UNITED STATES DEPARTMENT OF DEFENSE

DEFENSE HEALTH BOARD

CORE BOARD MEETING

Fairfax, Virginia

Friday, November 13, 2009

ANDERSON COURT REPORTING

706 Duke Street, Suite 100

Alexandria, VA 22314

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

PARTICIPANTS:

REV ROBERT G. CERTAIN

JOHN DAVID CLEMENTS, Ph.D.

WILLIAM E. HALPERIN, M.D.

EDWARD L. KAPLAN, M.D.

WAYNE M. LEDNAR, M.D.

RUSSELL V. LUEPKER, M.D.

THOMAS J. MASON, Ph.D.

DENNIS O'LEARY, M.D.

MICHAEL N. OXMAN, M.D.

MICHAEL D. PARKINSON, M.D.

GREGORY A. POLAND, M.D.

ADIL E. SHAMOO, Ph.D.

JOSEPH SILVA JR., M.D.

DAVID H. WALKER, M.D.

ALLEN W. MIDDLETON

COMMANDER EDMOND FEEKS

VICE ADMIRAL JOHN MATECZUN

KENNETH W. KIZER, M.D.

FRANK BUTLER, M.D.

COLONEL JOANNE MCPHERSON

ANDERSON COURT REPORTING

706 Duke Street, Suite 100

Alexandria, VA 22314

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

PARTICIPANTS (CONT'D):

COMMANDER JIM HANCOCK

CHARLES SCOVILLE

* * * * *

ANDERSON COURT REPORTING

706 Duke Street, Suite 100

Alexandria, VA 22314

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

P R O C E E D I N G S

(7:45 a.m.)

DR. LEDNAR: Good morning, everybody. I'm Wayne Lednar, one of the two Vice Presidents of the Defense Health Board. Welcome to day two of our Defense Health Board meeting. What I'd ask is for Mr. Middleton as our Designated Federal Official with us today, Mr. Middleton, if you would please open the meeting.

MR. MIDDLETON: Good morning. As the Alternate Designated Federal Official for the Defense Health Board, a federal advisory committee and a continuing independent scientific advisory body to the Secretary of Defense via the Assistant Secretary of Defense for Health Affairs and the Surgeons General of the military departments, I hereby call this meeting of the Defense Health Board to order.

DR. LEDNAR: In keeping with the practice of the Defense Health Board as we meet, we'd like to take a moment to stand in silence to remember and recognize those whom we serve.

(Moment of silence.)

DR. LEDNAR: Thank you. Please take your seats. This is an open session meeting of the Defense Health Board. What I'd like to do is to have all of us here in the room introduce ourselves. If you would please state your name, your affiliation and if you are a member of the Defense Health Board, if you would also include the kind of position that you serve with the Defense Health Board. If I might ask Mr. Middleton, would you mind starting and we'll go around this way?

MR. MIDDLETON: I'm Allen Middleton. I'm the Acting Principal Deputy Assistant Secretary of Defense for Health Affairs.

DR. POLAND: I'm Greg Poland, Professor of Medicine at the Mayo Clinic, in Rochester, Minnesota, one of the VPs of the Board and Chair of the Infectious Disease Control Subcommittee.

Col BADER: Good morning. Christine Bader. I serve as a Senior Advisor to the Assistant Secretary of Defense for Health Affairs.

REV. CERTAIN: I'm Robert Certain. I'm an Episcopal priest in Atlanta and retired Air Force Chaplain.

DR. HALPERIN: Bill Halperin. I'm Chair of the Department of Preventive Medicine at the New Jersey Medical School and Chair of the Subcommittee on Occupational and Environmental Health for the Board.

DR. KAPLAN: I'm Ed Kaplan, Professor of Pediatrics at the University of Minnesota Medical School, a Core Board member, and a member of the Infectious Diseases Subcommittee.

DR. OXMAN: I'm Mike Oxman, Professor of Medicine and Pathology at the University of California, San Diego, a Core Board member, and a member of Infectious Diseases and Pathology Subcommittees.

DR. PARKINSON: Good morning. Mike Parkinson. I'm Past President of the American College of Preventive Medicine and currently working with a number of health care organizations on quality and performance. I'm a Core Board

member and also a member of the Subcommittee on Health Care Delivery.

DR. KIZER: Good morning. I'm Ken Kizer. I'm the Chairman of the BRAC Advisory Committee that we'll be hearing from later this morning.

DR. SHAMOO: I'm Adil Shamoo, Professor at the University of Maryland School of Medicine and member of Health Care Delivery and Chairman of the Medical Ethics Subcommittee.

COL MOTT: Colonel Bob Mott from the Army Surgeon General's office. I'm the Army liaison.

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

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

CDR SCHWARTZ: Commander Erica Schwartz, Coast Guard Preventive Medicine liaison.

LtCol GOULD: Lieutenant Colonel Philip Gould, Air Force Liaison.

LCDR SPRINGS: Lieutenant Commander Julia Springs, U.S. Marine Corps Health Services.

CAPT LEE: Captain Roger Lee. I'm on the Joint Staff, J4 Health Service Support Directorate.

CDR SLAUNWHITE: Good morning. I'm Commander Cathy Slaunwhite. I'm a Canadian Forces medical officer in a liaison role at the embassy in Washington, D.C.

CAPT NAITO: Captain Neal Naito, Navy service liaison.

Col MCPHERSON: Colonel Joanne McPherson. I'm the Executive Secretary for the DOD Task Force on the Prevention of Suicide by Members of the Armed Forces.

DR. BUTLER: Good morning. Frank Butler, Chair of the Committee on Tactical Combat Casualty Care and today sitting in for Dr. John Holcomb, Chair of the Trauma and Injury

Subcommittee.

DR. FOGELMAN: Charlie Fogelman, Chair of the Psychological Health Subcommittee on the Board.

DR. WALKER: David Walker, Chair of the Department of Pathology at the University of Texas Medical Branch at Galveston and a member of the Core Board and Infectious Disease Control Committee.

DR. SILVA: Joe Silva, Professor of Internal Medicine and Infectious Diseases, University of California at Davis, and Dean Emeritus, Core Board member and also member of the Infectious Diseases Subcommittee.

DR. O'LEARY: Dennis O'Leary, President Emeritus of the Joint Commission, a Core Board member, and member of the BRAC Subcommittee.

DR. MASON: I'm Tom Mason, Professor of Occupational and Environmental Health, the University of South Florida College of Public Health and I'm a member of the Subcommittee on Environmental and Occupational Health.

DR. LUEPKER: I'm Russell Luepker and I'm Professor of Epidemiology and Medicine at the University of Minnesota, I'm a member of the Core Board and member of the Health Delivery Subcommittee.

DR. CLEMENTS: John Clements. I'm Chair of Microbiology and Immunology at Tulane University School of Medicine and also Director of the Tulane Center for Infectious Diseases. I'm on the Core Board and a member of the Infectious Disease Subcommittee.

VADM MATECZUN: Admiral John Mateczun, Commander of Joint Task Force CapMed and appreciative user of your services.

CDR FEEKS: Good morning. Commander Ed Feeks, Executive Secretary to the Defense Health Board.

DR. LEDNAR: Wayne Lednar, Vice President of the Defense Health Board and Global Chief Medical Officer of DuPont. If we can also do introductions in the remainder of the room.

COLONEL MCCLOUD: I'm David McCloud,

Colonel retired, Army Medical Corps, and I am the Chief of the Prosthetic Cancer Research Project at Walter Reed and I'm very fortunate in having what we're trying to define as a world-class operation, not bragging here, but we value what we do and I've been in this military for 45 years.

DR. COHOON: I'm Barbara Cohoon. I'm Deputy Director of Government Relations for the National Military Family Association, and I'm also a member of the TBI Family Care Giver Panel which was briefed yesterday, and thank you for accepting our curriculum. Also I'm a member of the Health Care Subcommittee and the TBI Subcommittee.

DR. WARD: I'm Claudine Ward. I'm a Preventive Medicine Resident at the Uniformed Services University.

MR. RAYBOLD: Ridge Raybold, Office of the Director, Armed Forces Institute of Pathology.

MS. JOVANOVIC: Good morning. I'm Olivera Jovanovic. I'm DHB support staff.

MS. CAIN: Christina Cain, DHB support staff.

COMMANDER BELTRAIN: Commander Linda Beltrain, Bureau of Medicine and Surgery.

MS. KITCHEN: Lynn Kitchen, Deputy Director of --

MR. DONOVAN: Bobby Donovan, Deputy Director of Future Plans and Strategies, Navy Medicine.

DR. FIRPO: Adolfo Firpo. I am a Fellow of the College of American Pathologists and a member of the AMA's Political Action Committee. I am a program evaluator, a health policy analyst and a former pathologist.

LT DANIELSON: Roxanne Danielson. I'm a Preventive Medicine Resident at the Uniformed Services University.

CDR HANCOCK: Jim Hancock. I'm the Director of Medical Services, Camp Lejeune, North Carolina.

COLONEL WARDELL: Scott Wardell, Deputy Chief of Staff, JTF CapMed.

MR. BRADLEY: I'm Bill Bradley. I'm Vice Admiral Mateczun's Executive Assistant.

LtCol HOBBS: Laurie Hobbs, OSD Health Affairs.

COLONEL EDWARD: Colonel Adolphe Edward, Chief of Staff at JTF CapMed.

MS. JARRETT: Lisa Jarrett, Defense Health Board support staff.

MS. GRAHAM: Elizabeth Graham, DHB support staff.

DR. LEDNAR: Thank you. Again, welcome to everyone. Before we start our first agenda item, Commander Feeks has some administrative remarks that he'd like to share. Commander Feeks?

CDR FEEKS: Thanks, Dr. Lednar. This is Commander Feeks. Good morning and welcome everyone. Thank you for being here. I'd like to thank the Hyatt Fair Lakes Hotel for helping with the arrangements for this meeting. I'd like to thank all the speakers who have worked hard to prepare briefings for us. I'd like to thank my staff, Jen Klevenow, Lisa Jarrett, Elizabeth Graham, Olivera Jovanovic, Christina Cain, and back at the home office, Jean Ward for arranging

this meeting of the Defense Health Board. If you have not already done so, please do sign the general attendance roster on the table outside. The law requires us to keep a record of who attends the meetings. For those who are not seated at the tables, there are handouts provided on the table at the far end of the room. Restrooms are located down this way and turn left. If you need telephone, fax, copier or message services, please see Jen Klevenow or Elizabeth Graham. If you would please put your personal electronics in a silent mode for the duration of the session. Because this open session is being transcribed, I'd like to call your attention to Ms. Christine Allen over on my right. Notice that she is not typing. She is recording. So the person who's going to type this transcript will not recognize the sound of your voice, so each time you speak, please say your name at the beginning.

Refreshments will be available for both the morning and afternoon sessions. We will have

a catered working lunch here for the Board members, ex officio members, service liaisons, allied liaisons, support staff and speakers and distinguished guests. For those looking for lunch options, there is a restaurant here in the hotel. There are numerous other options both sit-down dining as well as fast food very close-by. Just ask a member of the hotel staff about that.

For those who need to take the Metro after this meeting, the hotel operates a complementary shuttle to the Vienna Metro station every 30 minutes, so please see the shuttle schedule at the registration desk or the hotel front desk for information about that.

The date and location of our next meeting has yet to be determined, but at that meeting the Board will receive updates from the various subcommittees and consider various issues for recommendations to the Secretary. That's all I have. Dr. Lednar?

DR. LEDNAR: Thank you, Commander Feeks. We'll go into now our first agenda item, and the

board is grateful to have with us today Vice Admiral John Mateczun, Commander of the Joint Task Force, National Capital Region Medical. Admiral Mateczun has served as Joint Staff Surgeon and medical advisor to the Chairman of the Joint Chiefs of Staff as well as U.S. delegate to the NATO Committee on Chiefs of Medical Services. Present at the Pentagon on September 11, 2001, he subsequently served on the Joint Staff during Operations Noble Eagle, Enduring Freedom and Iraqi Freedom. Vice Admiral's Mateczun's ensuing flag assignments were as Chief of Staff, Bureau of Medicine and Surgery, Commander of Naval Medical Center, San Diego, and Deputy Surgeon General of the Navy. He has also served as Director of the Military Health System Office of Transformation and is a member of the congressionally mandated Task Force on the Future of Military Health Systems. Admiral Mateczun's awards include the Navy Distinguished Service Medal, Defense Superior Service Medal with Oak Leaf Cluster, Legion of Merit with Three Gold Stars, Bronze Star, Defense

Meritorious Service Medal, Meritorious Service Medal with Gold Star, Navy- Marine Corps Commendation Medal, Army Commendation Medal and Navy-Marine Corps Achievement Medal. He has many ribbons. Today he will share with us the DoD response to the Achieving World-class report developed by the NCR BRAC Advisory Panel of the Defense Health Board as well as a progress report on the Walter Reed National Military Medical Center. Thank you for joining us, Admiral Mateczun.

VADM MATECZUN: Good morning, Dr. Lednar and Dr. Poland. Thank you. Mr. Middleton and distinguished member of the Defense Health Board, guests who are here today. It's my pleasure to be able to present to you the Department's response to the Defense Health Board's Subcommittee report on achieving world class and progress at the Walter Reed National Military Medical Center. Today I hope to provide you a briefing and overview of the Department's response to the report and give you an update as

well on how some of the projects are going and then be able to answer any questions or engage in any discussion that you might have.

Background. In 2005 BRAC seems like a long time ago. 2007 and borne out of crisis, you may remember the "Washington Post" articles on Walter Reed Medical Center of February 2007, subsequent Dole-Shalala independent review group and other commissions that reviewed the situation within the National Capital Region. The Department had a National Capital Region Senior Oversight Committee to review those recommendations and take action. One of the recommendations was that there be a coordinating agency to oversee the BRAC realignments and integrate health care delivery within the National Capital Region. So the Joint Task Force was formed in September 2007, chartered by the Deputy Secretary of Defense, then Secretary England.

In November 2008 the FY 2008 NDAA required an independent review of the designs and plans for the new medical center to determine

whether they would be world-class and that Panel submitted their independent review to the DoD and Congress in July 2009. Subsequent to that, the Department did an extensive review of the recommendations and findings of the Panel. I will tell you if you've seen the report, and I think most of you have, it's an extensive response. Usually the Department's response to Congressionally mandated reviews are a page or two. This was a very thorough review of all the recommendations that were made and I can tell you that it was coordinated at the highest levels. One of the things that's happening in the Department is there are a large number of new political appointees coming in to prominent positions, the Secretaries of the Services, the new Under Secretary for Personnel Readiness of course was just nominated, but all of these personnel wanted to personally review this and I spent a lot of time talking with a lot of people about the background and history of what was going on, so there is a lot of interest in the

Department about this report and what's happening.

Additionally, since the Department's response has been submitted and included in the fiscal year 2010 NDAA as a follow on requirement to see how the Department is continuing to develop and implement those things which were recommended in the report so that the report was ready clearly by Congress as well who took a lot of the findings and recommendations, turned them into law and we'll be responding to those laws as we go forward. In particular, we have to develop a master plan. We have to recertify some things that they required previously, in particular that we haven't moved anything from Walter Reed until we have capabilities elsewhere. And we have to make sure that everything meets JCAHO standards and provide an assessment of risks and benefits to patient care associated with completing the realignment. It also requires a schedule for completion of requirements in our master plan and an updated cost estimate to provide world-class care within the National Capital Region.

We're working on those reports now. This is the conceptual drawing of Bethesda that you've seen. Actually, the pictures that you see look kind of like that now. I'm getting ready to go talk to the Chairman and the Joint Chiefs of Staff again on our progress toward the completion of the BRAC and this is a review of the construction that's going on on the Bethesda campus. Two major construction projects, the top two bullets there, the top two green lights, are RFP 1. That's the big buildings on either side of the tower at the Bethesda campus. Construction is really going along. It's getting close to two-thirds complete within the construction. Down at the bottom is RFP 2. The contract was awarded on RFP 2 and broke ground last Friday to start construction of those projects, and those are mostly administrative and support buildings particularly to take care of the wounded warriors. I got a couple of slides in the back and I'll show you some of the pictures of what's happening there. All of that construction is on or ahead of

schedule, not just on schedule. We're about 5 months ahead of schedule on the Bethesda campus on construction, about 7 months ahead of schedule on the Fort Belvoir campus on construction. You see one yellow light up there, and that is that while we're doing new construction, we're also doing renovations within the existing hospital buildings on the Bethesda campus. Those are just started. They require a series of moves. The Deputy Secretary required that we minimize the impact on patients and staff and so there is temporary swing space that's been put up. Orthopedics, physical therapy and pediatrics moved into those new spaces and now we're working through the renovations. They are only 19 percent complete and as we're opening up the walls we're finding that there is more to be fixed than we thought, so that's creating some schedule risk, but we're still on a timeline to make it through the end of the BRAC, so minimal construction risk, a little bit of schedule risk left on the Bethesda campus.

You can see the number of projects that

are going on. Those things that are up in blue at the top are the new contracts on which construction just got started. The kind of green down at the bottom are the big Buildings A and B for RFP 1, and a 943 space parking garage which will be open in a couple of months we hope to start to alleviate the parking congestion that's going on here on campus.

A couple of other things that are going in, you see some things in yellow that have been proffered by outside agencies, the Intrepid Center of Excellence for Traumatic Brain Injury, Psychological Health going up over on the right-hand side of the campus with construction going along very well. Should be finished within the year. And then the Fisher Foundation has donated three new Fisher Houses on the site where we had an old officer's club and gymnasium and those are being torn down and those Fisher Houses will be let, and then this year we'll start construction on that red parking garage up there that you see as well. So there's a lot of

construction going on all around the campus.

This is the Fort Belvoir Community Hospital. It will be the country's leading proponent of evidence-based design. It is well on schedule, actually ahead of schedule so that we'll have a significant amount of time for transition down to the Fort Belvoir Hospital. It's working from the outside in and so the clinic building is on the outside and the parking garages are more complete than the central inpatient ancillary services tower, so those will be going along perfectly well. There is still some cost risk here because of the contracting vehicle which is known as integrated design bid/build, IDBB, and so we're finalizing those prices now in terms of the contract.

For those of you who are familiar with Northern Virginia, this footprint is about the size of the Springfield Mall not very far from here and from one of the parking garages into the middle is about the length of an aircraft carrier for those of you who might be a little more

nautical, so it's two aircraft carriers pointing toward the middle there in terms of size. It's an extraordinary campus. There are a couple of great features here. I know that the Subpanel knows a lot of the evidence-based design features that are going into this. But also you'll see that in back of those clinic buildings there is room to expand. This is all green space construction and so we were able to provide space in the back for future expansion if that's necessary, and our population is certainly drifting south within the National Capital Region along the 95 corridor here, so we anticipate that there will be even further growth of this part of the campus in the future.

That's a quick update on the construction projects that are going on. I'll tell you that construction is part of what we need to do. We're green on construction. You also have to put gear and outfit these buildings once they're completed, and we anticipate that we'll have a contract out for outfitting before the end of this months. It turns out that this is an area

where there is tremendous private-sector competence and it's big business. This will be about a $400 million contract, and what we've done is put together the outfitting contracts for both of these hospitals so we'll have standardized equipment, we'll gain economies of scale in their purchase, their maintenance contracts, we'll gain economies on those because we'll be able to do it across systems, and we're trying to standardize patient safety items so that as you move from one of the hospitals to the other you're able to know the equipment and work through the patient safety aspects of that without having to orient completely to a new hospital.

I'll move into the Department's review of the Defense Health Board's Subcommittee's report. This is an executive summary if you will of the findings maybe a little bit reordered, but we're pleased that the Board that we thought that we could continue with construction and renovations and correct those deficiencies which the Defense Health Board had identified, and we're

certainly in the process of doing that.

Secondly, the Board identified an authorities issue as foundational. This primarily has to do with the relationships on the Bethesda campus. They recommended empowering a single official with complete organizational and budget authority in the NCR, and I'll come back to that with what the Department is doing.

Develop a comprehensive master plan. This has to do with both our vision for providing integrated delivery systems of care for our patients here within the NCR as well as what the facilities on particularly the Bethesda campus will look like in the future and how we'll be able to achieve world-class through that master plan. We need to engineer an integrated military health care culture, more fully incorporate clinician and end user input into plans, and then evaluate the design and build processes that we're using in these two hospitals for future use in the military health system. We didn't build any hospitals within the military health system for about 10

years. These are the first two new hospitals that we've built, and we've got eight new ones coming on in the next 5 years. So it is critical that we evaluate these processes and apply them to future construction projects.

I'll start out with what the Department thinks is the right way to respond to each of these recommendations. The Defense Health Board Subcommittee defined world-class medical facility, and Section 27.14 of the FY 2010 NDAA codifies that definition. The Congress accepted that definition, codified it and it's now part of law in the FY 2010 NDAA. The DoD is pleased to see that the designs for both Walter Reed and Fort Belvoir are sufficiently close to the newly defined standards to recommend construction and renovation projects should be continued. Where there are identified deficiencies, the Department is committed to correcting design and construction, provide a way forward within a comprehensive master plan for future construction projects within the National Capital Region

Integrated Delivery System, and on the Bethesda campus. I will tell you that there are some elements of the Defense Health Board recommendations that make it impossible to achieve the definition of world-class within the BRAC construction projects and within the BRAC timeline. It was never planned that way, and so now we have to adapt as things go. There has been an evolution of standards that the Department has used as we have gone through the BRAC process. First it was the BRAC and the BRAC was in 2005. The Department reviewed using its methodology with the Joint Cross-Service Working Groups to make the recommendations to close the inpatient facilities at Fort Belvoir and out at Malcolm Grow at Andrews Air Force Base and consolidate them into these two new facilities. Since then, in 2007 the Department's response to all of the recommendations of Dole-Shalala, the independent review group, resulted in what was known as enhance and accelerate on the Bethesda and Fort Belvoir campuses, primarily on the Bethesda

campus. There is some acceleration to make these facilities available as early as we can get them and to enhance what the BRAC vision was, so we've incorporated those now into the schedule as well. Now we have a new standard. This is the standard for world-class which has been codified within the FY 2010 NDAA, so that's a new law, and now we will have to work forward to meet that definition.

This creates a tension between the old design and the new design and the Department in its master plan will have to decide how it is going to approach achieving those world-class definitions. In particular, there are two parts of the definition that are involved here. One is single-patient rooms as a standard, so on the Bethesda campus they're renovating a significant number of rooms and if you count the intensive care and other units, well over 150 of the rooms will be single-patient rooms after the renovation is complete. That still leaves 203 patients are in what are known as single double-patient rooms. There is no additional space on the campus and so

to get to that standard of single-patient rooms, the Department would have to involve itself in new construction. Clearly that's not going to happen before the end of the BRAC. But in terms of the master plan, the Department will review the single- patient rooms and decide whether or not that is the standard and then if so how to get there. Operating rooms would be another example. Operating rooms are a matter of significant debate as we've discovered out in the community. We had a lot of surgeons out at UCLA Monday and Tuesday to meet with their future OR folks and we've discovered that there are a lot of commonalities. We've been working in the same direction on a lot of the ORs, but we will have to establish a definitive standard and then work toward achieving it on the campus. Once again, there's no new space that's on the campus within the current projects and you can't just add on to the projects as they're going. We are doing other backfill renovations at Bethesda. We're getting ready to review the renovations of the existing ORs at

Bethesda today to see if the plans for the future can be incorporated into those plans for renovation as a transitional step.

