

PART V

The Series of Events that Culminated in the Transformation of the Armed Forces Epidemiological Board From an Operational and Research Function to an Advisory One

There was considerable unrest in Washington during the early 1970s. The press, preoccupied with conflict-of-interest issues, scrutinized the activities of government officials almost daily, which led to a general bureaucratic housecleaning. In July 1970, President Richard M. Nixon appointed a blue-ribbon panel to study the Department of Defense. Responsible military medical officers were concerned that the AFEB and its Commissions might appear to be in violation of conflict-of-interest laws.

One of the strengths of the Commission system was that the leaders in the investigation of any given epidemiological problem were also members of the relevant Commissions; they, or their parent institutions, were the recipients of the AFEB's contracts to carry out the necessary research. Under this system, the country benefited from having the most knowledgeable people working on the problems that most urgently needed their expert attention. The civilian physicians and medical scientists that comprised the AFEB and its Commissions hardly considered themselves likely targets of any scrutiny, but nothing could have been further from the truth.

The first inkling that the Board was involved in the housecleaning came in a letter from Brig. General Richard Taylor dated 11 December 1970, which was transmitted to AFEB members on 30 December. General Taylor, who was the Deputy Assistant Surgeon General, indicated that there would be a tertiary review of the Board and its Commissions by "appropriate representatives of the U.S. Army Medical Research and Development Command." There have always been reviews of government-sponsored agencies, and properly so. The Army's Medical Research and Development Command is responsible for the expenditure of funds appropriated by the Congress, and is accountable for such monies. A number of Board and Commission members feared that the AFEB might be prevented from developing a scientific program relevant to military needs—the function which had been so effective for three decades. The members believed that the directive for bureaucratic scrutiny had come from sources higher up, and not from General Taylor's office.

At its thirtieth anniversary meeting on 18 February 1971, Dr. Colin MacLeod, a charter member who had been President of the AFEB from 1947 to 1955, addressed the Board and its military representatives on the issue of conflict of interest. His speech follows:

I do not intend to spend my time in empty accolades because we have important business at hand that must be addressed.

I suppose one of the reasons I get called upon to talk on occasions such as the present is my long association with the AFEB and its Commissions as well as with its predecessor organization, the Army Epidemiological Board, which began to be organized in late 1940 and 1941 under the awesome title of Board for the Investigation and Control of

Influenza and other Epidemic Diseases in the United States Army. It was not by chance that some of the moving figures in the organization of the original Board had served on a variety of Commissions organized by the Army during World War I, such as Francis Blake, A. R. Dochez and Fess Avery, stimulated by Steve Simmons. The idea of Commissions in the medical department of the Army is of course considerably older than World War I and goes back, if my memory serves, to General Sternberg himself and perhaps even before. They have a long and important history in American military medicine.

I was Director of the Commission on Pneumonia, which was established in 1941. It was one of the original Commissions of the Board and functioned throughout World War II. At the end of the War, in a general reorganization, some of the Commissions were discontinued or combined, presumably because they had accomplished their task well—or possibly because they had not done so. In any case, the Pneumonia Commission was discontinued and I was kicked upstairs to be a member of the Board, and shortly thereafter succeeded Dr. Bayne-Jones as President of AEB in the spring of 1946. He had been President for one year when Dr. Blake retired at the end of the war.

I am impressed with the recurrent patterns that have appeared over this 30-year period. At times, especially when cuts in funds are imminent or actual, there appear reactions that border on the paranoid, both from the side of the civilians on the Commissions and the Board and the military medical services—but I do not intend to dwell on this point, except to indicate that both are engaged in a common purpose and that each has much to offer military medicine. I would hate to see us get so smug that this statement of fact does not burn itself into our consciousness every day. I believe everyone on the Board and Commissions is aware that while they devise and carry out programs and make recommendations of both scientific and fiscal nature, the Congress places the ultimate responsibility for the expenditures of our tax funds on the military services and holds them accountable. This fact, from time to time, has caused a good deal of uncertainty about who does what and may lead to strained relations between the Surgeon General's office and civilian investigators as to the present time.

The Commission structure of AFEB antedates the Study Section system of NIH. I don't know how much the Commission structure influenced the Study Section development, but I should point out that Dr. Rollo E. Dyer, the then Director of NIH, was close to AFEB during World II and also [was] a very important member of the Typhus Commission, which also operated out of the Preventive Medicine Division of the Surgeon General's office. Actually, how do the Commissions differ from the NIH Study Sections? The differences are very great in actuality since the Commissions are entrusted with the responsibility of devising programs, and, in collaboration with the medical departments of the three military services, seeing to it that the programs are carried out. The Commissions are made up of experts in their area of concern, which is generally a well-circumscribed, disease-oriented area. To use a bit of modern government jargon, they are goal-oriented. Members of Commissions commonly derive a good deal of their support from Army Medical R & D funds, but this in no way **disqualifies** them from being members of the Commissions—in fact it is in their favor. The question is: can they be dispassionate about who else gets his work supported since they are in competition for the same funds? I will come back to that question in a moment.

