EXHIBIT 15

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Alexandria Division

NICHOLAS HARRISON, *et al.*, Plaintiffs, v. MARK ESPER, Secretary of Defense, *et al.*, Defendants.	No. 1:18-cv-641 (LMB/IDD)

RICHARD ROE, *et al.*, Plaintiffs, v. MARK ESPER, Secretary of Defense, *et al.*, Defendants.	No. 1:18-cv-1565 (LMB/IDD)

DECLARATION OF COLONEL SCOTT FRAZIER

I, Colonel Scott Travis Frazier, do hereby state and declare as follows:

1. I currently serve as the Director of Interagency Liaison Affairs for the Office of the Secretary of Defense. I have held this position since July 25, 2019. In the exercise of my official duties, I have been made aware of this lawsuit by counsel from the Army Office of General Counsel.

2. I submit this declaration in support of Defendants' motion for summary judgment and in opposition to Plaintiffs' Motion for Summary Judgment in the above-titled cases. I base this declaration upon my personal knowledge, information that has been provided to me in the

course of my official duties, the accession[1] of individuals living with the human immunodeficiency virus (HIV), my understanding of Army policy on accessions, and the Army's application of that policy in considering Sergeant Nicholas Harrison's request to be appointed in the National Guard as Judge Advocate General's ("JAG") Corps officer.

Background and Expertise

3. From May 22, 2017 to July 24, 2019, I served as the Assistant Deputy for Medical and Health Affairs for the Assistant Secretary of the Army, Manpower and Reserve Affairs (ASA (M&RA)). In that role, I was the senior policy advisor to the ASA (M&RA) who has policy oversight responsibility on matters concerning Army health and medical policy. In that role, I was responsible for developing, coordinating, and providing oversight of medical and health-related policy for the Department of the Army. My policy portfolio (referring to policies for which I was the designated subject matter expert) included reserve component policy, medical and health program funding, health professions personnel policy, medical readiness, and force management initiatives. As part of my duties, I provided guidance to the ASA (M&RA) on the Army's implementation of Department of Defense (DoD) medical and health policies. Specifically, I provided guidance on DoD Instruction (DoDI) 6485.01, Human Immunodeficiency Virus (HIV) in Military Service Members.

4. I have served on active duty as a commissioned officer in the Army since 2000. Prior to 2000, I served for five years as an enlisted Soldier and five years as a commissioned officer in both Reserve Components. After commissioning as an Active Guard-Reserve (AGR) Medical Service Corps (MSC) Officer, I have held leadership and staff positions at every echelon in the Army where I have been subject to Army medical personnel policy as a Soldier, implemented policy at each echelon, provided authoritative interpretation of existing policy and developed new policy for Army leadership approval. I have a Bachelor's Degree in Psychology from Missouri State University, a Master of Arts degree in Government from Harvard

[1] Accession means, in general terms, adding new people Regular or Reserve Components of the Military Services through enlistment, appointment as a commissioned officer, or induction.

University, and a Master of Strategic Studies degree from the U.S. Army War College.

Army Accessions Policy

5. Army accessions policies ensure that each applicant considered for appointment (officers), enlistment (enlisted personnel), or induction (drafted) into the Regular Army, Army National Guard, or U.S. Army Reserve meets DoD and service-mandated standards with respect to age, aptitude, citizenship, dependents, education, medical status, character/conduct, physical fitness, and dependency status. For accessions, overall aptitude requirements for enlistment and induction are based upon applicant scores from the Armed Services Vocational Aptitude Battery (ASVAB). Character/Conduct standards for accession are designed to minimize entrance of persons who are likely to become disciplinary cases, security risks, or who are likely to disrupt good order, morale, and discipline.

6. As a land-based fighting force, the Army must ensure that its personnel can be trained and are ready to deploy to fight and win decisively against any adversary, anytime and anywhere, including in joint, multi-domain, and high-intensity conflicts under austere conditions in any part of the world.[2] Accessions standards are vital in ensuring the baseline suitability of applicants for the rigors of military service and ensuring the demands of military service do not exacerbate an applicant's preexisting health conditions.

7. While meeting baseline accessions standards is an initial requirement to be considered for appointment, enlistment, or induction into the military, it does not guarantee acceptance nor guarantee that an applicant, once accessed, will be permitted to serve in the career field of their choice. The Army also considers the maximum number of soldiers it is funded to access (referred to as the "accession ceiling"), which is established each fiscal year for each component (Active, Guard or Reserve) and the individual accession goals for each career sub-specialty before making a final offer of acceptance to an applicant

8. Given the rigorous nature of service, accessions medical standards for appointment,

[2] Joint operations connotes operations in which elements of two or more Military Departments participate. Multi-domain means air, land, maritime, space and cyber.

enlistment, or induction of soldiers into the Army are designed to ensure that only medically fit applicants are considered for accession. Accessions medical standards are established by the DoD, and then the Army further adopts these as the minimum standards within Army-specific policies and regulations. Accordingly, the Army follows the DoD policy that applicants must be:

a. Free of contagious diseases that may endanger the health of other personnel.

b. Free of medical conditions or physical defects that may reasonably be expected to require excessive time lost from duty for necessary treatment or hospitalization, or may result in separation from the Military Service for medical unfitness.

c. Medically capable of satisfactorily completing required training and initial period of contracted service.

d. Medically adaptable to the military environment without geographical area limitations.

e. Medically capable of performing duties without aggravating existing physical defects or medical conditions.

DoD Instruction 6130.03, *Medical Standards for Appointment, Enlistment, or Induction into the Military Services* (2018) ("DoDI 6130.03").[3]

9. The Army implements DoDI 6130.03 through its own regulation, Army Regulation (AR) 40-501, *Standards of Medical Fitness*, which requires the Army to adhere to the minimum standards of DoDI 6130.03 and establishes additional, Army-specific accessions standards.

Army Policy on the Accession of Individuals With HIV

10. The Army's policy on the accession of individuals with HIV is based on the minimum requirements established by DoD policy. Under DoDI 6130.03, HIV is a disqualifying medical condition that precludes accession. DoDI 6130.03 allows applicants who do not meet its physical and medical standards to be considered for a medical waiver. However, the more specific policy, DoDI 6485.01, *HIV in Military Services Members*, sets forth

[3] To avoid duplication, military policies discussed in this document are attached as exhibits Defendants' Motion for Summary Judgment.

that it is DoD policy to deny eligibility for military service to persons with HIV, and contains no waiver mechanism. When two policies cover the same subject matter, the more specific policy takes precedence. Thus, under DoD policy, applicants with HIV are not qualified for accession.

11. Because the Army medical accession policy cannot be less stringent than that of the DoD, AR 40-501 also designates the presence of HIV as a disqualifying medical condition that precludes accession. The Army implements DoDI 6485.01 through its HIV-specific policy, AR 600-110, *Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus*, which similarly states that "HIV infected personnel are not eligible for appointment or enlistment into the Active Army, the ARNG [Army National Guard], or the USAR [U.S. Army Reserve]." Army Regulation 600-110 (2014) ("AR 600-110") ¶ 1-16a.

12. If an applicant with HIV wishes to be considered for accession into the Army, the applicant must request an exception to policy (ETP) to both AR 600-110 and DoDI 6485.01, both of which bar accessions of HIV-positive candidates. The Army Deputy Chief of Staff (DCS), G-1,[4] does not have authority to grant an exception to the requirements of DoDI 6485.01. The DCS, G-1 may favorably endorse a request for an exception and forward the action through the ASA (M&RA) to the DoD for consideration by the Undersecretary of Defense, Personnel and Readiness (USD P&R) to grant an exception to DoDI 6485.01. Alternatively, the DCS G-1 may deny the request for endorsement and refuse to forward the action for further consideration. The Army cannot grant an exception to AR 600-110 until it is relieved of the minimum requirements of DoDI 6485.01. Thus, only after the DoD grants an exception to DoDI 6485.01 would the Army have the discretion to grant an exception to AR 600-110 to ultimately allow the accession of an individual with HIV.

[4] "G-1" refers to a section of a military staff. The letter indicates the echelon of the section and the number indicates its function. "G" signifies division-level or above, and "1" indicates a "personnel" function.

Judge Advocate National Guard Accessions

13. The process to become a JAG for the National Guard is different than the process to become an active duty JAG. Unlike in the Regular Army (active duty) or the Reserve component, applicants for a position in the National Guard do not submit packets directly to a centralized board. Instead, the State Guard conducts an internal process and initially selects applicants for vacancies subject to completing all other accessions requirement. The National Guard's accessions process, like those of the Regular Army and the Reserve component, also includes a mandatory accessions medical screening. A "pre-selected" applicant for a National Guard position is preliminarily selected for an available vacant position, or "billet."[5] Next, the applicant prepares an application packet with their qualifications for the position, which includes their medical clearance for accessions. At that point, the applicant's application is submitted by the State to the Chief, National Guard Bureau (NGB) and will be considered by a NGB accessions board (for JAG applicants, there are quarterly NGB accessions boards). The NGB accessions board assesses applicants' overall suitability and potential service as a JAG, and in doing so considers several factors, including their age, intelligence, interpersonal skills, work ethic, character, leadership ability, and derogatory information. After considering these factors, the NGB accession board will only endorse applicants it determines are fully qualified.