One official with organizational and budgetary authority within the Capital Region. This is one of the things that Congress is requiring us to report about. Secretary Lynn in his response to Congress directed the NCR OIPT, and for those of you who don't know, the NCR OIPT is really comprised of the former members of the NCR Senior Oversight Committee in the Department. So it's the Vice Chiefs of each of the Services, the Assistant Secretaries for MNRA, the Assistant Secretaries for Installations and the Environment, the Comptroller of the Joint Staff, you name it, everybody from the Department comes and they give me advice on my way to the Deputy Secretary with these decisions. Secretary Lynn has directed that the NCR OIPT take on this issue and that they define what is the Walter Reed National Military Medical Center and that they review this issue of how to achieve the organizational authorities we

need to be able to get to a world-class vision.

Since the Subcommittee met in January of this year, the Deputy Secretary did establish enhanced command authority to the Commander of the Joint Task Force by deciding that each of these hospitals will be operated by the Joint Task Force, that is that the Joint Task Force will have OPCON over these two new joint hospitals so that that authority has been enhanced since the board met. Right now, Health Affairs, the JTF and the Services' SG are working to develop the funding flow equities. A large part of being able to achieve world-class is where does the money come from. The Department isn't much different than any other place in the world. Everybody wants to influence the funding flow, all good ideas have to be funded somewhere, so we're working through those authorities as well.

Develop a comprehensive master plan. The Department recognizes and endorses the importance of achieving a clear and common vision both for the Walter Reed campus and for the

National Capital Region Integrated Delivery System. We're already working on each of those to be able to meet the Congressional mandate. That master plan will include both facilities and health care delivery in the region and we have to have it all put together by the end of March in order to get it back over to Congress. The master plan will as directed by the Subcommittee work toward a concept and a vision that extends beyond the BRAC. It's not BRAC limited. It's how do we get to world-class in the end state. As the Subcommittee reports to us, it is a journey. There is not a completed state of world-class and those institutions certainly used as models I think provide a good illustration that you just don't have one plan, you have to constantly be adapting that plan both in terms of facilities, the services that you're going to be using for patients and the whole synergies between the integrated delivery system and the facilities.

Engineer integrated military health care. It's an interesting thought. I tell you

I've been involved in this now for 2 years and I think that everybody thinks that they know what they're talking about when they say military culture. I've become convinced that there is a large overlap between business processes and culture and that if culture is defined as the way we do things around here, then our heuristic devices for getting through the day are a part of the culture, and so our business processes at each of the hospitals are different. This is as much as it is about locality as it is about the service because all of our hospitals have different cultures in that respect. So we're working toward arriving at a place where we can work across those business processes, but we've got consultants working with us now on achieving the overarching cultural design for this new integrated delivery system. I'll tell you we've had within the Department a tremendous ability to reach out and have traveling fellowships that Health Affairs has put together out to Mayo, to the Cleveland Clinic, we've been to UCLA, we're going out to Inter-

Mountain, Kaiser Permanente on both coasts. A lot of folks would like to help us. These models are all close, but I don't think that any of them achieve exactly what we're looking for within our culture and integrated delivery system. We have a little bit of a different mission and so we will make sure that we form our culture around those things that are necessary for us to achieve our mission.

Fully incorporate clinician and end user input. We've been able to modify design processes. We had over 160 working groups not just with clinicians but with administrative staff as well to take a look at the space designs for the new Walter Reed and we directed the redesign of some portions of the planned outpatient building particularly those that are working toward cancer care and the pharmacy that was going to be located in the outpatient building. We're moving toward a concept of integrated cancer care through a comprehensive cancer center concept that I'm very excited about. We have world-class

research and service capabilities for our beneficiaries within the Military Health System. We have no organized comprehensive cancer center and so we are working toward the delivery of services both in Walter Reed, and then we've reached across the street to Dr. John Niederhuber at the National Cancer Institute to work with us toward achieving NCI Comprehensive Cancer Center designation as we go forward. Once again this won't happen coinciding with the end of the BRAC. It will take us some time to get there. We are committed to doing this for our beneficiaries.

Not everybody's suggestion gets incorporated by the way into design. We went back as part of our own review of how do you using these design-build processes, they're in use in the private sector a lot, but it used to be that in the Department we took about 2 years to 3 years to do the design and then the construction took about 3 years. Our timeframes don't allow us to that today, and even if you did, the design that you had would be outdated by the time that you

really got it out into contract. So we've overlapped those two processes, design and construction, to achieve speed and it's necessary but it's also very hard to manage. The sweet spot for inflecting the cost curve on the Bethesda campus for RFP 1 was January 2007. JTF wasn't in existence until September 2007. This Subcommittee didn't meet until late in 2008. So all of the things that we were doing were way past the most efficient time to inflect the cost curve. You have to understand the requirements early, and the Department has some risk here I think in the eight new hospitals that it's building over the next 5 years if we don't manage these processes efficiently and effectively, so you can't wait forever for local clinician input would be I think one of the lessons that I've learned. You need to take as much of it as you can and kind of get there. In fact, how many clinicians does it take to tell you what kind of an OR you need? Every surgeon I've talked to has a different idea. I'm not kidding, literally, every surgeon I talk to

has a different idea. They tend to approximate around a central theme, but the particulars are different. So within the Department as we arrive at what do these ORs look like, what does an ICU room look like, what is evidence-based design on a patient room, then moving toward a single standard may help us so that we don't reinvent this at each locality where there's a new hospital as we go. So this is a challenge I think not just for us. We do want to take the hard lessons that we've learned and put them into effect throughout the system for the benefit of our patients and for getting these projects done on time.

Further recommendations. We're continuing to work with those clinicians and we will be incorporating their concepts into the planning as we go forward from here. This is what I was talking about. This is to evaluate those construction processes for future MHS projects. In addition, we're going to use the Fort Belvoir Hospital as a design testing ground for evidence-based design. I told you that it's the

leading exponent of evidence-based design in the country, and so we'll be able to test out some of those concepts I think through metrics in a way that you can't do in theory. We'll see how they work in practice.

In conclusion, the Department is appreciative of the Defense Health Board's invaluable support and guidance. I see Dr. Kizer and Dr. O'Leary, and I know members of the Panel and some others, thank you so much for all of the help in putting this together. It was a very short timeline to try to define something that had never been defined before. It's now codified into law. Think of that. The Department is committed to providing world-class health care in the NCR. We will achieve the Panel's newly established definition of a world-class medical facility and we are preparing that comprehensive master plan for the integrated delivery system to include both facility and installation services.

I want to show you a couple of pictures. These are where we're accelerating the projects.

This is what the new RFP 2 will look like. You see on the left-hand side of the slide is that administrative building. The façade of that building is the old Naval Medical Research Center where all of the dive tables, if any of you are SCUBA divers or saturation divers, that's where all the dive tables in America were developed. In fact, there's a long history on this campus of cancer collaboration as well, so almost all of the lung protocols that are used today were developed in collaboration with the National Cancer Institute on this campus.

Over on the right-hand side you'll see the new towers that we're building for the wounded warriors. Those are 300 rooms/suites that exceed the ADA requirements, and an administrative building there in the middle with a dining facility for those wounded warriors and the ill and injured who will be residing on the campus.

This is a picture of those towers on the left- and the right-hand side in that medium building. The façade is over on the right-hand

side. It will all be gutted and then this new construction will go on in the back. It actually goes down five stories. There's a hill there. This was originally three different construction projects, a gymnasium and parking garage complex now incorporated within that admin building complex.

That's the end of the slides. I'm available for any questions.

DR. LEDNAR: Thank you, Admiral Mateczun. The design of this morning's session includes a presentation by Dr. Kizer on achieving world-class, and since that's so central to the discussion as Admiral Mateczun mentioned, my suggestion is that we ask Dr. Kizer to make his remarks and then both Admiral Mateczun and Dr. Kizer together can take questions. I think some of the thoughts that might be in some people's minds might be addressed by some of the comments that Dr. Kizer will include.

DR. KIZER: Good morning. Thank you. Thank you, Admiral Mateczun, for those comments.

I think that a number of your comments echoed things that I was going to say, so that should help catch up on some of the time.

Just to note a few milestones, since I believe the last time that we talked or had a conversation on this subject in this group was at the May meeting, early or mid- May, when the Subcommittee presented its penultimate report and then based on feedback from the board at that time made a few changes and reoriented or reformatted some things and then passed it on officially to the Defense Health Board at the end of May or first couple says in June. Whatever transpired took about a month. Then it was formally delivered to the Department. I should probably note that the findings of our report have essentially remained unchanged since they were first presented to this group in I think December 2008, so in essence the findings have been substantially out there for much longer than might appear from the official timeline.

As was noted, the Department formally

responded to the Subcommittee report in mid-October and briefed Congress a few days later. I should acknowledge that the Subcommittee recognizes the inherent challenge in compiling a composite report that so many different individuals contributed to as reflected in the report that John described which was quite lengthy. I think the Committee also appreciates and recognizes the varying levels of understanding and perhaps acceptance of the fact that the future is not what it used to be.

The President signed the National Defense Authorization Act at the end of October and notably a section as has already been noted in that extensive bill codified the Committee's definition of world-class and specified that a number of other things occur. On an editorial basis, I believe this is the first time ever that a standard of this type has ever been put into law, or at least into federal law, and I have observed that everyone has been focused on health care reform and perhaps some other issues, and

this completely went under the radar and many of the folks who I would have expected to have picked up on or commented on this legislation and this issue remain unaware of what I think is probably notable and ultimately will turn out to be fairly far-reaching that the standard has been put into federal law.

A bullet that probably should be on there but wasn't when I prepared these is that the Subcommittee after carefully reviewing the Department's response felt compelled to comment on the Department's plan of action and express some of its concerns to the Defense Health Board, and while the Admiral was speaking a memo was passed around that notes some of the Committee's concerns about the plan of action. I should note that actually that when our memo was prepared was formatted a little better than what is reflected in the copy that you have. Something happened in the electronic transmission and we'll clean that up for perhaps the formal for those who are concerned about how things appear.

Just a couple of other points in the way of background worth noting. The Committee was convened last summer. It officially met for the first time in September. Although the purpose of convening the Subcommittee was not necessarily to do this independent review, when the Subcommittee was convened it was to provide advice on the creation of the integrated delivery network here in the National Capital Region and subsequently the Committee was additionally charged to do this independent review. Notably, all but I think Dr. O'Leary who is a member of the Core Board, all of the member appointments have expired so the Subcommittee technically does not exist and I have done my best to reassure the Committee members, many of whom who are very anxious to continue in the role, that the delay in reappointment is not due to the findings of the report or the recommendations that were put forth.

Just a couple of other things that may be relevant to context or philosophy in thinking about the definition and the recommendations. We

certainly understood the Congressional charge of being a world-class medical facility to be a journey and not necessarily a specific designation which Admiral Mateczun has commented on, although I think the Committee may have a somewhat different take on this than what was expressed and we did comment in that in our memo. The Committee also took the view that world-class means the best of the best. This is the context or the way that the term is used in other settings. Ironically, if you go and do a Google search of world-class medical facility, you will quickly come to over 100 institutions in this country that list themselves without that, notably without any specification of what that means or how they self-determined that they were world-class. But the Committee felt that as is detailed in our report that much of what would constitute that can be objectively measured and specified, some of it cannot at least with current measurement perspectives or measures that are used. There has been some, or at least I have heard feedback and

have directly conversations that there are some varying interpretations of what world-class is taken to mean or what it should be taken to mean. I played football in college and many of my teammates were very good athletes and went on to play professional football, but only a few of them were ever all pro or would achieve that level of world-class, and I think in the athletic arena that are lots of very good, excellent athletes out there who never make it to the Olympics or perform at the level that would be considered world-class and I think you can use that analogy in other settings, and that is somewhat the context that the committee viewed what world-class should be taken to mean, that it's not for everybody, indeed, it's for a very select few who demonstrate a level of performance excellence that is truly the best in the world.

As I noted, the Committee also felt that the specifications should be objective and measurable whenever possible but acknowledges that a significant part, indeed, perhaps even the

majority of what constitutes a world-class facility or a world-class anything if we think of a health care facility, that probably the majority of what constitutes that is what we could consider invisible architecture, the culture, the emotional state of the folks working there, the values, things that are harder to perhaps specify and lay out as may be design standards for how a facility is constructed.

With that, I don't know that we need to necessarily spend time going through this. Admiral Mateczun and at previous forums I think we've covered many of the key findings of the Subcommittee. I would underscore that the Committee I thought was quite clear in its recommendation about continuing construction that that was a contingent recommendation. It was contingent upon a number of corrective actions being taken, course corrections being made and other things, that it was not a blanket recommendation which perhaps some have taken it to mean.

Let me focus perhaps on the response or the Committee's response to the report and make a few points. You can read what was said. I would note that what is included in this memo should not be taken to be an exhaustive list of the Committee's concerns about the plan of action that was espoused. It should be viewed more as an illustrative list of a number of issues.

First, I think the Committee certainly appreciates what seemed to be the Department's general agreement with the findings of the Committee, and frankly, while couched in Washington verbiage, the Department's candor that the current plans will not produce a world-class facility at Walter Reed, or at least certainly not by 2011. I think the Committee certainly would like to also commend the department for beginning to transition the military health care system from its historical service-specific, facility-centric of care delivery to a more modern integrated-service delivery model which is certainly the norm today in the VA and

increasingly the norm in the private sector as well.

Again the Committee after spending a considerable amount of time reviewing the Department's plan of action has some concerns that it feels should be brought to the attention of the full board and these are identified, or at least illustrative ones are identified in the memo as I've noted. I think first and foremost though the sense that the Committee got is that the Department may not have fully understood some of the recommendations or the essentiality of taking timely corrective action, and in viewing the plan of action, perhaps the most striking observation that was made essentially independently by all of the Committee members was the lack of detail and specific timelines, milestones, things laid out in the corrective-action plan. I think the Committee didn't feel particularly reassured that the needed course corrections would be accomplished based on reviewing the plan of action in view of the number of matters that were under review or under

development or under study or similarly in some sort of under mode or unresolved status.

I think the Committee was troubled by this given the amount of time that our findings have been out there. As I said, they've been essentially unchanged since December 2008, or certainly the most important ones. I think the Committee was also concerned about the OIPT that was identified as at least one of the primary vehicles to resolve some of these issues recognizing that this is an entity that has existing for a long time and has had a number of these issues before it and today it has not seemingly brought resolution to some of these matters.

I think I'm going to digress a bit from the slide, and I'm mindful of the clock. I think the Committee philosophically certainly agreed with the idea that development of world-class is not a destination but a journey, but I think the Committee's expectations as I suspect are those of the Congress were that it would be less of a work

in progress at this point than it is and would certainly appear to be by September 15, 2011 under the current course unless some changes are noted. I think the Committee was also somewhat dismayed by the seeming assertion that the Committee had concluded that the design plans were sufficiently close to the newly defined standard that construction projects should continue because I think that taken as stated and as reflected in the plan of action does misrepresent the Committee's findings and its position. To be clear, the Committee in its report I think was quite clear that neither the new construction nor the totality of what is apparently laid out at this point would result in a world-class medical facility and I think it was clearly stated that the current design plans were not those of a world-class medical facility and the recommendation to continue or not to call for a halt in construction was clearly contingent on a number corrective actions being taken, and I think I've already said, it was a very continent recommendation.

Quite candidly, the Committee is much less confident in its conclusion and its recommendation in that regard after seeing the Department's plan of action than it was perhaps a month ago.

The last point is I think the second most important recommendation of the Subcommittee in its report was the need to consolidate organizational and budgetary authority in a single entity, and where perhaps there have been some steps in that direction, the Committee certainly felt that this needed to happen quickly and needed to get on with things, and it does not see that reflected or that decisiveness reflected in that Department's response and frankly feels that failure to resolve this authority issue doesn't portend well for further progress and indeed is likely to be the cause of significant negative impact going forward.

We've detailed illustrative concerns in the memo. You can look at them. I'm mindful of the clock so I'm not going to go through those. Some things maybe just to highlight two or three,

the single-patient rooms that was commented upon, I think the Committee was rather surprised to see that characterized in the response as a newly defined department I believe was the verbiage that was used. Certainly the members of the Committee who have been working elsewhere have viewed this as a design standard that has existed for a long time. Dennis, as Chairman of the Joint Commission, can comment on it perhaps further. But this is hardly a new standard for world-class. This is a basic design standard for any new hospital being constructed anywhere. It's a minimal standard and not a stretch standard by any means. The Committee does recognize that there may be military-specific needs to maintain a few double rooms or two-patient rooms but feels quite strongly that the vast majority of rooms should be single-patient rooms and that would be necessary to meet minimal hospital construction standard in 2008 or 2009.

As for the operating rooms, I think that the Committee was pleased that the three new

operating rooms are likely to meet the size and infrastructure requirements, but the Committee is quite concerned about the 17 other operating rooms that would appear to remain substandard in various ways. The Committee was particularly also concerned about the apparent decision to locate frozen sections and surgical pathology substantially remote from the operating rooms which means at least if we understand things correct that the surgeon is going to have to break scrub, take the tissue sample, go down two floors, go through public areas, get the sample and then come back, all of which raises a number of infection and control concerns. It raises patent safety issues because as the surgeon is doing that as he or she is rescrubbing to come back into the sterile environment, the patient is going to have to be maintained under anesthesia for longer than would otherwise be necessary, and the Committee while we didn't to the surgeons who were involved, and I suppose it's possible, but the Committee has a hard time understanding or believing that the

surgeons who will be affected by this decision would be pleased by what's envisioned. If this is the decision that goes forward, there clearly will be a need for some very rigorous infection control and patient safety policies and procedures that would have to be developed, but I would underscore that the Committee continues to not understand the logic for this design decision and well as some other things.

Perhaps the last thing I would note in this regard, I'm happy to address other things that I've stated here or that aren't stated, having to do with example information management and information technology. We've spent a lot of time and have had some significant concerns about that particularly the funding for it, because during our deliberations we heard consistently that funds hadn't been allocated for the IT infrastructure needs. The plan of action talks about a $50 million procurement package for infrastructure that has been prepared and this is one of a number of examples where what's not said

is of more concern I think to the Committee than what was said, because what wasn't said was that the procurement package has been prepared but whether it is going to be operationalized or when it's going to be operationalized and whether the $50 million is actually set aside, the plan of action was silent and provided no information in that regard. Again, this is just illustrative of a number of other concerns where that type of detail which one would have I think expected to see in a corrective action plan was not available.

With all of these comments I think the Committee feels that this is an extremely important project not just for the Department of Defense but there are much larger implications as well. The Committee wants to be a constructive partner and help achieve the best possible outcome. We think perhaps one of the luxuries that we have is that we are independent and outside can put forth views that may not necessarily be popular in other settings, and whether it results in not being reappointed I

guess time will tell. With that let me stop. What's the format here for going forward?

DR. LEDNAR: Thank you, Dr. Kizer, and thanks to the Subcommittee for the very, very thoughtful work in reviewing the Department's position and then offering some additional feedback. I've asked Admiral Mateczun if he wishes to make a few comments initially to be in response to the Subcommittee's report, and after Admiral Mateczun has finished some comments, then we will open up the floor for questions to both Admiral Mateczun and to Dr. Kizer. Sir?

VADM MATECZUN: Thanks, Dr. Lednar. I'm not sure if I'm in rebuttal or surrebuttal at this point, but I'll keep an eye on the time and move ahead with some quick comments in how the Department works and what happens in an administration. Then the Department says it's committed to correcting deficiencies, that's a pretty big comment. In terms of a corrective action plan, that is a timeline which includes funding by the way. It's just not something that

happens in government that quickly. As you move ahead, and I frequently tell the folks who I work with as we go up to the Hill and they ask questions, we're in the Executive Branch of the government and our answer is we support the President's budget when we're up on the Hill. When the President hasn't submitted a budget yet which includes major portions of the program, then we cannot comment, so I'm not going to comment on the funding piece. I think the message here is that the Department is committed to moving ahead.

I will say that I don't know that we misunderstood the intent of the report. I think that there is new construction and there were deficiencies identified in that new construction and it's our response that we're committed to correcting those deficiencies. We may not agree completely with all of the recommendations. By far the substantial majority of the recommendations about deficiencies I think are accepted here you'll see in the Department's response. That doesn't mean that we agree with

everything that everybody said on the Subcommittee. So we'll be glad to work through those in whatever forum we need to because we are committed to getting to world-class.

The other part of it is that there's clearly new construction and achieving new world class in that new construction, and as the Committee pointed out, there is a substantial part of the infrastructure chassis at Bethesda that was built in the 1950s and the 1980s. Renovation was hot part of the BRAC process, and getting to world class and this new standard I think is separable from that. So as we take a look at achieving the rest of getting to world-class on the campus, those two things come together in the Department's approach, not trying to avoid or evade getting to world-class, but the BRAC portions of the construction are not the same as achieving world class in the parts of the chassis that are much older. I'll stop there and will glad to debate or answer any questions that you like.

DR. LEDNAR: Thank you, Admiral

Mateczun. I'd invite Admiral Mateczun and Dr. Kizer, why don't you comfortably return to the seats. I'll act as the facilitator to keep the questions in order. I would ask if first the Board and then we can open it up to the floor generally if you've got questions. If the question is worded to either Admiral Mateczun more specifically or to Dr. Kizer, if you'd please indicate that in your question. So I'll take the first question from Dr. Silva.

DR. SILVA: I don't know who's going to answer this. The overheads and the printouts don't give me any wisdom as to what is an RFP 1 and RFP 2. And each one, one is listed as 60 percent complete, 70 percent complete. What is the status of the ORs? Are they in RFP 1 or RFP 2 and are they done, do you have to make renovations, we have to go in there with a jackhammer to pull down hard construction?

VADM MATECZUN: There are three new operating rooms which all meet the definition of world-class within RFP 1 in the building that's

adjacent to the current operating rooms. So the new construction operating rooms are certainly going to meet that world-class standard. There are 17 existing operating rooms at Bethesda today. Those were not part of any BRAC project. There is currently a Navy planned renovation project. We're working with them about the 17 ORs and how we may work to start to move toward world-class with the renovations that are planned there, and since that's predecisional and is subject to contracting, I will stop there.

DR. LEDNAR: Dr. Parkinson?