Study Sections of NIH, on the other hand, are not goal-oriented and usually do not have any responsibility for the development of programs, although it is true from time to time that they may make recommendations about programs to NIH, but the Study Section as such will not carry that program out. They are passive, judicious bodies; [their] function is to review applications sent to them. Because of the very broad areas of biomedical science they must cover, it is not uncommon, at least in the wide area of medical microbiology and infectious diseases, that a Study Section may not have on its membership people who are intimately aware of the significance of the work proposed by particular applicants for funds. Possibly this happens infrequently but one knows of instances of sufficient number and seriousness to make one realize that the Study Section system leaves something to be desired. It is not covered by holiness as some would aver. Errors in judgment may be made on both sides: Work that has high scientific merit may be turned down or given a low priority, or on the other hand, pedestrian studies may be given a high priority and be funded because no one on the Study Section is sufficiently expert to make the appropriate judgment.

Study Sections are presided over by a Chairman who is relatively inactive in the intervals between meetings, whereas the Director of a Commission is continually involved in Commission affairs, and as everyone in this room knows, who is now or who has been a Commission Director, this involves a great deal of work the year round which is literally taken out of his own hide and that of the University where he works. The military services get a great deal of work, which is gladly done, but for which they do not have to pay.

It has been said by people who should know better that the Commissions consist of groups of people who hand

out money to each other—that they are on the inside track for Army research funds and prevent anyone else from breaking into their charmed circle. This is manifestly unfair, but all here have heard these uninformed and unfair criticisms more than once.

Actually, what does prevent the Commission members from being in conflict of interest, since it is true that members usually have a portion of their work that deals with Commission program supported by Medical R & D funds? There are a number of factors which historically have prevented this from happening. The first of these is personal morality and Commission morality. I realize a statement of this kind won't satisfy the green-eyed legal critics who see evil everywhere, but nonetheless personal morality is the strongest force in preventing conflict of interest not only in AFEB Commissions but everywhere else in human affairs. I am impressed by the concern the Commissions have had to avoid conflict of interest and I don't know of instances in AFEB where it has been a problem. As Dr. Bayne-Jones once remarked in another context, "You have to be like Caesar's wife and fall over backwards." I should also note that you cannot legislate morality nor can the Judge Advocate General or the General Accounting Office set down a prescription for it. But there are other factors that are somewhat more tangible and which minimize the possibility of conflict of interest. In the first place, the Commissions do not make the final judgment based on quality, relevance and cost. They recommend to AFEB which in turn deliberates on the recommendation and then makes its own recommendation to Army Medical R & D. It is of course uncommon for the Board to alter the recommendations of Commissions related to scientific judgment. This is not in the least surprising because after all, the Commissions are made up of the real experts in the field and are mature, responsible scientists who have remarkable dedication to their important tasks.

AFEB's recommendations are then acted upon by Army Medical R & D so that two echelons of review are imposed between the actions of the Commission and the awarding of a contract.

This three-layered formal mechanism of review obviously provides safeguards which I consider ample by themselves to prevent any hanky-panky were it to arise through any inadvertence.

There has also been built into the system from its beginning a very interesting set of controls imposed by the review for both scientific merit and relevance or pertinence to the mission of the medical departments of the three services. You will recall that NIH Study Sections pass on scientific merit alone. AFEB and its Commissions not only determine the scientific merit of a proposal but also make a judgment of its military relevance and whether the cost of carrying it out is reasonable because cost considerations influence both other judgments. Army R & D then takes these twin judgments and if it disagrees with the estimate of military relevance or cost, it can take appropriate final action—either pushing the ratings down or up. I suspect it to be rare that R & D disagrees with the judgment of scientific merit made by the Commissions and the Board, but we always have had recurrent discussions—sometimes sharp with the military representatives to the Commissions and the Board concerning the relevance of proposed research. This is as it should be since the scientist through ignorance may overlook important military considerations, and the scientific administrators may overlook the relevance of a particular piece of work because they are not fully cognizant of the implications for military medicine of the research proposed. They can't be experts on everything. So there have to be discussions of the merits of the case before arriving at the final decision and intelligent men can differ in this judgment.

Let me emphasize, however, that the determination of relevance at all three levels of judgment is an extremely important factor in minimizing conflict of interest on the part of the Commissions and Board. We have excellent proposals submitted which are turned down because judgment of relevance gives a low priority. If scientific merit is given a one rating and relevance a five, a proposal has no chance. By the same token, if the science is weak or off the mark and the relevance is great, it suffers the same fate—that is to say, poor science is never relevant. I should also emphasize that how much a project costs is extremely important in determining both its scientific merit and its relevance and cost cannot be dissociated as has been proposed. This idea is both shocking and alarming because of its naivete.

Because of these multiple sets of controls, the Board and its Commissions, I believe, have been able to function in an atmosphere singularly devoid of conflict of interest. I hope we will continue to function in this way for many years to come in our joint mission of preserving the health of our troops. This is our primary mission and let us not forget it. Sometime yesterday I thought, 'The mission is about to play second fiddle to bureaucratic neuroses.'

The subject of relevance has other implications as well as that of being an index of the [worth] of a proposal. And this gets involved in that old struggle about basic and applied research. This has been going on since the first Commission was established and I dare say will take up a large part of the obituary of the Board. When I was

President of the Board (9 years), there was one Commission whose meetings I made sure never to miss, because one influential and highly articulate member, himself an outstanding scientist as recent events have once again confirmed, invariably gave an emotional speech at the beginning of the meeting and at intervals thereafter to the proposition that AFEB should support practical research only—it seemed at times that anything that wasn't involved in the direct production of a viral vaccine should be out of bounds!