14. If the applicant receives a positive endorsement from the NGB board, a JAG applicant's packet is then forwarded to The Judge Advocate General (TJAG) of the U.S. Army for final approval. TJAG has the discretion to deny an applicant accession into the JAG Corps if he determines that the applicant does not possess the highest level of ethical and moral behavior, and professional proficiency to perform their duties as a Judge Advocate. If approved at the Army level, the candidate is offered a National Guard commission into the JAG corps of their affiliated State National Guard unit. However, if at any point in this process, the applicant is found to be ineligible

[5] "Billet" is the military term for the open position in the unit for a person of a particular rank and occupational specialty.

for accession, or the billet that they were offered becomes unavailable, or the Army determines accession is not in the best interest of the Army, the applicant may not be offered a commission.

15. The billet can become ineligible for fill, i.e. unavailable, when a military unit is "over strength." Over strength means a unit has more personnel on-hand than their manning authorization allows, roughly equivalent to hiring more employees than a payroll can support. Once a unit reports as over strength, it is generally forbidden from accepting new unit members until it has reduced its over strength number to match or fall below its authorized strength. Although over strength National Guard units are generally authorized to access new personnel, those units are not required to do so, and, based on the extent of their over strength, may be prohibited from doing so.

Sergeant Nicholas Harrison's ETP Request

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The waiver request was denied on December 30, 2014 because the Army Medical Accessions Standards, AR 40-501, does not permit an accessions waiver for HIV. *Id.*

20. On November 8, 2015, Sergeant Harrison submitted a request for an exception to AR 600-110 and DoDI 6485.01 to receive a direct commission as a Judge Advocate General Corps officer in the District of Columbia National Guard (DCARNG) despite having HIV. Information Paper - Request for Exemption to Policy for Identification, Surveillance, and Administration of Personnel Infected with HIV (July 11, 2016) ("Army Staffing Form"), attached as Ex. D. A request for an exception to these policies (ETP) would be routed through the U.S. Army Deputy Chief of Staff, G-1 (Personnel), through the ASA (M&RA) to the Acting Under Secretary of Defense (Personnel & Readiness) for consideration. However, ETP packets for medical standards can be stopped from further consideration at any point in the process if one of the intermediate levels declines to endorse the request (which would preclude forwarding to the next level for consideration).

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The foregoing information was provided to the Army DCS, G-1 for consideration of endorsement of Sergeant Harrison's request. *Id.*

22. As discussed, the DCS, G-1 did not have the authority to approve an exception to DoDI 6485.01, which would allow Sergeant Harrison to proceed in the accessions process. The DCS, G-1 could have favorably endorsed the ETP request and forward the action up to USD P&R, but here he did not do so and instead declined to endorse the request at his (the Army) level. *See* Army Staffing Form.

23. Because Sergeant Harrison was unable to meet the medical accession standards, his application to become a Judge Advocate General Corps officer never reached the National Guard Accessions Board.

24. Had the Army endorsed Sergeant Harrison's ETP Request, Sergeant Harrison would still not have been medically qualified for accession unless the DoD subsequently approved his request. If the DoD had granted the ETP, and the Army subsequently granted an ETP to AR 600-110, Sergeant Harrison would still have been required to complete the other screening and onboarding requirements to satisfy the needs of the Army in order to be offered a direct commission into the DCARNG as a JAG. First, he would have still needed to complete any outstanding steps in the medical accessions screening process with no deficits. Second, he would have had to successfully complete the additional non-medical accessions screening requirements including verification of physical fitness, dependency status, and conduct qualification. Third, if selected for accession, under Army and NGB policy, he would have been awarded the rank of First Lieutenant and therefore would have been required to seek approval for an age waiver. Fourth, he would have had to secure an open position in the DCARNG as a JAG corps officer. Fifth, he would have had to receive an endorsement from the National Guard Bureau Judge Advocate accessions board. And finally, he would have had to obtain the certification of TJAG.

25. Given that the DCARNG was reportedly over strength at the time of the Sergeant Harrison's packet submission (precluding assignment to a valid unit position)

it is debatable whether he would have subsequently been offered a direct commission in 2016 as a JAG even if he had successfully cleared every other accession process step required.

In accordance with 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 2nd day of June 2020.

SCOTT T. FRAZIER
COL, MS
United States Army

FILED UNDER SEAL
EXHIBIT A

FILED UNDER SEAL
EXHIBIT B

FILED UNDER SEAL
EXHIBIT C

FILED UNDER SEAL
EXHIBIT D

EXHIBIT 16

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
ALEXANDRIA DIVISION

- - - - - - - - - - - - - - - - - - - x
NICHOLAS HARRISON and :
OUTSERVE-SLDN, INC., :
Plaintiffs, :
vs. : No. 1:18-cv-00641
JAMES N. MATTIS, In His : LMB-IDD
Official Capacity As Secretary:
of Defense; MARK ESPER, In His:
Official Capacity As the :
Secretary of the Army; and the:
UNITED STATES DEPARTMENT OF :
DEFENSE, :
Defendants. :
- - - - - - - - - - - - - - - - - - - x

VIDEOTAPED 30(b)(6) DEPOSITION OF
DEPARTMENT OF DEFENSE GIVEN BY GARY BROWN

DATE: Thursday, March 14, 2019
TIME: 9:08 a.m.
LOCATION: Winston & Strawn
1700 K Street, N.W.
Washington, D.C.
REPORTED BY: Denise M. Brunet, RPR
Reporter/Notary

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(Appearances continued on the next page.)

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C O N T E N T S

(*Exhibits attached to the transcript.)

director. It was in the accession policy office at OSD at the Pentagon.

Q And so it was the director -- the assistant director of reserve and medical manpower?

A Yes.

Q What were your major responsibilities in this position?

A Well, the two biggest responsibilities, I would say, is I was the co-chair of the accession medical standard working group, or the AMSWG as other folks know it. And then the second main responsibility is I also co-chaired a working group called the MEDWG; it was the medical recruiting and retention working group, which primarily concentrated on the recruitment and retentions of health care professionals into the military as a recruiting and retention effort for that subpopulation throughout the DOD and the total force.

There were some other duties, but it was just general office stuff. But those were the two biggest duties I had.

Q And so I'd like to break down the first one a little bit more. As the co-chair of the

AMSWG, what did you -- what were those responsibilities?

A Yeah. So as the co-chair of AMSWG, I actually represented the military personnel policy aspect of that working group as -- and then Dr. Paul Ciminera was the co-chair that worked for health affairs as the medical representative to the working group, as the two of us co-chaired those efforts as the working group met.

So it was, you know, coordinating meetings, you know, room space, preparing documents for the meeting, you know, leading the meeting during the meeting, you know, kind of as the facilitator more or less.

We worked, obviously, as a group. Neither Paul nor I considered ourselves really co-chairs, if you will. We were more, you know, facilitators to make certain that folks were actually, you know, getting together and meeting on the topics, facilitating the meeting to make certain that it was, you know, being conducted and, you know, business was being performed.

Q And how long were you in that position?

A I arrived there mid-September of 2015 and then, of course, left mid-September 2018 to go to

Q So if someone entered the military for, say, a three-year term, and then developed a condition that is disqualifying under DODI 6130.03, would they not be allowed to re-enlist?

MS. BERMAN: Objection. Calls for speculation.

You can answer.

THE WITNESS: So you're talking someone who was in the military, acquired a condition, separates, discharges, whatever term you want, from the military --

BY MR. SCHOETTES:

Q Actually, no. So I'll stop you there. No. Someone who is still in, but has developed a condition that is disqualifying under the accession standards that, for purposes of this question, let's say would still meet the retention standards. Are accession standards -- do the accession standards apply to that person's re-enlistment from active duty back into the military?

MS. BERMAN: Objection. Vague.

You can answer if you know.

THE WITNESS: No, it would not.

BY MR. SCHOETTES:

Q So, before, when you said that the accession standards applied to re-enlistment, you were talking about people who had separated from the military and were seeking to re-enlist; is that right?

A That's correct.

Q How does the AMSWG, which stands for the accessions medical standards working group, evaluate whether a condition should be listed as disqualifying?

A Yeah, so the accession medical standard working group, of course, meets quarterly, but during the time that it's time to review the Department of Defense instruction 6130.03, they group together on a project really more routinely than quarterly in order to get tiger teams or subcommittees or groups together to talk about, you know, conditions and -- and the current conditions listed within the DODI in order to, you know, talk about revisions.

Q How are the tiger teams or working groups organized in terms of the conditions in the DODI?

A Yeah, so I can somewhat answer that. I will say that that did not happen during my tenure at OSD, but I am familiar with the process.

So when the time comes to look at a revision on the Department of Defense instruction 6130.03, the AMSWG, not only as a congruent group, but also calls upon subject matter experts based upon whatever condition they're discussing at the time or that particular -- we'll call them tiger teams, if you will -- whatever that particular tiger team is discussing in order to make certain that, you know, they've got experts in the room and within the conversations of discussing that particular condition that broadens the scope of research and revision needs beyond and outside of just the AMSWG.

And so that -- and they would, you know -- so they do that for each condition or, you know, medical topic that they want to discuss in prep for revision of that particular instruction.

Q So I guess my -- what I'm trying to understand is how the -- how it is determined what a particular tiger team is going to work on. Can you tell me that?

A Yeah. So it's really kind of, you know, just the business rule layouts of what the group decides. Typically, you would find that it may be by chapter or bodily system in the instruction or

a set of, you know, system -- unique system or, you know, specialized system grouping. You know, like one particular tiger team may look at the respiratory system. A different group will work at -- look at the cardiovascular system. Or it could be a group of systems that is broken down into the tiger teams.