DR. PARKINSON: Thank you both, Admiral Mateczun and Dr. Kizer. As I've been listening to this and thinking, to quote old Steve Covey among other people, begin with the end in mind. I think what the Defense Health Board and what Congress wants and what all of us in the Department is the functionality of a world-class health care system with a world-class facility as outlined in the subcommittee's work. To Admiral Mateczun's point, Congress works in fits and starts and does not use

3, 5, 10, 20 year strategic plans. So what we've got is a hodgepodge of legislative authority going back to the BRAC process of 2005 that has created a fits and starts planning cycle which frankly a leading health system would never do.

Having said that, if the goal in the wake of everything that's happened since 2002 and 2005 about the awareness that the DoD and VA that frankly were not measuring up to the needs of our beneficiaries, I think the Defense Health Board has clearly the responsibility to continue to highlight the gap between what is a world-class functional integrated delivery system with a facility and where the Department is. It may sound confrontational, but it's factual, so I would just offer that as we go into this extended dialogue and talk about next steps because this facility should represent the best of the best of world-class health care and if it's not there it really doesn't matter how Congress got us into this mess because they're not at the table, but they are at the table. So we just need to be on

as brokers in an evidence-based way for what is the delta and what is the Committee's and the Defense Health Board's confidence that given the current plans that we can bridge that gap.

DR. LEDNAR: Dr. Oxman?

DR. OXMAN: I had the privilege of attending the last meeting of the Subcommittee and was very impressed at the seriousness with which all of the members took their charge and the expertise that was brought to bear.

I have a concern because world-class is heavily dependent on the behavior of individual human beings. Physical plants don't make world class, but physical plans can limit world-class, and my concern with more than 20 to 30 years of experience as mostly Chair of an infection control committee at both a university hospital and a VA hospital is that some of the points that were brought forward by the Subcommittee address issues which would prevent not the practice of world-class medicine but which would be subpar in terms of the community standards. Admiral

Mateczun said that he had spoken to many surgeons all of whom had a different idea of what the ideal operating room should be, but I would vouch for the fact or I would bet that none of them thought that it should be 450 square feet and they were concerned whether the lights would be purple or green or the walls would be yellow, but I don't think any of them would view the 17 existing operation rooms as satisfactory in a new construction hospital whether it's the private sector or the VA or anywhere else.

The second thing is the issue of surgical pathology. I think that the idea of a surgeon either not participating in the evaluation of surgical pathology particularly with difficult cases and cancer cases or having to delay surgery significantly is not acceptable to me. We have a situation where we require signoff by the infection control committee on all new and revised construction on the final plans. I wouldn't sign off on plans like that because I think either way you try to solve it without physical continuity

will result in increased risk to the patient. So those are just two examples.

I guess the third example is the issue of command and control which is crucial and I think that my sense of the Committee's report and also, for what it's worth, my own opinion, is that it's crucial that with respect to the Walter Reed facility, an individual have both responsibility and authority and fiscal authority to do the best thing possible. I was particularly interested to hear Admiral Mateczun show us or tell us that construction is ahead of schedule and management, these are my terms, management seems to be behind schedule, and I think that's not a good thing.

VADM MATECZUN: In order, the operating room question within the current operating rooms, I don't think anybody would disagree that 450 feet is not an optimal OR. The question is how many do you need, 700, 800, 900 square feet and beyond? What does the space need to be? Can it be more rectangular than square? What we have are definitions of attributes.

When we take those attributes and we place them up against practice I will say that there are going to be differences of opinion and we need to accommodate. We will look again at the frozen section in your question, but once again I believe this is a practice and not necessarily a standard of care of which there are differences, and I've gotten in all honesty completely different opinions on how to accommodate that piece of what goes on.

There are only I think two things that we disagreed about with the report and that was one of them. The other was the replacement of the dialysis unit. You try to get as many adjacencies as you can. I don't disagree with that. There is no perfect plan. If there were a perfect plan then all hospitals would have looked that way and we would have discovered it. So you're I think constantly in the process of trying to adapt the plans that you can or the plans that you've got to the practice that you've got in a location. We are facility-centric when it comes to the

infrastructure in a lot of ways. I don't disagree. We'll go back and once again take a look at the frozen section problem, but I'm not sure what we're going to come to on that. We didn't disagree with very many things that the Subcommittee recommended.

In terms of authorities, I will challenge you that within the Department it would be nice to achieve unity of effort through somebody who has complete budgetary and operational authority. In the Department of Defense, that's the Secretary of Defense in all honesty and everything below the Secretary of Defense is fragmented to some degree in how we align those things. So we work to achieve an alignment of those authorities that will allow us to get to world-class. I am certainly committed to that and I'm as frustrated as anybody because I'm the guy who has to work through those authorities' questions.

DR. LEDNAR: Dr. Walker?

DR. WALKER: I'm a pathologist and have

been responsible for providing interoperative pathologist consultation for 40 years and this is an activity that should occur adjacent to the operating room and not to do so delays proceeding with taking care of the patient in the operating room.

DR. LEDNAR: Are there additional questions from the Board? Are there any questions from the floor?

DR. MCCLOUD: Dr. McCloud. Dr. Kizer, Admiral Mateczun, a lot has gone on today just as to the definition of world-class and it reminds me of Justice Potter Stewart ruling on an obscenity case. He says pornography is hard to define, but you know it when you see it. I think we would know world-class when we see it. Operating rooms at Memorial Sloan Kettering do that. It's everywhere. And so you're going out to UCLA and look at it, but right now it's not world-class.

The other thing, Admiral Mateczun has done a great job here. I've said this to you jokingly, sir, I wish he were an SES who could

stay on because the military treats these jobs sometimes as ephemeral ones, and I'm going to bring out the fact that Monday his Principal Deputy, General Volpe, has just gotten orders to go to Madigan, so you got to start over again, but that's the way we did it in the 1960s and that's the we're doing it now.

DR. KIZER: If I just make two comments. The Committee had early on an extensive discussion and used the pornography analogy in a number of others in thinking through whether you could define world-class, and the only thing I would perhaps and disagree on is that many elements as reflected in our definition of what would be world class can in fact be objectively specified and measured. The current performance metrics do not allow all of those things to be measured. As I noted, a substantial if not majority of what would qualify as world-class in those entities that at least appear to have, to use the statistical term, face validity for being world-class, much of that is brought out by the invisible architecture. It

is the culture. It is how people relate to each other and the values and other sorts of things along those lines.

In a different vein, I would note that the Committee is I think very respectful and appreciative of Admiral Mateczun's work here and his efforts and is also cognizant of the often difficult position that he finds himself in in trying to move forward working within both the military architecture as well as the government architecture, it's kind of a double-whammy. A number of the members of the Subcommittee certainly are not naive about government and have spent prolonged periods of time both wearing a uniform and working in the government, so I think the lens through which the Subcommittee viewed things was very cognizant of the limitations and constraints that are imposed upon some of the folks who have to manage and deliver the product. But as we say in the toxicology world, you can't let risk management guide your risk assessment decisions and you have to call things the way they

are and point out as was said the gaps and the holes and then figure out how you fill those as best you can.

VADM MATECZUN: I would say that as well as the Department's response, you've got the Congressional response to the Subcommittee's report. They read it and enacted into legislation those pieces that they considered important to achieving what they think needs to be achieved on the Bethesda campus as well.

DR. COHOON: I'm Barbara Cohoon with the National Military Family Association and we've been very active, our association, as far as with both the new Walter Reed construction and design along with Fort Belvoir, and I had an opportunity when your Subcommittee first stood up to come and talk to you.

The first time that we had an opportunity as far as being part of the charette at Fort Belvoir, and then I attended the charette for the new Walter Reed, the design team, the contractor who was hired to do the design, there

was a stark contrast immediately when you saw what products they had to choose from. The contractor for the new Walter Reed was only interested in getting the job done and moving on, and as you had different players from both Walter Reed and Bethesda sitting in the same room trying to explain to her issues that they were seeing trying to merge the two departments, they wouldn't hear of it. They wanted had a deadline, they wanted their money and they were moving on and whoever won the bid would then have to deal with what happened internally. So that drove a lot of issues. Even though voices were being raised, there were issues going on. The contractor would not listen.

On Fort Belvoir, it was the other way around because they were staying with the product the entire time, so they had what you would call skin in the game and a reason as far as wanting to compromise. So when you went to each charette, it was interesting to see the difference between the two. We brought this up, and DoD has tried very

hard to make that situation work, but as the report was being developed, we have now had administrative change and also we have a lot of positions that have not been filled yet as far as appointees to help push and drive a lot of this change.

The report demonstrated that certain areas needed to be fixed, but Congress is saying I'm sorry, we're not going to allocate you one single dime to increase the space for ORs or to do the single bed patients. They're not going to do that. So then that falls back on DoD as far as how we try to make that work.

As far as the culture piece, the military is the military, but it's like merging Coke and Pepsi in putting the two together. So no wonder when you go out into the civilian sector it makes it a little bit hard to find lessons learned in incorporating it into our particular piece.

As I mentioned before, we're seeing tremendous progress as far as trying to make all this work together and I spent quite a bit of time

at Bethesda and Walter Reed, and I'll tell you, when you're inside those facilities you have no idea that construction is going on around you. And people who are helping you, providers, they're making sure that you're being taken care of and are families are getting access even though the campus at Bethesda is under tremendous construction. And the same thing as far as Walter Reed. Even though they know they're closing, the providers there are very helpful, warm and friendly. When you drive by the new Fort Belvoir, that place is absolutely outstanding and patients are already starting to put in enrollment changes as far as to go down there because they see what that facility is going to be.

So I wanted to let you know that there are a lot of other factors going on and part of the reason why we are where we are is that there is a lot of different pieces involved. You've got Congress who dictates a lot of different things, you have DoD whose hands are basically tied and you have two different cultures working at the

same time. But our families are being taken care of.

DR. LEDNAR: Thank you for those comments.

VADM MATECZUN: Thank you, Barbara. We're tremendously appreciative of the work that the National Military Family Association and all of the associations. We will need to incorporate those comments into the reviews that the Department is doing and health affairs is doing on how to use these construction processes in the future with these lessons that we've learned from these first efforts.

Let me take this as an opportunity to springboard into looking at the future in a speculative way and not in a response from the Department. If you take a look at these two issues of single-patient rooms and operating rooms, they come together in the sense of probable proposals for new construction. If we're going to achieve single-patient rooms, then we're going to need to build another 100-patient rooms some place

on the campus. And the operating rooms need to be rethought. The concept on the campus needs to be looked at so that the operating rooms that are there right now and the new ones that are coming on board have to be complemented with a future look at the possibilities of moving outpatient surgery into an ambulatory surgery complex potentially to rethinking how we do the labor and delivery ORs and then to incorporate that into the master plan and new facility construction. I have found in my many, many trips to the Hill that they are tremendously supportive of making sure that we have what we need to provide world-class care.

DR. LEDNAR: Yes, sir. If you'd please introduce yourself.

COLONEL EDWARD: I'm Adolphe Edward again. I'm going to speak as both a pathologist and as a citizen. I live in Bethesda right across from the National Medical Center. I also serve on Montgomery Country Advisory Board, so I'm familiar with all the discussions.

I want to address an issue that I think

is critical and that is the idea of concepts and concept integration which seems to drive a lot of decisions involving BRAC and the objectives and goals. I'm very concerned about Vice Admiral Mateczun's distinction between a practice and a standard of care. We've dealt with this extensively at the State Department and at USAID as a public member of the performance review boards since 2007, because concepts gain meaning as they become operationalized and operation is performance which is practiced. You cannot define the practice of continuity of a surgical pathology frozen section suite close to the operating rooms in a vacuum because one distinction of health care as a market from the economics is that it's imperfect and one of the gaps that exists is in communication and the rapidity and the confidence of that exchange to make decisions which affect patient care. If the surgeon is not there and is convinced in the interaction with the surgical pathologist that this is the level of certainty upon which he can act and make definitive

decisions, you are sacrificing quality of the standard of care. So it is very important that we distinguish when we talk about practice elements or concepts and standard of care a concept that they are not dealt with in a vacuum. They coexist because, again, concepts gain meaning in practice or in performance.

DR. LEDNAR: Thank you. Dr. Oxman?

DR. OXMAN: I just have one comment, because one of the distressing things to me in attempting to read the DoD response to the Subcommittee's very specific report was the sense of being in a paper bag and not recognizing that there was no timeframe, there was no milestone, it was not at all concrete. Thinking about this as a naïve citizen and someone whose military experience is in the Public Health Service at the NIH and not in uniform in those days, the concept of the National Capital medical facility and practice is new. It's a new concept and it's different from the Air Force and the Navy and it requires not only new thinking and new

construction and new practices on the part of the military personnel who are delivering medical care, but it also requires a revision of the way business is done in the Department of Defense so that it's matched. I think probably one of the Admiral's frustrations is how difficult it is and how many people have to weigh in before you can buy a new eraser. That culture also has to change if the BRAC program is going to be successful. I think that one of the things that this Committee should do, that the Defense Health Board should do, is try to point that out and in fact to the extent that we can demand, demand those kinds of changes. But the problem is that the construction continues to go on and as you continue to build if you then have to change later it becomes more difficult, more expensive and more disruptive. So this is a time-dependent process and I think the Subcommittee felt urgency with respect to time and that's not reflected in the DOD's response.

DR. LEDNAR: Dr. Silva?

DR. SILVA: I appreciate all the candor

that's been expressed today. It's been bothersome for everyone. We all want to work toward the same goal. As I briefly mentioned yesterday, my opinion has not changed. If we're going to use the terminology of world-class, it's a misnomer where it sits right now. And if we're going to continue to use that term in the future, it may stall the appropriate processes to get to the place where it can be world-class. For active military, I would ask, and I'll bear to your personal conscience, that the coin of the realm in the military are medals. If you had a medal stating world-class, would you give it to this facility the way it is right now? Thank you.

DR. LEDNAR: Dr. Luepker?

DR. LUEPKER: There are attributes of world-class today at Walter Reed, there are attributes of world-class today at Bethesda. Those will be combined into something, we'll gain synergies and there will be more. When I look at "US News and World Report" 's reports on the best hospitals in the country, I find that they're

ranked differently for different services. I don't think that there is one standard that you achieve for everything that you do that says this entity is now world-class. We've struggled with that to some degree. There is a world-class facility, then there's the world-class integrated delivery system. I am struggling with what an integrated delivery system that's world-class means. I've been to the best. We are extraordinarily facility-centric not just in the DOD but across this country. I challenge you to find a system that really does patient integrated delivery of care that's oriented around the patient and not our delivery system. It's extraordinarily difficult.

When I struggle with this integrated delivery system and world-class, those facility pieces of it, I'm still trying to struggle with how do you do the primary care piece of an integrated delivery system that we integrate with the specialty care. We've got some great models of specialty care. We've got the Cleveland

Clinic, we've got Mayo. We've been out and we've looked at them. Their primary care systems aren't necessarily as integrated as I'd like to see for our patients within the delivery of care that we do. It's fragmented because of the way that we deliver care in America, that is that the continuing, the interface between primary care and specialty is a gap. And if we take a look at preventive services, there's a gap there too. How do we deliver those preventive services before they ever get to primary care? And on the far end, how do we integrate rehabilitation into that integrated delivery system?

I don't think we're naïve about this and I think that there are gaps that we have out there and certainly acknowledge those gaps. I'm not sure that it's not partly reflective of the American system of health care as well either.

DR. LUEPKER: I'm reluctant to get into the problems of the American health care "system," but let me say I've been troubled by this discussion both yesterday and today and the

responses by DoD. I think that our primary concern is patient care and safety, and at the minimum community standards. Let's not get into world-class quite yet. We have to do that. It concerns me that some of the things we're talking about are not community standards even.

I'm sympathetic, and with probably not enough sympathy because I live outside the Beltway, to the problems that confront us, but we seem to be hearing that the bureaucratic problems are so difficult that we just can't do this. I hear you talking about going and visiting other places to find out what they do. There's nothing inherently wrong with that, but you've had an expert committee look at this and give you advice. What I seem to be hearing and see in the reports is this advice isn't what you want to hear. It seems to me that this advice is to bring people to basic level of standard of care that I get in Minnesota and we expect around the country for all of our citizens and our service members.

VADM MATECZUN: There is no

question of standard of care. There is no metric on which the current way that we deliver care is measured that says that it's substandard or subpar. In terms of the Department's response to the committee's recommendations, we accept them wholeheartedly. That there is disagreement on two or maybe three very minor things I don't is reflective of the fact that we're headed toward adopting a solution that will get to those recommendations, and if I've in some way indicated that then I'm sorry.

As we work within the Department to be able to get there, I have to work within the constraints of government. That's quite true. So in terms of coming up and telling you we've identified the funding streams to do this, that and the other, you've identified them, we've identified what it takes to do that and the funding is coming and here is where it's coming from. Because of the way the government is structured and our yearly budget and our 5 year plans, it's impossible to do that. I can tell you

that the Department is making every effort to fund those things for which corrective action is identified.

Now to the specific deficiencies that are identified in the report other than one or two, there is funding on the way to fix all of them. But I would take exception, I would take strong exception, to any inference that we somehow do not meet a standard of care for each and every patient that we see. We are in the process of going toward a new standard of world-class, we understand that we're there, but there is nothing about the care that we deliver to patients today that is subpar or substandard in any way.

DR. LEDNAR: Dr. Kizer?

DR. KIZER: I was going to respond to your comment before, John, or just amplify perhaps a small point, but it does have some important nuances. The definition that was put forth was for a world-class medical facility and in there facility is specifically defined as what that is taken to mean. The Committee spent a substantial

amount of time on what might be perceived as an arcane issue of trying to segment this into a world-class system, a world-class facility, world-class care. There are a lot of ways you potentially could slice it and what was requested or mandated by the Congress and what was delivered was an operational definition of a world-class medical facility. I think much of that could be applied and has spillover if you want to look at individual services or systems or other things. It certainly provides a solid foundation to look at it, but the definition that was developed was for a facility as defined in the report.

DR. LEDNAR: I'm going to bring this session to a close. I think we've heard a lot of important input, reaction and comment. I really appreciate, Admiral Mateczun, your coming to be here with us yourself.

The sense I get is that this train is moving. The construction is underway and it's perhaps even ahead of schedule. The independent and very thoughtful review by the DHB Subcommittee

has offered what really is an external sense of experience for what is out there in the world today as input to the Department. Dr. Kizer has prepared and distributed this morning a memo that I would ask each only the Board to review. I would suggest that the BRAC subcommittee organize its thoughts if there's anything else on the basis of this discussion, Dr. Kizer, that you'd like to incorporate as a thought, we can then communicate that to the department so that you get that input, sir. For the Board, we want to be constructive and partnering with you. We recognize that we are advisory, but we want to offer the best insight and help we can for a successful outcome with you for the beneficiaries of the department.

DR. KIZER: If I could make two brief points. One is that when and if there is a Committee to continue this, we will be happy to continue this, but that's pending official reconvening of the group. Secondly, and perhaps not emphasized enough, the Committee would be happy to engage in face-to-face discussion with

appropriate and relevant individuals in the department if that were felt to be valuable. We'd specifically discuss this, and while no one on the Committee has an abundance free time, everyone felt that this was important enough that should a more direct communication be viewed as perhaps valuable and might facilitate resolution of some of these issues, either representatives or the Committee as a group would be willing to convent for that discussion at a mutually agreeable time.

DR. LEDNAR: Dr. Kaplan, and then we'll ask Admiral Mateczun to five us the final word as we close the session.

DR. KAPLAN: My question is to you, Wayne. Was this meant to be an informational session or is a formal action by the Board indicated after this discussion?

DR. LEDNAR: This was intended to be an exchange of information clearly to understand the communications back and forth and to identify a way ahead, so that there is no specific action per se other than to be sure that we're communicating

in an understandable and constructive way to the department in terms of our recommendations.

DR. KAPLAN: So the Board will take no "official" action at this point?

DR. LEDNAR: The Board will take as an action a communication to really clarify any points that we think would be helpful for the Department to have and to have in writing and to do that in a timely way. As Dr. Kizer said, if it would be helpful to Admiral Mateczun in the process to have a move live interaction of members of the BRAC Subcommittee who have expertise, that remains an offer if Admiral Mateczun would find that helpful.

DR. KAPLAN: If that's the case then the revised report that Dr. Kizer has presented to us this morning will be circulated to members of the Board before it's sent forward for comment or suggestions or not?

DR. LEDNAR: Yes. The communication that Dr. Kizer for the BRAC Subcommittee of the Board has prepared which we just received this

morning, we need as a Board to have a chance to review that, offer any comments back, but in a timely way to complete that so it can be communicated by the board to the department. Dr. Shamoo?

DR. SHAMOO: I think the only way the Board can weigh in is we have to adopt a report. I'm not saying the exact report. We can't just discuss it and it stays up in the air. So there has to be a plan of what we're going to do. The Subcommittee did their job. They have submitted a report for the Board for its deliberation. The deliberation has happened. There could be more deliberation. But then the Board has to act on it, either adopt it, modify it, put a covering letter on it or reject it.

DR. LEDNAR: One last comment by Dr. Oxman.

DR. OXMAN: Perhaps I'm mistaken, but my understanding was that the Subcommittee's big report to the DoD was endorsed by the Defense Health Board and it represents a Defense Health

Board recommendation. Now we have a response to that recommendation and we haven't had a detailed analysis of that response, but we have our Subcommittee that had an analysis of that response and it's reflected in this document. I believe that our obligation is to read this document and at least consider endorsing its transmission to the Department of Defense from the Defense Health Board.

DR. LEDNAR: Yes. That's in fact a rewording of just exactly what I proposed. Dr. Kizer, did you have any other suggestion?

DR. KIZER: I was going to comment that the memo that was prepared other than reprinting it in the way it was actually written, the memo is the memo. It is now in the public domain. I would strongly encourage the Board to officially forward it to the Department, but it's hard for me to imagine that the Department will not be aware and have copies of this probably in a relatively short time period through channels other than the official DHB channel or it's at least conceivable

that that might happen. I think the Committee would feel that an appropriation action of the Defense Health Board would be to forward it on to the Department with or without annotation according to how you choose, and if nothing else I think just transmitting it would be appropriate.

DR. LEDNAR: In fact, we will as a Board commit to review the Subcommittee memo, and as a Board if there are any additional comments, to make those and then to forward that officially to Admiral Mateczun. But I expect that the spirit of the comments were probably related in verbal discussion today in this morning's session. Admiral Mateczun, you've got the last word, sir.

VADM MATECZUN: Thank you. In summary, I would like to thank everybody again on the Committee and on the Subcommittee in particular for their work on this report. If you take a look at what happens to reports from Defense Health Board Subcommittees, this report has been extraordinarily successful. It's gotten a response out of the department, I think a very

detailed response, not with the level of granularity you'd like, but the level of interest, and the commitment of the Department has been extraordinary. In fact, some of the recommendations of the Committee now are taken into next year's NDAA and so adopted into legislation with a codification of the attributes of world-class. Not many reports are going to end up that way, so I think it's been an extraordinarily successful and help report and I appreciate all of the efforts of the board.