Despite the eminence of this critic and his record of high performance, I must make the point that if his advice had been followed, many of the most significant contributions of the Board would never have come about. I believe that our failures have been due to our inadequate appreciation of the lack of fundamental knowledge in a particular area and not because of failure to apply what was already known.

Lack of foresight is a crippling factor too. For example, we should have gone to work on meningococcal immunization immediately after World War II even though the effectiveness of the sulfonamides was undoubted. Mass chemotherapy or prophylaxis is just not good military medicine, although as a stopgap we may have to use it. Furthermore, there was enough experience then of sulfonamide resistance in other bacteria to make it almost a sure prediction that it would happen with meningococci also, especially under conditions of mass prophylactic use.

May I remind you of the sad story of malaria and the pickle we are in now because we did not use our wits after World War II and [did not] realize that resistance to chemotherapy on the part of the malarial parasite was inevitable and that the mosquitoes were not going to take DDT lying down either. I hope we will remember this tragic lesson in designing our future course of action because malaria is certainly going to be with us in the indefinite future and chemotherapy is probably not going to handle it unless some truly miraculous drugs are discovered.

Another crucial point about the support of the more basic relevant research is that you just cannot attract the best scientific minds—and we need them beyond all else—if their activities are going to be circumscribed by what is already known and by its application to military situations. As I have said, there never has been much of a problem applying what is known but the art of research consists of picking the significant things that need to be discovered—and then discovering them.

I have talked too long. Let me close by saluting the Board and Commissions on this 30th Anniversary—and also by saluting the perspicacity and deep scientific insights of so many extraordinary officers in the three military services who have been so strong in support of the best in science. I could only wish that the latter did not turn over so fast that the process of self-education has usually been completed about the time they are due to move on to another assignment. In actuality the real continuity in military preventive medicine resides in this Board, unpalatable as that statement may be to some of you. The trend that seems to be developing is to break that thread of continuity through the introduction of procedures so onerous and so unintelligent that the functioning of the Commissions and this Board will be virtually impossible. It seems that nebulous fears about a conflict of interest, [which] does not exist and never has, have caused the military medical services to run so scared that they are by way of forgetting their mission. Gentlemen, may I suggest that you revive your actions from that point of view and not from the point of view that there may be a staff man in some subcommittee of the House who fancies himself as a giant killer and really has little concern for the welfare of science—nor, I dare say, for the mission of the medical departments of the three services which is intimately tied to good science. Excellent science at the least cost has always been the hallmark of this organization, the AFEB. It looks as though we are in for an era in which both quality and economy are going to be sacrificed because we are afraid to stand up for what we know is true. As one who has spent a great deal of his time over the past thirty years working to improve the health of our troops, this saddens me deeply. As a taxpayer, it makes me simply angry.

Nevertheless, a management study of the AFEB was in progress. The three-member management study team included Elliott J. Williams, Lt. Colonel Phillip E. Winter, MC, (both from the Office of the Surgeon General of the Army), and Lt. Colonel Frank F. Jordan, MSC, from the Army's Medical Research and Development Command. The study team consulted with a number of Board members and Commission Directors and scrutinized records dating back to 1941, when the AEB was organized. Board members received a copy of the detailed management report on 11 May 1972, and it was formally presented to the Board at its meeting on 18 May 1971. Internally, the report was submitted to Dr. Richard S. Wilbur, Assistant Secretary of Defense for Health Affairs, and the three Surgeons General for their review.

RICHARD S. WILBUR, M.D.
Assistant Secretary of Defense for Health Affairs

The report attempted to review the accomplishments of the Board and its Commissions since their inception in 1941. A number of important contributions were highlighted, but there were many gaps. Special visits by individual Board members, Commission members, or small research groups, who had contributed to many important field operation problems, were left unreported. This unique program had had vast experience during the preceding thirty years; it is understandable that the management survey failed to grasp its magnitude.

Everyone concerned might have been more comfortable if the initial statements had simply said that the bureaucratic climate in Washington, and particularly in the Department of Defense, now required a reevaluation of many government-sponsored civilian agencies, including the AFEB. The management survey group could have set this tone in its study and presentation.

But a different tone was set from the beginning, which placed the AFEB in a defensive position. Disbelief, anger, and resentment were expressed during the discussions that occurred after the limited distribution of the AFEB management report. The Board and Commission members had always understood the concept that changes in government-sponsored agencies occur. The original influenza board, the AEB, and the AFEB had all accepted new charters that had been adapted to current trends. But the management report described "an obsolete bulky system" that was "too large" and "inflexible," "repetitious in its programs," and "uninformed of the reality of military medical problems."

One wonders what Stevens Simmons and Stanhope Bayne-Jones would have thought had they been

present. The men and women who had served the Board and its Commissions during the previous thirty years had served their country and served it well, without compensation, simply because they desired to contribute. The report's historical account of the Boards and its Commissions' activities was totally inadequate and inaccurate. This, combined with a "verbal spanking," bruised feelings. At this point, the AFEB could well have ceased to exist.

The report spoke of "problems of the AFEB that included "financial conflict of interest." It stated: "There is no question that the present system violates the spirit if not indeed the letter of the law. It is improper to hold a government contract and be an official member of the review group that technically approves one's research proposal even if the advisor leaves the conference room during the discussion." It referred to the practice of reappointing scientists to key assignments, but it specified that there was a good reason for this practice: The AFEB was the repository of the military's "institutional memory" for infectious diseases and other medical problems.