But typically, that's how they do it. It is -- you know, if you look through that instruction, it's very bodily system oriented or grouped in comparison of -- of, you know, sets of conditions that a particular group can discuss because there's commonality related to those conditions that those subject matter experts can come in and discuss.

Q Are tiger teams ever focused on a single condition?

A It could be based upon, you know, if the discussion of that particular condition, you know, warrants a more invasive or intense or long-term conversation based upon, you know, however much time you're talking about.

They very well could decide to say, hey, we need to look at this set -- this particular condition, you know, based upon what we know with

activities related to that condition; let's pull it out as a subset conversation so that this particular tiger team or a subset of that tiger team can kind of look at that condition and then bring it back into the team and then eventually back to the AMSWG for, you know, discussion about revisions of -- of that instruction.

Q Has there been a tiger team since 2010 focused on HIV solely? And let me alter that slightly. A tiger team or a working group, whatever -- because you referred to working groups earlier, correct?

A Yes.

Q And I'm not sure what the difference is -- maybe I should ask that first. What's the difference, in your mind, between a tiger team and the working group?

A It's -- the terms are kind of interchangeable. Based upon whatever the -- whatever the accession medical standard working group deems of -- how they're going to name the subgroups that do the research and get together and have the conversation.

It could be named one -- one particular revision period and it could be named another in

BY MR. SCHOETTES:

Q So that would have been in 2014?

A That would have been the -- I believe it was around January of 2015. So if you go off of the 2011 date -- most likely they probably did -- they were early. Otherwise, they were right on time if somebody wanted to consider the 2010 date.

So --

Q And then --

A Anyway, right into the normal pattern of when the typical revision/review would take place.

Q And it was that -- that was the start of the process that then resulted in the publication of this version dated May 6th, 2018?

A That's correct.

Q If you would turn to page 4 of Exhibit 2, under the policy section at 1.2, it describes, at c, that one of the -- that it is DOD policy to "ensure that individuals considered for appointment, enlistment or induction into the military services are" -- and then it lists five criteria. These are the criteria to which I was referring earlier.

Are these the criteria by which the accessions medical standards working group is

evaluating whether a condition should be placed on the list of disqualifying conditions?

A Yes. This is the basis for the review. Yes.

Q And so in the context of what we were discussing earlier in terms of the -- what I called the catch-all provision that might encompass a holistic review, are these the criteria that a reviewer would be expected to apply in that situation?

MS. BERMAN: Objection. Vague.

You can answer.

THE WITNESS: Yes.

BY MR. SCHOETTES:

Q So I want to walk through these criteria one by one and better understand them and then specifically how it might relate to HIV. So the first criteria is, "free of contagious diseases that may endanger the health of other personnel."

Is HIV considered a contagious disease that may endanger the health of other personnel?

A Yes.

Q And how is that? How would it endanger the health of other personnel?

MS. BERMAN: Objection. It's beyond the

scope of what this witness is being offered to testify about to the extent you're asking about medical information concerning HIV. He can talk about the policy.

THE WITNESS: Yeah. I mean, you know, free of contagious diseases that may endanger the health of others. You know, again, I can't -- I can't speak on the medical aspect of it, but, you know, from my understanding, you know, HIV, if exposed, does endanger the health of other personnel.

BY MR. SCHOETTES:

Q Do you know what kind of exposures would endanger the health of other personnel?

MS. BERMAN: Same objection.

THE WITNESS: I would leave that up to the medical experts to say what those are.

BY MR. SCHOETTES:

Q But the body as a whole, the AMSWG, makes decisions about which conditions should be listed as disqualifying conditions, correct?

A Yes.

Q And so in order to evaluate a condition under this criteria, it's necessary for the non-medical members to understand how and why a

condition may or may not endanger the health of other personnel, right?

MS. BERMAN: Objection. Assumes facts not in evidence.

You can answer.

THE WITNESS: Yeah. Through the -- through the advice and recommendations of the medical providers -- that's all a part of the tiger team efforts, if you will, to be sure that the medical providers are, you know, at the time of the revision/review of this particular session, providing us the information to consider about, you know, the medical aspects of exposure to HIV and how that ties into the policy consideration.

BY MR. SCHOETTES:

Q So what did they tell you about what the routes of exposure to HIV would be that would endanger the health of other personnel?

MS. BERMAN: Objection. The discussions of the AMSWG are being withheld under the deliberative process privilege. So to the extent you're asking about specific recommendations that were given, I'm going to instruct the witness not to answer.

If you know what the conclusions were,

hospitalization versus what that individual is going to require in terms of time lost for treatment or hospitalization? I'm not understanding.

A Yeah. So, again, I mean, I'm not a medical provider, so I can't give the medical perspective to this. But from a policy perspective, you know, this goes down to a medical provider and military service determination to determine the excessive time outside of the norm of a particular condition or treatment for the condition above and beyond what the medicine would typically see.

Q In your example or your description, how is the medical -- the subject matter expert, the medical doctor, assessing what the amount of time lost is in a particular -- I'm still -- let me withdraw that.

These criteria are set for a condition, correct, not an individual?

A Yes. Set for a condition or physical defect that --

Q So, I mean -- so that's my question.

A Yes.

Q They're set for a condition, not for an

individual?

A Yeah. Free of medical conditions or physical defects.

Q Right. So in evaluating which medical conditions are to be listed as a disqualifying condition, I'm not understanding what the -- what the medical evaluation is between -- between. It is just based on what would be reasonably expected for that condition, correct?

MS. BERMAN: Objection. Vague.

BY MR. SCHOETTES:

Q Yeah -- well, I'll try again. Let's use an example. So a medical provider comes to you and says what we think would be reasonably expected to treat this condition is going to require four days in a year that this person is going to be absent from their duties. How does the AMSWG decide whether that constitutes excessive time lost from duty?

A So the AMSWG would consider -- one of the aspects that they look at, of the many, they consider, obviously, in-service experience of trends of conditions that -- where folks have acquired, you know, different levels and activity of time lost for duty, along with, you know, the

advice of the medical experts of what typical norms should be versus what something [sic] would be considered excessive, and that, you know, those conditions would be considered, you know, as recommended for being disqualified from entering military service, so that individuals that would have those conditions that requires -- that typically requires those excessive times lost would be disqualified from entering military service and, again, you know, would be part of the service determination based upon that service criteria.

Q When you say service criteria, you're referring to how a particular service branch might assess whether the time is excessive?

A Yes.

Q But in the example I gave you, the medical folks have come to you and said, it's going to be four days. So they've already provided their assessment of what would reasonably be expected. How does the AMSWG as a whole, then, decide whether four days is excessive or not?

A Well, those are recommendations that come from, you know, the subject matter experts in the field that know typical time frames of conditions

that would typically provide an excessive loss of time of duty in order to render routine care for that condition or physical defect of that individual, of an individual, and -- along with service determinations of, you know, duty requirements and time.

You know, it's a -- it's a holistic consideration of all of those types of comments, along with, you know, the -- you know, what have we experienced in service in consideration of considering excessive time lost versus a condition and what, you know, the medical providers would opine on with those conditions that would take them away from duty.

And then that's -- you know, all of that is put together and then -- you know, then a determination is made, hey, these particular -- this condition or particular sets of conditions typically requires a treatment regimen that would require an individual to be away from their regular duties, you know, and an excessive time lost from their duty.

Q Is it the case that the AMSWG just relies upon the medical folks saying the time is excessive? That's kind of what I hear you saying.

A Well, the --

MS. BERMAN: Objection. Mischaracterizes the testimony.

Go ahead.

THE WITNESS: The medical provider, of course, is, you know, only one of the recommendations. It's, you know, the service members that -- or the service that is part of the working group, so the services have reps on the AMSWG as well. So they know what their duty requirements are and what their mission sets look like. And then, you know, mixed with the opinion of the medical provider of conditions that, you know, would typically take an individual away from duty related to their medical condition or physical defects, along with, you know, historical trends of knowing the conditions that have treatment modalities or regimens that are typically time-intensive for care. And then a determination is made on those conditions.

BY MR. SCHOETTES:

Q So that's what I'm trying to understand, right, is that interface between the medical folks and the folks who understand the requirements of being in the field and performing your duties.

reasonable.

Q Okay. How about two days away in a year?

MS. BERMAN: Objection. Calls for speculation.

You can answer.

THE WITNESS: Yeah, I'm not a medical provider. I have no idea if that condition would warrant more than that or not. I don't -- I can't answer that.

BY MR. SCHOETTES:

Q Again, I'm not asking you to provide a medical opinion as to whether a condition would -- requires two days or eight days or ten days. I'm saying, if a condition required two days away for treatment in a year, would that be considered excessive time lost from duty?

MS. BERMAN: Objection. Calls for speculation.

You can answer.

THE WITNESS: Well, I don't know -- I don't know of the condition. Maybe two days is excessive based upon the condition. I have no idea. Maybe that -- whatever condition it is, maybe it could be controlled with a one-hour visit one time a year.

So if it was a too long -- two entire day visit in proportion and in sequence of it, that would be excessive outside of that condition requirement, and I -- that's a medical determination based upon whatever condition and treatment requirements that that individual would need for medical conditions and physical defects.

BY MR. SCHOETTES:

Q So for purposes of my question, let's assume that the two days are what medical professionals have said would reasonably be expected for a person with this condition. So it's completely within the norm. Is that two days away from duties in a year considered excessive time lost?

