terms of giving rapid
3 turnaround feedback.

4 But we would appreciate if you had the opportunity
5 to look this over in the next few days to give us feedback on any
6 questions or comments that you might have. I think it would be
7 very constructive for us as we put this out.

8 Our current plan is to administer this and start
9 administering it in the next week or so. I mean, that is a deal
10 that we realize is very aggressive. We have an execution plan
11 that is going to involve -- it is going to be executed through
12 NARMC.

13 They are planning a pretty major effort to put this
14 on the website so that people have web access to it, and they can
15 complete it that way. We have a stand alone server that we are
16 standing up that will provide 128 byte or even higher encryption
17 so that we will provide some security for the web.

18 And as well as hard copy questionnaires, and will
19 be walking and almost developing a grid map, corridor by
20 corridor, and section by section, to hand it out, distribute it,
21 and make sure everybody who is there, or has been relocated, has
22 an opportunity to complete the questionnaire.

23 Some of our challenges I think are going to be to
24 come up with a complete list of everybody who was at the Pentagon
25 at the time, and to track to see where they have been relocated

1 to.

2 There are some significant challenges, in terms of
3 managing the database. We anticipate that if everybody completed
4 the questionnaire, there would be over 24,000 questionnaires
5 turned in. That's a monumental task in terms of analysis.

6 We have had offers of a lot of help, and I think as
7 this evolves that we -- and depending on what the future of our
8 military is in terms of other interventions, we may accept some
9 of those offers of help.

10 And we may be contracting some of this work out,
11 and a lot of it depends on where we go from here. That is really
12 all the prepared comments that I had.

13 I guess one additional thought, and that would be
14 that we have been working with -- we have invited the psychiatric
15 consultant and some of the people in the psychiatric community to
16 look at the questions that were here, and offered an opportunity
17 to provide better questions, perhaps a better subset of questions
18 that might more accurately be more useful, in terms of collecting
19 a background psychological assessment.

20 And I know that our psychological and psychiatric
21 community would like us to do this in a longitudinal fashion, and
22 I think the questionnaire alludes to it on the cover sheet.

23 The cover sheet provides an introduction that is
24 designed to be handed out to every individual. So one of the
25 questions is, is the cover sheet sufficient in terms of defining

1 the purpose, of defining what it is that we are trying to
2 capture.

3 And getting back to the longitudinal component, we
4 would envision that there would be a subsequent questionnaire to
5 assess the psychological morbidity over time, where thinking
6 depends on the psychological community.

7 But I think a six month and perhaps even a one year
8 follow-up, I think they would believe that would be necessary.

9 DR. LANDRIGAN: Could I ask you to speak to two
10 other issues, and whoever is the relevant person. Number One is
11 environmental sampling, air sampling, and other forms of
12 environmental sampling.

13 And, number two, what plans -- I realize that it is
14 early, and I am not trying to embarrass you, but I am just trying
15 to get the information.

16 What plans are you formulating for monitoring the
17 health of the people who are going to be in there in the days and
18 weeks ahead doing the demolition, and the clearing of rubble, and
19 all the rest of those dirty horrible tasks?

20 COL. MALLON: I think those are excellent
21 questions. I think that I would suggest that an environmental
22 sampling is being done by the Environmental Protection Agency, in
23 conjunction with the State Health Department, and the State
24 Environmental Quality people.

25 This is a separate operation. Anything outside the

1 Pentagon is considered environmental, and has to do with
2 environmental waste, and environment remediation.

3 The inside work in the Pentagon is being looked at
4 as an occupational health work place. The standards that are
5 being applied are OSHA standards and that sampling, and that work
6 is being done by our industrial hygiene people at the Center for
7 Health Promotion and Preventive Medicine through Walter Reed Army
8 Medical Center.

9 As well as the industrial hygienist from the Air
10 Force and the Navy participating in the sampling effort. Now,
11 that started essentially the evening of the first day, and then
12 has continued over time. We have been sampling and doing
13 personal dosimetry on workers, as well as going into and doing
14 individual office indoor air quality assessments, where we get
15 complaints from workers who are going back in and doing reentry.

16 If we are getting complaints from workers, we are
17 having an industrial hygienist go in and do a direct reading and
18 instrumentation to assess the problems in the immediate space.

19 DR. LANDRIGAN: And monitoring the future workers?

20 COL. MALLON: Well, we have both a Pentagon health
21 clinic, a military health clinic, as well as a civilian
22 occupational health clinic. We intend to use the surveys as a
23 way to monitor, particularly if people indicate that they had
24 been involved in the recovery, or in the remediation effort at
25 the Pentagon, that that will give us a good starting point to

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS

1323 RHODE ISLAND AVE., N.W.

WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1 sample that particular cohort over time.

2 DR. LANDRIGAN: If you would like, let me take a
3 few minutes --

4 DR. OSTROFF: Can I just ask one question first?
5 How many people among the injured are still hospitalized in
6 relatively severe -- I mean, I am thinking in terms of
7 administering the questionnaire, and how you are going to do that
8 with individuals who have the more severe injuries.

9 COL. MALLON: Let me say that the execution plan
10 for administration of the questionnaire is still in the
11 formulation stages. The latest information that I have heard is
12 there were approximately a hundred people still hospitalized,
13 some in varying degrees of severity.

14 PARTICIPANT: That is not correct.

15 COL. DINIEGA: It was down to 20 something
16 yesterday.

17 PARTICIPANT: It is actually less than that, and I
18 think it is less than 20, but I don't know that we need to say
19 exactly what the number is.

20 COL. MALLON: It's nice to have updated
21 information. Thank you.

22 COL. ENG: It is less than 20, because the Walter
23 Reed command has been tracking and going around and it is really
24 very few.

25 COL. MALLON: And for the people who were

1 hospitalized, we were planning to track them separately, and to
2 actually go out and do essentially a supplemental questionnaire
3 to get more detailed information for those who were actually
4 injured and hospitalized.

5 COL. DINIEGA: Phil, before you answer, this was
6 brought up when General Peake was here yesterday, and I think
7 there are two different efforts here. One is for the regular
8 employees of the Pentagon, which is what they want to do.

9 And I think in our discussion and in the discussion
10 yesterday, you were talking about the recovery operation, and the
11 workers in the recovery operations.

12 DR. LANDRIGAN: That's absolutely correct, and we
13 are making really that same distinction up in New York between
14 people who were nearby, and when I say nearby, I include people
15 who might have been in the buildings, but got out.

16 And versus the folks who are going to be involved
17 in the recovery demolition operation, which up there is probably
18 going to last 6 to 12 months. So they are going to be exactly as
19 you said, Colonel, a real occupational cohort who needs to be
20 surrounded with the OSHA type protections, which are very
21 different from what is going to apply to the people who were
22 transiently exposed.

23 COL. DINIEGA: But I think Tim said that --and if I
24 am not mistaken, but that when you are doing the sampling in the
25 Pentagon, in the offices close to the impact area, you are using

1 OSHA standards as the levels to follow?

2 COL. MALLON: That's correct.

3 COL. DINIEGA: So it is not for the recovery
4 personnel, but it is for people who might go back to the offices
5 near the recovery area.

6 COL. MALLON: Now, it is my understanding that EPA
7 and OSHA were actually monitoring those people who were actually
8 in the immediate crash site and monitoring those individuals, and
9 collecting data.

10 DR. LANDRIGAN: And that's what happened up there.

11 So I am sure that the people are cross-talking. So that makes
12 sense. The one point that I had made to General Peake when we
13 spoke yesterday was that I was urging that some attention be
14 paid, in addition to the air sampling, which is quite correct and
15 absolutely necessary.

16 But I argued that in addition to that that there is
17 a case to be made for taking other kinds of sample to compliment
18 your sampling. One kind of sampling which I did not mention to
19 General Peake, because I didn't think of it at the time, is the
20 notion of doing like samples of surfaces, especially surfaces
21 that might have black soot on them, combustion products.

22 And, of course, you are going to find polysilacaram
23 or hydrocarbons, and that is a given, but the real question is
24 whether or not there is any dioxin, any furan, any other more
25 complex combustion products that may have been generated by the

1 burning of plastics.

2 And if they are there, that's okay, as that is not
3 a show stopper, but it does mean that attention needs to be paid
4 to properly clean those up before you let either military or
5 civilian personnel go back into those particular areas.

6 And my guess is that if that stuff is there at all
7 that it is going to be geographically pretty delimited. It is
8 going to be in the areas where there was black smoke, but
9 probably not much beyond that. But it will not show up on an air
10 sample.

11 COL. MALLON: I understand, and I am pressed to
12 reassure you that I think or I know that wipe samples have been
13 taken.

14 DR. LANDRIGAN: Good. Good.

15 COL. MALLON: We requested a complete analysis, to
16 include the dioxins, the pHs, and also lead, and the things that
17 you would expect to find in an old building.

18 DR. LANDRIGAN: Then the other thing -- and we have
19 seen this up in New York -- is we know -- I don't know
20 specifically about the Pentagon, but we know that quite a bit of
21 asbestos was used in the construction of the World Trade Center.