The report commented that the AFEB was not responsive to "the changes in missions and priorities of the military medical departments." There were certain exceptions to this statement on the AFEB's limited organizational flexibility. For example, the Commission on Epidemiological Survey, which I directed, had Colonel Dan Crozier as its executive officer. The report commended this arrangement. When the report noted the overlapping responsibilities between the commissions, it was critical that members of the AFEB system and those of the in-service laboratories had no functional means of communication and coordination. (This criticism was valid, and the situation had been partially corrected when, beginning in 1960, the Preventive Medicine Division of the Army Surgeon General's office had referred its problem to USAMRDC. They, in turn, had consulted with AFEB and non-AFEB contractors to address the problem. Operational questions for the Preventive Medicine Division traditionally had been transmitted to the Board.) The study group foresaw "a requirement for joint operational advisory groups in such areas as the medical aspects of environmental pollution and securing and retaining scarce health professionals in a zero-draft force."

The following two options were recommended in the management report:

Option I: Keep the AFEB intact, with administrative options to eliminate conflicts of interest; fix a tenure policy; and appoint younger members. At a minimum, it would be necessary to (a) prohibit members of the AFEB from holding research contracts, (b) limit tenure to four years, (c) reduce the number of Commission members by one-third to one-half, and (d) restrict the size of the Commissions to no more than five to seven members.

Option II: Separate the operational and research advisory missions of the AFEB. The Board could be retained as a joint advisory group for advice on operational problems on preventive medicine. The Army Surgeon General could establish advisory groups tailored to the requirements of the medical research and development program. The Board would remain as a joint agency to provide the three Surgeons General scientific and technical advice and assistance in developing and executing preventive medicine programs, policies, and procedures as required. Board members were to be selected on the basis of their scientific and academic standing in fields related to the Board's function, including, but not limited to, communicable and chronic disease epidemiology and control, environmental health, data collection and analysis, health-care delivery, and health maintenance. The management agent for the Board would be the Surgeon General of the Army.

The study group concluded that:

- The AFEB and its Commissions have been of inestimable value to the Armed Forces for over thirty years in providing expert medical advice in the control of infectious diseases
- The availability of trained preventive medicine officers, the emergence of a military medical research

DAN CROZIER, M.D.

Dan Crozier was closely affiliated with the AFEB, particularly with the Commission on Epidemiological Survey, for more than a decade. He served effectively as Deputy Director of this Commission. At his retirement in 1973, I, who was then the Chairman of the Commission on Epidemiological Survey, said, "You, Dan, have been meticulous in every detail, wise in decision making when it related to important medical science problems, hardworking, and selfless in your performance of the job [he served simultaneously as the Commander of the U.S. Army Medical Unit at Fort Detrick], forthright and dogged in spelling things out when the lines were thin, and perfectly refreshing and generous in your consideration of others."

Dan Crozier developed a fine medical research unit at Fort Detrick, whose members, including himself, made scientific contributions of lasting value. A laboratory there, now known as USAMRIID, is an important national resource for the study of the pathogenesis and control of highly virulent agents, and is of inestimable importance to our country.

and development community, and the growing effectiveness of the organization for the prevention of disease has materially lessened the need for AFEB assistance in both field investigations and contract research

- There is a viable requirement for an AFEB, especially one that has interests extending beyond the confines of classic disease control, and that can provide scientific and technical advice on priorities, policies, and procedures in applying new technological and epidemiological principles to chronic disease control, environmental pollution control, and the design of new systems of health maintenance
- * The organization of the Commissions should be revised so that they (a) are severed from the Board's control, (b) function as consultants in the research and development structure, and (c) are effectively removed from the onus of a conflict of interest
- * The Surgeon General of the Army should remain the executive agent, but the members of the Board should also be appointed as consultants to the Assistant Secretary of Defense for Health and Environment
- A separate medical research advisory system should be established for the Surgeon General of the Army
- The Army's Director of Health and Environment should be given sole staff responsibility for supervising the Board, including its operation and maintenance, with funding through the Army's Office of Maintenance for proper administrative support
- * There is no requirement that the executive secretary of the AFEB be a physician qualified as a preventive medicine officer

The Board Considers the Management Survey Report

The Board and the Commission Directors met on 12–13 July 1972 at WRAIR, and the discussion was devoted almost entirely to the management survey report. As requested, most Board members and Commission Directors had previously submitted letters to Executive Secretary Colonel Bradley W. Prior, offering their comments. General Richard Taylor of the Research and Development Command, who was the Surgeon General of the Army from 1973 until 1977, and senior staff members of the three services attended this meeting. Dr. Dammin and Colonel Prior prepared detailed minutes of the discussions, which had been taped during the two-day meeting; the minutes were transmitted to each member and Commission Director. (That document, which comprises 109 double-spaced typewritten pages, is on record in the AFEB office.)

The discussions, which were often heated but always under control, focused on (a) why change was necessary, (b) why the management report did not more accurately portray the Board and its Commissions' activities during their thirty years of creditable performance, (c) which of the options, I or II, was best suited to satisfy the current bureaucratic climate, and (d) did the respective Surgeons General really want to have a board like the AFEB? Colonels Edward L. Buescher, MC, Jerome Greenberg, MC, and Robert J. T. Joy, MC, all of whom were familiar with AFEB activities, were positive that a change in scope and function was indicated. They stressed the improved and expanded intramural scientific capability to deal with problems of military medical significance, and the improved recruitment of qualified personnel to key positions in preventive medicine. The participants left the meeting exhausted and with an element of unease, but finally understanding why the Research and Development Command was required to make basic changes in this long-standing and effective organization.