MS. BERMAN: Objection. Calls for speculation.

You can answer.

THE WITNESS: And the other part of that would be what is the mission requirement to perform the mission from a manpower perspective so that that mission is conducted safely and successfully.

BY MR. SCHOETTES:

Q And how do you get that information when

you're deciding, as the AMSWG, whether to put a condition on the list of disqualifying conditions?

A So that is part of the conversation of mixing the services and their mission and duty requirements with medical conditions that warrant, you know -- that potentially could warrant excessive time lost for [sic] duty based upon the determination of each particular service and their duty and mission requirements is to -- how those things would be determined.

Q And that's what I'm asking, what those people from the services discussed and figured out was going to be excessive time lost for purposes of applying this criteria to a condition?

MS. BERMAN: Are you asking about particular discussions that were actually had or are you asking still about your hypothetical situation?

BY MR. SCHOETTES:

Q I'm asking about my hypothetical situation. I'm asking about how this applies to anything, to any condition. What is excessive time lost from duty and what's acceptable time lost from duty?

A Yeah, so duty requirements are based upon

the mission set of the service and what the service is asked to -- to perform from a duty perspective. So if the commander is going into theater and it's an austere and hostile environment and the commander says, listen, for the next six months, we're in a duty position that any loss of manpower jeopardizes the mission, puts us unsafe, makes the mission unsuccessful, then any time lost during that six months would be excessive in order to safely and successfully perform the duty.

Q But how can the AMSWG possibly apply that as the standard for all people entering any branch of the service? You're talking about a specific instance where a commander has decided that any time lost is excessive. So are you then saying that the AMSWG, then, applies this criteria as being any time lost is considered excessive?

MS. BERMAN: Objection. Mischaracterizes the testimony.

You can answer.

THE WITNESS: The excessive time lost for duty is -- you know, of course in here it says from military service. So it's service component-specific based upon mission and duty

requirements and under the advisement of the medical professionals that determine the typical and routine treatment or care for someone with medical conditions or physical defects that would take them away from duty in an excessive time lost in comparison to what the military service has determined to be the duty, manpower requirement in order to safely and successfully conduct the mission.

BY MR. SCHOETTES:

Q All right. Let's move on. Is well-controlled HIV expected to result in separation from the military service for medical unfitness?

MS. BERMAN: Objection. It's beyond the scope of what this witness is being offered to testify about.

You can answer.

THE WITNESS: Can you rephrase the question, please?

BY MR. SCHOETTES:

Q Sure. Is a person with well-controlled HIV, well-managed HIV, expected to be separated from the military service for medical unfitness?

MS. BERMAN: Same objection.

deployment for illness in evaluating whether a soldier who requires two days for his treatment would be considered excessive time lost from duty?

A Again, I'm not aware of a policy that says a specific set of days. As the services and the commanders in the field, you know, provide their experience and recommendations as part of the accession medical standard review process, those would be things that those particular teams would take into consideration as to whether folks would be -- you know, what the pattern typically is of folks that would need to take time off in the field and at a commander's discretion.

Is there a certain time frame where maybe things are aggressive and hostile in the mission environment, that allowing anybody the capability of moving away and taking a knee for a moment on the battlefield wouldn't be advantageous to anybody -- and maybe there's times to where, you know, that would be warranted.

But again, those are things that, you know, the commanders and, you know, the personnel, manpower folks that -- that consider those things as part of excessive time lost from duty. Again, not a specific -- not days of -- a specific set of

days on the policy, but obviously a consideration of, you know, here's what happens when, you know, folks are off duty for routine illness or a condition that's warranting them to be away from duty for, you know, routine treatment that would typically relate to their medical condition or their physical defect.

Q In assessing the next criteria, which is "medically capable of satisfactorily completing required training and initial period of contracted service," did the subject matter experts indicate that people with HIV that is well controlled would be difficult -- would have trouble completing required training or the initial period of contracted service?

A Again, I can't answer that. That would have been in the conversations prior to my arrival into the assignment. What I will say is that these, you know, five criteria here really aren't in sequence and congruent with each other. There could be conditions that are determined contagious diseases that may endanger or harm other personnel, that a condition would only meet that particular criteria and not the others versus, you know, a condition that, hey, there's no way that

individual there would make it through basic training without complications, or their initial period of contract service.

But it may not be a contagious disease that endangers the health of other personnel. So it may be the fact that some of this criteria doesn't apply to every condition considered, that only some may.

But again, I wasn't in the room during the initial conversations of -- and the processing of the HIV to the point that whether they would have considered an HIV of a condition that people would not have made it through that required training or initial period of service at the time [sic].

Q Did you have more?

A No. That's it. Thanks.

Q In preparing for your deposition on the topic of work of the accessions medical standards working group considering -- concerning the medical accession standards for individuals living with HIV, did you talk to anyone who was involved in those conversations?

A I personally did not speak to anyone individually and have a conversation about, you

know, everything that was said in regards to the review of HIV as an aspect of the accession medical standards.

Q And we covered earlier everything that you did to prepare for your testimony on this topic, correct?

A Yes.

MR. SCHOETTES: Counsel, I'm just going to place an objection on the record that I don't think that this witness could be properly prepared to answer these questions without speaking to the individuals who actually assessed the -- I'm sorry, I shouldn't use that word -- who evaluated the standard for individuals living with HIV, the accession standard.

MS. BERMAN: Well, I'll respond that, again, he's only being offered for the DOD's overall policy as it pertains to this document, 6130.03, and to the work of the AMSWG as it relates to HIV. But as we discussed and has been an issue throughout this case, the actual deliberative discussions and other processes of the AMSWG are being withheld understand the deliberative process privilege.

So he couldn't -- I would not instruct

him to testify to those particular discussions even if he knew about them.

BY MR. SCHOETTES:

Q Are all members of the Armed Services provided with health care?

A Are all members of the --

Q Actually, let me rephrase that. Are all active duty members of the Armed Services provided with health care?

A Yes.

Q Are all deployed members of the Armed Services active duty?

A They're placed on an active duty order. They may not all have come from the organic active component inventory.

Q Are all of those deployed members provided with health care?

A Yes.

Q Are members of the Armed Forces expected to follow the treatment plan of their medical -- of their health care providers?

MS. BERMAN: Objection. Outside the scope of what this witness is being offered to testify about.

You can answer if you know.

THE WITNESS: Yes.
BY MR. SCHOETTES:
Q Are members of the Armed Forces, in fact, ordered to adhere to prescribed medical treatments?
MS. BERMAN: Same objection.
You can answer.
THE WITNESS: Ordered to follow? I'm not sure I could answer that.
BY MR. SCHOETTES:
Q What about with respect to HIV specifically? Do you know if service members living with HIV are ordered to adhere to their medical treatment?
MS. BERMAN: Same objection.
You can answer if you know.
THE WITNESS: The ordered part, I'm not -- I can't speak on that. I'm not sure. And the only reason why I say that is, you know, patients have the right to their care requirements and determinations, but I don't know about the ordered part for care. I'm not sure I would be the one that would answer that part.
BY MR. SCHOETTES:
Q I want to move on to the fourth criteria,

which is "medically adaptable to the military environment without geographical area limitations."

This standard is about deployability, essentially, right?

A Yeah, to be able to be called upon without geographical area limitations, yes.

Q And is someone with well-controlled HIV medically adaptable to the military environment without geographical area limitations?

A I don't know that I know all of the geographical limitations because, oftentimes, those change based upon where the mission is located and what may or may not be going on in that geographical area at the time.

So I can't say an accuracy either way as to whether they would be limiting or not. I suppose if -- if there was some, you know, medical care requirement that couldn't be facilitated and instituted in that geographical region for whatever reason, that would be limiting.

Could those change with time and not really be aware of where those consistently and congruently may be every time? That would be very hard to tell. But I suppose in those

circumstances and situations, it would be limiting.

Q And again, the criteria is not about assessing a particular geographical area or a particular condition. It's about being able to go anywhere, right?

A Yes.

Q So I'll ask the question with that in mind again. Is HIV a condition that would make someone not medically adaptable to the military environment without geographical area limitations?

MS. BERMAN: I'm going to object. To the extent you're asking for a medical opinion, this is outside the scope of what he's being offered for. But he can testify to the policy conclusion that the AMSWG reached.

THE WITNESS: Yeah. So the policy conclusion would be that there could potentially be geographical areas to -- where that would be limiting.

BY MR. SCHOETTES:

Q And what is the AMSWG's understanding as to why it would be geographically limiting? And I think you may have already described this, but I wanted to get an answer to this question.

A Well, again, it's based upon, really, medical provider determination, but I would say that probably the -- an example would be what's the -- what's the medical treatment venue and availability look like for a specific geographical region? You know, what's the access? What's the level of care, equipment, supplies, personnel availability, you know, which geographically worldwide -- sometimes geographical locations are the -- that's not controlled by the United States. It's controlled whatever country we may be in sometimes.

So if that is limiting to the ability to provide treatment and care, then that would be an area that is geographically limiting to that individual and condition.

Q And were there any specifics provided about whether a person living with HIV that is well controlled would experience those types of limitations?

MS. BERMAN: Objection. I'm going to object again that the discussions of the AMSWG are being withheld under the deliberative process privilege. But if the witness knows what the AMSWG's conclusion was as to this criteria

concerning HIV, he can answer.

THE WITNESS: Yeah, I don't have the knowledge on that aspect of it to answer from what the conversations were.