22 Basically, they sprayed asbestos on the steel beams
23 up to about the 40th story of the first tower, at which point in
24 1971 the spraying of asbestos became illegal. So thereafter they
25 used vermiculite and other insulating materials.

1 But there is a lot of asbestos, and of course it
2 has been liberated. Now, the air samples that have been taken to
3 my understanding up there have all been within OSHA standings,
4 and that is really not surprising because those of you who don't
5 know how air sampling works, you take a little bit of air through
6 a filter, and you collect the solid material on the filter, and
7 you express it in terms of the number of fibers per -- over the
8 number of cubic meters of air that you bring through in eight
9 hours.

10 So it averages, and that's good because the OSHA
11 standards for the most part are set as what is called an eight
12 hour time weighted average, and you measure a person's average
13 exposure over the eight hours.

14 And either they are above the standard or they are
15 below it, and so far they have been below it. But the trouble in
16 a very uncontrolled work place like this is that you have got
17 asbestos in the dust, and it is very unevenly distributed.

18 There is cold spots and there is hot spots, and up
19 at the World Trade Center, they found some dust containing as
20 much as 4.5 percent asbestos. That is the upper limit, and some
21 have been 1 or 2 percent, and a number have been below the limit
22 of detection, which is a perfectly expected sort of right skewed
23 distribution, and that is what you would expect to see in this
24 kind of environment.

25 But it says to me that there is a threat of

1 asbestos there, and even though the 8 hour time weighted averages
2 are probably going to be below the standard, almost always it is
3 still going to be necessary to fit those workers who are in there
4 doing the heavy duty work with proper respirators.

5 And that fortunately is the solution of the
6 problem. It is an unpleasant solution because people don't like
7 to wear respirators, but it will do the job, and it will keep
8 them from getting exposure, and I am sure that you are doing the
9 same thing here. I just wanted to run through the logic.

10 DR. LANDRIGAN: Who would have the sampling
11 results?

12 COL. MALLON: EPA. It has been a great cooperative
13 effort between the Feds, the State, the City, and people like
14 myself in the academic arena, and the Federal EPA have been the
15 lead agency for the environmental sampling up there.

16 DR. LANDRIGAN: Do you have a point of contact up
17 there that you would refer us to?

18 COL. BRADSHAW: This is Colonel Bradshaw. Our
19 environmental folks are in touch, and have been up to New York
20 and visited, and have talked with OSHA, and EPA, and the Coast
21 Guard has actually been there since -- some of the best
22 respirators that they had were from the Coast Guard HAZMAT team.

23 So I think that all of the proper connections have
24 been made, and our folks are talking on this.

25 COL. MALLON: So, Colonel Bradshaw, the Air Force

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

1 point of contact for the sampling?

2 COL. BRADSHAW: Colonel Sprester, and then Tom
3 Neal, a doctor of patient medicine and physician, who has been up
4 there; and also one of our public health people went up. Those
5 are some of the specific issues that they were looking at.

6 COL. MALLON: Understood. One of the concerns that
7 we had -- and we were touching base with the National Guard and
8 the reserve folks -- was that on the news and in the New York
9 Times, you see people walking around without wearing their
10 respirators.

11 And I think that we had enforced with the State
12 Surgeon from New York just a couple of days ago when I spoke to
13 him personally, and I said and basically reiterated what Dr.
14 Landrigan had said, that the asbestos levels were in fact high.

15 And that they were required to wear respirators but
16 in fact as the pictures represent --

17 COL. BRADSHAW: Our folks noticed when they went up
18 there that a lot of the rescue workers were just wearing the
19 little particulate masks, and our people, as soon as they got
20 there, the Coast Guard gave them the respirators.

21 So our people were in respirators, but they did
22 notice that was a problem in New York. So we had --

23 DR. LANDRIGAN: It is sort of an anartic city.

24 COL. DINIEGA: There is a group of military
25 personnel that have been very involved with the recovery effort,

1 and you see them on t.v. all the time now, the Old Guard
2 Soldiers, who are on rotations who help with the recovery effort,
3 and they are in the crash site.

4 DR. LANDRIGAN: Are they wearing --

5 COL. DINIEGA: I'm not sure.

6 COL. MALLON: It was our intent to work through the
7 chain-of-command to ensure that people were following the
8 recommended respirator protection requirements to make sure that
9 the command enforced the wear.

10 DR. OSTROFF: Can I try to shift the conversation
11 back to the questionnaire, and to the major issue that we were
12 asked to deal with? I do have a couple -- first of all, let me
13 commend you.

14 I am sure that the situation is very stressful. It
15 is very difficult to think about doing something like this in the
16 context of this situation. So I think the Board strongly
17 supports this being done, and it will be an interesting exercise
18 to see what the response rate will end up being.

19 My guess is that it will be quite good, but you
20 never know. One issue that when I look at this -- and, you know,
21 I work for CDC. We have 71 people up in New York, many of them
22 doing epidemiologic work. And we have been very sensitive to
23 this issue of we are not doing research.

24 And that we are doing essential public health
25 things, and this particular questionnaire is a questionnaire that

1 is designed to protect people's health, and I think that is very,
2 very important.

3 And that in circumstances in the future that you
4 would want the best information that is available so that you can
5 to the maximum degree possible protect our health and safety.

6 The second thing when I look at this that I have
7 some questions about is the choice of the term "registry." And I
8 am wondering what the logic behind using that particular term is
9 since it has certain connotations in the military setting,
10 particularly around Gulf War registries and things of that
11 nature.

12 And I am wondering if you considered using a
13 different title.

14 COL. MALLON: Let me share with you what the
15 thought processes were. I think that when we originally came up
16 with the word registry the thought was that we could actually
17 motivate participation, with the idea that people would be more
18 interested in getting their name on to the registry and be part
19 of the group.

20 So that if something were to happen down the road,
21 perhaps just like in the Gulf War situation, people would be
22 particularly motivated to participate. And I think that we have
23 had some subsequent discussions that would encourage us to
24 rethink the use of the term registry.

25 But then we looked at the psychological component

1 and the intent of our psychiatric community, which is to follow
2 this group longitudinally over time to see if there is any
3 morbidity in this worker population.

4 So perhaps it really is appropriate to call it what
5 it is, and a registry that we intend to follow people over time.

6 DR. OSTROFF: I'm not sure I know the answer.

7 DR. BERG: Bill Berg. I think the -- now this
8 first page is intended to be the introductory letter?

9 COL. MALLON: Yes.

10 DR. BERG: Okay. I think you could rewrite it so
11 it is more inviting and user friendly. It comes across to me as
12 a bit bureaucratic. You start out, "It is important that we look
13 after our people."

14 And then you sort of drop that line to the second
15 paragraph, where you say, "go see your doctor." You use the word
16 survey, and we want to know information, and there is going to be
17 more questionnaires.

18 And I would read that and say what does this have
19 to do with me, and then you have the opportunity to help others.

20 It is important. And that comes across to me -- and again
21 looking at some of the questions, we want a whole bunch of
22 engineering information so that we know next time whether to make
23 the wall 10 inches thick or 12 inches thick.

24 And I think you could benefit from setting out a
25 more straightforward and open manner, or a more clear cut manner,

1 what benefit is going to come to people who fill out this
2 questionnaire.

3 You may want to think in terms of whether these are
4 issues that people want to talk about, and this is a chance to
5 give us some feedback. The word registry is problematic, but you
6 may want to address the issue that there may be long term
7 psychological or other health effects, and this allows us to
8 follow you and let you know of information.

9 In other words, address the question of what is in
10 it for me if I fill this thing out. I have been through a
11 horrible experience, and I may be injured, and now I have got 14
12 pages of incredibly detailed questions. Why should I fill it
13 out. So I think shifting it that way may help your response
14 rate.

15 COL. MALLON: Thank you. Understood.

16 DR. OSTROFF: Dr. Haywood.

17 DR. HAYWOOD: Is it contemplated that a similar or
18 identical questionnaire will be given to both civilians and
19 military?

20 COL. MALLON: Yes.

21 COL. GUNZENHAUSER: Tim, maybe I am not seeing it,
22 but there is probably going to need to be an explicit statement
23 of the privacy of this information, and it won't be released to
24 any supervisors, any personal information.

25 And I think we have got to make sure that our chain

1 understands that clearly.

2 DR. OSTROFF: I think that is very important. I
3 mean, what if you put down that your last name is Rumsfeld or
4 something like that. There will be a lot of interest in the
5 particular responses that you would get in a situation like that.

6 COL. DINIEGA: How are we going to control that?

7 COL. MALLON: I beg your pardon?

8 COL. DINIEGA: How are you going to control access
9 to the questionnaire?

10 COL. MALLON: The questionnaire will be handed out
11 to the person who is going to complete it, and collected back at
12 the health clinic.

13 COL. DINIEGA: I thought you were saying something
14 about access on the web page. That's why.

15 COL. MALLON: There will be an information sheet
16 distributed to Pentagon employees addressing how they can access
17 the questionnaire on the Pentagon web page.

18 So if you have dot-mil address, or a DoD e-mail
19 address, our server will screen to permit only access to the dot-
20 mil addresses, and that is one way to restrict access.