The 12–13 July meetings and events during the coming several months helped to smooth frayed sentiments. The worst did not occur because rational minds on each side of the issue had the same thought: "What is best for our country and our military services?" During this critical period, Dr. Gus Dammin, General Hal Jennings, and General Richard Taylor led the AFEB toward a much happier outcome than had earlier appeared possible.

Armed Forces Epidemiological Board and Directors and Deputy Directors of the
Commissions
18–19 May 1972

Seated, left to right: Dr. William McD. Hammon, Dr. Edwin H. Lennette, Dr. Gustave J. Dammin, President of the Board, Dr. Francis S. Cheever, and Dr. Charles H. Rammelkamp, Jr.

Standing, left to right, front: Dr. Gordon Meiklejohn, Dr. David Minard, Dr. David Taplin, Dr. Bennett I. Elisberg, Dr. Richard M. Krause, Dr. Paul C. Beaver, Colonel Bradley W. Prior, MC, USAF, Executive Secretary, Dr. Robert L. Kaiser, and Dr. Floyd W. Denny, Jr.

Standing, left to right, rear: Dr. Lewis W. Wannamaker, Dr. William F. Scherer, Dr. Saul Krugman, Dr. Theodore E. Woodward, Dr. Charles L. Wisseman, Jr., Dr. Abram S. Benenson, Dr. George G. Jackson, Dr. William S. Jordan, Jr., and Dr. Thomas R. Hendrix.

The Armed Forces Epidemiological Board

**LIEUTENANT GENERAL
HAL B. JENNINGS, MC, USA**
The Surgeon General

**BRIGADIER GENERAL
KENNETH DIRKS, MC, USA**

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Section I, Part V

GUSTAVE J. DAMMIN, M.D.

There are few among us who possess the competence, commitment, wisdom, and equanimity that Gus Dammin displayed. His productive war record was followed by a stellar career as an experimental pathologist at Washington University School of Medicine in St. Louis and at Harvard Medical School. The AFEB was fortunate to have him as a contributor to several of its Commissions, a member of the Board, and its President from 1960 to 1972.

During this twelve-year period, the Board and its Commissions dealt with substance abuse in the military, immunization practices, and changes in the organization of the AFEB. Gus steered a steady ship. He saw issues and problems through to their best solutions by his appointments of consultants; the Board and its Commissions flourished under his guiding hand. A careful and dedicated scientist, Gus Dammin not only advised other investigators, but he also made major contributions of his own. His leadership of the AFEB was of unquestioned historical significance.

At the July meeting, General Taylor appointed Colonel Richard Barquist, (chairman), and Colonels Dan Crozier, Edwin Buescher, Robert Joy, Thomas Lamson, and Kenneth Dirks to a task force and charged them to develop a workable plan for a new advisory system for the Army Medical Research and Development Command. Colonel Dirks presented the task force's report to the AFEB on 15 December 1972.

Between the July and December 1972 meetings of the Board, Dr. Dammin and Surgeon General Hal Jennings held productive discussions. Dr. Dammin's December 1972 memorandum to the Board and the Commission Directors, which follows, described this progress:

I had an extended and very encouraging telephone conversation with Gen. Jennings last Friday about the Management Survey Report, the proposed DOD Directive, the Board and Commissions. He mentioned how grateful he was for our standing offer to help in the development of an effective successor to the AFEB and then described more recent considerations by his staff of the future of the AFEB. He stated that the proposed DOD directive, as we reviewed it in July as part of the Management Survey Report, had not been released. Indeed, it was being recalled from DOD for revision. Further consideration of the proceedings of the AFEB meeting in July led Gen. Jennings to inquire further about the feasibility of having commissions support the work of the AFEB in its reorganization. Gen. Jennings and his staff are now undertaking a revision of the DOD Directive so that it will provide for a Board-Commission structure. It will, of course, differ from our present pattern in that its primary function would be advisory in relationship to policy, plans and operations and no longer relate to research and its funding. I believe that the distinction which must be made now between preventive medicine operations and research was discussed in sufficient detail at our July meeting and so covered in the Minutes of that meeting.

Speaking for the Board and its Commissions, I assured Gen. Jennings again of our willingness to help him and his staff, and the DOD, promising to set aside sufficient time during our 15 December meeting for a review of a revised DOD Directive which would call for a Board-Commission organization. Planning and funding preventive medicine research would receive separate consideration at this meeting. Gen. Jennings is to have Gen. Taylor and Col. Greenberg confer with Lt. Col. Wilks and me on the agenda. I had begun drafting an agenda and had just spoken with Lt. Col. Wilks about it, when I received a call from Gen. Jennings on Friday.

Again in December 1972, Dr. Dammin distributed the following memorandum, which indicated further good progress, to the membership:

I returned yesterday evening from the meeting of our Commission on Rickettsial Diseases which covered two full days of reports and discussions of almost all aspects of rickettsia] disease. This surely is the kind of meeting that must be in the planning of the Board that is to succeed ours. There is no other meeting under any sponsorship which brings together as many workers and as much knowledge about rickettsia] disease.