BY MR. SCHOETTES:

Q On the final criteria, whether the person is medically capable of performing duties without aggregating existing physical defects or medical condition, what conclusion did the AMSWG reach about whether HIV was a medical condition -- I'm sorry, let me rephrase that.

What conclusion did the AMSWG reach regarding whether performing the duties of a service member could be accomplished without aggravating existing physical -- without aggravating the HIV?

MS. BERMAN: Objection. Form.

You can answer.

THE WITNESS: You know, I would go back to say that, you know, again, these five criteria, you know, aren't consistent and congruent and holistic with each other. Again, I wasn't around for the -- you know, all of the initial conversations of HIV. It could be that criteria 5 -- it may have not have been applied to that

particular condition. 5 may apply to some other type of condition.

So I can't answer that -- you know, whether the five criteria would have necessarily been applied to the HIV consideration or not.

BY MR. SCHOETTES:

Q And I understand that these criteria -- that a person must meet all of these criteria in order to access, but I hear you saying that you don't know the answer to the question I posed, is that right, regarding criteria 5?

A Yes, I don't know the answer.

Q Is cost of treatment a basis for creating an accession standard barring individuals with a particular medical condition?

A I know that I was not involved in conversations about just cost being considered for a condition.

Q So in your time as the co-chair of the AMSWG, you were never involved in conversations about the cost of treatment as a basis for creating an accession standard barring individuals with a particular --

A Just the cost of treatment, no.

Q Now, you're saying just the cost of

treatment. So are you indicating that cost of treatment is one of the considerations?

A No.

MR. SCHOETTES: Let's go off the record.

THE VIDEOGRAPHER: The time is 11:17 a.m. This completes media unit number 1. We are now off the record.

(Whereupon, a short recess was taken.)

THE VIDEOGRAPHER: The time is 11:32 a.m. This begins media unit number 2. We are now on the record. Please proceed, Counsel.

BY MR. SCHOETTES:

Q A couple of more questions about 6130.03. Is it possible to get a waiver to the accession standards?

A Yes.

Q Is it possible for someone with HIV to apply for a waiver to the accession standards?

A Apply for a waiver for [sic] accession standards. Yes.

Q To whom would they apply for a waiver?

A It would be through the service, the military -- the respective military service for which they're applying.

Q Has anyone ever been granted a waiver

with HIV?

MS. BERMAN: Same objection. And compound.

You can answer.

THE WITNESS: It's trying to prevent the exposure and the harm of other individuals, is what is trying to be prevented. And any level of risk would still risk accomplishing that prevention.

BY MR. SCHOETTES:

Q Right. And is that "any level of risk" sufficient to place HIV on the disqualifying conditions list?

MS. BERMAN: Objection. Scope.

You can answer.

THE WITNESS: Can you rephrase the question?

BY MR. SCHOETTES:

Q You said that any risk of the harm of exposure, which would be transmission, is designed to prevent that harm -- let me try again. Maybe I'll just restate it.

If there is even a very, very, very, very low risk of transmission occurring, is that sufficient to justify placing HIV on the list of

disqualifying conditions for accessions?

MS. BERMAN: Objection. Scope.

You can answer.

THE WITNESS: It's -- any level of risk is a consideration if it avoids the prevention of harming -- of exposing and harming other individuals.

BY MR. SCHOETTES:

Q All right. Let's move on to the next sentence which says, "Persons with HIV infection remain a risk to virus transmission via the walking blood bank in forward deployed settings."

What was your understanding of what the authors were trying to communicate to you, as a co-chair of the AMSWG, with respect to the risk of transmission via the walking blood bank?

A Remaining at risk for a virus transmission and the actual transmission within the walking blood bank, that would be more for a medical provider to answer exactly how that virus transmission risk exists within a walking blood bank based upon medical procedure and medical knowledge.

Q So did -- this is coming from medical professionals. Did you understand them to be

MR. SCHOETTES: I have one --

MS. BERMAN: Sure.

MR. SCHOETTES: -- follow-up.

FURTHER EXAMINATION BY COUNSEL FOR PLAINTIFFS

BY MR. SCHOETTES:

Q Counsel just asked you a question clarifying the process by which the AMSWG assesses whether excessive -- a condition would present excessive time lost. And with that clarification, I want to ask, what amount of time did the medical people on the AMSWG tell the operations people treating HIV would require away from that person's duties?

A I don't recall. I don't recall.

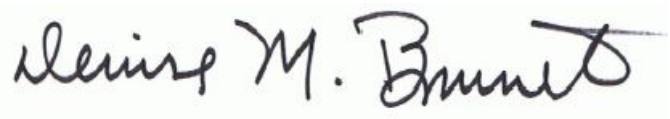
MR. SCHOETTES: Nothing further.

THE VIDEOGRAPHER: The time is 3:19 p.m. This concludes today's 30(b)(6) video-recorded deposition of the Department of Defense with Lieutenant Colonel Gary Brown. We are now off the record.

(Whereupon, at 3:19 p.m., the deposition of GARY BROWN was concluded.)

CERTIFICATE OF NOTARY PUBLIC

I, Denise M. Brunet, the officer before whom the foregoing deposition was taken, do hereby certify that the witness whose testimony appears in the foregoing deposition was sworn by me; that the testimony of said witness was taken by me stenographically and thereafter reduced to print by means of computer-assisted transcription by me to the best of my ability; that I am neither counsel for, related to, nor employed by any of the parties to this litigation and have no interest, financial or otherwise, in the outcome of this matter.



Denise M. Brunet
Notary Public in and for
The District of Columbia

My commission expires:
December 14, 2022

Veritext Legal Solutions
1100 Superior Ave
Suite 1820
Cleveland, Ohio 44114
Phone: 216-523-1313

March 29, 2019

To: Keri L. Berman, Esq.

Case Name: Harrison, Nicholas, et al. v. Mattis, James N., et al.

Veritext Reference Number: 3235718

Witness: Gary Brown Deposition Date: 3/14/2019

Dear Sir/Madam:

Enclosed please find a deposition transcript. Please have the witness review the transcript and note any changes or corrections on the included errata sheet, indicating the page, line number, change, and the reason for the change. Have the witness' signature notarized and forward the completed page(s) back to us at the Production address shown above, or email to production-midwest@veritext.com.

If the errata is not returned within thirty days of your receipt of this letter, the reading and signing will be deemed waived.

Sincerely,
Production Department

NO NOTARY REQUIRED IN CA

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3235718
CASE NAME: Harrison, Nicholas, et al. v. Mattis, James N.
DATE OF DEPOSITION: 3/14/2019
WITNESS' NAME: Gary Brown

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have made no changes to the testimony as transcribed by the court reporter.

_____ _____
Date Gary Brown

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal

this _____ day of_____, 20____.

_____
Notary Public

_____
Commission Expiration Date

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3235718
CASE NAME: Harrison, Nicholas, et al. v. Mattis, James N.
DATE OF DEPOSITION: 3/14/2019
WITNESS' NAME: Gary Brown

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

_____ _____
Date Gary Brown

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They have listed all of their corrections in the appended Errata Sheet;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal this _____ day of_____, 20____.

_____
Notary Public

_____
Commission Expiration Date

ERRATA SHEET

VERITEXT LEGAL SOLUTIONS MIDWEST

ASSIGNMENT NO: 3/14/2019

PAGE/LINE(S) / CHANGE /REASON

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Date Gary Brown

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____

DAY OF _____, 20_____ .

_____

Notary Public

_____

Commission Expiration Date

EXHIBIT 17

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
ALEXANDRIA DIVISION

- - - - - - - - - - - - - - - - - - x

NICHOLAS HARRISON and :
OUTSERVE-SLDN, INC., :
Plaintiffs, :
vs. : No. 1:18-cv-00641
JAMES N. MATTIS, In His : LMB-IDD
Official Capacity As Secretary:
of Defense; MARK ESPER, In His:
Official Capacity As the :
Secretary of the Army; and the:
UNITED STATES DEPARTMENT OF :
DEFENSE, :
Defendants. :

- - - - - - - - - - - - - - - - - - x

VIDEOTAPED 30(b)(6) DEPOSITION OF
UNITED STATES ARMY GIVEN BY PAUL ASWELL

DATE: Tuesday, March 12, 2019
TIME: 9:10 a.m.
LOCATION: Winston & Strawn
1700 K Street, N.W.
Washington, D.C.
REPORTED BY: Denise M. Brunet, RPR
Reporter/Notary

Veritext Legal Solutions
1250 Eye Street, N.W., Suite 350
Washington, D.C. 20005

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(Appearances continued on the next page.)

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ALSO PRESENT: Solomon Francis, Videographer

C O N T E N T S

(*Exhibits attached to the transcript.)

thing. However, the medical waiver authorities are different. So I can't speak to how a particular medical waiver authority at a particular time might grant a waiver.

So they potentially could have an officer candidate that might be granted a waiver, whereas an enlisted candidate might not have been granted a waiver for the same disqualifying condition or vice versa, because it's based on the discretion of the agency that's granting the waiver.

BY MR. SCHOETTES:

Q To your knowledge, has a waiver for accession ever been granted to an individual living with HIV?

A My understanding is there have been waivers granted or exceptions granted, if you will, with the testing protocols that I described to you. In other words, initially, those DOD agencies could make an individual, say, that completed their test and it came up positive and then made an initial disqualification. But there have been -- I can't speak to any particular individual, but my understanding is that that has happened in the past where a follow-on test was granted and then it found that the individual did

not have the actual infection present.