21 The other is that we are limiting our distribution
22 of who we are providing the information to.

23 LT. COL. RIDDLE: Dr. Atkins.

24 DR. ATKINS: I was thinking of Dr. Ostroff's
25 comments about research. If one of the aims is to look at sort

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

1 of long term psychological consequences, as well as other medical
2 consequences, it would seem that there is more information that
3 one would like to look at the things that might be important
4 effect modifiers of that.

5 But I am imagining that some of that might get into
6 sensitive areas, and I was just thinking like looking at marital
7 status and other sort of social connections, and things that
8 might make people more or less vulnerable to the psychological
9 consequences.

10 And I don't have a suggestion. I am just sort of
11 wondering what your approach is, in terms of whether you can
12 capture more information about the things that we could predict
13 might may somebody more vulnerable.

14 And whether you want to capture it at this point,
15 or whether it be something that you might capture down the road
16 and follow up with surveys.

17 COL. MALLON: Well, I think that one of the unasked
18 questions should be does the questionnaire strike the appropriate
19 balance between the kinds of effect modifier questions assessing
20 the appropriate psychological baseline, as compared to the other
21 questions that we are asking in regards to injury and to exposure
22 assessment.

23 LT. COL. FENSOM: Lieutenant Colonel Fensom. One
24 thing that we found a real effective motivator with these kinds
25 of questionnaires was a guarantee up front that anyone who fills

1 it out is going to be informed as to the results of the survey,
2 or at least made knowledgeable about any helpful product of the
3 inquiry.

4 DR. OSTROFF: Yes. And the other requirement is --
5 I mean, looking at the elements of informed consent when you are
6 talking about informed consent is that there has to be some
7 contact identified that they can call to ask questions if they
8 have particular questions about the questionnaire itself.

9 Or the use of the questionnaire, and any of those
10 types of things, or again how information will be provided back
11 about the findings.

12 DR. BERG: Bill Berg. Speaking to elaborate a
13 little bit on the confidentiality. You may want to consider
14 whether this is releasable or obtainable under the Freedom of
15 Information Act.

16 It is kind of a medical record, but it's really
17 not, and it may be worth at the least running this by the Judge
18 Advocate to see whether it would be protected or not; and if not,
19 what might be done to protect it.

20 DR. OSTROFF: Thank you.

21 COL. ENGLER: Dr. Engler. In regards to that, when
22 questionnaires are done in a clinic setting, if you put on every
23 page that this is protected under quality assurance, and there is
24 a fine if you use this for anything else.

25 It is a standard disclaimer that a lot of us are

1 putting on our e-mail also to protect it from exposure. And if
2 you don't have that -- you know, we all use it regularly.

3 The other thing, just at the end of your
4 questionnaire, the civilians aren't going to have a primary care
5 doctor. Frankly, a lot of active duty don't either. They don't
6 go see them.

7 And the Walter Reed command has made a great effort
8 during this to -- there has been training of the non-psychiatry
9 staff to raise awareness about approaches within regular clinics.

10 And I think you should rather say please contact
11 whoever -- you know, if somebody is coming to the allergy clinic,
12 or to the internal medicine clinic, or whatever, and that is
13 their home. What people identify as their home may not be the
14 primary care, the DeLorenzo Clinic.

15 And we are all prepared to provide that support,
16 and probably getting information out about the questionnaire to
17 the clinics throughout the Walter Reed health care system, and I
18 would think the Navy and Air Force as well, would make you
19 partners in that.

20 Otherwise, the patient will go to the person that
21 they trust, or the individual, and if they don't know anything
22 about it, that will raise distrust of the processes to really be
23 effective.

24 And I think stressing that you provide some kind of
25 nurturing support through this, because this reads very cold, and

1 if you are really struggling with something -- the people who you
2 probably want to hear from the most will be the least likely to
3 fill it out.

4 COL. MALLON: Understood. I should say that we
5 were planning to do information sheets that providers could give
6 to the patients, and some of the information that we talked about
7 could be rolled up into that information sheet, and that the
8 patient could actually take away with them.

9 For example, the uses of the questionnaire, and the
10 restrictions on how it is going to be disseminated, and all of
11 that. I think the other thing that we are going to provide is an
12 information sheet to health care providers so that if a patient
13 comes in and they know nothing -- the health care provider knows
14 nothing of the questionnaire, they can call one of us, and we can
15 provide some background, and give them some insight.

16 And to try and lay it out on the information
17 sheets, but we will also have points of contact and phone
18 numbers.

19 COL. GUNZENHAUSER: Colonel Gunzenhauser. I had a
20 question about the sort of delivery and your oversight of
21 obtaining as complete a response as possible.

22 I don't know how you are planning on doing that
23 exactly. I know that is something that you will have to give
24 some thought to. Normally if this is a survey and you get a 20
25 percent response rate, there is going to be some concern about

1 what that really means.

2 And obviously it is not a non-administered
3 tracking, and who is responding and who isn't. And there are
4 going to be some questions about do you need to contact these
5 people, or resubmit a survey, or how you are going to do that.

6 And whether you are using command channels, or
7 whether you are using some off-line way of delivering this to
8 them. Have you given any thought to that?

9 For example, in here, if you are going to resurvey
10 them -- I know that you said later that we may resurvey you, but
11 you may send this instrument again if you don't get a response,
12 and you probably should have a statement about that in here.

13 COL. MALLON: Well, what kind of thing did you have
14 in mind?

15 COL. GUNZENHAUSER: Well, for example, if you
16 intend -- let's say you find a 10 percent response rate when you
17 send this out to 20,000 employees. If your intention is, well,
18 we will send it again to those that didn't respond, you should
19 say if you don't -- you might make a comment in here that you
20 will send another survey later.

21 CPT. SCHOR: Just a question. I think this follows
22 up with Colonel Diniega's and Colonel Gunzenhauser's questions,
23 and that is the use of the word we. I think that occurs maybe 3
24 or 4 times in the cover sheet.

25 Perhaps it was intended that we is the DeLorenzo

1 Clinic, but it doesn't seem to come across very clearly here. Is
2 we CHPPM? Is we -- that's bad English isn't it? And strike that
3 from the tape, please.

4 But some idea of who is actually sending it out,
5 because I think it then gets into how does it -- will it get tied
6 back into the health record for civilians or active duty.

7 And if it does get tied into the health record, I
8 am not sure that you are going to necessarily be able to do it
9 with just a last name and a date of birth.

10 COL. DINIEGA: The first name is on these.

11 CPT. SCHOR: Okay. But it is still kind of shaky
12 though.

13 COL. BRADSHAW: This is Colonel Bradshaw. I am
14 going to jump in since I have been preempted twice if you don't
15 mind. I wanted to follow up on a couple of things, but I have
16 several things actually.

17 I did want to be sensitive to what Dr. Ostroff
18 mentioned about the registry, and the CCEP registry in
19 particular, because for one thing, I think we want to make sure
20 that people don't think that I need to have to answer to this
21 questionnaire, or otherwise I am not going to get compensated for
22 what has happened to me.

23 We discussed this earlier and it was raised by Dr.
24 Zimble, I think; but that we are going to take care of our people
25 no matter what, you know. So that is going to happen, whether or

1 not you answer this questionnaire or not.

2 But there is a lot of things that we may get and
3 you may benefit from you yourself, and that needs to be stressed,
4 and I agree with that. But also that we may post-hoc be able to
5 gain knowledge from by doing this, and that all needs to be put
6 in context I think with the questionnaire.

7 So I agree with those comments, and I just wanted
8 to mention that. The other thing is that you have to consider is
9 that if you were thinking by saying registry that you were going
10 to ensure that you increased your participation, you also may
11 have ensured your selection bias if those are the only people
12 that respond are the ones that want to make sure that they get
13 the compensation.

14 I mean, these are just all sorts of issues that we
15 have learned the hard way I think from the Gulf War sort of
16 experience. The other thing is that -- just a few things about
17 the questionnaire itself.

18 We were contacted I think by CHPPM and had an
19 opportunity to look at some earlier versions of this, although I
20 noticed that there were some things missing from the earlier
21 versions that I have seen, and I am sure that reflects a
22 continuing kind of massaging of the whole thing.

23 But the question that I had was on Section B, the
24 mental health or emotional questions that you have. What is
25 underneath that? What were you actually trying to establish from

1 the mental health? Is this the mental health baseline; and if
2 so, what was or what instrument did you draw those from?

3 COL. MALLON: The first question first. It was
4 intended to be the mental health baseline. Now, since those
5 questions were prepared, the psychiatric consultant and a number
6 of other psychiatric professionals within the Army have gotten
7 together, and they are also looking at that same set of questions
8 to make sure that those are the set of questions that they want
9 to have included in here. So those questions are being relooked.

10 COL. DINIEGA: Are they being relooked by them as a
11 single person? I mean, a group of people that are going to come
12 up with one answer? Colonel Engel had stated that he was
13 involved with some of the questions, and he was not very happy
14 with the earlier versions of the questions.

15 And he thought that quantity wise that it was not
16 enough, and he had made some comments this morning about that.

17 COL. BRADSHAW: Yes. I know that you have been
18 talking with Dr. Ursano at USUHS, who is probably one of the
19 preeminent people, at least in PTSD, but it also has worked at
20 the Oklahoma City group, and many others in this area. So I
21 didn't know how much you were considering or if this reflected
22 their input.