At the meeting, I received the revised draft of the proposed DOD Directive (5154.8) which calls for Commissions to serve with the new Board. If promulgated as scheduled, the reconstituted Board would begin its service on 1 January 1973. Should this not proceed as planned, then the new Public Law 92-463 ends the service of our Board on 6 January 1973. Discussions which I had at the meeting hinted that the new Board and its Commissions may not be organized soon enough to avoid a discontinuity in AFEB activity. I mention "AFEB because I understand that the Army intends to continue the use of the present name of the Board.

The 15 December 1972 meeting of the AFGB and its Commission Directors **was most** productive and served to clarify many of the issues; that meeting's agenda appears on page 131.

During the meeting, General Hal Jennings reaffirmed his views that (a) the AFEB was greatly desired and needed by the military services, (b) the name AFEB be retained, and (c) the AFEB could establish ad hoc task groups (formerly called Commissions, and in the future to be called Subcommittees of the AFEB), provided that there were a limited number of members, that the AFEB and its Subcommittees comply with the new Public Law 92-463, and that they avoid any semblance of a conflict of interest. General Jennings stressed the need for the AFEB to work closely with the new panels (or advisory groups), which would be discussed by Colonel Dirks; although the AFEB could not advise on the awarding of a contract,

The Agenda of the 15 December 1972 AFEB Meeting

- 0900 Introduction and Announcements: *Dr. Dammit, President*
Lt. Col. Wilks
Lt. Gen. Jennings
R. Adm. Geib
Maj. Gen. Steel
- 0915 The Future AFBB: *Lt. Gen. Jennings*
The Research Advisory Structure: *Col. Dirks*
Discussion
- 1000 Recess and Coffee
- 1015 Military Reports
Chronic Diseases: *Col. Cutting*
Medical Fitness (Physical Standards): *Mnj. Friedlander*
Venereal Diseases-1972: *Col. Cutting*
Discussion
Navy: *Capt. Alexander*
Air Force: *Col. Nugent*
- 1100 Reports of Commissions
Streptococcal and Staphylococcal Diseases: *Dr. Wannamaker*
Acute Respiratory Diseases: *Dr. Denny*
Influenza: *Dr. Meiklejohn*
Viral Infections: *Dr. Scherer*
Epidemiological Survey: *Dr. Woodward*
- 1215 Recess and Lunch
Executive Session—Board Members, *Commission* Directors, and Deputy Directors
Group Photograph
- 1330 The AFEB Archives
A Moving Portrait of Dr. Joseph E. Smadel: *Dr. Woodward*
- 1345 Reports of Commissions
Malaria: *Dr. Powell*
Parasitic Diseases: *Dr. Beaver*
Environmental Health *Dr. Minard*
Cutaneous Diseases: *Dr. Blank (Dr. Strauss)*
Immunization: *Dr. Benenson*
Enteric Infections: *Dr. Hendrix*
Rickettsial Diseases: *Dr. Wiseman*
Discussion
- 1530 Recess and Coffee
- 1545 Executive Session—Board Members
- 1630 Adjournment

it could render advice on the proposal. General Jennings asked the board to study the new AFEB charter and to make comments and suggestions. He suggested that the AFEB plan its next meeting in conjunction with the meeting of Preventive Medicine Officers in April 1973, and that no further meetings of the AFEB Commissions should be held until their charters had been approved.

Colonel Dirks then presented the task force report and delineated the ground rules, compatible with Public Law 92-463, for government-sponsored boards and committees. These regulations were deemed to apply to the AFEB, or to subsequent commissions or advisory groups, that would serve the Army Medical Research and Development Command. The law specified that (a) advisory meetings be public; (b) there must be a timely announcement of each meeting in the *Federal Register*; (c) records must be available for public inspection and copying; [NOTE: The military recognized that there must be special exemptions for privileged or confidential information. T.E.W.] (d) detailed minutes of each meeting must be kept; (e) an officer of the federal government must be present at each meeting; (f) meetings will be called only by that responsible federal officer or with his prior approval of the date, time, place, and agenda; and (g) Committee tenure will be for two years, and will be subject to renewal only by the approval of the head of the responsible agency.

Colonel Dirks concluded his presentation by stating that those now establishing the advisory system for USAMRDC should maintain their previous vigorous effort to recruit highly qualified consultants in infectious diseases, and that the members would not be eligible to hold contracts with USAMRDC during their period of service.

The newly recommended system embraced the establishment of research-proposal review committees (entirely separate from the AFEB) that complied with the new public law on advisory committees, conflict of interest, and other statutes closely related to in-house laboratory professional expertise, and would facilitate the coordination of in-house and extramural military research.

The Board Is Reorganized Under Its New Charter

General Jennings's and Colonel Dirks's presentations and their comments during the ensuing discussion were favorably received by the Board and Commission Directors. Then Colonel Dirks presented the AFEB's proposed new charter. The Board met in executive session, and after making a few minor revisions, recommended that the document be adopted. (See Appendix 4 for the text of that charter, which was adopted on 15 December 1972.)

During this time, the entire Army structure was being reorganized. For example, the Surgeon General's Office in Washington would now be concerned primarily with policy; a new Health Services Command in San Antonio would handle operations. The new organization, which was to become effective in July 1973, might well place new demands upon the Board and its newly formed Subcommittees. General Jennings suggested that the AFEB might wish to assume responsibility in the four following categories:

Communicable Disease Control, which would include (a) formulating an immunization policy, (b) using chemoprophylaxis for contingencies, (c) evaluating of the monitoring and surveillance procedures, (d) advising on immediate and anticipated needs in infectious disease control, such as meningococcal meningitis and gonococcal urethritis, and (e) analyzing the infectious disease problems that might emerge and affect women as their numbers in the military increase.