And -- now, whether you would call that a waiver or an exception or just a further review, that was how the -- that was how I would characterize it. It just -- it was a -- to correct an erroneous test.

Q So I think my question maybe was still accurate, even though it didn't attempt to catch that nuance. But -- so it would still be true that a -- or is it true that an accessions waiver has never been granted by the Army to an individual actually living with HIV?

A As you know, I've been doing this since 2009. I'm not aware of any in that time. And I -- I've in the past asked the question, have we ever, and I cannot recall anyone ever identifying an individual that was granted an accession waiver for -- if they were HIV-positive.

Q If you would turn to page -- also on page 4, actually, the next section, 1-16a says, "HIV-infected personnel are not eligible for appointment or enlistment into the active Army, the ARNG, or the USAR (see chapter 5)."

First of all, the ARNG is the Army National Guard?

policy. But as far as who makes that decision to make that call, it's obviously the responsibility, as a matter of policy in the Army's Office of the Surgeon General, but it is ultimately approved by the Secretary of the Army personally.

Q So in terms of any more stringent standard reflected in AR 40-501, that would be the responsibility of the Army's Office of the Surgeon General and then ultimately approved by the Secretary of the Army?

A Yes.

Q With respect to the standards that are already in 6130.03, does the Army play any role in helping to determine what those medical -- disqualifying medical conditions are?

A The Under Secretary of the -- of Defense for Personnel and Readiness and the Defense Health Agency participate in a program that includes the -- a medical standards working group that the services participate in. And in addition, as the medical standards are being discussed or evaluated in the -- this work, it's the Army -- it's called the AMWG [sic] -- in this group - AMSWG, the Army --

Q Accessions medical standards --

A -- medical standards working group. As the -- the AMSWG. As this body deliberates, they come forward with recommendations which are then, based on what the DOD leadership, OSD leadership considers is appropriate, are placed into revisions to DODI 6130.03. The services then are allowed to comment on those changes. And then, ultimately, OSD makes the decision as to what's going to be in the policy.

But the working group gets to comment on it, and then the Army and the other services get to comment on it specifically before it goes into the -- into the instruction. So while the other services and the Army are not responsible for the policy, they have considerable input into development of it.

Q Do you know who is the representative for the Army on the AMSWG?

A There are times when both G-1 and OTSG represent the Army -- Office of the Surgeon General represent the Army on that, but it's usually a -- a senior official, a senior executive. Different -- different folks have done it from the Office of the Assistant Secretary of the Army for Manpower Reserve Affairs, from the

are pseudo-obstruction, megacolon, history of --

THE REPORTER: You need to slow down.

THE WITNESS: Sorry.

THE REPORTER: Pseudo-obstruction...

THE WITNESS: Megacolon, history of volvulus, V-O-L-V-U-L-U-S, or chronic constipation and/or diarrhea.

And so when you look at all those diagnoses, any of those, regardless of whether -- of what caused them, regardless of whether they are persistent, regardless of whether they're symptomatic or asymptomatic, regardless, if it's within two years, then supposedly the examining physician is not supposed to -- they're supposed to be disqualifying the individual.

So if you've got any of those conditions, or history of them, current or history of that, you're supposed to be disqualified regardless of why you had the condition, regardless of whether it was still present. Because you had the condition, you're disqualified.

Q Okay. And I think there's an ultimate reading of this, and that's why I wanted to hear what your understanding of it was, because I think if this was written with more clarity to -- to get

your point across, it would say regardless of cause, persistence or symptomology in the past two years.

Because I think this is saying you have to have a current or a history of gastrointestinal, functional and motility disorders within the past two years that is persistent or symptomatic in the past two years. You've stated what the --

A I believe we interpret that.

Q Okay. Would you look at one more thing for me, and that is, on page 10, 2-14. It is the section covering the genitalia. And under female genitalia, a(3), it lists a "Current or history of dysmenorrhea that is incapacitating to a degree recurrently necessitating absences of more than a few hours from routine activities does not meet the standard."

That seems to me a standard that is, again, somewhat symptomatic and subjective. And this does not mention whether medication can be taken. But if you look to -- I'll just stop there.

So is dysmenorrhea another condition that a person could access with that might require

daily medication?

MS. ENLOW: Objection. Outside the scope. Vague.

THE WITNESS: I am not sure what would allow a person that has that diagnosis of 2-14a(3) -- I'm not sure what the threshold would be for them to be granted a waiver, whether it would be controlled by medication or controlled by diet or controlled by physical activity or something. I don't know what would be the threshold for that. But they would be eligible for a waiver if the waiver approval authority determined that that condition did not -- would not interfere with their being able to serve completely -- serve their first term of service completely and also to finish their initial entry training.

BY MR. SCHOETTES:

Q But I want to go back to what the policy is, which is that you would not need a waiver for current or history of dysmenorrhea if it was not incapacitating to a degree recurrently necessitating absences of more than a few hours from routine activities.

Am I misreading or misunderstanding what

that says?

MS. ENLOW: Objection. Outside the scope.

THE WITNESS: For most of these, they are worded this way. If you look at other examples of conditions, some say the condition is disqualifying. Others say if it has a caveat -- for example, this one has for this condition, or history of it, if it's -- only if it's incapacitating for a particular period of time or a particular -- for a particular -- to a particular threshold is it disqualifying.

This one is a classic one for saying it may not be disqualifying. You know, you cannot say that that particular condition is automatically disqualifying.

BY MR. SCHOETTES:

Q Right. So it is not disqualifying by the terms of the policy, correct?

A It is not necessarily disqualifying.

Q And it doesn't say anything about whether you would be controlling your dysmenorrhea through hormone replacement medication.

MS. ENLOW: Again, outside the scope.

THE WITNESS: It's silent on that. If

the physician determined that it was disqualifying -- and in the waiver process, that would be the time that that kind of discussion would take place, that kind of evidentiary -- you know, evidence being presented that would mitigate the condition.

MR. SCHOETTES: I'm done.

MS. ENLOW: Can we take five minutes?

MR. SCHOETTES: Yeah, you certainly can.

THE VIDEOGRAPHER: The time is 1:31 p.m. We are going off the record.

(Whereupon, a short recess was taken.)

THE VIDEOGRAPHER: The time is 1:41 p.m. We are back on the record. Please proceed, Counsel.

MS. ENLOW: I don't have any questions for Mr. Aswell. I would request that the witness read and sign.

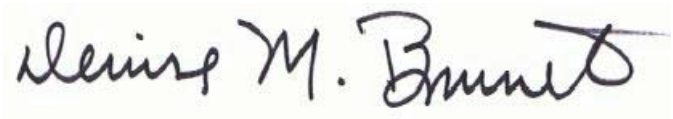
MR. SCHOETTES: Very good.

THE VIDEOGRAPHER: The time is 1:41 p.m. This concludes today's 30(b)(6) deposition of the United States Army through Mr. Paul Aswell. We are now off the record.

(Whereupon, at 1:41 p.m., the deposition of PAUL ASWELL was concluded.)

CERTIFICATE OF NOTARY PUBLIC

I, Denise M. Brunet, the officer before whom the foregoing deposition was taken, do hereby certify that the witness whose testimony appears in the foregoing deposition was sworn by me; that the testimony of said witness was taken by me stenographically and thereafter reduced to print by means of computer-assisted transcription by me to the best of my ability; that I am neither counsel for, related to, nor employed by any of the parties to this litigation and have no interest, financial or otherwise, in the outcome of this matter.



Denise M. Brunet
Notary Public in and for
The District of Columbia

My commission expires:
December 14, 2022

Veritext Legal Solutions
1100 Superior Ave
Suite 1820
Cleveland, Ohio 44114
Phone: 216-523-1313

March 26, 2019

To: Ms. Enlow

Case Name: Harrison, Nicholas, et al. v. Mattis, James N., et al.

Veritext Reference Number: 3235716

Witness: Paul Aswell , 30(b)(6) Army Deposition Date: 3/12/2019

Dear Sir/Madam:

Enclosed please find a deposition transcript. Please have the witness review the transcript and note any changes or corrections on the included errata sheet, indicating the page, line number, change, and the reason for the change. Have the witness' signature notarized and forward the completed page(s) back to us at the Production address shown

above, or email to production-midwest@veritext.com.

If the errata is not returned within thirty days of your receipt of this letter, the reading and signing will be deemed waived.

Sincerely,

Production Department

NO NOTARY REQUIRED IN CA

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3235716
CASE NAME: Harrison, Nicholas, et al. v. Mattis, James N., et al.
DATE OF DEPOSITION: 3/12/2019
WITNESS' NAME: Paul Aswell , 30(b)(6) Army

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have made no changes to the testimony as transcribed by the court reporter.

_____ _____
Date Paul Aswell , 30(b)(6) Army

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal

this _____ day of_____, 20____.

_____
Notary Public

_____
Commission Expiration Date

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3235716
CASE NAME: Harrison, Nicholas, et al. v. Mattis, James N., et al.
DATE OF DEPOSITION: 3/12/2019
WITNESS' NAME: Paul Aswell , 30(b)(6) Army

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

12 Apr 2019 _____
Date Paul Aswell , 30(b)(6) Army

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They have listed all of their corrections in the appended Errata Sheet;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal this 12th day of April, 2019.