DR. LEDNAR: Thank you, Admiral Mateczun, and thanks to all who participated in this discussion this morning. We will now take a 15-minute break. Thank you.

(Recess)

DR. LEDNAR: I would like to call the session back to order. We've in a flexible and agile way elected to amend the agenda. As our first item of business in this reconvened session, we're going to have a discussion to follow-up on the morning panel in that discussion. Dr. Kizer

has prepared for the BRAC Subcommittee of the Board a memo. We've asked everyone to read it. We will have a short discussion about the memo to understand it if there's any information that the Board would like some additional understanding. Then the intent will be to as a Board vote on this memo with the intention that there would be a formal written communication by the Board including the Subcommittee's memo communicated to the Department of Defense within the next 7 days or less. I said within; no later than.

I think it will be most helpful to the Department to get it sooner. It will be important for the Board with the amount of deliberation and expertise it's got to be respectfully but clear to the Department about where we stand. With that, I'll open up the floor to questions or comments. Dr. Poland?

DR. POLAND: The one thing I would suggest which I think we'd probably do anyway is whatever the changes in this that it be accompanied by a cover letter, and not that we're

likely to get very far with it, but in part calling out the idea that Congress has created a sort of difficult situation here in terms of how one might have optimally planned and resourced something like this. In an attempt to in part make clear this isn't an issue of DoD not responding to Congress' intent or DHB making suggestions that aren't feasible, both are right and both are trying to work within the constraints of what Congress gave them and as Russ or somebody else said, it's not the way that a world-class integrated system would have approached this, but it is what it is and both sides are working within the constraints of what they have.

DR. LEDNAR: Dr. Oxman?

DR. OXMAN: I don't completely agree because I think that what's needed is a modicum of cultural change in the Department of Defense so that it's easier to delegate real authority and responsibility because that's one of the things that's missing.

The other thing if we're going to have a

cover letter, I think it's very important to point out that construction is going on actually ahead of schedule, that as the construction goes on, the ease and cost of making changes that are necessary will increase and therefore time is critical, and what disappoints me about DoD's response is it appears to me to have ignored the critical issue of time.

The last thing is I think if you've ever been involved in any construction at all directly or indirectly, this is going as far as I know without a facility plan. I'm not talking about a plan for the delivery of care. I'm talking about a construction plan, an integrated facility plan, that integrates the BRAC construction with the future or concomitant construction with other funding. So I think that time is critical and I think that we need to make that clear and be demanding in a cover letter if we're going to fulfill our responsibility as an independent advisory group. The administration has changed, the advice is written down, and I think we need to

try to get change occurring as quickly as possible.

DR. LEDNAR: Dr. Clements?

DR. CLEMENTS: One of the things that became apparent to me in reading all of this and listening this morning, and you probably all already knew this so it's kind of revealing to me, was that there are really two different things going on here, and this was pointed out by the Admiral as well. There was the BRAC and the consolidation of the two hospitals into one and Walter Reed, et cetera, and then there was the congressional mandate for a world-class medical facility which was an essentially unfunded mandate which was imposed on top of that. And rather than the DoD pushing back and saying we appreciate that, sir, but we can't do that with the resources you provided, they're trying to make this into what it can't become because rather than Congress saying what do you need and how long do you need, Congress said this is how long you have and this is what you have, and that's not the way to go

about constructing a world-class medical facility or an environment.

So I don't see any way possible under the guidance and the resources that have been provided to DoD for them to accomplish the mission that Congress has given them on top of everything else. I think one thing that we could do in a cover letter is essentially point that out and say we appreciate Congress' intent here. We think it's vitally important. We don't see any way that it can be accomplished given the resources and the time constraints and here are the things that we've identified as deficiencies in the current plan. I really like the next- to-the-last paragraph that Ken has put in this which is the Committee concludes it will not be world-class if the needed corrections are not taken in a timely manner, but then to say but that does not appear to be possible given the constraints that have been imposed upon the Department. Because I don't think that anything we say is going to change the basic formula, that is, they're trying to respond

to BRAC, they don't have the resources to build a new hospital or they don't have time to build a new hospital and put together those kinds of plans. I don't think you can reconstruct this in the existing facility.

DR. KIZER: Technically, the mandate for world-class was part of the appropriation bill that did authorize funding and to date about $2-1/2 billion have been appropriated for Walter Reed and Fort Belvoir. I'm not sure whether the Committee would agree with the assertion that it is not achievable with currently authorized funding or that markedly more progress could be made in the timeline that's authorized.

DR. LEDNAR: Dr. Kaplan?

DR. KAPLAN: Yes, I agree with that next-to-the-last paragraph that the thing is that when that is worded, it has to be clearly worded, and at least my suggestion is so that when we say it can't be done that it doesn't come across as saying we're letting you off the hook. In other words, it can't be done, but it has to be worded

some way so that somebody looking at that saying they caved in.

DR. OXMAN: I would like to comment related to what Ken Kizer just said, and that is we don't know anything about budgets and money and that's not our business. What we can do is we can provide a document which the Department of Defense if it doesn't have the ability to find the necessary funds could use in going to Congress for that money. I don't think we should comment. For all I know, it would be very easy to change the appropriation and come up with funds from the Navy to do the renovation. I have no idea and I don't think anyone on this Board either knows that or has any business trying to guess.

DR. LEDNAR: What I sensed in both the Subcommittee's recommendations and the discussion to them is there's an absence of clarity that there is a plan and there is a lack of signals that progress is being made. The Subcommittee's recommendations have been out there for almost a year. It will be in about 3 weeks, and December a

year ago the Subcommittee made its recommendations without clear evidence of progress. There are some specific areas of concern like the ORs, single rooms, adequacy of the connect between surgical pathology and the operating rooms and items like that. I haven't said the word fund and funding and streams at all. I think that there are some substantive aspects to support good-quality care that have been identified by the Subcommittee that there's a lack of evidence that there is adequate progress particularly since at least the BRAC portion of the timetable is September 2011 and that will be here before we know it. So not having evidence for a year from the recommendations doesn't give confidence that the next year will see real progress unless some things change.

DR. LEDNAR: Dr. Parkinson?

DR. PARKINSON: I also want to draw attention to one of Ken's comments. I think there is embedded in the Committee's response to the response that there are actions that could be

taken today to alleviate both the pace and direction of getting to world-class medical facility and that that is why there is an urgency, that the Committee believes that it doesn't require new legislation, it doesn't require new funding, it requires the Department's will to get on this even when the Committee has self-identified itself as being a resource to help to roll its sleeves and do this if it would be useful. So I think the other element of the cover letter is something to that effect, that this Committee feels that there are actions that are being taken, there are actions that could be taken, there are activities that could be underway today that could impact the delivery of a more likely to be world-class facility by time certain 2011 if that's indeed the decided flow of the discussion that your Committee had, Ken. What was a little weird and disconcerting to me is that Congress comes back in this year's NDAA and says by the way, now we want to see the master plan by March 31, 2010, when really any forward-leaning

integrated health system would have done this in 2003 for where they wanted to be in 2011 or some timeline like that. So now we're going to do it after the facility is essentially open or 3 months before it opens to see the master plan for a world-class medical facility.

Again, this is not pointing fingers at the Department or at Admiral Mateczun or his Committee, it's the way government does work, but we've got to as the DHB/Subcommittee on this area say this is just nonsense, folks, and we can make it better today in a constructive way in that cover letter which would add to this if that's the sense of the body.

DR. KIZER: I might add that the essentiality for having a master plan was presented to this Committee last October. That was one of the first obvious things that jumped out that was missing. That's been a consistent and stable recommendations throughout our deliberations with the Department. Our deliberations were totally transparent and the

Department is well aware of what our thinking has been. I think we're disappointed that having this as one of the prominent recommendations for such a long period of time that less progress has been made in developing the master plan, and I think in some ways that's reflected by the Congress in a relatively short timeline.

There are two or three things like the authority issue and the master plan issue that if rapid, substantial progress were made in that regard, it would change the whole complexion of how things are viewed. There are some critical decisions that have to be made that both facilitate forward progress that would be very consistent with the tone and the specificity of the Committee's recommendations, and absent those, I don't think the Committee at least is very enthusiastic that the end result will be achieved anytime soon if ever.

DR. LEDNAR: Admiral Mateczun shared that the Department has an expectation from Congress to respond by March 2010 and that's going

to be a pretty important communication. The Department I'm sure will make that deadline. What I think is important and where the Board can be helpful is to give some input to the Department that can be reflected in the Department's communication back to the Congress around the master plan and other items in a way that can help the Department. Again that comes to the communication of the Subcommittee's findings to the Department in a timely way, and the more we can make the most-important issues clear and frontloaded especially to Dr. Parkinson's point that there are some actions that can be taken today, that will set the track record for what could really help the Department by March as it responds to Congress. Dr. Luepker?

DR. LUEPKER: I don't want to let them off the hook here, so that if we say at the end of this we realize you have lots of problems in doing this, that isn't helpful as an advisory committee. I think if there are some actionable items and there seem to be, and Mike is talking about it, we

ought to hold their feet to the fire, and the larger plan. I see this as useful to DoD. When they go up to the Hill to describe what they need, they have an advisory board that says you need to do these things. I can't estimate the financial aspects of this. They haven't told us anything about this, and I certainly can't figure out all the convolutions of culture and things like this. I do think that the Committee has said this is what you need to do to make this the best facility you can for the people they take care of and we need to keep pushing in that direction. And blaming Congress, I'm sorry, we can do that. We do that every day, but it doesn't go anywhere.

DR. LEDNAR: Dr. Oxman?

DR. OXMAN: I think there are two things to remember. When this Committee gave its report there was a tremendous sense of urgency because as we speak and by 2010, the construction will be finished and things will have been done which will interfere with -- I don't think world-class is even the appropriate term. I think standard of

care. So that I think there is an enormous urgency and I don't think the fault is Congress'. I think the fault is the DoD. If the DoD is charged by Congress to do something that it can't do with what Congress provides, how is Congress going to provide adequate funding if DoD doesn't say it? We're in the position of being an independent board of experts. If you look at the composition of our Subcommittee. This is the most distinguished group that Congress could find to advise them. So that I think we have to both demand or request of the DoD that they pay attention to the time-critical aspect of this and provide them with ammunition if they need to go to Congress.

DR. LEDNAR: I see two actions or two documents. One is the document that Dr. Kizer and the Subcommittee prepared and shared with us, and I'm going to call in a moment for a vote of the board on this document. The second is building a DHB cover letter to go with this document which gets at some of these additional points in a clear

and direct way. First, Dr. Shamoo?

DR. SHAMOO: Dr. Kizer, I know we are finished discussions so that's why I waited since my point is trivial. I think since we're going to attach this memo with a DHB formal letter, we should have it addressed correctly, saying Wayne Lednar, Vice President, rather than Acting President, because this is going to go way up and it may raise red flags.

DR. LEDNAR: I think that's why we'll ask for the staff's help. Obviously it's partly format and it's partly getting the words correct. But I think if we accept the content of the report as the Subcommittee is bringing it to us -- Ken, did you have something?

DR. KIZER: I was going to note that in the draft before the one you received, you were actually listed as Vice President and Acting President. Based on a query, I was advised that the appropriate term was Acting President. I am now advised that that is not the appropriate term. I would consider correction of that as a

nonsubstantive change. Feel free to correct it as appropriate. I think I might not be quite as willing to accept other changes in the memo.

DR. LEDNAR: Do I hear a motion from the Board about the Subcommittee's report?

DR. SHAMOO: So moved.

DR. LEDNAR: Second?

DR. MASON: Second.

DR. LEDNAR: Is there any discussion? So moved. The Subcommittee's report is accepted. The Board appreciates the work of the Subcommittee and Dr. Kizer in particular. It is the unanimous position of the Board to accept the BRAC Subcommittee of the Defense Health Board's report. All in favor?

(Chorus of ayes.)

DR. LEDNAR: Any opposed? None. It is a unanimous vote on the Subcommittee's report. Dr. Kizer?

DR. KIZER: For clarification, does that acceptance also include the action item of forwarding it to the Deputy Secretary?

DR. LEDNAR: Can you say that again?

DR. KIZER: The vote and the action taken was to accept the memo of the report, and for clarity I was asking whether implied in that was also forwarding the memo to the Deputy Secretary in the Defense Health Board.

DR. LEDNAR: We'll do this as a separate motion. With the report accepted, is there a motion?

DR. OXMAN: So moved, and it should be stated that it was unanimous.

REV CERTAIN: Are we going to write a cover letter to go over this?

DR. SHAMOO: You don't need that. The cover letter is we're going to vote on it. You said so yourself, even though to be very honest we don't need to.

DR. LEDNAR: There will be a communication of this report to the Department. There will be a prepared cover letter to accompany this report that will be communicated to the Department.

REV CERTAIN: In that cover letter would it be wise for us to state very strongly that any deficiencies not corrected that the correction be included in the master plan? The Admiral said to do that we'd have to build a whole new patient care tower because you can't go to single-bed rooms and still have enough beds to meet the needs. It didn't look to me like there's a whole lot of space left out here, but that's a major deficiency that apparently has no solution short of an additional construction piece. So should we include that recommendation or urge or insist that that additional bed facility be included in the master plan when it is finally prepared?

DR. LEDNAR: Dr. Silva and then Dr. Poland.

DR. SILVA: Thank you. I don't know if we need to state that. I like the way John framed the comments because there are many other important items that have to be addressed. The IT is probably underfunded from where I sit without

knowing anything about the facility. But if we send it up saying that there are multiple deficiencies and recognize them and work toward the future to repair them or correct them in order to get the world-class status, and I think that that was the spirit, John, that you were proposing. Just say we have problems. Don't sweep it under the rug. Let's move on to the future. You're doing what you're doing. I don't know if you could even turn off any pouring of concrete or anything at this point.

DR. SHAMOO: Obviously from all the comments there is a time constraint and urgency to the time constraint. Should we label the memo to attach to this called urgent on the top or somewhere in the subject matter? Otherwise they may just sleep on it for a few months.

DR. LEDNAR: We'll have to seek some wisdom on that. Dr. Poland, then Dr. Parkinson?

DR. POLAND: In part I think let's let our executive staff handle some of those details, but this is a memo or report back to us as the

parent board. It needs to have a cover letter that is addressed to the Deputy Secretary but c.c.'ed to the ASD for Health Affairs so that it doesn't just go there and stay but yet both see it. The particulars about whether it has urgent or how those are listed I think we'll seek the appropriate advice of our executive staff, but I think the intent is let's get this to the Deputy Secretary and I would add to the ASD.

DR. LEDNAR: Given the interest we have to get this communication to the Deputy Secretary quickly and the need to prepare a cover letter, I'm going to ask if anyone would like to work with Dr. Poland I to draft those words knowing that we're going to sign up for getting a draft together in the next day or two, quickly, because we really want to get this communication next week to the Deputy Secretary? Dr. Oxman. Dr. Clements. Dr. Poland. Anyone else?

I think we have a plan. Thank you for the energy. This is an important item for the Department. This is an important item for the

Board. We have said that the Defense Health Board is an independent advisory group of expertise who volunteer to provide the very best insight possible to the Department of Defense and this is a test of our walking the talk and I hope that those on the Board feel as though it's been a delivery and thorough consideration and feel proud of the product and the message that's being communicated. And especially to Dr. Kizer and the Subcommittee, this has been a very challenging task that they've taken on and a complex solution, but the Subcommittee is going to need all of our help on the Board to stay the course, and that's what we're here to do.

So that we will conclude our discussion of this agenda item, and returning back to the agenda as it was originally published, we'll go into our next agenda item which is a report by Dr. Shamoo of the Medical Ethics Subcommittee. Dr. Shamoo is the Chair of the Medical Ethics Subcommittee of the Defense Health Board. Dr. Shamoo is Founder and Editor-in-Chief of the

journal "Accountability in Research" as well as Professor and past Chair of the department of biochemistry and molecular biology, Professor of Epidemiology and Preventive Medicine and a member of the graduate faculty of applied professional ethics affiliated with the Center for Biomedical Ethics at the University of Maryland. He also serves as guest faculty of the Applied Research Ethics Program at Sarah Lawrence College. Dr. Shamoo will provide a brief report on the Subcommittee's recent activities, and Dr. Shamoo's material may be founder tab 10 of your meeting book. Dr. Shamoo?

DR. SHAMOO: Thank you very much, Dr. Lednar. Ethics requires a lot of training, but this is the first time we've had an ethics presentation in 3 years of the Defense Health Board's existence, so maybe this is a good start to have more of them.

I'm just going to give you a quick overview of our activities of our inaugural meeting. Who are the members? The bylaws task

force for the Committee. We had an August meeting and agenda topics. The most important part is the topics for future meetings. We spent most of the time, 2-1/2 hours, on that topic.

These are the members of the Committee. All of you know them. We have a person from the ASDH office, Ms. McCracken. Here are the tasks of the Subcommittee by the bylaws, to study the moral values as they apply to medicine and their practical applications in clinical settings. I won't review the rest of it.

We invited two leading bioethicists in the country who have experience with national security/defense issues. They have served on national commissions in both of these areas, Dr. George Annas from Boston University, and Jonathan Moreno who is currently at the University of Pennsylvania. Dr. Annas gave us a quick overview, but also he went over very large studies and ethical challenges of prevention in the U.S. military of suicide, how that study ought to be conducted and what are some of the pitfalls. Dr.

Moreno is interested in the area of neuroethics. This includes the ethical challenges associated with psychophysiology and neuroscience-based technology where you read the mind. He has a book actually published 3 years, "Mind Wars." That includes lie detectors, functional magnetic resonance and infrared. You can actually image brain and/or some of the peripheral blood flow and some of these instruments are being used in the field with either little or no validated research studies.

I said the topics will be very important. What are the topics, how we prioritize them and how we're going to address them. The topics come from the ASDH office. Is there is a question, that will take top priority or from the Executive Director or the two Vice Presidents or from the Chairmen of all the Subcommittees, if they confront an ethical issue and they have written me about it, I have solicited their input. Other issues of course we came up with and these are the topics we prioritized and the reason we

prioritized the first three is Dr. Smith from the ASDH office has an interest in this topic and he will need our input, and that is the treatment of the enemy to be addressed by Dr. Smith, force feeding of hunger strikers, detainees treatment and medical care of the wounded enemy. It may not be currently the highest priority, but this is one of the priorities that was brought to us.

The second one, research and controlled clinical trials. Commander Feeks recommended Lieutenant Maury to us. They want to do research in combat zones. Can you do a clinical trial in a combat zone? That's it in a nutshell. What are the ethical issues surrounding issues of informed content? How are institutional review boards going to act in combat settings? And evaluate the protocol. The whole issue of research with human subjects in the military requires maybe an overview also.

The third topic is ethics education for medical personnel within the medical health system. Currently there is no such program and we

want to investigate it and we will ask Commander Feeks to have someone to brief us on the current status in the Military Health System whether there is any training in medical ethics within the system.

Most members of the Subcommittee felt this Board needs medical ethics training, and they really thought even for half a day to a full day, but I told them you guys are very important and very busy and you may never sit for half a day, let alone a full day. So we have narrowed it down maybe to a couple of hours, maybe an hour. But anyway, you need to be familiar even with the terminology and some of the implications of what we will be doing. That was everybody. There was no discussion on that issue.

The use of unscreened blood transfusion on the battlefield was the topic. As you know, there is currently some practice where we dealt with blood transfusion one time in one of the Subcommittees that you grab the nearest soldier and you give them fresh blood that has not been

tested, that is, not within FDA compliance. If there is an emergency obviously and there is no blood which is FDA compliant, you will use that first. Then as some of the old DHB members remember that with the matter of providing just one additional military airplane they were able to reduce I think by over 50 percent -- Colonel Bader, do you remember by 50 or 70 percent? You don't remember that. Sorry. You may have not been involved in it too. Dr. Poland, weren't you on the teleconference? I'm going to keep going until I find someone.

REV CERTAIN: My memory is similar to yours, Dr. Shamoo.

DR. SHAMOO: Thank you. I knew I wasn't having some delusions.

So there are things you could do to get the compliant blood into the field if you do certain things without starting to consider heroic means to give them a blood transfusion. And it's of course safer in the long run.

I think the third topic we already

talked about. No, we didn't. The ethics treatment of the wounded soldier that is the physician's dual loyalty, that is, to get him quickly back into the war zone versus keeping him in a hospital. This is no different than issues related to physicians for a football team or basketball team, how fast you are going to the solder back to the battlefield.

There are issues of research misconduct. For probably some of you that's not on your radar screen. There was a former military physician and researcher who was involved in a big scandal that was in the newspapers. Has any one of you heard of that? Amazing. It was on TV also. One. Mike Parkinson. A surgeon, and since it's my area, I'm aware of it. But there are others also in the military including research misconduct with a few cases here and there.

The ethics of performance-enhancing drugs and technology to soldiers. The other topic was something I'm not personally enthusiastic about because I think it's a deep hole that we go

into and we will never come out of it. That is, a significant number of former high-ranking active military officers who retire to become lobbyists and project managers for the medical industry. That's a very big order and I don't know how we can put our arms around it to be very honest. You can see that it's low in priority.

These priorities will change as we see something much better and we could reprioritize them. So it's a fluid situation. We are not stuck with it. A colleague insisted that we have hand and face transplants conducted at AFIRM and there are a lot of ethical issues involved with that.

These are our topics. This is what the Medical Ethics Subcommittee became after we lost seven members because of renewal problems. Now you can understand why I was disturbed by it. We are really in suspension until we know about the renewal of board members.

This is what they decided for future meetings. Obviously in 2009 with only three

members, we're not going to meet, and in 2010 we will meet quarterly. Thank you. I will be glad to answer any questions.

DR. LEDNAR: Thank you, Dr. Shamoo. Are there any questions for Dr. Shamoo?

DR. LUEPKER: Dr. Shamoo, when you address these issues, is the outcome a position piece or a report of some type? Is that where you're headed?

DR. SHAMOO: On each topic we will deliberate on it. First we will collect expert opinion and we will collect the literature, and then we will produce hopefully a one to three page white paper back to the board for their adoption, approval, changes or whatever they want.

DR. LEDNAR: Dr. Parkinson?

DR. PARKINSON: Dr. Shamoo, this is an excellent list. I would suggest when you get reconstituted that maybe the first thing that you might want to consider is a fundamental exploration. I remember we talked about the profession of arms and the profession of health

and medicine to define at a high level, what are the guiding principles that are extant in our training curriculum materials, in our residency programs, because I think that review and asking the department to produce DoDIs, Service-specific policies so you can do a policy review of what's out. I don't think there is a consistent approach, yet there is a good body of knowledge that's taught at USUHA, it's taught at the academies, it's taught selectively at some of our officer training schools and our initial health profession schools, NMSO and some of these things that's out there but there is no inventory on this. I think a scrutiny from your fully composed body of what's out there, what's on target, where is our huge hole, would be the first step before we get into the individual hot-topic issues as opposed to ethical foundational work which I think will be most useful to do.