23 COL. MALLON: At this point, it does not reflect
24 their input.

25 COL. BRADSHAW: Okay. Because I would caution that

1 you not go out with the mental health until you have incorporated
2 Dr. Engel, and Dr. Ursano. And I think we also in the Air Force
3 provided questionnaires that were used in the Kobar Towers
4 bombing.

5 And we worked with the Oklahoma City group that did
6 the bombing of the Murrah Federal Building. So there is a number
7 of validated instruments on the mental health, and it is a quite
8 extensive list.

9 You can't obviously use it all, but that's where I
10 would say that Dr. Ursano and Dr. Engel, and some others, might
11 help you comb that list down. But if you can use instruments
12 that have been validated elsewhere -- and some of them may be
13 copyrighted, but I think it would be preferable that we use those
14 for comparability and other purposes.

15 So that is just my comments on the mental health
16 section briefly. Other minor comments --

17 DR. OSTROFF: Be quick.

18 COL. BRADSHAW: Yes. The other one was simply on
19 the health status. I noticed that you only mentioned new health
20 problems, and we had wondered about the context of old health
21 problems made worse. And just one editorial. Malcolm Grow is G-
22 R-O-W and not G-R-O-V-E.

23 DR. OSTROFF: We are going to have to break it off
24 or otherwise we are not going to get into our subcommittees. Let
25 me make a proposal here. I think the Board strongly supports

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

1 what you are doing.

2 We think that it is very important and if you can
3 give us your time frame for getting this thing finalized, what we
4 could do or what I could suggest, is that if you provide us an e-
5 mail address or some way to get in contact with you, each of the
6 individual members can take this, and take a look at it, and
7 provide you back specific suggestions about what we think could
8 be potentially improved to make this maximally beneficial to the
9 people in the Pentagon.

10 COL. DINIEGA: Should there be a tie-in -- there is
11 nothing in here about previous knowledge or heightened awareness
12 already of the New York incident.

13 And psychologically I would think that if people were aware that
14 they would have reacted a little differently than the others.

15 DR. OSTROFF: I don't know. I am just -- well,
16 were there time sequences such that everyone was aware?

17 COL. DINIEGA: Yes, everyone was aware. It was on
18 t.v.

19 DR. OSTROFF: Then that might be a very good
20 question then. So what is your time frame to finalize?

21 COL. MALLON: We would ask for input by the close
22 of business on Friday. I realize --

23 DR. OSTROFF: That's pushing it, but that's fine.

24 COL. MALLON: -- that is pushing it and asking
25 people for a lot.

1 DR. OSTROFF: Well, we are again very committed to
2 helping you develop the best instrument you possibly can and
3 that's fine. I think speaking for the Board, that is fine.

4 COL. GUNZENHAUSER: Can you read that e-mail
5 address?

6 LT. COL. RIDDLE: I will get it out to you today.

7 COL. BRADSHAW: This is Colonel Bradshaw. I think
8 we can also make available if people are interested the Kobar
9 Towers investigation if you want to look at that for a
10 comparison.

11 LT. COL. RIDDLE: What we would like to do because
12 of the issues is to have the environmental and occupational
13 health subcommittee meet in here, along with the health promotion
14 and maintenance subcommittee, to discuss the four accession
15 questions.

16 And then I was going to try and get with Dr. Shope
17 and Dr. Berg, and Dr. Campbell, and we are going to meet with
18 some folks, and look at the draft recommendations that we have
19 from the last meeting on the DoD Immunization Program and the
20 Medical Risk Assessment.

21 And we will move over to next door and then we can
22 just have the break, and then we will have the refreshments
23 around 2:30, and then meet back in here at 2:45. And then if you
24 can record the session in here, and I will take notes next door.

25 COL. MALLON: The thing that I would ask is that

1 time is really of the essence. So if people had the opportunity
2 to look at the questionnaires today, the earlier on that we get
3 the feedback, then the easier it is to incorporate and make
4 changes.

5 We are doing the web-based issue, and we are doing
6 this by teleform so we can scan the results in. So I would just
7 ask that the sooner we get the comments, then the more useful
8 they are going to be.

9 LT. COL. RIDDLE: And I will mail out the contact
10 information to Colonel Mallon today.

11 DR. OSTROFF: Let me just ask before we break. Are
12 there any board members that are opposed to this going forward?

13 DR. HAYWOOD: Not in principle

14 COL. MALLON: Did I hear a consensus in terms of
15 calling it a registry or just a questionnaire?

16 DR. OSTROFF: My gut instinct is not to call it a
17 registry, but I understand why there may be reasons for and
18 against it. I think it is not the Board's decision.

19 COL. MALLON: I will pass along the recommendations
20 of the Board.

21 DR. OSTROFF: Right. I think that is a word that
22 connotes things, and I appreciate what Colonel Bradshaw said, in
23 terms of not wanting people to assume that this is the only way
24 they could get compensation and other issues.

25 And that as long as the -- and again my perspective

1 is that the narrative statement at the beginning needs to be a
2 bit more nurturing. I think that would be very helpful.

3 But if you clearly indicate to people that there
4 will be follow-up, I think that you should be able to get around
5 that particular issue of the fact that there is going to be --
6 well, I mean, I would be very open about the fact that you think
7 that their health and safety is important. That you are our most
8 value asset.

9 And that their health and safety is so important to
10 you that you think it is very important to continue following
11 along their health and well-being.

12 DR. LANDRIGAN: Would you even go so far as to call
13 it a health and safety questionnaire to make it plain that that
14 was the thrust?

15 DR. OSTROFF: Health and Safety Assessment. I
16 might use a term such as that. But I do think that the narrative
17 has to be a bit more nurturing.

18 CPT. SCHOR: Gary and I were talking and would the
19 Board suggest that the cover letter be signed by the Secretary of
20 Defense?

21 COL. DINIEGA: Wait a minute now. Who is
22 sponsoring the questionnaire? If it is the commander of
23 DeLorenzo, that clinic commander already has a tie with the --

24 CPT. SCHOR: With the Secretary of Defense.

25 COL. DINIEGA: Well, he runs the clinic for the

1 Pentagon. If you want it to be the Secretary of Defense, that is
2 a whole different ball game guys.

3 CPT. SCHOR: But the point is that the Navy and
4 Marine Corps knew nothing about this effort until today.

5 COL. DINIEGA: That's right. The question is who
6 is the sponsor of this questionnaire. Who is pushing it, and who
7 is testing it.

8 COL. MALLON: Admiral Clinton. It has going up to
9 his level, and he has endorsed it.

10 COL. DINIEGA: No, but did he ask for it?

11 COL. MALLON: That's a good question.

12 COL. DINIEGA: That's the question.

13 DR. OSTROFF: I would think that -- I mean, at
14 least from my perspective -- and again I work in a very different
15 atmosphere than you do -- that certainly if it is a product of
16 the clinic, the clinic director should be the primary signatory.

17 But I think in terms of demonstrating the
18 importance of this particular effort, having a co-signatory that
19 is at a relatively high level will demonstrate the commitment to
20 peoples' health and safety. And I would support somebody at a
21 fairly high level endorsing this effort.

22 COL. MALLON: Thank you very much. I appreciate
23 your comments and if you could e-mail me more detailed comments
24 that would be great.

25 DR. OSTROFF: Thanks. We appreciate you coming

1 down.

2 (Whereupon, the meeting was recessed at 2:22 p.m.,
3 and was resumed at 2:29 p.m.)

4 DR. OSTROFF: David, why don't you start the
5 discussion.

6 DR. ATKINS: Okay. Well, my understanding is that
7 we have four individual questions, and this is a little different
8 than what was written. The other group is looking at
9 immunizations, and so we are responsible for all four questions.

10 DR. OSTROFF: Yes, accession questions.

11 DR. ATKINS: All right. So my proposal is that we
12 go in order to just discuss whether people have specific comments
13 about any of the individual issues that didn't get aired in the
14 previous discussion.

15 And then we will come back to sort of the overall
16 question, in terms of how our response should be addressed,
17 because I think we need an overall response that that
18 incorporates specific answers on their questions.

19 DR. OSTROFF: Right. And then the other thing that
20 has to be decided -- and again time is relatively critical -- we
21 don't have much discussion time -- is that either someone takes
22 the primary responsibility for drafting these specific responses
23 to each of the questions, or you dole them out individually.

24 I would argue that since many of these issues are
25 so similar to each other that maybe we could give the assignment

1 to possibly two of the subcommittee members to draft the
2 responses, in terms of what the recommendations would be. But
3 that is an essential thing that the subcommittee has to do before
4 we break.

5 DR. ATKINS: Okay. So we were asked in order of
6 accession, the first issue was the lengthening of the interval
7 for the physical exam. Does anyone have any questions? I stand
8 corrected. Let's go in order of the questions.

9 The first one is about the use of the EKG, and we
10 heard that there are different implementations of the policy on
11 two sides, and we heard quite strong feelings from each side
12 arguing to retain the current policy.