_____
Notary Public

03/31/2024
Commission Expiration Date

SAMEER AHMED SHABAB
NOTARY PUBLIC
REGISTRATION # 7109615
COMMONWEALTH OF VIRGINIA
MY COMMISSION EXPIRES
MARCH 31, 2021

Page 1 of 2

~~Page 127~~

ERRATA SHEET

VERITEXT LEGAL SOLUTIONS MIDWEST

ASSIGNMENT NO: 3/12/2019

PAGE/LINE(S) /	CHANGE	/REASON 7/
7/7-9	Change to read: "I work at the Headquarters Department of the Army in the Deputy Chief of Staff G-1, Deputy Chief of Staff for Personnel"	Corrected Capitalization
7/11-12	Change to read: "Chief of Army Accessions, or Chief, Accessions Division"	Corrected Capitalization
10/20	Court Martial	Corrected Spelling
16/15-17	Army Regulation	Corrected Capitalization
18/1 (& other locations)	Defense Instruction	Corrected Capitalization
18/8-9 (& numerous other locations)	Army Regulation	Corrected Capitalization
23/25 & 24/1-4	Cadet Command, U.S. Army Cadet Command, U.S. Military Academy, the U.S. Army Recruiting Command, the U.S. Army Reserve Command and the Army National Guard	Corrected Capitalization
24/13-15 (& other locations)	Regular Army and U.S. Army Reserve	Corrected Capitalization
31/12 (& other locations)	U.S. European Command	Corrected Capitalization
31/25	Coalition Provisional Authority,	Corrected Capitalization
33/19-20	Reserve Officer Training Corps	Corrected Capitalization
36/20-22	Identification, Surveillance and Administration of 21 Personnel Infected With Human Immunodeficiency Virus	Corrected Capitalization
37/13	"is much less rapid"	Corrected language
41/19	"when we include forms"	Corrected language
44/14	Human Resources Command	Corrected Capitalization

12 Apr 2019 — Paul L Aswell

Date — Paul Aswell , 30(b)(6) Army

SUBSCRIBED AND SWORN TO BEFORE ME THIS 12th

DAY OF April , 2019 .

Notary Public

03/31/2021

Commission Expiration Date

SAMEER AHMED SHABAB
NOTARY PUBLIC
REGISTRATION # 7109615
COMMONWEALTH OF VIRGINIA
MY COMMISSION EXPIRES
MARCH 31, 2021

Page 2 of 2

~~Page 127~~

ERRATA SHEET

VERITEXT LEGAL SOLUTIONS MIDWEST

ASSIGNMENT NO: 3/12/2019

PAGE/LINE(S) /	CHANGE	/REASON
48/22	"the other regulations"	Corrected Language
50/17	"being used to disqualify"	Corrected Language
53/13-14 (& other locations)	U.S. Military Entrance Processing Command	Corrected Capitalization
60/17-18	U.S. Army Recruiting Command	Corrected Capitalization
62/2-2	Standards of Medical Fitness	Corrected Capitalization
77/14	DoD Medical Examination Review Board.	Corrected Language/Capitalization
79/11	"very minor medications -- minor medications"	Corrected Language
93/20-21	DOD Medical Examination Review Board	Corrected Language
96/5	stringent AR 40-501 guidelines	Corrected Language
96/8	services to have their own medical criteria than	Corrected Language
104/2-4	Army National Guard Chief Surgeon and we ask the Command Surgeon of the U.S. Army Recruiting Command,C	Corrected Capitalization

12 Apr 2019 — Paul I Aswell

Date — Paul Aswell , 30(b)(6) Army

SUBSCRIBED AND SWORN TO BEFORE ME THIS 12th

DAY OF April, 2019 .

Notary Public

03/31/2021

Commission Expiration Date

SAMEER AHMED SHABAB
NOTARY PUBLIC
REGISTRATION #7109615
COMMONWEALTH OF VIRGINIA
MY COMMISSION EXPIRES
MARCH 31, 2021

EXHIBIT 18

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
ALEXANDRIA DIVISION

- - - - - - - - - - - - - - - - - - x
NICHOLAS HARRISON and :
OUTSERVE-SLDN, INC., :
Plaintiffs, :
vs. : No. 1:18-cv-00641
JAMES N. MATTIS, In His : LMB-IDD
Official Capacity As Secretary:
of Defense; MARK ESPER, In His:
Official Capacity As the :
Secretary of the Army; and the:
UNITED STATES DEPARTMENT OF :
DEFENSE, :
Defendants. :
- - - - - - - - - - - - - - - - - - x
RICHARD ROE, VICTOR VOE, and :
and OUTSERVE-SLDN, INC., :
Plaintiffs, :
vs. : No. 1:18-cv-01565
JAMES N. MATTIS, In His :
Official Capacity As Secretary:
of Defense; HEATHER A. WILSON,:
In Her Official Capacity as :
Secretary of the AIR FORCE; :
and the UNITED STATES :
DEPARTMENT OF DEFENSE, :
Defendants. :
- - - - - - - - - - - - - - - - - - x

VIDEOTAPED 30(b)(6) DEPOSITION OF DEPARTMENT OF DEFENSE GIVEN BY PAUL CIMINERA

DATE: Tuesday, March 5, 2019
TIME: 9:05 a.m.
LOCATION: Winston & Strawn
1700 K Street, N.W.
Washington, D.C.

REPORTED BY: Denise M. Brunet, RPR
Reporter/Notary

Veritext Legal Solutions

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(Appearances continued on the next page.)

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ALSO PRESENT: Orson Braithwaite, Videographer

C O N T E N T S

(*Exhibits attached to the transcript.)

Q Do you know when the full reissue prior to April 28th, 2010 was for DODI 6130.03?

A I believe it was 2005.

Q Do you know when the reissue before that was?

A So at this point my memory may not be as accurate as more recent events. There was, I believe, a 2004 and a late 1980s version. No, that's -- I would have to refer to documents to -- to be more specific back on those dates.

Q So you think it was reissued in 2005, but that it was also reissued in 2004, or was one of those a modification or change, as we've called it?

A I'd have to refer to documents to be certain.

Q Do you think there may have been between -- only one reissue from the late 1980s until 2004?

A I would have to refer to documents on that one as well.

Q So if you'll turn now to -- well, actually, what is the purpose of 6130.03?

A There's a purpose statement listed on the front page which indicates that it "establishes

policy, assigns responsibilities and prescribes procedures for physical and medical standards for appointment, enlistment or induction into the military services."

Q All right. If you'll turn to page 4 and look at section 1.2c. I'm sorry -- yes, 1.2c. This sets forth the standards by which a medical condition is evaluated with respect to accessions, correct?

A I don't know if I would use the term "standards." I would refer to criteria.

Q Okay. So this sets forth the criteria by which a medical condition is evaluated with respect to accession, correct?

A Yes.

Q Here it says that the first goal or the first criteria is to "ensure that individuals considered for appointment, enlistment or induction into the military services are free of contagious diseases that may endanger the health of other personnel," correct?

A Yes.

Q Is HIV a contagious disease that may endanger the health of other personnel?

A Yes.

Q In what way?

A There's a number of potential scenarios in military service where an individual with HIV could endanger the health of another individual, be it a service member or indigenous population, civilian, et cetera. One that is particularly a concern, and is a very military-specific issue, is combat injuries and the ability to transfer virus from an individual with severe injuries to an uninfected individual who is taking care of that individual or may be bringing that person out of harm or caring for a deceased body on the battlefield.

Q And what circumstances would be required in those situations for transmission to occur?

A So the individual would have to have a potentially infected body fluid exposed. In the case of trauma, typically blood would be our biggest concern. And the individual exposed would have to have either non-intact skin or exposure to a mucous membrane.

There's also the potential for percutaneous injury if they are providing IV treatment or -- in the current battlefield capabilities, we have some additional abilities to

truly been documented. Certainly in Vietnam we were concerned with individuals who were -- had Vietnam service having higher rates of hepatitis, and that is thought to be related to transfusions that occurred and the inability to screen the blood supply at the time for hepatitis. At the time, hepatitis was not very well understood and the technology wasn't there to -- to screen it.

And there's always diseases that we are not yet even aware of that could be transmitted through blood transfusion. So we have blanket screening criteria regarding, have you had a fever in a particular period of time, to try to reduce the probability of those issues.

Q So setting aside transfusion-related transmissions and just focusing on the concern you raised about transmission in providing care to a person with an infectious disease, are you aware of any documented cases of transmission of, let's say, hepatitis C in that way?

A I've not done a literature review, so I really can't answer the question.

Q Or hepatitis B?

A Can you specify what population we're interested in at this point in terms of

transmission?

Q Yeah. I'm talking about to another solder who is providing care to -- or transport -- to an individual with hepatitis B.

A All right. So I haven't done a literature review. I think there were some concerns that might have been the case as well in Vietnam where individuals had hepatitis B and some of the transmissions could have been related to that, but I'm not aware of any -- any literature at this time.

Q You said there were several scenarios in which an individual with HIV may endanger the health of other personnel. Can you -- and we've talked about one. Can you tell me about the others?

A So there's a potential for blood transfusion from the donor who is HIV-positive to a recipient who is HIV-negative.

Q And this is in the context specifically of what's referred to as the walking blood bank?

A That is the military-specific -- military-unique situation that drives our concern.

Q And I have spoken with someone -- we have a witness who we've spoken to about this process

of blood donation through the walking blood bank. But you understand that a person living with HIV is instructed not to donate blood, correct?

A Yes.

Q And all blood donation is voluntary in the military, correct?

A Under non-emergent standards, that is correct.