DR. SHAMOO: Mike, as usual you have very keen and important questions and that was discussed in detail. We wanted to know what

medical schools, especially the Uniformed Services University and others, is currently being taught there.

DR. LEDNAR: I think in this area and is true of all the Subcommittees, as we identify areas of opportunity, in this case ethics, it will be important to have a conversation with the Department. Some of the questions may in fact come from the Department like from Dr. Smith. Others may be thoughts within the Committee of important areas for the Department to consider that might be proposed by the Subcommittee to the department. I think what's helpful in that kind of orienting discussion is to try to get the question as clearly framed as possible, the scope is understood as possible, that the priority of either the Department or the Subcommittee is understood by both so that the Department is getting useful product and it's ready to receive it and will assist in its implementation.

I'd encourage again with the help of our senior staff, who are the right people in the

Department to have these conversations so that we get the very best traction of this independent advice. Are there other questions or comments for Dr. Shamoo? We look forward to the success of the senior staff in terms of appointments being acted upon so that Dr. Shamoo and the Medical Ethics Subcommittee is fully staffed with its complement of experts soon so that you can continue this important work.

DR. SHAMOO: Thank you.

DR. LEDNAR: Thank you. Our next agenda item is for Dr. William Halperin to share with us information regarding the Military Occupational/Environmental Health and Medical Surveillance Subcommittee as an update. Dr. Halperin is currently serving as Chair of the Department of Preventive Medicine at the New Jersey Medical School as well as Chair of the Department of Quantitative Methods for the School of Public Health at the University of Medicine and Dentistry in New Jersey. As Chair of the Defense Health Board's Military Occupational/Environmental

Health and Medical Surveillance Subcommittee, he will share with us an update regarding the Subcommittee's recent activities. Dr. Halperin's slides may be found under tab 11 of the folders. Dr. Halperin?

DR. HALPERIN: Thank you very much. I'm going to aim for 5 minutes. Let's start with bastardizing a quote from Mark Twain who responded to an editor and was under deadline by saying, "With more time I could be briefer."

You're more familiar with the work of this Subcommittee in the area of occupational and environmental health. We've briefed you on chromate exposure in Iraq and dioxin exposure in Iraq and so forth. What we're going to focus on a bit today is the surveillance part of our charge. The members of the Subcommittee are very well-situated for dealing with acute exposure and acute turnaround reports having epidemiologists, industrial hygienists, occupational physicians, biostatisticians, et cetera.

Now we come to the charge to the

Subcommittee that deals more with surveillance, and the origin of that charge if you go way back is from Dr. Winkenwerder in 2002 which said the AFEB which is now translated into our Subcommittee if you will, that we would meet with the DoD Centers for Deployment Health Research of which there are three to receive mission briefs and then we would develop in coordination with the directors of these centers an appropriate strategy to accomplish an ongoing program review, et cetera. Essentially the Subcommittee the way we interpret this is going to assess these three research centers and in a certain way become an ongoing standing review committee for these centers. This is a major undertaking to say the least.

To accommodate this task, we needed to do it within the capacity that we have, and I'll tell you how we're dealing with the first review. The first review was at the Naval Research Center that is responsible for the Millennium Cohort Study. The reason that we worked on that one

first is because of the size and the importance of the Millennium Cohort Study. If you remember, they started accruing participants in this study in 2001. The goal is 170,000 participants, and they're up to about 140,000 participants by now. Each participant will be followed for 20 years. That's 3.4 million person years of observation time. I think it would be very hard to find another study anywhere that comes close to the magnitude and the capacity of the Millennium Cohort in the future to answer all sorts of questions.

Aside from accruing, that is registering and getting the participation of the members, they have sent questionnaires to 140,000 members every 3 years so that when this is all said in done over 20 years, then they have seven or eight rounds of questions amongst 170,000 people, and this is a huge volume of work. The way we chose to deal with this charge is a little bit novel which is that Ed Feeks and I after discussing in a telephone conference with the Subcommittee members

what it is that was of interest to the Subcommittee members that Ed and I went out in a little reconnoitering to San Diego and spent time with the scientists out there trying to understand the issues that they were facing and the issues from our point of view that were most substantial. That report which essentially is drafted is going to the rest of the Subcommittee members, we will have another telephone conference to prioritize which are the major issues that they are most concerned about, and do we need a return visit to further debrief the scientists in San Diego. If we do, we will be headed back and we will then periodically be visiting with the Naval Research Center on the Millennium Cohort Study. Then we will turn our focus to the other two deployment research centers in turn.

Essentially that is what I intended to tell you about this morning. If you have questions, I'd be happy to answer them briefly. I would like to reserve a minute for Tom Mason who accepted the challenge yesterday if you'll

remember the discussion about should there be an electronic medical record that is functional and available, Tom has written a draft having to do with all sorts of exposure information and how it should be collected and be available. You have it in front of you. The goal is for you to look at this and then send comments to both of us that we'll look at and revise the recommendation, and then bring it to you as a vote either at the next meeting or perhaps electronically in between.

DR. LEDNAR: Thank you, Dr. Halperin. If I can ask, before Dr. Mason shares with us the wording of the draft to address an issue that came up yesterday, do we have questions for Dr. Halperin?

DR. KAPLAN: Bill, a few years ago there was a Committee that went out there. Was it last year?

DR. HALPERIN: It was the summer 2008.

DR. KAPLAN: There were a series of recommendations in the report. Where is that? Has that been taken into consideration and so

forth?

DR. HALPERIN: Yes. A large number of us went out and were briefed on some of the work of the Millennium Cohort, there were a series of presentations, wonderfully informative and entertaining, but it didn't quite get translated into action if you will. Subsequently the charge has been given to our Subcommittee. We looked at those recommendations. We thought that some of them were not deep enough if you will, so we decided rather than to say something, that it was wiser to hold back and take a refreshed view of it, but those comments were used to inform us of what questions we should address out there.

DR. LEDNAR: Dr. Poland?

DR. POLAND: Bill, with the three centers then, is it the plan to do something like each one would be reviewed in depth every 3 years, for example, or how do you plan to approach that?

DR. HALPERIN: I think it depends on the state of the Centers. My sense, and it's only mine, it's not the Committee's sense, is that with

the Naval Research Center there are enough issues that we ought to be engaging with them every 3 months until things are worked out, and then the frequency could become longer. So I think we have to frame the frequency of this to what we encounter. This is a major undertaking that they're engaged with out there.

DR. LEDNAR: What Dr. Halperin just said reminds me of what we mentioned yesterday for all of our Subcommittees, and that is for the Subcommittee Chairs to take a look at their membership in the Subcommittee hope that all will be reappointed but anticipating that some may not. And looking at are there critical skill gaps, are there volumes of work coming to the Subcommittee issues that suggest that we need to staff the Subcommittee in a way different than we do today? I think Dr. Halperin has put his finger on an understanding of a request to the Subcommittee which the current staffing may not be in a position to meet. Dr. Luepker?

DR. LUEPKER: Bill, as you know, I

chaired a review committee for the Millennium Cohort in 2005 and then 2 weeks ago in Frederick they came out and presented to a group aside from me that does not represent this group under the aegis of AIBS. There are some serious worries about this program and I guess I'd like to be included if possible as we move forward.

DR. HALPERIN: Volunteers accepted with an A. Accepted.

DR. LUEPKER: I accept it.

DR. LEDNAR: Thank you. We will ask Dr. Mason to share his thoughts. Dr. Mason?

DR. MASON: I'll be very brief. What I've attempted to do is capture the essence of the discussion that we had yesterday, and since we in our Subcommittee have been tasked to do the impossible. Qarmat Ali. Sodium dichromate. Still classified. Those of us who have active clearances. Come to Washington. No read-ahead materials. Still classified. Sit in a room within a room. Get briefed. Get all the information that you have and 24 hours later have

something we can go public with. There's a better way to run a railroad. Very simply where we are, very simply, is we need to systematically provide for the ability to assess exposures realized by persons in uniform for their lives and we can't do it because we're not set up to do it.

Yesterday there was this plaintive cry with regard to records being lost and disconnects, et cetera. We are sympathetic to that. We recommend that the electronic medical record plays a part, but will not by any stretch of anyone's imagination replace the hard work that is presently ongoing. Predeployment, postdeployment, postdeployment health reassessments, the nurturing of individuals. What we really are interested in is before the person, him or her, takes his or her oath that we have a really good sense of what's going on. Those of us who are interested in the epidemiology of suicide need to pay attention to family histories. We are a product of so many exposures that we realize before we ever take any oath, before we ever put on any uniform, and we

need to pay attention to that. We need to be very holistic in our approach to military medicine.

What we're suggesting very simply is let's get serious. If we don't start as we said in West Philly when we fought the drug lords, we didn't get in this mess overnight and we're not going to dig out overnight, but if we don't start doing something today we're doomed to failure. What I'm suggesting very simply is read this whenever you have an opportunity and not while you're driving. Look at it. I'm an environmental epidemiologist. That's what I do. That's the what I think. That's the way I look at issues.

The sooner we can actually characterize these individuals and the sooner we can actually deal with the reality and we can actually improve on the assessment of information and use the tools that are available to us, body parts, biologic materials, sync/h that deal exposure. There is not a sync/h for every possible thing that our uniformed services might actually be exposed to, but we get asked and we will continue to be asked,

and quite frankly, I'm very concerned. If we look at agent orange and we look at the Gulf War, we're staring down issues that are related to exposures realized by persons in uniform who are really going to make some of those activities pale because the magnitude is so much larger and the issues are even more complex. We need to get serious about ways in which to utilize techniques that have been used in our own occupational environment. Just because you got a uniform on is not different in any way in many respects from exposures that we realize at a work site. Use some of the respective tools. Use sampling methods. Be creative. When persons come to a clinic, get access to biologic materials. Update the information. Yes, electronic medical records can play a part. They're not going to answer everything at all. But it will push us we believe in the direction that we should be going.

So just consider it. I'm not the least bit protective of any of my words. I'm an academician periodically and I'm also from the

Alsace, I come from a German/French background, so I write exceptionally long sentences. Break them up. Break them up into short, simple declarative sentences. That's what I tell my students. I don't do it. I tell them to do it. Thank you very much.

DR. LEDNAR: Are there any questions for Dr. Mason? Dr. Parkinson?

DR. PARKINSON: Trés bien. It struck me that probably too many years ago there was a discussion which I think would be very useful for your Subcommittee or committee of a committee or whatever to create a useful, understandable framework for optimal individual exposure assessment and a codification. I go back to the experience with agent orange. Of these so-called I was in unit X during the day that the smoke came over turned out to be absolutely if not useless near useless until we got a biomarker of absolute exposure. But it seems to me what the Department could use unless some preventive and occupational colleagues can tell them you've got it today in

Air Force manual X, in other words, what are the leading currently known exposures of interest, what are the emerging exposures of interest and what are the futures exposures of interest and what are the currently available biosensors a la the old radiation detector that we do in X- ray units in terms of acoustic shockwaves? What is the state of the technology that the Defense Health Board can push to say you need to get this embedded in a helmet next year? It would seem to me that that would be an action agenda on the sensor biological monitoring or whatever that would leapfrog the Department with an action agenda that right now is Brownian motion out there, it's the exposure de jure and what are we going to do about this without an assessment of what's currently capable or developmentally there and involves reaching into the research labs, it involves are that are not traditionally epidemiology at all. Maybe you guys are doing that, but I think it might be a good thing to do.

DR. MASON: I thank you very much for

those comments. We play a role, but we play a minor role in comparison to all of the complementary sister disciplines, and until we start doing this which we are not, until we start doing this, we're going to wind up with addressing the concern right now and losing the sight of the fact that there are hundreds of thousands of individuals there who would actually benefit from a systematic review, analysis and promulgation and publication of findings that have an impact on preventive medicine.

DR. LEDNAR: I think what Dr. Parkinson's comments remind us of is the real benefit that the Defense Health Board can provide to the department by leaning forward, anticipating, seeing opportunities for connection within the department of technology expertise, with theater need and connecting those dots in a way that also allows us to understand the experience and to be able to be in a position to answer questions.

DR. MASON: Correct.

DR. LEDNAR: Dr. Fogelman?

DR. FOGELMAN: Tom, can we have your email address?

DR. MASON: --

DR. LEDNAR: So the request is for comments on the draft that you've received, if you would email them to both Dr. Mason and Dr. Halperin for consideration by the Subcommittee. Is there anything else, Bill or Tom? Thank you for that report and that discussion.

Our next agenda item is going to be presented by Dr. Frank Butler. Dr. Butler is a retired captain and Chair of the Committee on Tactical Combat Casualty Care, as well as a member of the Trauma and Injury Subcommittee. An ophthalmologist and former Navy SEAL, he is currently serving as a medical consultant to the Navy Medical Lessons Learned Center as well as an Adjunct Professor of Military and Emergency Medicine at the Uniformed Services University of the Health Sciences. The Board believes trauma and injury treatment and prevention should be a

Department of Defense core competency and is thrilled to have members of this Subcommittee participate in ensuring that such efforts optimally meet the needs of our Service members. On behalf of Dr. John Holcomb, Chair of the Trauma and Injury Subcommittee, Dr. Butler will provide an update on the subcommittee's recent activities. His presentation slides may be found under tab 12 of the meeting binders. Dr. Butler?

DR. BUTLER: Thank you. It's a pleasure to be back. Commander Feeks has asked me to talk fast which is a tall order for us Georgia boys, but I'll give it my best shot.

I would like to bring the Board's attention to two proposed votes that we will go over as we proceed with the brief. The first has to do with battlefield trauma care research priorities. The second has to do with proposed TCCC burn management strategies.

First I would like to give the Board a little bit of feedback. I'm sorry that Dr. Oxman is not here.

DR. OXMAN: I'm right here.

DR. BUTLER: I have some answers to the questions that you raised about what happens to our memos after we sign them and send them out. I think you'll be pleased with a couple of these actions.

You'll remember in Key West we talked about the fact that the literature right now says that among our total combat fatalities, about 20 percent of this might have been prevented with optimal care, and there are now several units who have been using TCCC since the start of the war who have reported zero preventable fatalities despite sustaining about 800 casualties total including 60 deaths. That was translated into the Defense Health Board memo that was signed out by Dr. Holcomb and Dr. Wilensky on August 6 that said that's have everybody and their deploying combatants to do TCCC, let's teach the medical officers what their medics are learning so that they will know. They don't get this stuff in medical school and they don't get it in most

residencies. Let's teach combat leaders to know what their medics are supposed to know. It's their responsibility to make sure it's done right. They have to know what it is. We need to better capture the point of injury data and we need to have a process improvement program that's ongoing. So that was the substance of the memo.

Interestingly, within a month it got picked up and was the feature article in "USA Today." For any of you who didn't see this, I'd be glad to email it to you. The thrust of the article was 20 percent indicates a problem. Second, the Defense Health Board has proposed some solutions. Third, Pentagon, what are you doing about it?

With respect to what are we doing, the memo found its way to Dr. Karen O'Brien who is the Command Surgeon for the U.S. Army Training and Doctrine Command. TRADOC trains everybody outside of medical in the Army. So Colonel O'Brien and I went and briefed her four-star commander about the contents of the memo and he agreed in August of

this year to implement TCCC training for everybody who gets on to a battlefield and for all combat leaders. It was a huge success.

Your memo found its way to the Army Surgeon General's Working Group on Point of Care Injury Documentation and that group used the recommended card as the new standard of care for documenting care on the battlefield. The good news is that the Army has a form that does this. The bad news is of course that the Army has another form, so take that for what you will. This just came out. Your memo found its way to the Deputy Medical Officer of the Marine Corps, and on October 30 this message was released by the Commandant of the Marine Corps that said, "Effective now, this is our new standard of care in the Marines and we will train all combatants, all combat lifesavers and all medics in this." So thanks for the Board for their support and I hope you're pleased with some of the actions that have been taken in the interim.

I'd like to share this study with you.

If traumatic brain injury is the signature injury of this war, tourniquets are the signature lifesaving intervention of this war. This came out in the "Journal of Emergency Medicine" a couple of months ago. It's the largest tourniquet paper as far as I know that's ever been published, 499 casualties, tourniquets on 651 limbs, overall survival was 87 percent. Many of these casualties died of their polytrauma, they were injured in other places besides their extremities. The author noted that there was a very low survival if the tourniquets were applied aftershock had already set in. Complications include transient peripheral neuropathies at 1.5 percent, limbs lost due to tourniquet use, zero. That's a number we can live with. It's sad to note that there were 10 fatalities who died of extremity hemorrhage with no tourniquet being placed. So the battle is being well fought but not completely won.

In the interests of time, what I will do is save the discussion of this fascinating Hextend study that's about to be published and come back

to that with the Board's permission. This is complex. You will have questions about this and it's a great discussion, but it won't be short.

I think it's a reasonable question for this Board to say how are the things that you are recommending for trauma care being accepted by the civilian trauma sector. We had a panel session that was presented in early October at the American College of Surgeons' Clinical Congress. We had a panel session on trauma care advances in the military and TCCC was the prehospital segment of that discussion. In the Scudder Oration which is their named trauma oration each year, Dr. Brent Eastman who is the Chairman of the Board of the American College of Surgeons and a former chair of the Committee on Trauma said the military has got this right. They've got an incredibly well-functioning trauma system in theater. Every Thursday the trauma system as a group get together and discussion every patient who came into the system that week. We discuss every hospital that he or she was admitted to, what was done for them

there and how they responded. And as a process improvement system, I've never seen anything like this. It is fantastic. They react to these conferences by publishing clinical practice guidelines that are implemented in CENTCOM. We all know the military can sometimes be a little sluggish in getting things done and committing to a specific course of action. This is an example of a system that works and these clinical practice guidelines, I really commend them for your perusal. They are posted on the internet and available for anybody to look at. Very positive comments from Dr. Eastman.

On to the new items. The first is battlefield trauma care research priorities, and the second is the treatment of burns. In trying to establish research priorities, we've discussed before that TCCC has had an historic focus on preventable deaths. There are so many great people in this room doing so many great things for our casualties, but the hospitals can't do anything, the rehab people can't do anything, the

family advocates can do something but they can't help the casualties themselves unless we get them off the battlefield alive, and that's our focus. If you read this paper by Joe Kelly that was published in the "Journal of Trauma" last year, potentially survivable deaths, 232 out of a cohort of 982, 85 percent of the preventable deaths were hemorrhage. Using that, the Committee addressed the issue of let's provide some input to our leadership on what we think the priorities are if you are interested in getting your soldiers, sailors, airmen and Marines off the battlefield alive. This is what they were noncompressible hemorrhage control, damage control resuscitation which is the military's term for resuscitation that takes into account more than just fluid volume. You take into account the effects on coagulopathy, the effects on perhaps a forming clot at the site of the injury, the effects of immunomodulation with the fluid that you're using. It is a different way to look at fluid resuscitation.

Documentation of care and process improvement. Improved battlefield analgesia, better ways to train on TCCC, a truncal tourniquet for proximal injuries, better fluid resuscitation for casualties who have hemorrhage and TBI, monitor-driven fluid resuscitation, surgical airway kits and testing of new tourniquets and new hemostatic agents. We should probably stop here and address any concerns, issues or comments that the board has about that list or we can come back to it.

The second vote item is treatment of burns and TCCC. I will say that we have not previously addressed this in our guidelines and you may be thinking it's 8 years into the war. Have these guys been sleeping? Burns have not historically been a leading cause of potentially preventable death nor are they now, however, they're becoming increasingly prevalent and both our leaders in theater and our medics are saying give us some guidance about what to do for burns on the battlefield. I would like to acknowledge

the incredible input on this from the Army Institute of Surgical Research Burn Center. This is where all of our burn casualties go. It's one of the premiere burn centers in the world, and they helped us out immensely with this. We wrote 12 chapters in the "Prehospital Trauma Life-Support Manual." They helped us out by writing one on burns this time, and they did both the chapter and the initial draft of the guidelines.

You'll recall that our phases of care are broken into care under fire, tactical field care and evacuation care. What do you do when you're still in the middle of a gunfight? You get your casualty out of the burning vehicle and you stop the burning process even in the middle of a gunfight. Once you are in a position of relative safety, it might just be behind a wall, it might be that the fighting has stopped, but now you really have a chance to focus on the patient, and this is burn care 101 in many respects, if it's old hat I apologize. Some of it will be new.

First is to pay attention to whatever facial burns the casualty might have because those may indicate inhalation injuries and indicate the need for aggressive airway management. Estimate the total body surface of area of burn using the rule of 9s is pretty standard. Cover the burn area with dry, sterile dressings. This is going to disappoint the people who make millions of dollars selling antibiotic and silver-impregnated things to the military. The burn people said there's not much indication for that. Dry, sterile dressings; if you have somebody with extensive burns, we have a rescue wrap that will serve nicely both to cover their burns and to prevent hypothermia.

Third is that resuscitation is significantly changed. If you have wrestled with the Brooke and Parkland formulas, ISR has determined, A, they're too complicated for medics to calculate on the run out there on the battlefield; and B, they overresuscitate the casualties. There are significant numbers of abdominal compartment syndrome and ARDS in some of

our burn patients and the burn surgeons feel that cutting back on the fluids might not be a bad thing. If the burns are greater than 20 percent of the total body surface area, start fluid resuscitation early on. Lactated ringers, normal saline or Hextend can all be used. If you use Hextend, don't exceed a liter because of coagulopathy concerns. The initial fluid rate is pretty simple. You just take the percent total body surface area burned and multiply by 10, and that is your initial IV rate in milliliters per hour. That works if you're up to 80 kilograms. If you're a big person then they increase that fluid a little bit to 100 milliliters an hour. If you are in hemorrhagic shock it's a different story. Bleeding shock takes precedence over burn shock. There is no argument from the burn surgeons or the trauma surgeons that that was the case, in which case you would restrict fluids and not give more than a liter of Hextend. Analgesia according to the guidelines is they worked previously. The burn folks said absolutely do not

start antibiotics prehospital for these severely burned patients. If you need to do that because they're also shot in the abdomen then do it, but don't do it just for burns. Then lastly, a question came up from the medics concerning, What can we do through burned skin? The answer is anything that you can do. You don't have to avoid doing intraosseous infusions or things like that or needle decompression if you have to do it through a burn. When you move into evacuation care, it is essentially the same as during tactical field care except that there was an emphasis on preventing hypothermia in these helicopter evacuation platforms because it's cold up there at 12,000 feet.

Those are the proposed two items. I will mention that both items were reviewed by the Trauma and Injury Subcommittee on November 4 and were approved unanimously by the 7 of the 10 members who were present at the meeting. That's the lot. Questions?

DR. LEDNAR: Thank you, Dr. Butler. Dr.

Poland?

DR. POLAND: Two questions from an internist so naïve to the surgical aspects. One is, is it possible that at least a controlled level of hypothermia might be desirable?