13 And I forget the acronyms -- but on the MEPCOM
14 side, and on the DoDMERB. So does anyone want to make specific
15 comments about the effectiveness or appropriateness of EKG and on
16 issues that did not come up previously?

17 DR. HERBOLD: Just a clarification on the processes
18 so we can streamline this. Could you clarify? The first two
19 questions start with, "Is there any evidence-based literature
20 that supports this tool for screening."

21 And then the last two don't use that; is there any
22 evidence-based literature for -- and I am paraphrasing -- dental
23 screening, or for this or that. Should we approach it in one
24 way, on what is the evidence?

25 DR. OSTROFF: I would try to make it as

1 standardized as possible.

2 DR. HERBOLD: And then that takes us out of the
3 realm determining sub-OSD policy. I think if we answer, if we
4 can -- and this is just a suggestion open for discussion.

5 But if we can say is there good evidence that says
6 that EKGs are good screening tools to baseline your medical
7 record for accession, and then can we do it for all four, and
8 that's my suggestion and it makes it parallel.

9 DR. OSTROFF: And Dr. Haywood?

10 DR. HAYWOOD: That wasn't quite the question. The
11 question was as a screening tool, and there is no medical record
12 until the screening is finished as I understand it. Is that
13 right?

14 DR. HERBOLD: Well, two comments. We probably both
15 should go back to what Dr. Clinton's exact phrasing is, but the
16 records generated at MEPS, or at DoDMERB, do become a part of
17 your health record if you are accessed.

18 So, your panograph, your Standard Form 88, and all
19 those things, become part of your record, and I still have mine.

20 DR. OSTROFF: And I can say that the statement here
21 is very concise, asking us to evaluate if any evidence-based
22 literature supports utilization of the ECG as a predictor of
23 cardiovascular problems among asymptomatic individuals between
24 the ages of 17 and 35, with a negative cardiac history.

25 I think that is a pretty clear and concise

1 question, and I don't know if you want to address that
2 specifically.

3 DR. HAYWOOD: I think the answer is no if you put
4 it in those terms.

5 DR. OSTROFF: That's the way the question is
6 phrased.

7 DR. HAYWOOD: Well, if you have already assumed
8 that the population is healthy --

9 DR. SHANAHAN: Well, I find this a little
10 bothersome.

11 DR. OSTROFF: That is the question before us.

12 DR. SHANAHAN: There is no question about that.
13 Tim, I think you answered that question one way, and if you
14 looked at it in a strict isolated sense in which it is presented
15 in this particular written question.

16 However, today, we have seen that there are many
17 other sides to that story, and I can at least see the way that I
18 am perceiving this question is that it leads us into an area that
19 I wouldn't exactly call it a set-up.

20 But if you answer under these strict terms, it will
21 then be expanded to cover other areas which are issued between
22 DoDMERB and MEPS, and other people that are involved in this
23 issue. It is a much broader issue clearly than what is specified
24 here.

25 DR. OSTROFF: Well, Dr. Haywood could comment, and

1 again this is not my area of expertise. So I am in a little bit
2 of a disadvantage.

3 But I don't know of any national organization that
4 would recommend using an electrocardiogram as a screening tool in
5 asymptomatic individuals. And we could make some sort of a
6 caveat recognizing the fact that there may be some special
7 circumstances which might warrant the use of the
8 electrocardiogram.

9 But I don't think there is any evidence-based
10 knowledge, and certainly I think we could say that based on
11 AMSARA data that there certainly is very little information to
12 suggest that it is particularly cost beneficial.

13 DR. SHANAHAN: That's why I think that when you
14 answer the question as written, you get one answer, but there are
15 other issues to consider. For instance, the Air Force is
16 concerned that some 60 to 70 percent of the accessions have to
17 meet flight status, and flight status requires passing an ECG.

18 There are other issues related to that in terms of
19 the quality of physical diagnosis that goes on during a physical
20 exam, and whether it really is adequate to cover what an ECG
21 might do, which is a very objective assessment.

22 I know in my case that no one ever accessed my
23 pulse in any of my physician examinations to the point where it
24 would have done the same thing as an ECG.

25 Now, we have seen that they are very low numbers,

1 but if you eliminate the ECG altogether, what you have done
2 basically is created a problem in aviation, and probably in the
3 submarine service, and probably in some other areas.

4 Now, those areas I think we should be knowledgeable
5 of, but I am a little confused as to whether we should put such
6 considerations into our deliberations.

7 If we look at this directly, it answers the
8 question one way, and if we look at peripheral issues, we may
9 answer it another.

10 DR. OSTROFF: I think that there are probably set
11 policies regarding what type of screening needs to be done, for
12 instance, for people who are going to be pilots, and people who
13 are going to be riding on submarines, and doing things like that,
14 which are totally separate from getting an EKG at accession.

15 DR. SHANAHAN: So, under special duty status, and
16 you could be -- well, a very simple way to clarify this is if you
17 are hospitalized, you can be returned to full duty is what the
18 discharge line says.

19 However, you are not returned to special duty. You
20 have to go to see a diving medical officer, or a flight surgeon
21 to get put returned to special duty, and flight surgeons and
22 diving medical officers use a different set of standards for
23 return to special duty. So that is very clear and within service
24 bounds. Those are service specific issues.

25 DR. ATKINS: I think the problem that people are

1 grappling with is -- and what we run into all the time on
2 guidelines, is that there are issues of evidence, and there is
3 evidence of other considerations, which sometimes go beyond the
4 evidence.

5 So my proposal is for each of these four issues, we
6 have a response that summarizes what we know about the evidence,
7 and then we have a place to comment on whether we think there are
8 other considerations which would be important in the absence of
9 evidence, or even to override what existing evidence we have.

10 And I am not sure whether we can resolve all those
11 disparate opinions on those other considerations. But I guess
12 maybe what we can do is go through it and see how much of an
13 agreement there is on sort of the evidence as it stands.

14 And then air the places where people think we can
15 agree that the evidence isn't compelling, but we think there are
16 other issues that somehow need to be addressed in our response.
17 Is that --

18 DR. OSTROFF: That seems perfectly reasonable to
19 me.

20 DR. HERBOLD: Can I suggest a two-sentence approach
21 to this? For example, it looks like on question one is that we
22 would suggest that no body of literature that supports
23 utilization of the ECG as a predictor of cardiovascular problems
24 among asymptomatic individuals between the ages of 17 to 35 with
25 a negative cardiac history.

1 And then the second sentence would be that this
2 assumption, that this means -- that the foregoing statement
3 assumes that there is an adequate cardiac history obtained, and
4 then also that it is the Board's understanding that there really
5 is not just one accession standard.

6 It's not like that everybody is taking it at age 16
7 and lined up, and then you attrite into one area or another of a
8 national military service. You see, there are different
9 accession standards.

10 The assumption in Dr. Clinton's opening sentence is
11 that there is only one accession standard.

12 COL. POSTLEWAITE: Could I address that? There is
13 only one standard, but because the Services have the capability
14 of waiving, that gives them the opportunity -- well, the whole
15 idea of a standard is are you qualified or disqualified. If you
16 are disqualified, then that requires further evaluation.

17 DR. HERBOLD: But just to follow this for a second.
18 You cannot waive something that has not been accomplished. So
19 you cannot waive an EKG, an aberrant EKG, that you think is just
20 a technical application issue if the EKG has not been applied.

21 So how can you waive something where the standard
22 says that either DoDMERB or the standard says this should be
23 done, and so DoDMERB and MEPS independently make the decision to
24 waive it off priority?

25 COL. POWERS: What they do is they gather further

1 information, and they gather all the medical evidence from the
2 candidate's medical records. They evaluate that and then they
3 make an opinion as to whether or not to waive that standard.

4 So it is not done at the point in time at the
5 evaluation station.

6 COL. LEE: I would like to clarify a little bit. I
7 think you are talking several different things, and I am not sure
8 that you understand it. You are each talking several different
9 things.

10 DR. HERBOLD: I think I do. I think I can -- I ran
11 this and I put the HIV surveillance policy into place for the
12 Department of Defense at the pre-accession level in 1986.

13 I understand DoDMERB, and I understand MEPS, and I
14 understand the complexity of the situation.

15 COL. LEE: Okay. Because a flying physical is not
16 an accession physical.

17 DR. HERBOLD: I understand that.

18 DR. ATKINS: I'm sorry that I am doing a very poor
19 job sharing this.

20 LT. COL. FENSOM: Well, if it is any help, this is
21 a debate that has gone on in the Canadian side a few years ago,
22 and we did take away the ECG as a universal screening tool for
23 all the reasons that you are talking about, and maintaining the
24 requirement for special circumstances for air crew potential
25 candidates.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

1 And in terms of preserving the base line aspect of
2 things, we obtain that at age 35 as per the Canadian Medical
3 Association guidelines for periodic health.

4 But we have recruits at 35 and over, and of course
5 they get an ECG if they are going through the recruiting process.

6 DR. OSTROFF: It sounds reasonable to me.

7 DR. ATKINS: Julian.

8 DR. HAYWOOD: The question presented here though is
9 fairly straightforward; evidence as a predictor, and I think
10 evidence as a predictor is that it is not cost effective.