Health Maintenance, which would encompass (a) establishing an advisory service on community public health, (b) serving the healthy, in activities such as health education and nutrition, (c) giving advice regarding the risks in exposure to unusual environments, (d) developing and evaluating procedures designed to detect disease early, and (e) designing the optimum procedure for and frequency of periodic health examinations.

Environmental Quality, which would include two major areas of concern: (a) those environmental

hazards posed by military activities, such as noise generation and chemical pollution, and (b) that of the soldier dislocated from his immediate environment.

Physical Standards, which would be concerned with (a) the bases for acceptance for and rejection from military service, (b) the study of the examination methodology on which these major decisions are based, (c) the development of age- and job-adjusted standards for men and women, and (d) the design of the health-maintenance physical examination, the examination for retention in the service, and similar examinations.

These areas of need for the armed forces clearly embraced many of the activities with which the AFEB and its Commissions had previously been concerned. Additionally, in its new advisory capacity, the AFEB's field of responsibility would be broadened. The way was now clear for further progress; major misunderstandings had virtually faded, and the stage was set for the Board's spring meeting on 18 April 1973. The agenda for that meeting appears below.

This meeting ended the original AFEB and its Commissions, which had worked so productively and effectively for over thirty years. It ended the wise and inspired leadership of Gus Dammin's thirteen-year presidency of the Board. General Jennings said: "This meeting signals the end of a glorious era, which, I want to assure you, isn't going to cease [just] because the Department of Defense has made a new charter for this organization, [as required by] new laws that have been enacted and other factors." He then presented the Army's Outstanding Civilian Service medal to Francis S. Cheever, Floyd W. Denny, William McD. Hammon, William S. Jordan, Jr., Edwin H. Lennette, Charles H. Rammelkamp, Jr., and me. General Jennings announced that Gustave J. Dammin would receive the Distinguished Public Service award, which would be presented to him by Assistant Secretary of Defense Richard S. Wilbur at a separate ceremony.

Edwin H. Lennette, M.D., Ph.D., took the chair and succeeded Dr. Dammin as President of the Armed Forces Epidemiological Board on 18 April 1973.

The Agenda of the 18 April 1973 AFEB Meeting

Chairman: G. J. Dammin, President

1200 Luncheon Meeting: *Executive Session, Board Members*

1330 Introduction and Announcements
G. J. Dammin
Lt. Col. N. E. Wilks, Executive Secretary

1345 Guidelines for the New AFEB
 The Surgeon General, Dept. of the Army, *Lt. Gen. H. B. Jennings*
 The Surgeon General, Dept. of the Navy, *V. Adm. D. A. Custis*
 The Surgeon General, Dept. of the Air Force, *Lt. Gen. R. A. Patterson*
 Discussion

Chairman: E. H. Lennette, President-Elect

1500 Documentary Film and Report on the AFEB Archives: *T. E. Woodward*
 Discussion

1530 Recess and Coffee

1545 Executive Session: *Preventive Medicine Officers and Board Members*

1630 Executive Session: *Board Members*

1700 Adjournment

FRANCIS SARGENT CHEEVER, M.D.

Sarge Cheever graduated from Harvard College, and from Harvard Medical School in 1936, then served his internship and medical residency at Presbyterian Hospital in New York. He held faculty teaching and research positions in microbiology at Harvard from 1938 to 1950, when he accepted an appointment as Professor of Microbiology and Medicine at the University of Pittsburgh School of Medicine. In 1958, Sarge was appointed Dean of that medical school. A sensible, practical approach to problems was his trademark.

Sarge brought these attributes to the Commission on Enteric Infections of the AFEB, which he directed from 1955 to 1963. He served as a member of the Board from 1965 to 1973, and could always be depended upon for help. In the early 1970s, Sarge joined Horace Gezon as a field consultant for the Army in surveying the problems of infectious diarrhea in Vietnam. Their field studies and recommendations proved to be of inestimable value and greatly aided the chief surgeon in implementing control measures.

FLOYD W. DENNY, M.D.

Floyd Denny was an honor graduate in medicine from Vanderbilt University School of Medicine, where he trained in pediatrics. His interest in infectious diseases led to his appointment as a research fellow, and later as the Assistant Director, of the Streptococcal Diseases Laboratory at Case Western Reserve University School of Medicine. His association and friendships with John Dingle, Charles Rammelkamp, Bill Jordan, and others was kindled there. He played an important role in the pioneering studies on streptococcal diseases and their relationship to rheumatic fever at Warren Air Force Base. In 1960, Floyd was appointed Chairman of the Department of Pediatrics at the University of North Carolina School of Medicine. He has made major contributions to our knowledge of infections caused by mycoplasma.

Floyd served as Deputy Chairman of the AFEB from 1955 until 1957 under his mentor, Dr. John Dingle. His long experience with Board activities included serving as the Director of the Commission on Acute Respiratory Diseases from 1967 until 1973, and as a member of the Commission on Streptococcal Diseases from 1954 until 1973. As a full Board member, he was committed to doing his share and much more. His AFEB commitments were taken in stride with his heavy academic responsibilities at Chapel Hill.

WILLIAM S. JORDAN, JR., M.D.