DR. BUTLER: This question has come up with TBI patients and so many of the patients that we have now are polytrauma. If somebody is in an IED explosion, the person is typically suffering from blast injury, penetrating trauma, burns and blunt trauma. The concern is when we think of hypothermia, as a diving medical officer we're concerned when people drop under 33 or 32. If you read the studies on hypothermia and coagulopathy, however, it's a different story and there are people who define hypothermia in trauma as anything below 36 C because that's when the clotting factors and the platelets functions start to be affected. We try to keep people so that they don't have this impaired coagulation that may contribute to their bleeding to death.

DR. POLAND: My second question relates

to the observation that at least historically all the battlefield casualty care and algorithms that have been developed are probably very male-dominated. Just to give a simple example, we've shown that even in the thinnest women, their deltoid fat pad is thicker than heavier men, and so IM deltoid injections have to use different needles in women versus men. Is that an issue at all for some of the algorithms that you're talking about? After all, they have different percent body fat, different pharmacokinetic compartment sizes, et cetera.

DR. BUTLER: In theory, women would be a little bit protected from hypothermia, and there have been some studies in divers that show that there's a pretty direct correlation between your fat pad layer and how well you do in cold water, and since women do a little more body fat, they do a little bit better in cold water. But there are no differences in any of our algorithms based on gender. They're based on size.

DR. LEDNAR: Dr. Halperin?

DR. HALPERIN: I avoid doing algebra and some other things in public, but if you go back to your tactical field care, is there a typo in the first line there?

DR. BUTLER: Probably.

DR. HALPERIN: It says, "The fluid rate is calculated as percent TBSA times 10 cc's per hour." Should it be times kilogram? No, that's not it. It's the top one. There's something funny.

DR. BUTLER: You're missing the kilograms.

DR. HALPERIN: So it should be times kilograms?

DR. BUTLER: No. The ISR took out the kilograms to simplify the math because we can't do algebra either. But they did put the restriction that this formula really is designed for the individual between 40 and 80 kilograms.

DR. HALPERIN: So it's 10 cc's per hour per kilogram?

DR. BUTLER: Ten cc's per hour times

percent body surface area burned.

DR. MASON: Is percent an absolute number? Let's say someone was 50 percent burned, that would say 5 cc's an hour.

DR. BUTLER: 500 cc's an hour.

DR. MASON: It would be 50 times. It's an absolute and not a percent.

DR. LEDNAR: Bill, does that answer your question?

DR. HALPERIN: No, but maybe now is not the time.

DR. LEDNAR: Dr. Parkinson?

DR. PARKINSON: Dr. Butler, wonderful results and application. As a matter of fact, I think one of the things that the Board would benefit from is that we learn from our own best-practice examples as to how a Subcommittee using evidence focuses on a problem of major impact, does classic quality-improvement work such as supplying models that are out there, brings it to a rapid recommendation, brings it to the DHB for dissemination, and then where did it go

subsequent to that? If we had a crisp description, case study, of this probably represents as far as I know a best practice to the early history of the DHB, not that the DHB did this, it was your Committee and it was good trauma surgeons who did it, but I think summarize this action step in the context of the DHB would be very informative, and if there is an orientation for DHB members it should be part of an orientation material in terms of a best-practice case study. What are we all about here? We're about this. We're about using the leverage of a multidisciplinary DHB with focused expertise around a problem that matters to improve outcomes. I think this needs to be distilled into a best practice in a short order, not a 20-page manuscript, but I think it would be very instructive for all of us because I think it's excellent.

DR. BUTLER: I think it has been a wonderful combination of both backgrounds and abilities. I'll be honest that the TCCC Committee

was skeptical about being moved under the DHB because we weren't sure how an action- oriented group like that composed mostly of very forward-leaning operators and the medics who support them would integrate into the process here. However, I think the thing that is the redeeming quality is that we have always been committed to, understanding that we're not going to have RCTs on the battlefield, you use the absolute best evidence that you can find, and we look very for it. Second, the best answer in the world doesn't do you any good if you can't translate it into action. We have worked hard to try to figure out how to get people to pay attention to the things that we recommend, and absolutely we'd be glad to work with the board on some of the strategies that we've developed.

DR. LEDNAR: Dr. Oxman?

DR. OXMAN: I must say I would like to commend Dr. Butler and his colleagues for this fantastic job, and it certainly makes me very proud to be a nominal supporter.

DR. LEDNAR: If I understand what Dr. Butler would also like is for us not to be only nominal but to be active in supporting the work of the Subcommittee because you have a request for a vote. Is that correct, Dr. Butler?

DR. BUTLER: Yes, sir.

DR. LEDNAR: Would you like to frame the question for vote to the Board, please?

DR. BUTLER: The first vote would be to endorse the battlefield trauma care research priorities with the understanding that they are blended into the context of the many other things that the military does research on. We understand that we only have a little piece of the picture to address, but there are a lot of people selling things to the military that should not be on the battlefield that may be on the battlefield that certainly a lot of research dollars will be spent on. I am mindful of the field surgical laser which is a carbon dioxide laser that was being actively marketed to the military that was going to be placed into the hands of the medics so that

they could do surgery with their carbon dioxide laser in the field. We still have the flying robotic surgery trauma pod out there consuming a lot of R&D dollars. We absolutely support innovation, but first things first, and we still have young men and women bleeding to death out there where a solution could be near at hand if we really focused our research efforts on noncompressible hemorrhage and damage control resuscitation.

DR. LEDNAR: Dr. Oxman?

DR. OXMAN: I'd like to move that we endorse that with enthusiasm.

DR. MASON: Second.

DR. LEDNAR: Is there any further discussion on the proposal? Commander Feeks?

CDR FEEKS: First of all, Captain Butler, if you wouldn't mind, could we go back to slide 15 so that people can look at it. My question is, what is the form of this recommendation? To whom is it addressed?

DR. BUTLER: I think we should work with

the staff to find out how best to address it as we did with the recommendations for the JTF Capital Region. We have had no much success in impacting the research priorities of the DoD in the past and whatever we were doing in that area was wrong, so I think we should re-explore that question and try to come up with a good answer.

CDR FEEKS: So that this would take the form of a memorandum to the Secretary of Defense recommending that those things be research priorities for the Department of Defense? Is that right?

DR. BUTLER: I think it would list all of these things but would have a special emphasis on the top two.

DR. LEDNAR: Dr. Shamoo?

DR. SHAMOO: I think it will be very appropriate that the Subcommittee give us one page or two pages in writing to see exactly what it is with some minimal paragraphs or two of logic behind it, approved unanimously by the Subcommittee or approved by a majority of the

Subcommittee and come back here for our vote because we're voting on something not definitive to be very honest and I don't feel that I'm competent to vote on it now. Maybe everybody else is.

DR. LEDNAR: Dr. Parkinson?

DR. PARKINSON: I applaud the effort that you've had a demonstrated effort in the focused efforts on the TCCC training, but just as the DHB is just learning to walk, no less run, I think that probably the executive team or leadership needs to begin to say what are our primary quarters versus our desired future quarters versus whatever. Is for example reviewing DoD's allocation of research monies, to your point, Frank, there's a lot going on out there. Is the first shot across the bow that the DHB wants to make in this area as opposed to saying it's been brought to our attention that there has been perhaps a lack of sensitivity to the TCCC's research things and we'd like a briefing on how the DHB in its new constitution

could be of more service to the department in allocation of research dollars? This is a strategy issue with staff and I think it should be thought about a little bit before we pass a resolution and send off a hotwire memo in any event. Again this is late at the end of the meeting and late in the day and we don't good decisions generally, so there might be a more deliberative process here which totally may move that way, Frank, but it may be a little premature right now for us as a body.

DR. BUTLER: I understand the concerns. Dr. Shamoo, I absolutely understand that this would benefit from a line or two of explanation under each of these subject headings and I will send that to the staff and let them send it to the Core Board.

DR. LEDNAR: I think that will help bring some clarity and focus to really make sure that not only we but as it goes further that the intention of the Subcommittee is well understood. I think that would be very helpful and we look

forward to that additional document. Dr. Butler, there was a second aspect of action you were seeking?

DR. BUTLER: The second was as the Board knows I think, we maintain a set of TCCC guidelines that are published on the Health Affairs website. We don't publish the changes to the guidelines until we get Board approval and this information will not go out to our medics until we get Board approval. Does it need an action memo from Health Affairs? Do we need to send this up to Ms. Embrey again? I don't know. We could talk about that with the Board, but we do need Board approval before we can get this information out to our medics.

CDR FEEKS: What we have is Captain Butler's slides have bulleted points of recommended changes to the TCCC guidelines to address specifically the treatment of burns in the combat casualty care setting by medics in the field, and that's slides 18 through 25. These are the new guidelines that were recommended and that

were unanimously adopted by the Trauma and Injury Subcommittee at their meeting and are brought forward now for Core Board approval.

DR. LEDNAR: Dr. Poland?

DR. POLAND: In looking through these, there are at face value I think are no difficulties medically with them at all. The one concern I was raising is this feels far down in the weeds to me for DHB to be involved in in the sense of we have not ever historically gotten involved at the level of saying an IV rate is going to be this, or a clinical algorithm, or the way something is going to be treated is X. There is nothing wrong them at all. It's just that this be somewhat precedent setting for us to be involved at this level.

CDR FEEKS: In fact, sir, you're exactly right that there is a new relationship between the people who write the guidelines for tactical combat casualty care and the Defense Health Board in that the Trauma and Injury Subcommittee effectively isn't now the scientific

advisory board for that, and every recommendation that gets passed up requires Core Board approval so that this is new and it's correct.

DR. BUTLER: And it may be worth rethinking at some point because there are a lot of fine-tuning things that we do to the guidelines that may not rise to the level where they really absolutely have to be approved by the Core Board. Your time here is limited and I'm not sure everything needs a Core Board look. As we have been directed by Ms. Embrey and Commander Feeks to function at present, you are required to take a look at any change that we make.

DR. LEDNAR: Dr. Parkinson, Dr. Shamoo and then Dr. Kaplan.

DR. PARKINSON: I think it should be 8 cc's instead of 10. I'm just kidding. It's late. I think it's fine, but clearly to my point earlier, we're just learning how to ride this bike and frankly that's okay, so we are now realizing as Core Board members the delegated authority that the Core Board has given to our Subcommittees of

experts has a tremendous impact, and so if there's a timeliness to this, and I will you as nonsurgeon, nonburn expert primary care doc, simplification of practice guidelines can have a huge impact on outcomes. In other words, these old myths about burned skin and what about the infection risks versus the other, that alone could be very impactful by getting it out in the field and if it's our mission to do that and if it's our charge to do that, I would move that we adopt these guidelines as recommended by our Subcommittee Chair.

DR. LEDNAR: Dr. Shamoo?

DR. SHAMOO: Fifteen slides to me makes no sense. I would like to see it as a memo from the Subcommittee as to what are the guidelines, one, two, three and the changes, and we'll improve them and they could extract whatever portion they want and put it on the website rather than approve just a set of slides. I just don't see us doing that if this is precedent setting.

DR. LEDNAR: Dr. Kaplan?

DR. KAPLAN: I think I would agree with Adil. I've been writing guidelines for many, many years and I agree that simplicity is important. On the other hand, if they come out as a guideline, I think they need to be formatted in which a way, and maybe they are, that they have appropriate references with them rather than just a series of slides. Perhaps that's what you already have, but I would rather than see them formatted before I would care to vote for them at this point in time, not that there is anything wrong with it. I'm not qualified to say so, but I think that I need to look at them a little bit more.

DR. LEDNAR: Dr. Silva?

DR. SILVA: This is an important area that we're all burrowing our way through and I like your term, Mike, riding the bike.

I have two comments, one about this set of guidelines and the previous one. I should have spoken up at that point. A lot of professional societies, all kinds of hospital systems, have

guidelines, but I think the caveat here is it's just a guideline, it's not the standard of practice, we got to be careful here, and that's also been weighed in on by our civil courts in medical malpractice. In California I serve as a consultant to our prison system where we're now looking at the standard of practice of physicians and this keeps coming up. So I'm highlight the sunset here down the pike as we get into guidelines that it's just a guideline, that it's not a standard of care. If we cross the other way then all kinds of things will ripple out of this. This is a caveat.

In terms of the first slide on research priorities, I think a lot of these look good but I feel uncomfortable like anyone here because I don't know all the research going on. I think whatever we draft we send it up. We should have some feedback from DoD from whoever runs the research programs to say why they didn't fund this one or that one or why the priorities are different. We're not here to guide research I

don't think. That's not within our mission.

DR. LEDNAR: I think on the last point that Dr. Silva brings up, what we can do is recommend to the Department that certain people talk to each other about research and together develop what's a rationalized for DoD set of priorities because we don't have all of the information, and until that discussion occurs with Dr. Butler's group and perhaps others who are much closer and much more expert in this, we won't get to the right set of priorities that should be going forward. Dr. Oxman?

DR. OXMAN: I'd like to respectfully disagree with Dr. Silva about guidelines, and that is when the CDC or any other body has guidelines, they have the force of law because if I do something other than the guidelines and I am sued for malpractice, for example, who is Mike Oxman to contradict guidelines from the CDC even if they're incorrect as they have been in the past? So I think guidelines often do have the force of law. But I think also that we have a new Subcommittee

in a sense and they're doing work that's very time-dependent. Our troops are being wounded as we speak and so I think we have to balance our care and conservatism with the need to move quickly. I guess the Executive Committee will have to figure out how to do that, but I would urge us that if we have a Subcommittee that works hard and that has expertise that we don't have, we need to be able to support them, we need to be able to trust their judgment as much as possible, and in this particular area we need to move quickly.

DR. LEDNAR: Dr. O'Leary and then Commander Feeks?

DR. O'LEARY: On Mike's point actually I think in the world of medical malpractice, the issue is not guidelines, it is the standard of care which is different, and compliance with guidelines can be used as an affirmative defense in the case, but it is not the standard of care, that's different, and the reason for this distinction is because there are all sorts of

guidelines, and as you know, some guidelines are in conflict with each other. Guidelines often reflect a certain unintended bias sometimes and intended bias. All that having been said doesn't mean that it's not important to pay careful attention to the guidelines, but I don't want them to be made out to be more than they are.

DR. SILVA: The standard is what a reasonable and prudent practitioner would apply.

DR. O'LEARY: That's right.

DR. SILVA: That's the standard. That's been laid out in courts of law in numerous state supreme court levels and our Supreme Court.

DR. LEDNAR: Commander Feeks?

CDR FEEKS: What you see happening today is going to happen more and more often as the Defense Health Board grows into its new identity. You have Subcommittees populated by subject-matter experts who forward recommendations to the core of the Defense Health Board which is a strategic decision-making body. Just like any other strategic decision maker, you don't have the

luxury of only making decisions about stuff you know a lot about. There are people on this Board who know a lot of stuff that you don't much about, but we have a collection of very bright people who are not being asked to make strategic decisions based upon the recommendations of very bright o who know a lot about what they're talking about.

Historically our ancestor organizations didn't even have any trauma or surgery expertise at all. The Defense Health Board now covers the spectrum of all matters related to health including now one of our newest Subcommittees, trauma and injury, and they have looked very carefully at this and they think that this set of guidelines for burn care in the battlefield setting by battlefield medics is the right thing to do, and now they've presented it to a strategic decision-making body for action.

DR. BUTLER: If I could jump in here, I really appreciate the comments of the Board and I think based on the comments I need to take another minute and explain to you how these guidelines are

developed and published.

If you look on the website, the website has the guideline.

CDR FEEKS: This is the MHS website. Right?

DR. BUTLER: This is the Military Health System website. It says here is what you do, and that's what we conveyed to the 21-year-old medic who has to learn everything about medicine that he's going to know in 16 weeks. It is here is what you do. As physicians, do we need to justify the things that we're recommending? Of course. So the way that we provide the scientific background is we work with the American College of Surgeons' Committee on Trauma, we have a huge section of the "Prehospital Hospital Trauma" manual that we own. I for better or worse am the editor of the military version of the "Prehospital Trauma" manual. If you wish to explore the scientific basis and the evidence that we have for the things that are in the 10 pages of guidelines, I would commend for your reading pleasure the 500

pages that are in the "Prehospital Trauma Life Support" manual that does provide extensive documentation and available evidence for what we're recommending with the caveat, again, there are no RCTs on the battlefield so that we do the best we can with what we have.

DR. LEDNAR: Dr. Luepker, then Dr. Poland?

DR. LUEPKER: I am not an expert in this. I however understand the urgency of getting the state-of-the-art recommendations to the field and I'm not deterred by the slides. I think if it's a formatting issue, we can vote on it and let experts format it. I think this should come to a vote today. I don't think we're going to get more.

DR. LEDNAR: Dr. Poland?

DR. POLAND: Frank, I think you just said something to me. I think you implied that through the ACS that these are vetted through a professional organization.

DR. BUTLER: Through three professional

organizations, the Committee on Trauma, the National Association of EMTs, and the Prehospital Trauma Life Support group.

DR. POLAND: That I think changes things considerably. I know that when we attempt to come up with guidelines at the Advisory Committee on Immunization Practices for just a vaccine if you will, we'll spend a half-day hearing the evidence base in order to vote. I think it's a very different thing if those guidelines are evidence based and have been vetted through professional organizations, in this case multiple ones. I think it becomes not quite this, but almost a little bit more pro forma then for us as a Board to have heard that, to hear from our own expert Subcommittee that they agree with these vetted guidelines through professional societies and I think makes our job and my conscience a little easier that I don't have to go and review all of those data before I vote on something like this.

DR. LEDNAR: Dr. Kaplan?

DR. KAPLAN: Can you interchange the

word "vetted" and endorsed? If they've been endorsed by those groups, and I have no problem with it either.

DR. POLAND: That's what I meant.

DR. KAPLAN: You meant endorsed?

DR. POLAND: Endorsed.

DR. KAPLAN: Let the minutes show that you agreed with me.

DR. BUTLER: I would add to this already complex discussion the fact that while the Executive Committee of the Prehospital Life Support Group has looked at the chapter that is going to be included, the new manual is not coming out until September 2010, but all the chapters are in and we have the burn chapter.

CDR FEEKS: I was looking for the American College of Surgeons' page. Thank you, sir.

DR. BUTLER: For the prehospital trauma section, the American College of Surgeons endorses the guidelines that are developed by the Prehospital Life Support Executive Council which

is a collaborative effort of the National Association of EMTs and the Committee on Trauma so that the entire American College of Surgeons hasn't see these, the entire Committee on Trauma has not see them, but the PHTLS group has seen them.

DR. KAPLAN: So the word is endorsed. Can you say that these guidelines as Greg pointed out have been not vetted bur endorsed by an august group like that before?

DR. BUTLER: We will be able to say that in September 2010 when it's published and there's the actual seal of endorsement from the American College of Surgeons.

DR. KAPLAN: But for all intents and purposes, it has been endorsed, we're just waiting for the printing presses to get rolling?

DR. BUTLER: That is correct.

DR. KAPLAN: If it's been endorsed then I have no problem with it.

DR. LEDNAR: Dr. Parkinson?

DR. PARKINSON: This is to my point that

what we have is we have a charter and we have bylaws, we don't have an OPs manual for the Defense Health Board and we need to start creating that yesterday. I know you've got everything else on your plate Ed, but guidelines approval, how does it work from the Committees? Obviously the criteria is that it's important, it's neither necessary, it may not even be sufficient for it to be endorsed by an outside. There will be military unique things where they will not be able to go perhaps to the Prehospital Committee of the ACS because they've never seen these types of stuff from the military. So somewhere there needs to be for the five or six actions of the DHB which comprise 90 percent of our work, we need an OPs manual that is informative to our Committees and that is informative to our Board members both for orientation and for preliminary vetting with a minimal amount of bureaucracy and a minimal amount of codification so we facility this. This is not surprising, it's a healthy dialogue, but all the more reason that the OPs manual build has to

start.

DR. LEDNAR: Dr. Shamoo?

DR. SHAMOO: Before something we were discussing on research, and I was going to ask the leadership is the research portfolio of DOD on health part of our own prerogative here to discuss and make decisions? My understanding was yes if I remember the charter and the bylaws, but if that is true, then we need to look at the mix of research rather than keeping those in one thing at a time and we don't know how this fits.

CDR FEEKS: This is a recommending body to the Secretary of Defense and there is no reason why it can't make recommendations on areas of research, but I think your point is well taken that it should be in the context or it should take the whole picture into account.

DR. LEDNAR: What I've heard is that there has been a lot of discussion before today by people who are very close to this issue of trauma care. It's been very thoroughly evaluated by our Subcommittee. It's been brought here for us to

understand. I think that Dr. Shamoo raised a good point, and with Dr. Kaplan I heard a similar thought that it's a little hard to know what we're voting on without a little bit more packaging of the thought, and I expect that for Dr. Butler that all of this is already there, it's a matter of perhaps working with the staff to just pull this together into a document.

With that said, I come back to Dr. Luepker's thought and that is will there really be any additional value to delay a vote by the Board on the basis of what we've heard? Do I hear a motion.

DR. SILVA: So moved.

DR. SHAMOO: I want to hear what the motion is.

DR. LEDNAR: Can someone propose a motion? Dr. Silva?

DR. SILVA: I propose that we approve the publication as soon as possible since lives are on the line of the recommendations related to tourniquets and also fluid replacement in burn

1 therapy. Does that help, Dr. Butler?
2 DR. BUTLER: It absolutely does. Thank
3 you.
4 DR. LEDNAR: Second?
5 SPEAKER: Second.
6 DR. LEDNAR: Is there any discussion?
7 DR. KAPLAN: Yes. A question, now or in
8 a new format?
9 CDR FEEKS: What's being proposed
10 is that the new guidelines for treatment of burns
11 in the battlefield setting by combat medics be
12 adopted. That's what's being proposed.
13 DR. OXMAN: Now?
14 CDR FEEKS: Yes.
15 DR. OXMAN: Recognizing that with staff
16 help it'll be put into a format that's a little
17 more typical than a set of four slides?
18 DR. SHAMOO: I would like to see it in
19 writing. I'm not going to vote on a set of slides
20 on an oral discussion that I don't know what it is
21 going to be. So I'm going to withhold my vote if
22 I'm going to vote on something I don't know

anything about. I need a document to be responsible for my vote on it.

DR. BUTLER: Can anybody pull down the TCCC guidelines from the website now? As I said, there's a 10-page set of guidelines. What we would do is take the text that's in those slides and incorporate those into the 10 pages of guidelines that are already there so that it would be a cut and paste into a 10-page existing document, and the document is available on the internet. Maybe we could get it up on the screen somehow.

DR. LEDNAR: Dr. Parkinson?

DR. PARKINSON: If I can propose that we're all well intentioned here but we're trying to put 5 pounds into a 2-pound bag here all of a sudden because we don't have our OPs manual processes right, and it's more important I think that we do this right the first time than we create a sturm and drang, if we could say rapid cycle, whether that's 24 hours or something, we know where it is on the website and we can print

it off and put it in an email attachment to the Board members in an hour. We could give the Executive Committee the authority absent any strong objections, but I think Adil's point is absolutely right. It was there. I didn't know about it. Frankly, four slides with 10 bullets is good, but it's an intro. So I'd feel much more comfortable if we were true to a process and begin to develop that process using this as our first time out of the chute. There is no attribution here. It's just doing it better than we would if we just approved right now.