11 DR. ATKINS: Does anyone from -- well, DoDMERB said
12 they strongly support retaining it? Does anyone want to speak on
13 behalf of what the issues would be if we basically put out a
14 statement saying we don't think it is indicated?

15 COL. WEIEN: Sure. The DoDMERB position is that
16 two of our major customers, the Air Force Academy and the Naval
17 Academy, favor this because of the flight physical aspect later
18 on.

19 The danger would be that we would admit some people
20 into those two institutions, and they would get three years of
21 expensive education under their belt, and then not be eligible to
22 go into an aviation career, which is for the Air Force Academy in
23 particular something they want a high percentage of their
24 graduates to be qualified to do.

25 And which is why they tell me that they favor the

1 use of the screening ECG.

2 DR. OSTROFF: Well, let me just say that with the
3 amount of medical screening that you do on the people that come
4 to these academies, the number of instances that you will have
5 where you will be faced with that situation after 3 years of
6 training, and you are suddenly going to discover that somebody
7 has an abnormal electrocardiogram given these particular
8 parameters, is so banishing low that I can't believe that is a
9 particularly serious -- I mean, just from the epidemiologic point
10 of view, it is so remote that that is going to happen in
11 justifying its continuation, and the cost of that continuation,
12 just isn't fair.

13 DR. ATKINS: Does anyone feel -- Phil, before he
14 left, raised the question about we had those 126 records, and we
15 weren't sure whether it was 3 or 126 --

16 COL. WEIEN: Miscellaneous.

17 DR. ATKINS: -- who might slip through the cracks
18 and end up --

19 DR. ATKINS: Or 126.

20 COL. KRAUSS: I tried to give you a high estimate,
21 and I used all remedials that had an abnormal ECG code. But the
22 fact is that only three of them ended up as permanent
23 disqualification, and they were all listed under miscellaneous.

24 So the reality is that if you put on all the
25 disqualifications related to cardiac, but even that

1 miscellaneous, it was less than .01 percent.

2 COL. WEIEN: I think perhaps -- and, Tim, please
3 correct me if I misstate this, but the question was is there any
4 evidence, epidemiologic evidence, for the use of this as a
5 screening tool.

6 And I think the intent is to take the answer back
7 and then overlay that with the policy and other considerations to
8 come to a final decision.

9 COL. CORCORAN: That is correct.

10 COL. WEIEN: I don't think this Board is being
11 asked to make the final decision about screening EKGs; is that
12 correct?

13 COL. CORCORAN: That is correct.

14 COL. WEIEN: So the Air Force Academy can weigh in
15 and say for our people we still want it if they choose to do so.

16 COL. CORCORAN: That is correct. There have been
17 historical questions on that. In fact, the sickle cell trait
18 screening that this Board considered, there was a policy that was
19 put out by, I think, Dr. Martin in like '96 or '95 perhaps, and
20 that basically said that given the results from the AFEB Board
21 and so forth, and so on, there is no requirement to do sickle
22 cell screening at the accession level.

23 Well, one service basically at that point said
24 thank you very much for that opinion, but we are going to go
25 ahead and still screen for sickle cell. Fine. But that was

1 decision made by that service given their circumstances.

2 But at our level, at the DoD level, the accession
3 policy level, the thing was essentially stopped.

4 DR. ATKINS: Would they be able to -- I mean, if
5 the Air Force says we still need to do it, given the politics of
6 it, are they then going to have to apply it back to your side, or
7 can they just selectively apply it?

8 COL. LEE: No, it can just be applied to the Air
9 Force Academy alone, in and of itself.

10 CPT. SCHOR: Just a question. Especially with
11 EKGs, if the -- and I think Colonel Powers raised a question
12 about the standards, and does a test allow you to support the
13 standards for that given an individual. That is not quite the
14 right way to say that perhaps.

15 But the standard talks about conduction
16 abnormalities and rhythm abnormalities that are in the DoDI. If
17 the DoDI includes those as disqualifying conditions, how can you
18 possibly make a diagnosis of those without --

19 COL. POWERS: That's the whole thing. Would any of
20 these individuals come to your attention through any other means
21 other than the ECG?

22 DR. OSTROFF: Well, my guess is that if somebody
23 did a systematic review of those 126 records, where individuals
24 got disqualified, you would realize that very few of them --

25 COL. POWERS: Absolutely.

1 DR. OSTROFF: -- were disqualified solely based on
2 an electrocardiogram. That there is some medical history there
3 that knows that these individuals have had cardiac arrhythmias or
4 tacharrhythmias, or Wolff-Parkinson-White, or whatever it happens
5 to be.

6 COL. POWER: Right.

7 COL. WEIEN: If it would be useful to the Board,
8 DoDMERB will review those 126 cases for you.

9 DR. OSTROFF: Excuse me?

10 COL. WEIEN: If it would be useful to the Board, we
11 can review those cases, and if Margo can identify them by social
12 security number.

13 DR. ATKINS: The point is that no screening process
14 is going to be a hundred percent. Otherwise, we would be doing
15 CAT scans on everybody. And it is really sort of a debate as to
16 whether is it a prevalent enough condition to be worth screening,
17 and the logistical implications of screening everybody.

18 DR. OSTROFF: The answer is no.

19 DR. SHANAHAN: That's why I was talking about if
20 you answer the question directly, because I think Ken has got an
21 extremely valid point. You argue that you can pick this up on
22 history and physical examination.

23 But I think that history is often hidden in
24 physical examinations for the military. All of us who have done
25 physicals for aviation and other special activities know that as

1 well as just general experience.

2 The other issue is the adequacy of the physical
3 exam to pick up these things. So you have got different things
4 going on, but the fact of the matter is that the best way to
5 screen for the particular issues that are brought up within the
6 DoDI is with an ECG. But that is not the question that is being
7 asked.

8 DR. OSTROFF: Exactly.

9 DR. SHANAHAN: And that's where I am having
10 problems.

11 DR. ATKINS: I think the issue is the conditions
12 that are listed in the DODI, or the interpretation of what
13 conditions would not make one able to complete one's duties.

14 So people put in specific conduction disorders.
15 The data that we have from your side suggests that not a lot of
16 people are getting through. The process is clearly imperfect,
17 but because it is an uncommon condition, without screening not a
18 lot of people get through --

19 DR. LEE: Who are being attrited.

20 DR. ATKINS: Right. If the measure is completing
21 training and not having to be attrited, the current process is
22 working pretty well. Sure. There is some people who are
23 slipping by with conditions that they would have gotten excluded
24 from.

25 But the fact is that they actually were still able

1 to complete training.

2 DR. SHANAHAN: Well, that is a third issue the way
3 I see it. If the question was put to us what is the best way to
4 ensure that all applicants meet the requirements in DoDI, the
5 answer would probably be getting an ECG, all right?

6 If the question is as it is presented, is there any
7 evidence to show or to support the utilization, the answer is no.

8 DR. OSTROFF: But the best way to do it might be to
9 do a electrophysiologic studies. Are you going to recommend that
10 if you want to go to the endth degree to make sure that nobody
11 has a cardiac arrhythmia that you don't have to take the EKG at
12 the time that they have a tachyrrhythmia?

13 I mean, there are ways to definitively diagnose
14 these conditions that nobody in their right mind is going to
15 recommend be a normal screening procedure.

16 DR. HAYWOOD: But you are not going to do an EPS
17 without an EKG.

18 DR. OSTROFF: Well, I understand that, but I mean
19 an EKG is not going to guarantee that you are going to diagnose a
20 condition.

21 DR. SHANAHAN: Well, I wasn't saying that. I am
22 trying to point out that there are a bunch of different issues
23 here besides the question as posed to us.

24 And in fact when we go to other questions, and if
25 we go back to what Colonel Powers has said, you know, does it

1 meet the intent of the DoDI, you brought that up several times.

2 Well, that's not what question one is asking. It
3 is not asking whether it meets the intent of the DoDI.

4 DR. ATKINS: Since I'm probably going to be tasked
5 with taking a first draft at this, here is what I would probably
6 say. I would say that current evidence doesn't support the use
7 of an EKG as a useful screening test in this population, in an
8 asymptomatic population of these grounds.

9 That some cases who would otherwise be excluded
10 under current DoDI may be or might be detected, but that the
11 yield of that does not appear sufficient to justify it as a
12 routine policy.

13 That this does not abrogate the need to do a
14 careful screening for symptoms for evidence of symptomatic
15 cardiac disease, and that there may be other conditions, other
16 issues, including specific service needs that would justify
17 screening on a more selective basis. Does that capture the
18 general --

19 COL. GARDNER: There is one more piece in there. I
20 think the point here is that MEPS and DoDMERB are simply not
21 medical care. They do screening to rule out people who are
22 ineligible for military service.

23 And when they have abnormal findings, either they
24 qualify or they don't qualify, but there is no medical care
25 involved in terms of following them up to make sure that things

1 got taken care of.

2 And that is a totally different concept than what
3 the preventive health task force has been dealing with. There
4 you are talking about a medical care setting, and when you find
5 something, you follow up on it, and you lower the risk.

6 And I think that is the problem here, is that if
7 you simply look at do the meet standards or not, then obviously
8 that's a cost effectiveness issue as to how hard you look.