After he graduated from Harvard Medical School in 1943, Bill Jordan trained in medicine at Boston City Hospital, which provided him the opportunity to learn from Dr. Maxwell Finland. Bill then served for two years as a medical officer in the U.S. Navy; in 1947, he joined Dr. John Dingle's group in preventive medicine at Case Western Reserve University School of Medicine. He developed his talents as a virologist and immunologist and played an important role in the Cleveland Family Study, a classic in epidemiologic analysis. This work, sponsored by the Commission on Acute Respiratory Diseases of the AFEB, sparked his interest in military medicine, since he regularly reported the results of investigations on influenza, adenovirus infections, and atypical pneumonia. A major contribution of this work was the report that two separate filterable agents were responsible for acute gastroenteritis.

In 1956, Bill Jordan became Deputy Director of the Commission on Acute Respiratory Diseases and, in 1959, he began an eight-year period as its Director. Under his leadership, members of various Commissions made great strides in defining the etiology and epidemiology of various respiratory infections. This information helped improve methods of prevention and control of these infections in military personnel.

Because of his special talents and interest in the role of preventive medicine in the military, Bill Jordan was appointed a member of the AFEB in 1967. He contributed to all activities of the Board; without his wise counsel, some of the difficult problems faced by the Board would not have been resolved so effectively.

In 1976, Bill was appointed Director of the Microbiology and Infectious Disease Programs of the National Institute of Allergy and Infectious Diseases. In this position, he has coordinated our national effort in the prevention of infectious diseases in civilian populations, and he has brought this expertise to the deliberations of the AFEB. Bill Jordan, with his experience and intelligence, is a national resource.

GORDON N. MEIKLEJOHN, M.D.

After graduating in medicine from McGill University in 1937, Gordon served his internship and residency in medicine at the Montreal General Hospital, Canada. This was followed by a fellowship in medicine at the Rockefeller Foundation. From 1944 to 1946, he served as a lieutenant in the U.S. Navy. He joined the faculty of the University of California, where he was appointed Professor of Medicine in 1951. From 1951 to 1975, Gordon served as the Distinguished Professor of Medicine and Chairman of the Department of Medicine at the University of Colorado in Denver.

Gordon is one of the most longstanding and devoted contributors to AFEB activities. He served as a member of the Commission on Influenza from 1948 to 1973, and directed that Commission from 1971 to 1973. He has been a pillar of support in conducting the year-to-year surveillance *studies* on the incidence of and the antigenic changes related to influenza. These continuing serological observations, many of which are conducted at Lackland Air Force Base and other key laboratories, are closely correlated with those of the Centers for Disease Control in Atlanta, the World Health Organization, and the AFEB. These painstaking observations are of great importance in helping select the particular influenza viruses that are incorporated in new vaccines from year to year.

DAVID MINARD, Ph.D., M.D.

David Minard was awarded his doctorates in both physiology (1937) and medicine (1943) by the University of Chicago. He served with the U.S. Navy and, beginning in 1943, was assigned to amphibious forces in both the Atlantic and the Pacific fleets. Later in his Navy career, he was head of the Physiology Department of the Naval Research Institute, where he directed the Thermal Stress Division from 1961 to 1963. In 1954, he earned his M.P.H. at the Harvard School of Public Health.

He published numerous papers on subjects as varied as histamine metabolism, cerebral and renal circulation, thermal radiation, air blast effects, the effects of metabolism and water balance on survival, combat stress, heat stress, high-altitude effects, body-temperature regulation, human calorimetry, ionizing radiation, work physiology, and occupational health. The Board profited greatly from his contributions as a member of the Commission on Environmental Health beginning in 1965, and he directed this Commission from 1970 to 1972.

Harvey Blank, M.D.

Commission on Cutaneous Diseases
Member 1959–1973
Director 1962–1973

Paul C. Beaver, Ph.D.

Commission on Parasitic Diseases
Member 1953–1973
Director 1967–1973

Rodney R. Beard, M.D.

Commission on Environmental Hygiene
Member 1942–1944; 1954–1973
Director 1956–1965

Victor P. Bond, M.D.

Commission on Radiation and Infection
Director 1965–1968
Commission on Epidemiological Survey
Member 1968–1973

Wilbur G. Downs, M.D.
Commission on Malaria
Member 1962–1973
Director 1965–1969

Alto E. Feller, M.D.
Commission on Acute Respiratory Diseases
Member 1941–1946; 1947–1948; 1951–1967
Director 1955–1959

Thomas R. Hendrix, M.D.
Commission on Enteric Infections
Member 1968–1972
Director 1970–1972

George G. Jackson, M.D.
Commission on Acute Respiratory Diseases
Member 1954–1973
Acting Director 1971–1972

Irvine H. Lepow, M.D.
Commission on Immunization
Member 1960–1971
Director 1964–1965

Harry Most, M.D.
Commission on Parasitic Diseases
Member 1953–1973
Director 1961–1967

Donald M. Pillsbury, M.D.
Commission on Cutaneous Diseases
Member 1954–1968
Director 1954–1962

Robin D. Powell, M.D.
Commission on Malaria
Member 1964–1973
Director 1969–1973

William S. Tillett, M.D.
Commission on Pneumonia
Member 1941-1944
Commission on Streptococcal Infections
Member 1948-1967
Director 1949

Stanley J. Weidenkopf, M.P.H., Ed.D.
commission on Environmental Health
Member 1965-1973
Director 1966-1970