DR. LEDNAR: Is there any further discussion? I'm going to need some help on Robert's Rules of Order.

DR. SILVA: I'll withdraw the motion.

DR. LEDNAR: So the motion that Dr. Silva is withdrawn. What I hear as a proposed path forward is, Dr. Butler, that you with the help of the staff pull together a document, you can link or direct us to useful reference materials, but to build a document then that can

be shared with the Core Board, and the Core Board commits that we will have a prompt review and vote on that.

DR. BUTLER: I can do that.

DR. LEDNAR: Commander Feeks?

CDR FEEKS: I was going to say if it seems new to us, I think that this is a species of a recommendation and recommendations are what this Board has always been about. If this is a new-looking species, it will become more familiar the next time and the next time, so that that is one thing. The next thing I would say is you are not obliged to redo the work of the Subcommittee because they've already done that for you. That's all.

DR. LEDNAR: I think that's understood. To Dr. Parkinson's wise counsel to us, we want a streamlined, efficient, bureaucratically scrubbed process that we can use because this kind of issue will come up increasingly in the future. Dr. Kaplan?

DR. KAPLAN: I think what you've said is

fine with me, to see a document. The other thing I was about to say was that if I get up a leave it's not because I'm mad, it's because we have to catch an airplane.

DR. LEDNAR: I think one other aspect as our operations practice is evolving that I would suggest is that we understand this approach that the DHB staff work with the briefers who are coming to the Board as much as possible to present at that time something that would be easy for us to vote on so that we don't add the extra step of leaving the Board meeting and needing to prepare a document after the fact.

DR. BUTLER: When I redo the guidelines and incorporate these five slides into five lines in the document, I will highlight those in red and I'll remind the Board that everything in the document except for those five lines has been approved by ASD Health Affairs previously so that it's not a vote on the entire set of guidelines because many of what's in there might be new to you.

DR. LEDNAR: I think we have a plan going forward. Thank you, Dr. Butler, for this discussion and presentation, and we look forward to receiving your document to the Board just as soon as you're able to do that. I'm going to suggest that we do one additional brief and then we're going to break for lunch. I take that back. With the very wise of our preventive-health thinking for our health, Commander Feeks says in fact that the food has been laid out. The time and temperature considerations suggest that we not wait another hour before we consume what's there. So we're going to ask Commander Feeks to give us instructions and what we're going to do next.

CDR FEEKS: It's been a really full day and we still have some more work to do. I appreciate everyone's patience. Let's get our lunch and bring it in here and we'll continue. So let's resume our work in 15 minutes.

(Recess)

DR. LEDNAR: I'd ask if we can continue. Please feel comfortable to eat your lunch. I hope

that's okay with Colonel McPherson. Let me introduce Colonel McPherson who is our next speaker. She is currently serving as the Executive Secretary of the DoD Task Force on the Prevention of Suicide by Members of the Armed Forces. Prior to this recent appointment, Colonel McPherson served as the Chief Financial Officer for the Air Force Medical Service. There she was responsible for the execution of $5.1 billion annual budget serving 74 military treatment facilities and 2.6 million beneficiaries worldwide. Colonel McPherson was the key fiscal adviser to the Surgeon General, Headquarters AFMS Staff and the Major Command Medical Staffs on all Air Force Medical Service policy matters. She had specific responsibility for financial statement preparation and audit readiness for AFMS in support of the Defense Health Program's budget submissions and prepared the Air Force Surgeon and Deputy Surgeon General to represent AFMS positions on financial matters appearing before the Senior Military Medical Advisory Council, Congress, CSAF

and CKAF. Her presentation slides may be found under Tab 13 of your meeting binders. Colonel McPherson?

Col MCPHERSON: Thank you. As you may have recalled from an earlier introduction, I began work at this job last week. I had my training on FACA Wednesday and Thursday. I met General Volpe on Friday. On Tuesday we had our first Task Force meeting, and since Wednesday evening I've been with this August group. Therefore, in my continuing quest to smash 3 months of learning into 10 days, I am providing you your update this morning on the Suicide Prevention Task Force. I would ask your indulgence of my neophyte status. I would rather not be perceived as the gentleman on the screen.

A quick overview. Obviously, the Task Force membership questions, this will be the shortest briefing you have today, quick summaries from the October and November meetings and then where we're planning on going in the future.

Neither General Volpe nor Ms. Carroll

were able to be here today. Ms. Carroll was here yesterday. She's flying off to Germany this morning and hopefully one of them will be available at the next update, otherwise I will be here with your next quarterly update.

The questions to be addressed by the Task Force are mandated in Section 733 of the 2009 NDAA. They generally fall into three basic categories, trends, causal factors, effects of deployments, specialties affected or most affected by suicides in the military, then education and preventive programs, what's in place, what's working, suggestions for ways ahead on those. And then a plethora of questions related to investigations and how we do investigations and how investigations are standardized.

In August they had a very quick organizational meeting where they got their training and learned about special employees and regular employees, and their first public meeting was October 1 and there was a review by each of the services on the suicide prevention programs

that they do have in place at this time. We also had information from Army Surveillance and Research, and of course the Armed Forces Institute of Pathology.

October 8 was a meeting in San Diego in conjunction with Ms. Bonnie Carroll's program, the Tragedy Assistance Program for Survivors which was founded by her in the early 1900s when her husband was killed in a C-12 airplane crash and has now taken on a specific focus for survivors of suicide. There were several briefings provided. The DODSR report was gone over, the DCoE folks were out there and then the rest of the day was spent with families who had lost a loved one to suicide. Then for several of the Board members who stayed, the Task Force members stayed and spent the weekend with a group of 350 family members who had lost their loved ones to suicide and experienced what Ms. Carroll's program is about.

November 10, Tuesday, we went had additional briefings from the DCoE and excellent

briefings by General Sutton, Colleen McGuire and a superb briefing by Colonel Hoge. I think most of you are familiar with some his work which was interesting, CHPPM briefed, and in the Service panel discussion we had three young ladies who had both attempted and survived their suicide attempts talked to us. There were very striking similarities in their stories which rolled in with a lot of the information that Ms. Carroll is discovering in her work with suicide and the family members of suicide victims.

For the future, I think most of you have heard that General Volpe is moving out to Madigan Army Medical Center in the February-March timeframe. He will still continue to be a Co-Chair of the Task Force. We are though going to accelerate a lot of things prior to his departure. The game plan right now is there is a prep session just to get organized since I just came on board and look at our way ahead, do we want Subcommittees, what's our travel schedule going to be, what is the schedule working backward

from August when our report is due to Congress, what else are we going to do and how are we going to run the Subcommittee. Then December 15 our focus is on the large number of questions related to investigations and how we investigate. Then in January there is also the DOD/VA Joint Conference on Suicide Prevention which rolls immediately into the next Task Force meeting. Pending your questions, that is the extent of the comments I was prepared to make today.

DR. LEDNAR: Colonel McPherson, you have in your usual way jumped right into the saddle and are galloping off on this. We are impressed by how much you've done in the last 2 weeks.

A thought for you. The meeting on December 15 is called to my mind. That's the thought of root cause understanding, and obviously one way to look at suicide attempts is it's a tremendously significant plea for help in someone who's feeling overwhelmed and without other options. The thought I'm having is not to overmedicalize this issue in how we go at it or

how we would propose solutions. In some ways this issue of suicide may reflect how Service members are able or not to live and operate in the culture with the demands of being in the military these days, whether it's OPs tempo or other things. An analogous message from the civilian setting that we try to reinforce is that the health and safety of the work group is the responsibility of the line commander. We in the medical field advise, offer counsel, engage resources, but the responsibility for the health and well-being of the service members rests with the line. To the extent that they're not only involved but understanding what are all the levers that are involved in what could be this outcome of suicide beyond the medical, that I think will be very important to having a solution which is both sustainable and effective.

Are there other questions or comments? Dr. Silva?

DR. SILVA: Thank you for assuming this important post. I think everyone knows here knows

that suicide in the military is a big issue for the country. It's really touched all of our citizens. Have the rates gone up or down -- I know you're new to the post -- versus in the field versus in the United States on return from a mission?

Col MCPHERSON: The overall rate for the Army has just now matched the civilian rate of about 20 per 100,000. From the information I've briefly reviewed, we are seeing more of them at home than we are seeing in the field. The briefings from the first one reviewing the minutes were very clear that every single one of the Services briefed at that time that were not seeing a correlation with number or length of deployments with the suicide. I've learned a new term which is the confounding of data. Because so many of them are Reservists and Guards and once they move out we are not tracking to find out if they then later on commit suicide, so that's one of the things that we'll be looking at. There does not seem to be any tracking once you've departed

active Service, but right now the data that we saw shows that there is not a correlation to number of deployments and that are much more still happening at home versus in the field.

MR. MIDDLETON: Dr. Silva, one of the things that might help as well is that as Colonel McPherson said, in the Guard and Reserve because of the vagaries with which some of these are reported by local coroners, there's not a really good tracking system for the Reserve and Guard to determine exactly if there is a correlation of a deployment and an actual suicide versus something that's reported as a different cause of death, and it's one of the confounders that we have in the Department and it's one of the things that I know the Task Force is going to wrestle with. We talked the Assistant Secretary of Reserve Affairs office about the same issue so that we will have an understanding on the reserve and guard side. The actives are a little clearer numbers, but on the Guard and Reserve side it's really a problem.

DR. SILVA: At U.C. Davis School of

Medicine in the last 3 years we've had two suicides in men and all have had Iraqi experience. I don't know how to get my arms around that problem. I know the AAMC is worried about it, but that's only one cohort of people in the military who train. Maybe the Dean at USHUS could talk to the people in the AAMC about accumulating data because I hear about it grapevine and I haven't had time to confirm it, but a nearby school has had a similar experience with veterans returning.

MR. MIDDLETON: I'll pass that to Colonel McPherson. Maybe that's one of the considerations she could use with the Task Force to talk to Dr. Rice over at the university.

DR. HALPERIN: Again recognizing that you're new to the job, I see that Colonel Hoge has briefed your Panel, but are there epidemiologists and public health people on the panel?

Col MCPHERSON: Sir, I don't believe so. I'd have to go back. Their names are listed and I have their biographies. They're with me in

a briefcase. I could take a quick look.

DR. HALPERIN: It's my obtuse way of making a suggestion that there ought to be.

Col MCPHERSON: Congress determined who was to be on the Task Force.

DR. HALPERIN: That's a problem. There might be a way to staff the Panel with some consultant public health -- then the next question I want to ask you again not expecting that you would know with being there for 5 working days. Is there a liaison between this Panel and the Millennium Cohort?

Col MCPHERSON: Not specifically, but we have learned about them and right now my Booz Allen staff is making contact with them because that became very apparent all through the briefings on Tuesday that we need to be talking to those folks out there. It's going to be very interesting to see what they come up. That's going to be an incredible source of information.

DR. LEDNAR: Dr. Shamoo?

DR. SHAMOO: I have extensive experience

with the National Alliance for the Mentally Ill. I used to be on their board of directors as a matter of fact. They are very familiar and they deal with issues. They are the largest organization with issues of suicide. They have a committee on military personnel, issues of mental illness and suicide. So I would suggest if they could helpful you may as well knock on the door and see if they could be helpful.

DR. LEDNAR: Are there any other comments for Colonel McPherson?

DR. COHOON: Barbara Cohoon of the National Military Family Association. I know you're chartered by Congress, but I think it would be very interesting to know as far as the impact on the family member and family members of those who were left behind especially since Bonnie Carroll is looking at that particular piece. We do hear that they are left with a lot of issues.

Also to you in looking at suicide as far as the family and are we looking at children or adolescents or the spouse themselves because of

the frequent deployments? We are not really doing a very good job of tracking of that. I know that in the NDAA that just passed they're going to be looking at the impact of the war on children, but since you're looking at suicide, I think it would be important to know how many suicides we've seen within family members because of the frequently deployments.

DR. LEDNAR: Are there any other comments? Colonel McPherson, we look forward to work that your Task Force is doing and hearing updates, and obviously if there is any way that the Board can help connect resources within the board to the work of your Task Force, we are certainly eager to do that.

Col MCPHERSON: Thank you.

DR. LEDNAR: Thank you. Our next agenda item is a presentation by Commander Jim Hancock. Commander Hancock was deployed as the Joint Task Force Surgeon for multiple missions in support of Naval Special Warfare. Commander Hancock and his team developed and deployed the new concept of

operations for resuscitative surgery aboard small combatant ships engaged in distributive operations which serve as the prototype for today's expeditionary resuscitative surgical system. In spring 2008, Commander Hancock deployed as Task Force Surgeon with the 2nd Battalion, 7th Marines, in support of Operation Enduring Freedom. Faced with extended casualty evacuations, Commander Hancock developed and deployed the Tactical Trauma Team concept with mobile trauma bays providing advanced resuscitative trauma far forward in support of expanded company operations. In February of this year, Commander Hancock was selected as the Navy and Marine Corps representative on the Chairman, Joint Chiefs of Staff's Grey Team which is tasked to evaluate and advise the Chairman on all facets of traumatic brain injury treatment. Subsequently, he deployed back to Iraq and Afghanistan in efforts to optimize the treatment of traumatic brain injury. Commander Hancock currently serves as Director, Medical Services, Naval Hospital, Camp Lejeune,

and serves on the Navy's Trauma Advisory Council. His personal decorations include the Legion of Merit, Purple Heart, Meritorious Service Medal, Two Awards, Joint Meritorious Medal, Navy and Marine Corps Commendation Medal, Two Awards, and Navy and Marine Corps Achievement Medal, Three Awards. Commander Hancock, we appreciate your traveling up from Camp Lejeune to share your experiences with us.

CDR HANCOCK: That was a whole, big discussion to say that you have a simple emergency physician standing in front of you, and what I hope to do today is bring you the story of what your work is doing so as you go on these long days and you eat your meal as you go, why are you doing it? I hope to bring that to you today. So we'll talk a little bit about what's going on in Afghanistan and why it's different than what we saw in Iraq, why it's different than what I saw in Kosovo, why it's been different than other way that we've had. We'll talk a little bit about NATO because this board has to be cognizant of the

fact that we work well within ourselves, but what happens when we go outside ourselves. Then we'll talk a little bit about my passion which is adaptive resuscitative medical efforts and combat training for medical assets and why that's important, and why the Board should understand what that means.

What you normally have sitting here at your Board is a 20,000 foot view. You really look from the very stratosphere to try to make these strategic decisions. What I hope to do is bring you to ground zero.

Ground zero in Afghanistan for me in March 2008 was the fact that I was supposed to deploy on a mission that involved the training and mentoring of Afghan police. We as a battalion were supposed to go through and replace Army unit and establish FOBs and replace them. The reality is as you may remember from the news that in 2008 the Taliban didn't want to play our game. They changed the table. The reality was that General Cohen said to us, "Marines have to be Marines. I

want you to go be Marines." What did that involve? That involved the nonsequential taking over, the simultaneously taking over of 10 FOBs over 11,000 square miles. So my AOR was to provide trauma support to the State of New Hampshire with a single shock trauma platoon which is 20 people, an emergency physician and a family physician, and our indigenous assets. That's why when Dr. Butler talked to you about having to have that pretraining why it's so important.

The reality is that that mission statement often goes unnoticed, that little red part there, the counterinsurgency operation, because we in the Marine Corps do not deploy without a special MAGFT. What does mean to you? It means that we don't normally deploy without our own support and logistics support, but this was supposed to be a training mission and it turned into something quite different.

The reality was that our AOR was 11,000 square miles. When you compare that to what happened in Iraq, it was significantly different.

What you see outlined is our AOR for each company versus what we had the year before in Iraq. The reality of Iraq is that we were very successful. We took a trauma support system and we made it the model that you saw attributed there. In fact, if you had -- in Iraq in those years, you probably could get it analyzed before it defused by helicopter. In other words, we had acute trauma support available.

That was very different than in Afghanistan. In Afghanistan, time and distance was of the essence. In Afghanistan, you had a population that was strung out. The Chairman likes to say that we are rebuilding in Iraq and we're building in Afghanistan. It is very different. You're talking about a population that has a life expectancy of 42 years of age, a population that understands and appreciates that one-third of their women will die in childbirth. One-third of their children will die before the age of 6 of disease or injury. It's a reality of their world. You're talking about a population

who has been fighting since the beginning of time.

It's not built up at all. The reality is that there is one single road in all of Afghanistan. That road is called the Ring Road. It has the dubious distinction of being the most mined road in all of the world. Why is it important? It's important because as we try to provide medical care, as you make your decisions to provide medical care across the DoD, the reality is that there are times when our enemies understand it better than we do.

On a normal mission to a FOB, this was our mission, just trying to go visit the FOB to understand what was going on, what can happen to you on a daily basis?

(Video played)

CDR HANCOCK: IED; one dead immediately. Both of my gunners were shot. Now come the RPGs. Understand this was not a combat mission. This was a mission for the resupply of medical assets to the FOB. This had nothing to do with combat. Understand that this was done at

about 10,000 feet. Understand that you're on a mountainside. Ladies and gentlemen, I will submit to you that if we can provide trauma care at this edge, that we can provide trauma anywhere in the world in any conflict at any time.

The reality was that in his atmosphere that was brutal, in this atmosphere that I saw 140 degrees in July, minus 40 in February all in the same place, in an atmosphere where you've had a drought for 10 years, in an atmosphere when you have 120 days of wind in Southern Helmand Province. What does that cause? What you see here is a brownout. We had great resuscitative capability planned for that day until the brownout came and we lost of our helicopters because we couldn't fly in it. This stuff will get into everything. This sand is so fine that it is like confectioner's sugar.

The reality is that the Afghan people are affable, they're hard working, and most of them, at least the educated ones which is 98 percent of the population, they just want this war to be over. The reality is that in their culture they grow poppies like we grow

corn. This is the village center. They're not trying to hide their poppies. It's not like growing marijuana in California. This is their culture and this is what they provide. The reality is that anywhere you find water in Afghanistan and green, that's where you're going to find families. You're going to find culture. The reality is that they live in these mud huts, and you wonder why disease and famine is there. The fact is that they live with their pets, they live with their livestock, they live in their culture without any heat, any running water or anything that goes with that.

The reality is that no matter where you look in Afghanistan you're going to see the ravages of war. These people have been fighting since the beginning of time. Several distinctive attempts have been made to occupy this country, whether it's the castle of Alexander the Great, or the modern warfare of you see with the Russians in the 1980s when they failed to succeed and take over this country.

The reality is that this harsh environment breeds things that you'd never imagine, whether it's the

neurotoxic elaphids of the snakes that we currently don't have good antivenom for, all the way to the dogs. The Afghan people and Michael Vick have a lot in common. They enjoy dog fighting. It is part of their culture. This is Cujo. Cujo lived outside our FOB. He weighed about 180 pounds. It was interesting though, because every day we had a combat day, you could hear the dogs howling. Why was that? Because it was not unusual to drive out of the FOB and see Cujo feasting on human remains. That's how he survived.

All the way to the scorpions. I've been by scorpions in the deserts of Iraq. It hurt, it stung, it was bad. When I was stung by a scorpion in the fields of Afghanistan, what I can tell you is it felt like a ball bat. Furthermore, we've had 20 isolated cases of abdominal compartment syndrome without pancreatitis from this little bugger. We can't explain it, but it's there.

NATO medicine. I would ask you to close your eyes and think back to the "Star Wars" move to the bar scene, and what you would see is NATO medicine. Why is that?

Because you're going to see different uniforms, different languages, different ways of doing everything. All of them are right in some contexts. In some context to some degree all of them are right, but it's different.

The reality is to understand NATO you have to understand the language. What is the language difference? We talk about levels within the U.S. construct about levels of care and how we provide that. The difference between levels of goals is because it's a financial difference (inaudible) it is a modern hospital. It has brick and mortar. It is funded by the British government absolutely. It has laboratory capabilities. It has X-ray capabilities that is portable and digital so that they can be read remotely. It has modern trauma bays or a trauma system -- wherever you ago. But again, the funding for this comes from the British government. What is the problem with this hospital? Why am I bringing it to your attention? The problem is (inaudible) you saw was that there were five different countries' gears. Why is it a problem? It's not a problem until you try

to provide power to it, you try to provide an adapter to it, you hook an oxygen supply up, it becomes a difference.

This was prophetic. I dropped off some casualties at this Kandahar Role 3 and I got this picture here and it tells the story. What does it tell the story of? It tells us that there are different countries that take different care of their stretchers. Some clean them, some don't. What you really should see in this slide is that there are only two of those stretchers that will fit in my MRAPs, that will fit in my helicopters. That's the big issue.

Then when you talk about purple, you hear purple, your tri-service, your DoD. We in the military have problems with that at times. I'm a Naval Academy graduate and I'm a USUHS graduate. I have a lot of reasons to hate the Army. So every time I've worked with them I've felt like there was a service issue, so we did our very best. In March 2008 up in Kulat and Zabul Provinces, the Army was doing one heck of a job. Unfortunately, they were taking massive casualties. When they were taking those casualties, they were

having to over fly the FST, the forward surgical team. The reason they were having to do that is because they had no holding capability there. I had a shock trauma platoon that wasn't currently engaged. It only made common sense to put me there, provide them a triage capability and provide them a holding capability. I knew what I was going to do and my boss said go do it, get it done. Being a planner, I thought to myself I came up with about 4 hours of my life that I'll never get planning on how I was going to deal with the Army, how I wasn't going to end up with a price tag at the end of the day. That all went out the door when we landed because there were six dead bodies laying next to the LX and there were five they were working on inside. Ladies and gentlemen, we dropped our bags and we went to work. For 2 weeks we worked tirelessly and we worked seamlessly. We can do this. What you're doing works. It's just a matter of making it happen. And we do have an Air Force hospital. It is everything you would expect from the Air Force except for the golf course. Here you have a brick-and-mortar structure. In fact, it is very well staffed and very

well thought out. The reality of the limitations of this hospital is the fact that it is covered up in Afghan nationals because we have no place to take them. If they are hurt in the ravages of the war we want to take care of them. This comes to the ethical question, what do we do with them at that point? It doesn't take you long in Afghanistan to understand that time and distance is the mode of all evil. If you have a severely injured patient in Afghanistan and you try to do a ground support, two things are going to happen. Your patient is going to die because of the length required, and you're going to blow up. It's not if. It's you're going to. So it becomes a necessity to fly most casualty evacuations. We have a premise about the Golden Hour which I'll get into, but if you look at those time distances, and those are one-ways which is the reality of 2008. This has been corrected and it is very much more robust at this point, but it is a problem.