9 But when you look at the medical care issue, and
10 are these people going to get the medical care that they need if
11 they do have problems, and the EKG is a good example, I think
12 that everybody needs a baseline EKG in their chart at some point,
13 because it helps you so much later on when things happen and fail
14 to go back to that.

15 But the dental situation relates in the same way.
16 There are recruits who are arriving at training in what they call
17 Dental Cat 4, which means that you are not deployable or not
18 available to move forward until you get examined by a dentist,
19 and problems either taken care of or defined as not needing to be
20 taken care of.

21 And we don't have that same for medical, and they
22 may have problems that may need to be looked at and developed,
23 and evaluated, and taken care of, and counseling given, and so
24 on. That does not happen at MEPS.

25 And so you have to take that into consideration,

1 and so the medical care issue is the part that is missing from
2 these questions.

3 DR. ATKINS: So what I am hearing you saying is
4 that just using attrition rates may not be a sufficient standard
5 if there is a lot of undetected disease that we should be
6 treating differently.

7 I would argue that I don't think the data would
8 support that, but I would agree that attrition data may not be
9 enough. I mean, I don't -- I am not sure that you would find a
10 lot of treatable cardiac disease with an EKG.

11 COL. GARDNER: I guess my point is that everybody
12 needs a health maintenance exam at the onset of military service,
13 just like they do a dental exam. We don't have a medical Cat 4
14 that says that you are not eligible to move forward until we have
15 reviewed your history and physical and determined -- and given
16 you the counseling and immunizations, and everything else that we
17 think you need before you can move forward.

18 That MEPS exam in the Army is your first physical
19 exam. Your next one is not for five years, and there is no
20 enforcement process to ensure that even the five year one
21 happens. And that is a question that might need to be addressed
22 separately.

23 But I think it should be addressed by the AFEB as a
24 way to get an enforced health maintenance program into the
25 medical side the way they do the dental side.

1 DR. ATKINS: But that is not the responsibility of
2 the accession process.

3 COL. GARDNER: Absolutely not. Absolutely not.

4 DR. ATKINS: All right.

5 DR. OSTROFF: Keep going.

6 DR. ATKINS: I am going to propose that we skip
7 over to the dental one, because I think that is the one where
8 there is again more -- I heard more disagreement about.

9 And I think we heard competing data. So I just
10 want to invite it for any comments. We heard data from the
11 MEPCOM side that their current screening process, which does not
12 involve dentists or panographs, has not led to major problems in
13 terms of attrition due to dental disease.

14 And so I would say that we don't have good evidence
15 in front of us to support that and them changing their policy.
16 The question is are we asking DoDMERB to change their policy and
17 give up something that has been now standard, in terms of dental
18 exams by dentists, including panographs. Any comments in terms
19 of general direction of that?

20 DR. SHANAHAN: Well, I think once again we are
21 faced with some of the same issues. If you read the question, it
22 is asking whether if the need for service academy and ROTC
23 applicants to be examined by dental professionals using
24 panographic.

25 Now, that is a somewhat more open question than

1 question one was, but the way I kind of boiled down the
2 discussion was that I saw it coming from two ways. One was the
3 services are saying that what they are getting now is adequate in
4 many ways.

5 But the other issue was are we meeting the DoDI,
6 and we heard a dentist tell us that you can't meet the DoDI
7 without having a dentist do an examination. I am not sure how
8 specific he was about whether he needed panoramic studies. So
9 again there are two issues here.

10 DR. ATKINS: Again, I think if you asked a
11 cardiologist could you meet a DoDI, or if you asked a
12 neurologist, I think you would get a different response.

13 DR. SHANAHAN: Well, the critical piece of evidence
14 that I would really like to see is what is the percentage of Cat-
15 3s and 4s who are being accessed into our training centers,
16 because to my knowledge no one has ever really -- that is a good
17 way of looking at the cost and the burden of getting people at
18 the Class Two, which is what you need to deploy them.

19 COL. DUNN: But if the circumstance is that they
20 are willing to accept that cost, should that be a major
21 consideration then?

22 DR. SHANAHAN: Then again it gets back to are we
23 answering the question in terms of meeting the DoDI or meeting
24 the needs of the service.

25 COL. DUNN: Right now for non-scholarship

1 applicants, they do not see a dentist, and while officers will be
2 accessed as officers as well. It is the scholarship applicants
3 that have to see a dentist.

4 And from Cadet Command's perspective that just does
5 not make a whole lot of sense. Do it for everybody, or don't do
6 it for anybody.

7 DR. OSTROFF: Well, let me just make a comment. I
8 mean, I think with this particular issue, this one I think you
9 are indeed correct is the most difficult I think to negotiate our
10 way through, especially since most of us are not particularly
11 expert in this area.

12 You know, the bottom line for me is whether it
13 meets the DoDI or not, and I understand the importance of that.
14 But ultimately what we are trying to do is to maximize accession,
15 while at the same time assuring that we have healthy soldiers,
16 healthy airmen, healthy sailors, and healthy marines.

17 And if indeed there is a commitment that the dental
18 work can and will be done -- I mean, my concern is not that some
19 are getting panography, but that others aren't quite frankly.
20 That is my bigger concern.

21 I think that the current policy is not justifiable
22 epidemiologically to do it on scholarship recipient ROTCs, and
23 not to do it on non-scholarship recipient ROTCs. I mean, what is
24 the logic behind that. It doesn't make any sense to me.

25 There is almost the same amount of investment, with

1 the exception of the scholarship, in those two groups. And the
2 current policy doesn't make any sense to me.

3 I understand that there might be very good
4 rationales behind it, but if the intent is to ensure that these
5 people have healthy mouths, I think that this is the one area
6 where I would like to see more rather than less personally.

7 LT. COL. RIDDLE: And if you have not had time to
8 look at the evidence in the abstracts, in the articles, for the
9 people who have identified to work these issues, we have them,
10 and we have them available.

11 And there is pretty good evidence on these issues,
12 and I think that is what you need to look at, at what is the
13 published literature, and how does this support. And I think you
14 will get an idea of is this a necessary screening tool for these
15 conditions. There is some pretty good literature out there.

16 And I did get a chance to review that literature,
17 and I share Steve's concerns about it as well. But I think there
18 are two ways of answering this particular question, and we have
19 to decide on which way we are going to answer it.

20 DR. SHANAHAN: And I would suggest that it looks
21 now like there are three ways. We can answer each question
22 directly.

23 DR. HERBOLD: Rick, I --

24 DR. OSTROFF: You must be psychiatrists.

25 DR. HERBOLD: We can answer the question in the

1 context of what the current accession standard statement is in
2 the DoDI, or we can answer the question in the context of do you
3 really think that this should be your accession standard, which I
4 have heard several folks say.

5 And I think we could answer it three ways, and that
6 might -- I don't think that triples the work. I think it will
7 send a message. It will answer Dr. Clinton's question, and it
8 will also send a message that we recognize that there is a depth
9 to this, and that there are different levels.

10 And so we could find three different ways to answer
11 your questions, which must mean that we all are psychiatrists.
12 But at least we have answered them, and we have answered it in
13 the context of the concerns that we have heard around the table
14 today.

15 And I would be happy, Dave, to help you work through that.

16 DR. OSTROFF: Okay. Let's work on the fourth one
17 very quickly.

18 DR. EDWARDS: May I make a quick comment? May I
19 have a chance to make a comment? I am Dr. Edwards, and I am one
20 of the dentists in TRICARE management activity.

21 Let me just say that I like your approach. I think
22 Dr. Clinton -- and I hate to speak for Dr. Clinton. I really
23 shouldn't be trying to do that. But I think he would very much
24 appreciate your comments and your exploration of the issue in
25 depth.

1 And maybe not just addressing the question that he
2 initially posed to you, because as you can see, this is a very
3 difficult issue. On the surface, it looks very simple, but it's
4 not really.

5 I would also suggest that you not concentrate so
6 much on the panograph issue. I think there has been a lot of
7 discussion about panographs, and we are talking about abstract
8 articles about panographs, and how ineffective they are as a
9 screening tool.

10 And I would suggest that we not concentrate so much
11 on panographs, but concentrate on the dental professional exam.
12 And does it in fact require a dentist to make a judgment on some
13 of the standards within the DoDI.

14 Now, I think we would agree -- Captain McKinley and
15 I both would agree that we should look at revising the standards.

16 I mean, I have learned a lot from this discussion today and that
17 maybe we don't have the standards in place that we need to have.

18 And I think we should look at the revision of those
19 standards, and we have already been doing that with the AMSWG. I
20 would also suggest to you that if you give us a tasker to go out
21 and collect more data for you, where you can make a business case
22 decision here, with additional data that USUHS suggested maybe
23 getting some data from the recruit training centers, we would be
24 happy to do that for you.

25 I would also suggest that if the DoDMERB standards

1 are eliminated, and the dental requirement for DoDMERB is
2 eliminated, that the dental services will need additional
3 resources to manage and treat those patients in the Service
4 Academies of all the dental disease that we are going to find
5 within the academies that we are not finding now.

6 Also, for ROTC students, somehow we will have to
7 get those folks out into the civilian world and get their dental
8 care done at civilian prices. So we will need additional
9 resources.