The reality of IEDs is that if you take August 2007 and look at the number of IED injuries in Afghanistan and you compare it to August 2008, they went up

sixteenfold. I don't have the numbers for this year, but I know they went up. The reality of an IED attack is that it's an asymmetric attack. It is the chosen limiting factor of our opponent and the reality is that we're going to get three surgical patients from that single IED attack. Armed with this information and the information that no matter what you think of when you close your eyes and you think of trauma, you think it's trauma, it's going to personnel and equipment intensive in order to do it right.

I knew that going into this. I knew that I was going to get these three victims at least from an IED attack. I was familiar with Dr. Cowley's on the Golden Hour. The unfortunate part about the Golden Hour is it has been used as a moniker versus reality. The reality is that a trauma patient is a continuum. When you treat a trauma patient, they may not have an hour, they have minutes and we'll talk a little bit about that.

The reality in combat is that 75 percent of people who die in combat, die almost immediately and there's almost nothing I can do. If I wound you in an

operating room, if I shoot you through the head, there is not anything I can do to repair that. It's the other 25 percent that we're concerned about. Of that 25 percent, there's about an 8 percent that I know me as an emergency physician cannot correct without a surgeon. But that leaves me 18 percent that I could, and I was put in a situation where my surgeons were going to be 2, 3 to 4 hours away at the time and we were trying to battle that. My first reality was that I had to take first of that first minutes, the Platinum 10 Minutes, if you will, catastrophic hemorrhage control, airway, tension pneumothorax. So I came up with a system to try to get my medical assets within 10 minutes of the line. My first reality was that we didn't have particular CASEVAC vehicles. We had the CAT2 MRAPs and I was very happy when the supply officer came to me and he said, "I have your ambulance package for the Cat 2 MRAPs." I looked at him askance. I'm looking behind for a truck and he's carrying a box. In reality, back here in the States to somebody this made sense. This made sense to be able to turn that MRAP into an

ambulance, that you would take the stanchions that you see and be able to put them up. The reality is, does anybody believe that you could provide trauma care in that space? No, you could not. We have fixed that. We have developed an ambulance version of this that is currently deployed in Afghanistan and Iraq that works very, very well.

My next reality was that I'm a Navy doctor. I go with the Marine Corps. We provide ourselves in resuscitative medicine. We put our tens and we go down range and we do it and we it fast, we drill to the point we need to be able to get it up in an hour to provide that surgical care. The Taliban did not like my tents. They shot in 107 rockets and they burnt me to the ground. I'm not an overly bright guy, but that was an experience that I wanted to live through again.

The reality was that if I were going to treat these victims in that first 10 minutes and I had to be provide that care and I had to be able to provide stabilization for that 2 to 3 hours that I know I was going to, I had to come up with a different system.

That system was what's called a tactical trauma team because I had a paucity of assets so I had to be able to move that out. What was my least-common denominator to provide effective combat care? In my reality that was half of a shock trauma platoon. That was an ER physician, an ER critical-care nurse, a PA or an IDC and some highly trained corpsmen. How I was going to do that was I took a CONEX box off of a ton. I hooked up an air conditioning system to it. I gave it a generator. We traded 3 pounds of good American Starbucks coffee and got some welding done and we put up some stanchions. Why was this capability important? It was important because I had to be able to get to that first minutes, but I had to do it safely. We lined this with Kevlar blankets and off we went.

The reality was that I could go with the Marines where they were going. I could set up immediately. I could treat that first trauma care immediately up on there, and I could do it safely in an austere environment. Why is that important? It's important because what you see there in the yellow dot is the first times the

Marines have fixed bayonets since World War II and went to hand-to-hand combat and we're 300 yards away. Why was that important? That was important because this village was in the middle of an IED field. There was no way in and no way out. I had to provide it to the point of care. I was tucked behind a big wall to provide that care, but I was within 300 yards of the fight. The reality was it took about 2 seconds for me to get my first patient. My first patient was shot through the buttocks. He was awake, he was happy, he said, "Doc, this is going to be a bar story. Let me tell you where I was shot," and off we went. But the reality was that he was hurt a lot more gravely than he thought he was. In essence, the bullet had tumbled off of his acetabulum and it ended up in his liver and I was able to tell that because I was able to do that testing at the point of contact. That changed that young man's care drastically.

The reality was that I was taking very young men with minimal training, 8 to 16 weeks of training, and putting them in a combat environment of a full trauma center. This is why TCCC is so important. This is

why we have to get it right. The reality was that we're going to take care of these gravely injured patients. These are patients with trauma scores greater than 16. That doesn't mean anything to you. What it means is they should die. They should not survive their injuries. The reality means that we have to provide clinical essence of what to do. Do I put an airway in this guy or do I hold on to what I've got because he's maintaining his airway and I have to hypotensively resuscitate him because he's going to be prolonged from surgical care which was the right answer. But me as a trauma physician for 15 years, it took everything I had not to intubate this guy before I put him on a plane. The reality was is that what I had was a system that we had to be able to provide that up-close care. The reality was when I got an injury we would roll in an MRAP. That was the best-protected vehicle that I had. I would provide care as we moved all the way back to the mobile trauma bay that was within that 10 to 15 minutes. We would be able to provide that trauma support right from the point of injury out. When we got to the mobile trauma

bay, that was in a safe location that was protected that allowed me to provide that continued emergent ICE resuscitative care at the point of contact.

Case in point. This is Corporal Nickels. Corporal Nickels was shot on August 8 of last year. He was shot from zone 1 to zone 3 of his neck. It went into the base of his neck and came out the opposite side in his jaw. His trachea was severed, and I got to him within 2 minutes. In there we were able to use cutting-edge resuscitative care to provide a way of providing a tourniquet, if you will, i.e., an endotracheal tube, which was placed between the two ends of his trachea. How was that done? That was done because I had a video laryngoscope. I had a video laryngoscope that had just came out. It came out in March 2008. I saw it at a trade show. I called the owner of the company at home and said, sir, I want to buy one of these before I go to Afghanistan. I think it might be important. Let me write you a check and pick one up. He said, "Doc, God bless you. I'm a retired Marine. I'll meet you in the parking lot at Twenty-nine Palms in 10 minutes and I'm going to

give you one," and he did, and it provided that care. Our system has to allow for resuscitative care to stay at the pointy end of the spear in advances. Corporal Nickels had a good outcome. We got him splinted him and we got him stabilized, and 3 hours later we were able to get him out in a helicopter. Within 48 hours, our system has advanced so much that he was back here at Bethesda and he got amazing care. He got care that was so good that he was able to speak, walk and talk, in fact, he did it well enough to start dating a Redskins cheerleader. It wasn't until Colonel North came to the FOB at Nalzad that I realized what we were in. This was my fifth combat tour, but I still didn't have a good appreciation for the 8-1/2 months we took fire every day. I was sitting there and a 107 rocket came over and exploded and it was nowhere near us, and Colonel North and looked at me and he said, "Doc, you know I was Cason, Vietnam. I was awarded the Silver Star and a Bronze Star. It was a horrible place." I said, yes, sir, I've read your book. Another one comes in and it lands and he says, "Doc, I was at Fallujah. For 11 it

was living hell." I said, yes, sir, I lived through it. Another one came in and he said, "Doc, I've never seen a place like this." That put it into reality, ladies and gentlemen, about what we're doing in Afghanistan.

Adaptive resuscitative medical efforts. When you look at what my jalopy was, and that's what they called it, they called it, and Oopty was the call sign for my mobile trauma bay. I took offense but I understood it. There had to be a better way. The reality was that before I left country we drew up plans and we provided a more armored capability. This was an armored personnel carrier that we put a top on and provided resuscitative care. It was better. But it wasn't good enough. I came back and I briefed the Commandant of the Marine Corps on this asset. I briefed and Admiral and the Joints Chiefs of Staff. Ladies and gentlemen, your DoD in 4 months' timeframe from the time I gave the brief, this was produced in 4 months from start to finish. This I would submit to you is the most-advanced resuscitative care that is out there. This has everything that a trauma bay of

modern-day 2009 can provide at the point of impact. In fact, on August 31 it went to combat and has done remarkably well. We have nine of these currently in combat. I would submit to you and submit to this board that if we can do it in 4 months for this, we can do a lot of things on this fast track that you discussed today so eloquently.

The reality is that our combat training, whether it's TCCC, whether it's getting that effort of understanding what our people are seeing in what environment. Ladies and gentlemen, I had two confirmed kills protecting my patient the first month I was in Afghanistan in 2008. I'm not proud of that fact, but it's the reality of what we do. It has to be. We have to understand our training processes to the point that we cannot put our ladies and gentlemen that we train in harm's way where they're using their heart and not their head. It has to be engrained. That culture has to change. Case in point. On June 23, I had 23 major casualties that I took care of that day. Unfortunately, I lost two of my corpsmen that day. The reason I lost my second corpsman was because

I trained him for 2 years, I taught him better, but his heart took over. We had trained him that when he hears "call corpsman up" that he runs to the battlefield and he takes care of his buddy who is down. He takes care of the quad amputee Marine who was laying on the ground next to him. But unfortunately, a bomb blast blows up behind him as you'll see here and he loses situational awareness and goes around the sweeper that was leading him to his patients. This is very hard to watch. (Video played.) -- believes that this is important because he doesn't want this to happen to anybody else. He sees his patient. He's trying to get there. He's doing what he's supposed to do, staying behind the sweeper taking sniper fire. He's moving forward until they start screaming "corpsman up" and he takes off to go see the patient. He lost his legs. The guy behind him lost his life. It's not pretty to see, but it's the reality of the decisions you make a day-to-day basis are so important to us.

I was appointed to the Grey Team which went in and looked at traumatic brain injury. It has been called

the sentinel illness of his war. I'm the fat guy that got blown up and sustained a traumatic brain injury which is why folks like to hear my viewpoint on it. Folks, I will tell you that being blown up, I was a college football player, I was concussed. When I got blown up it is a very different event. It is a very different event. I can tell you that 95 percent of the patients that I treated in country were for traumatic brain injury are straight shooters. They understand exactly what happened to them, it was witnessed, they have a particular set of symptoms. Everybody wants to get up tight about the other 5 percent because there are two sets of liars. The first set, about half of that 5 percent, is my First Sergeant who comes back with his 1st Lieutenant and he helped me put him in the body bag. He had been blown up and then the sniper had taken him down. The corpsman who was with him said, "Doc, the First Sergeant was out for about 5 to 8 minutes. He's been blowing chow. He can barely walk, but he's starting to clear and I think he's going to be good to go." The First Sergeant looked me dead in the eye and said,

"Doc, I was not knocked out. I'm fine. I'm going to go kill the guy who killed my lieutenant." I want 100 of him. I love that man. He's a hero. But I had to protect him from him. The other 2 percent are the ones who people want to talk about. They want to talk about the Lance Corporal who was sitting in a truck 50 yards from a blast, I had five corpsmen between him and the blast, and he says, "I got knocked out." Folks, I don't care about him. I care very much about his medical care, but I don't care about figuring who he is. Let's just take care of him and move on. He's served his country. Let's just take care of him, move on and not get into what happened to him there because I can't explain it.

What can I explain about traumatic brain injury? I can explain that our education levels have to go up. We found that across the FOBs. We have to be able to get away much like TCCC, much like a panel like this endorsing those guidelines, to get them out there, and get them out there with authority, so that that education process has to happen. The next thing is we have to symmetry. You're right, sir, whoever

mentioned that earlier. The symmetry has to be there. I can tell you that DARPA is lit up on it, the Joint Chiefs of Staff, right from Admiral Mullens's mouth, this will happen and it will happen in the next 6 months. What was that mean though? Then we have to figure out what the diagnosis is because quite frankly we don't understand the disease, so we're getting there. We have our best and we have our brightest, guys like Colonel Macedonia or Colonel Jaffe, they're all in it and they're in it heads up, Brigadier General Sutton. Then we have to figure out the treatment process, what do we do, when do we do it? Do we hypo resuscitate this particular population? What happens when it's cold? What happens when we're at 10,000 feet? Those are all things that we have to answer. A Board like this can govern what that research is going to look like not only ethically but finance it.

Ladies and gentlemen, I would submit to you that no matter what we do, when you go to combat it's going to have a cost. It's going to have a cost whether you have post-traumatic stress disorder, you come home

without your legs or you come home with problems from a traumatic brain injury. Somebody's going to pay the cost. Nobody ever comes back from a conflict the way they left. It's just a reality. But when it's the deepest, darkest day in D.C. And you're up into this quagmire of what you do on a day- to-day basis and you think I got to go through one more brief, what I would ask you is to remember this, these gentleman on June 23 are fighting for their lives and through your efforts I stand humbly before you and submit that I think what your work does is these same two gentlemen on January 17 in Las Vegas standing on prostheses alive and well.

Thank you. I appreciate the honor of the podium. I hope it was instructional. I will take any questions you might have.

DR. LEDNAR: Commander Hancock, thank you very much for the presentation, the heroism and innovation that you bring to our Marines and to our soldiers in the field. We really stand in awe of you. Thank you. Are there any questions or comments for Commander Hancock?

CDR HANCOCK: Thank you. I know it's late. I appreciate your attention.

DR. LEDNAR: Thank you, Commander Hancock. Our last agenda item, we appreciate Dr. Scoville being patient with us. Dr. Charles Scoville is a retired colonel and Chief, Amputee Patient Care Service at the Military Advanced Training Center at Walter Reed. He served for 29 years in the Army, with his most recent assignment prior to retiring in October 2003 as Chief, Physical Therapist Section, Army Medical Specialist Corps, and Consultant to the Surgeon General, U.S. Army. Dr. Scoville is a graduate of the Army War College. His awards include the Legion of Merit, Meritorious Service Medal and the Army Commendation Medal. He has also been awarded the "A" Proficiency Designator, military recognition for outstanding qualifications in physical therapy and continued demonstration of exceptional professional ability, as well as the "8Z" Proficiency Designator, the military recognition for demonstration of exceptional

professional achievement in the design, conduct and publication of clinically relevant medical research. Dr. Scoville's presentation slides may be found under Tab 15. Dr. Scoville, thank you for joining us.

DR. SCOVILLE: Thank you. I'm here representing General Franks and the Panel for the Care of Individuals With Amputations and Functional Limb Loss. I will briefly go over the Subcommittee membership, what we had covered in our June meeting and what we plan to look at in our next meeting.

Our membership has dropped off significantly because of individuals who have either been assigned into positions where there is a conflict with this or family members have been assigned into positions that conflict with our Committee. So we have dropped down currently to six active members and we have nominated a number of individuals to replace those who have left our Committee.

Our last meeting was held in San Diego

Naval Medical Center. They have opened the C5 which is the Comprehensive Combat Casualty Care Center. We provide care for individuals with limb loss and traumatic brain injury at that center. We discussed the VA DoD Center of Excellence requirement from NDAA 2009. We did an update of the amputee program looking at the numbers and the trends we have seen over the years with the program. Dr. Ficke discussed the Army's approach to hand transplantation as this has advanced and the capabilities are now available. We have several Service members who are interested in hand transplantation, so we looked at how we would be approaching that and making sure that the Service members were well educated as they entered into this process.

We looked at the Task Force sustainment of amputee patient care and what will we do to keep the skill sets that we've learned? In this current conflict it took us a year to get our staff really up to the level of performance with the tactical athlete population that we're dealing

with. We were very skilled at taking care of the dysvascular tumors but not the high-end rehabilitation that our service members deserved. We looked at the clinical competencies and financial support as we looked toward the sustainment and discussed the need or the requirement to go forward and get CARF accreditation, the Committee for Accreditation of Rehab Facilities, for our facilities and also the accreditation of our prosthetic labs which is something that the VA has been doing.

We have a meeting scheduled for December 1 which will take place at Walter Reed. Joe Miller who is our lead prosthetist will be talking about the latest advances in prosthetics and how we will look at the population distribution of the prosthetics. As we get new items and they first come on the market, they come on the market in very low quantities. So Power Knee which we are now using are producing about 10 every 2 months, so how do you select which are the patients who would get the latest technology? We're looking at

the research advances, and what we've been doing at the Intrepid Center at Military Advanced Training Center at Walter Reed and out at the C5, and will again do an update on the numbers and distribution of the patients. We have recently received funding through a joint incentive fund to bring DCVA and Walter Reed together in amputee patient care. Dr. B.J. Randolph is a retired colonel who now works for the VA will be presenting that. I will look at the role of the military in coalition military missions as to whether there is a requirement for uniform prosthetists and then some of the DoD to VA transition timelines. We've been involved with missions with a number of countries' coalition forces. We've sent teams into Iraq, into Sri Lanka and we've gone to Colombia every year. We've been into Pakistan and we're preparing for another mission into Pakistan. I talked with our Surgeon General's foreign consultant the other day and China has asked for some assistance there so that there are a number of those missions coming

up.

Currently we have used Joe Miller who is a reserve officer to assist in those missions. That's the one prosthetic military asset that we have.

DR. LEDNAR: Thank you, Dr. Scoville. Are there questions for Dr. Scoville? Dr. Silva?

DR. SILVA: Thank you. That's wonderful work. Of course, the war is moving on and the number of amputees I understand have diminished to what degree since a year ago?

DR. SCOVILLE: In the last 6 months we have the same number of amputees as we had had the similar 6 months a year ago. The shift has been in the last 6 months we have had no amputees from Iraq, so 1 year ago we had 24 amputees, 12 were from the Iraqi conflict and 12 were from the Afghan conflict. This year in the past 6 months we've had 26 individuals with major limb loss and all of them were from Afghanistan.

DR. LEDNAR: Are there other questions for Dr. Scoville? I know an issue that you've

been thinking about, although what you've just said makes me change what I was going to say, and that is as we were watching the experience in Iraq over time, the number of soldiers experiencing traumatic limb loss was going down and that's wonderful. The question was how we maintain and retain in a sustainable way the skills and the rehabilitative effectiveness that's been developed around the need for care for soldiers in this war? Afghanistan is again unfortunately generating more amputee cases to take care of, but at some point we hope that there will be a reduction in the number of the new patients with limb loss. The challenge will be how do we hold onto, how do we retain that terrific capability that has been developed over the last 8 to 10 years going forward? I'm not looking for answer now, but clearly it's important.

DR. SCOVILLE: We've looked at this. For a while following the end of hostilities we will continue to have a patient population. We've had over 110 individuals of the 938 who have had

major limb loss who have had their amputations done up to 5 years after their initial injury. The average time is about 2 years. So they've had a limb salvage which has been successful, but the patient does not have the functional level they desire so they elect to have an amputation to be able to increase their functional activities. That will provide some.

If you look at the data prior to this conflict, we were averaging within the DoD over 100 individuals a year through motor vehicle accidents, training accidents, tumors and other situations who had major limb loss. Prior to this conflict, we would provide initial care for those individuals and they would be discharged from the service. As a result of our successes with patient care, we've had over 130 individuals returned to active duty, over 40 of those have redeployed back into theater with prosthetic devices, and we are now maintaining people on active duty with limb loss, so that population with the motor vehicle accidents, training

accidents and such would be engaged in care through the military for a longer period of time looking at their potential to return to service.

DR. LEDNAR: That's a great success story. Dr. Parkinson?

DR. PARKINSON: It dawns on me that we often times look internally as in Wayne's question about sustaining our internal capability in DoD. All of our activities like so many things that DoD develops have huge implications for the civilian population and I wonder with the global epidemic of landmines all of which will never be removed, the global epidemic of amputation injuries due to those landmines and a global epidemic of Type II diabetes which now be complication-related amputations, frankly, we're on the cusp of that, if there shouldn't be some exploration in your committee of international ties, alliances, fund raising, whatever? That's a little off scope maybe or maybe you've already talked about that. It's just a question.

DR. SCOVILLE: We have done that. As I

say, we've been down to Colombia, into Bogota and Medellin every year for the past 5 years. We've gone in for anywhere from 4 days to 2 weeks. They are getting two new amputees a day between their fighting with the FARC and their fighting with the drug cartels down there. We've gone to Sri Lanka and worked with them. The potential is there. In our current situation we're relying all on civilian prosthetists to provide our prosthetic care. So without military assets, we are stretched on what we can accept as an additional mission and on capabilities.

DR. PARKINSON: Perhaps it's more over a cocktail conversation sometime than a formal mission, but there are national private voluntary organizations and humanitarian organizations that might be looking for a niche or a cause. While it's not in your mission, rather than going country to country it might be that the equivalent is the Eliminate Polio Rotary Club initiative or a thing like that. It's not DoD mission related, but it certainly is an application and it would be

a tremendous application of what we've done.

DR. SCOVILLE: And we've also looked at using the Institute of Surgical Research in burn care and how we care for the civilian population in times where we're not at war to maintain our skill set. So we are looking. We have a task force looking at sustainment and figuring out what are the best ways to address this in the future.

DR. LEDNAR: Are there any other questions or comments or Dr. Scoville? If not, Dr. Scoville, thank you very much for that update and we look forward to hearing from you again. Thank you. Commander Feeks, if you would, please. What Commander Feeks and I are doing is huddling, and that is, Dr. Butler has been working hard since he left the podium to give us something to look at, and if Dr. Butler, you would explain to us and introduce this document that has just been given to us, please.

DR. BUTLER: The document that you just received the exact same document that's on the Health Affairs website except for the part in the

box which is the new treatments recommended for burn therapy so that is the part in the box that is the subject of the vote. As you look through the guidelines, what we have there is here's what you do for training combat medics. There are 1,000 slides that go along with this because it takes a little bit more than just giving them a document and saying do this to train them. This is in outline form what we recommend for battlefield trauma care supported by the PHTLS chapters in the military version of the "Prehospital Trauma Life Support" manual and by the training curriculum used by all the services that's also on the Health Affairs website.

DR. LEDNAR: So that the boxed material identifies the content that goes with the recommendation. Again to Dr. Shamoo's advice to us which is good, and that is if we can with the help of the staff pull this together into a document that should be fairly straightforward to prepare that includes this content material relative to the recommendation that is then

circulated to the Core Board and we can rapidly turn it around and get it back and let you know. Dr. Silva?

DR. SILVA: I know the hour is late and we're getting ready to leave, but quite frankly as an internist, it would take a month to have done what the surgeon has done here in about a half-hour.

DR. LEDNAR: Our gratitude, Dr. Butler, to our heroics. We should be behaving more like surgeons and trauma specialists than some of us do. Thank you for that.

At this point this concludes our business and I'd at this point turn to Mr. Middleton as our Designated Federal Official and ask if he would adjourn the meeting. Mr. Middleton?

MR. MIDDLETON: Thank you, Dr. Lednar. This meeting of the Defense Health Board is adjourned.

(Whereupon, at 1:00 p.m., the PROCEEDINGS were adjourned.)

* * * * *

ANDERSON COURT REPORTING

706 Duke Street, Suite 100

Alexandria, VA 22314

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

CERTIFICATE OF NOTARY PUBLIC

I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

/s/Carleton J. Anderson, III

Notary Public in and for the
Commonwealth of Virginia
Commission No. 351998
Expires: November 30, 2012

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190