10 So if you do decide to eliminate the dental
11 professional exam and the radiograph as a screening tool for
12 DoDMERB and ROTC scholarship applicants, please also suggest that
13 Dr. Clinton give us more money. Thank you.

14 DR. ATKINS: So as a process issue, who else would
15 like to help craft this position on dental stuff? Okay.

16 DR. OSTROFF: Physical exams.

17 DR. ATKINS: Physician exams. What I heard was a
18 neutral position from DoDMERB about extending the interval. Our
19 task force does not have a position statement on the frequency of
20 periodic health exams, though I would say that in this age group
21 nothing we say would argue against extending it, people with a
22 normal baseline exam, and extending that to a longer interval
23 than two years.

24 We heard comments that from a logistical standpoint
25 that might raise issues on the MEPCOM side. So any comments on

1 that? Does anyone want to weigh in on whether extending it to
2 five years would be a problem?

3 Let me break it down. >From an evidence
4 standpoint, does anyone here have evidence that says that we
5 should retain a two year standard for physical exams?

6 DR. OSTROFF: No.

7 DR. SHANAHAN: Let me get one point of
8 clarification though. I guess Colonel Lee -- if it is four years
9 or something like that for deferred status, you are going to have
10 some kind of medical assessment before you process. Am I
11 correct?

12 COL. LEE: Yes, we will. We will do an interval
13 history. From a medical point of view, our concern is -- well,
14 you already heard Dr. Krauss talk about a fair number will lie to
15 us. That will continue.

16 And if we make the assumption that a full physical
17 is better than an interval history, if that assumption is valid,
18 that's our primary concern, because we have applicants at a high
19 risk behavior, a high risk activity that we don't see for a
20 while.

21 DR. OSTROFF: Let me just add the caveat that -- I
22 mean, I think things are a little bit backwards here as I do with
23 many things that happen, which is that I think that the people
24 who get the better screening should have a longer interval than
25 people who don't get as good a screening.

1 And it is obvious that the DoDMERB gets much better
2 -- I always get it all wrong. That your people get better
3 screening than your people.

4 COL. LEE: Let's say they get different screening.

5 DR. OSTROFF: Different screening, but not as
6 intensive screening as your people get. And so I think that
7 there may be some rationale behind accepting the initial
8 screening examinations that are done for the candidates to the
9 service academies, et cetera, than for those that come in under
10 the MEPS system.

11 DR. ATKINS: Yes. My understanding of where this
12 came from was actually from that side, who cared more about the
13 interval, than on the enlisted side.

14 DR. OSTROFF: And I could perfectly well see the
15 justification for retaining the current MEPS requirements, while
16 extending the requirements on the other side.

17 DR. ATKINS: Well, I guess my proposal would be
18 that we have a statement that says based on the current evidence
19 we think it would be acceptable to extend the interval for
20 officer accession exams beyond two years.

21 That due to a higher risk and logistical issues on
22 the MEPCOM side there may be arguments for retaining a two year
23 standard and leaving it like that, and that there is not
24 definitive evidence either way. Does anyone want to take issue
25 with that?

1 DR. SHANAHAN: Not entirely, except that I think
2 that Colonel Dunn made an extremely good point about the problem
3 with ROTC, and ROTC is getting acquisitions as I understand it
4 through both DoDMERB and MEPS.

5 So by doing that I don't think we are necessarily
6 addressing his issue, or we may be solving one side of the prong,
7 but not the other side of the prong.

8 COL. LEE: Actually, I think you are solving the
9 waive issue from his issue for both of them if you say officer
10 accessions, because both of us do officers.

11 DR. SHANAHAN: Right.

12 COL. LEE: Now, the other issue, Jim, you can
13 address if they are meeting your intent.

14 COL. DUNN: Their extending the validity period for
15 officer accessions would be my intent, because I am assuming that
16 would apply to scholarship and non-scholarship.

17 DR. SHANAHAN: Okay. Because I think we do have to
18 recognize that we are dealing with two distinct populations.
19 There are very great differences demographically between those
20 two populations.

21 DR. ATKINS: And I was hearing logistical concerns
22 from your side, in terms of what it would mean --

23 COL. LEE: Absolutely, because kids go from MEPS to
24 MEPS and I am talking about 500,000 to 800,000 records that I
25 would have to keep on. Yeah, there is a lot of logistical

1 problems for me. Plus, we do HIV/DAT, which we would have to do
2 more, because our waiver is only for two years.

3 And if we extend that to five, DoD will probably
4 not give us that waiver. So we would have to do a repeat.

5 LT. COL. RIDDLE: But direct commissions come from
6 MEPS. So if you were to word it strictly officer, you have
7 direct commissions that come through MEPS.

8 COL. LEE: Right, but we do officer and enlisted
9 physicals. So yours would still be good for five years.

10 LT. COL. RIDDLE: But you would not have my record
11 for five years. I would be an officer coming through MEPS --

12 COL. LEE: But you would move on and you would be
13 in the service, and your record would be in your medical record.

14 COL. BRADSHAW: I don't see where there is a
15 problem with saying that they could be valid for five years, and
16 then by policy MEPS wants to do it more often, then that's MEPS
17 policy, because most of their concerns are logistical and not
18 really evidence-based that I hear.

19 DR. HERBOLD: Yes. So the question is you could
20 have stricter standards, depending upon which hoop you want
21 people to jump through. Here it is the relaxation of standards.

22 So if we relax it to 5 years, and you still need it
23 for 2 years, you can do that. The barrier right now is that the
24 DoD says 2 years, and so we need to relax it to 5 years if the
25 evidence supports that.

1 COL. LEE: We, MEPCOM, couldn't change the policy,
2 and perhaps accession policy, and I will tell you it is going to
3 be a food fight because the recruiters will say, hey, look, the
4 AFEB says it is good for 5 years, and so we don't want to bring
5 them back for another time.

6 It will be problematic if that is the way it is
7 put, although accession policy, which is OSD level stuff, could
8 say we are going to make a policy that we do it for two, but then
9 they are put in kind of a trick, too, then because officers and
10 enlisted --

11 COL. DUNN: You require a medical history right now
12 which is not directed by DoD.

13 COL. LEE: Actually, it is.

14 DR. OSTROFF: I think it is.

15 LT. COL. EDMONDSON: But as far as this specific
16 issue -- and you bring up a good point, but if it gets to that,
17 and when it gets to that, that will follow to me, and we will
18 resolve it at that time.

19 But for the sake of this meeting and the task that
20 you all have, I like the discussion and where you are going with
21 it, and I think it is appropriate for the issue that was brought
22 up earlier. The way you worded it, and you will have to work on
23 it.

24 DR. ATKINS: And does our response have to say
25 something that if the physical is being considered valid for a

1 longer period that there has to be an interval screening question
2 about health status, or is that something that is just an
3 implementation piece that would be assumed?

4 Because the assumption was that if you had not had
5 a physical, there would still be some process of saying --

6 DR. OSTROFF: Yes, I would think it is pretty
7 critical to ask them if they had been in a motorcycle accident or
8 something like that.

9 CPT. SCHOR: I would recommend including a comment
10 as to how frequently you should reassess their interval history.

11 I don't think there is any other DoDI that would cover that
12 period of time.

13 So unless it is stated explicitly, it is not going
14 to get done. So a recommendation that shapes that would be
15 helpful.

16 COL. CORCORAN: In Title 10 law, U.S. Code, Title
17 10, and in Section 10.206, they talk about ready reserve, because
18 I asked the question is there a law there that actually dictates
19 the length of time for physical exams or for medical histories,
20 and actually there is, at least for the ready reserves.

21 And it says here to be examined as to his physical
22 fitness every five years, or more often, as the Secretary
23 considers necessary. So it gives the latitude of every five
24 years.

25 And then it says number two, and this is again the

1 law, to execute and submit annually to the Secretary concerning a
2 certificate of physical condition. So I don't know if physicians
3 wrote this, but to me that sounds like an interval history.

4 CPT. SCHOR: I happen to have seen some of this on
5 the JPMPG and some of the tools that are used
6 by the reserves for assessing interval history, and they look
7 really good. So that may be particularly helpful to suggest some
8 of those tools.

9 COL. DUNN: But in terms of what we are doing with
10 the Airborne School, which allows the DoDMERB physical to be
11 valid for 5 years to jump out of planes, is that within 4 months
12 of attending airborne school the student submits a statement
13 saying there has been no significant change in his health status
14 since the original physical.

15 And if there has been a significant change, then he
16 is required to get another physical. So that statement is on a
17 DA Form and is sufficient --

18 DR. OSTROFF: I have to exert the Chair's
19 prerogative and we are over time unfortunately. I think we have
20 sufficient information for you to craft responses to the specific
21 questions raised by Admiral Clinton, and let's go ahead and end
22 the subcommittee meeting.

23 We need to go into the Executive Session for I
24 think the last 15 minutes that we have, and if memory serves me
25 correctly, the executive session is only for board members and

1 for Dr. Riddle.

2 So we thank the rest of you for your participation.

3 (Whereupon, at 3:19 p.m. the meeting was

4 concluded.)

5

6