Q When is it not correct?

A There is a potential in a significant battlefield situation where individuals may be required to donate to save the lives of others. It would be a command decision.

Q And so they would order someone to donate blood?

A I'm not an expert in that area, but I think the potential exists.

Q Does command have access to or know which individuals are living with HIV?

MS. BERMAN: Objection. Calls for speculation.

You can answer.

THE WITNESS: Based on my military experience, some select individuals in the command may be aware.

BY MR. SCHOETTES:

Q Certainly the medical -- those providing medical care in a unit would have access to the medical records of all of the service members in that unit, correct?

MS. BERMAN: Objection. Lack of foundation.

You can answer.

THE WITNESS: So in a combat environment, there really is no medical record available and you may be treated by someone from another unit who may not know you or your background. We try to keep these things to those who really have a true need to know and -- you know, to protect the individual's privacy.

So I think you cannot generalize that there would be knowledge of the individual's seropositivity by the treating team in a combat situation.

BY MR. SCHOETTES:

Q Are you aware of the process by which individuals are chosen for the walking blood bank?

A I have a familiarity with the process as it currently exists in Afghanistan.

Q Is there a system, a computer system,

that individuals doing the blood collection access in order to determine who has been pre-screened for donation?

A I believe so.

Q So there are some medical records available to those doing the blood collection in the field?

MS. BERMAN: Objection. Mischaracterizes the testimony.

You can answer.

THE WITNESS: So as I said, I'm somewhat familiar with the processes in Afghanistan, and by that, I mean the processes that existed when I was there, which was 2007, 2008. They may have changed since then. In that particular situation, we had a pretty -- what's the term? -- mature fighting war zone. So processes were able to be established to provide a walking blood bank with as much pre-screening as we could do, given the constraints in resources in a deployed setting. And so safeguards were put in place as feasible.

And so the answer is, yes, there's a pre-screened group of individuals in that situation who would then be recalled to provide blood as needed.

BY MR. SCHOETTES:

Q Would you agree that it's important to know the processes by which blood donations occur in the field if basing a decision in part on risks of transmission through such transfusions?

A Yes.

Q Would a person with well-controlled HIV endanger the health of other personnel?

MS. BERMAN: Objection. Calls for speculation.

You can answer.

THE WITNESS: So I think my earlier statement was, yes, we consider HIV -- HIV a contagious disease that may endanger the health of other personnel.

BY MR. SCHOETTES:

Q Right. But I'm putting the qualification or caveat on that, which is, if a person's HIV was well controlled, what effect would that have on whether they would -- may endanger the health of other personnel?

MS. BERMAN: Objection. Calls for speculation.

You can answer.

THE WITNESS: So well controlled is a

term with -- I'm not sure what the medical definition of that would be. I'll answer the question with undetectable viral load. And my previous statements were reflective of the fact that we're talking about individuals with undetectable viral load.

BY MR. SCHOETTES:

Q So are what you saying is you are still concerned about -- or the undetectable viral load has no effect -- hold on again.

What you're saying is that you are still concerned about transmission via providing care during combat injuries -- as a result of combat injuries or in transporting an individual with a combat injury even if the individual with that combat injury has an undetectable viral load?

A Yes.

Q Do you think there is any effect on the risk of transmission in that situation based on the undetectable viral load?

MS. BERMAN: Objection. Vague.

You can answer.

THE WITNESS: Based on scientific principles used in medicine, an undetectable viral load would produce a less probability of

You can answer.

THE WITNESS: Yeah, I would not state it that way. You are -- you're inferring causality of documentation based on a particular viral load. There's other reasons why it might not be documented, and that could be the availability to provide comprehensive health surveillance information in a combat setting.

So I would think the place to look for -- or to try to confirm that would be a research study in a location with a high prevalence of HIV, such as some of the countries in Africa, and then look at the caregivers who care for those individuals and see what the seroconversion rates are. But that's complicated by other potential routes of exposure, such as sexual contact with HIV-positive individuals through unprotected intercourse.

So it's very difficult to tease out what the true risk is. So I would not say that undocumented cases is evidence that there's no risk.

BY MR. SCHOETTES:

Q Mischaracterized a little bit what I said, so I want to go back.

First of all, the study that you just referred to as the kind of study you would want to see, were you talking about a study of people engaged in combat and then would have combat injuries?

A I think -- it's very hard to do any study in a combat zone. So I was thinking, as a surrogate study, to look at individuals who are caring for trauma victims or combat victims in some of the African countries that have high seroprevalence of HIV and also have complex humanitarian emergencies occurring which results in conflict. That may be a population you could look to, but there's many -- many potential flaws in such a study to understand truly what the cause of that seroconversion would be.

Q Including the fact that the individual providing the care is much less likely to have an injury of their own through which transmission would be more likely?

A Yes. So if I can paraphrase what you're stating -- and that's one much my concerns with the combat situation, is the person caring for the individual who is injured may also be injured and, in a combat setting, we find people have abrasions

all over their body in their skin due to effects of the environment, due to having to do rough work in a deployed setting, and then they may also be injured and expect to care for their, quote/unquote, battle buddy.

Q All right. Providing buddy-care is -- I think I've heard -- buddy-aid I think I've seen it referred to as, correct?

A Yes.

Q But I was also asking about what the baseline risk is before we put into the calculus the undetectable viral load. And my understanding is, one, there's been no documented cases of HIV transmission in this situation, correct?

A In situation -- what situation are you referring to?

Q Combat injury, buddy providing aid, that individual has an open wound as well -- there's not been any documented cases. I believe you stated that earlier.

MS. BERMAN: Objection. Form.

THE WITNESS: I'm not aware of any documented cases in that situation.

BY MR. SCHOETTES:

Q Have there been any reported cases, as

distinguished from documented cases?

A There are reported cases of transmission in the, quote/unquote, controlled health care settings that may be relevant.

Q I'm talking about in the context of combat injury, providing aid.

A I'm not aware of any.

Q If the risk was of any significance, would you expect to see some reports of such transmissions?

MS. BERMAN: Objection. Calls for speculation. Lack of foundation.

You can answer.

THE WITNESS: So at the risk of sounding presumptuous, I think the best surveillance systems we have to detect this occurring would be in the U.S. military, having worked in this area before in previous jobs.

However, our current processes are designed to reduce the risk of that occurring due to the HIV screening we do. So there would be a very small likelihood, under our current processes, that the individual being treated has HIV. So that would make it very unlikely that we would be able -- that we would have cases to -- in

our surveillance system to detect or document.

This is one of the reasons why I suggested to try to get -- peel this onion, so to speak, would be to look at areas that have a high prevalence of HIV and see what the transmission there is. But again, that would be difficult to get the kind of evidence base we would want to make a high-quality, evidence-based decision and quantify that risk.

BY MR. SCHOETTES:

Q I think you referred to the context of health care -- provision of health care as an analogous context in which to look. Is that accurate?

MS. BERMAN: Objection. Mischaracterizes the testimony.

THE WITNESS: I did not use -- I would not say analogous. But when you're trying to make a policy decision, you're looking at other situations that could inform your decision. And one area where there is data is health care.

BY MR. SCHOETTES:

Q Has there ever been a documented transmission of HIV via blood splash in that context?

A I believe I answered it. I'm not aware of any documented, but there's suspected transmission.

Q And I'm sorry, maybe my question wasn't clear --

A There may actually be a couple of documented cases. I would have to look at the -- the studies again to see those cases, and I believe they were some time ago. It may have been related to high viral loads, but I would have to look at the literature again.

Q So your answer there was talking about the context of provision of health care?

A Yes.

Q Unrelated to battlefield or --

A A controlled -- let's just say in a controlled environment, using health care standards and processes which are used in the United States.

Q Which is generally going to include universal precautions?

A Yes.

Q And you said there may be some documented transmissions via blood splash perhaps from earlier on, from several -- many years ago?

A In that setting, yes.

Q Has there been a documented transmission in that setting from someone with an undetectable viral load?

A I do not believe so.

Q So we've discussed combat injuries and providing care, as well as transfusion-related risks. Are there any other ways in which a service member's HIV may endanger the health of other personnel?

A There are other theoretical risks, such as sharing of toothbrushes or personnel hygiene products, I guess you would say, but these are theoretical risks.

Q How do you distinguish a theoretical risk from other types of risk?

A When I use the term "theoretical," I'm typically referring to risks that are supported by principles accepted in the medical -- within medical training and experience and knowledge that may not be documented. By "documented," I mean they may not have individual case reports documented in medical literature, peer-reviewed medical literature.

Q And for purposes of the record, can you

explain the difference between a report and a documented transmission?

A Reports can be in many forms, so I'm not exactly sure what your question is asking about. Are you referring to case reports in a peer-reviewed journal or public health reports of communicable disease?

Q Let me ask the question a different way. In order for the transmission to be documented as having occurred through a certain mechanism, do other potential routes of transmission need to be ruled out to a reasonable degree?

A Yes.

Q So there could be a report of an HIV transmission that does not result in a documentation that it happened through a particular means of transmission?

MS. BERMAN: Objection. Vague.

You can answer.

THE WITNESS: Right, it's vague. I would have to see the report to evaluate whether or not the conclusions of the report are supported.

BY MR. SCHOETTES:

Q Okay. I think what I'm trying to get at is, there can be a case report of a transmission

and that the -- it becoming a documented case of transmission in a particular way would happen down the road, right, after an investigation? Does that comport with your understanding of how these processes work?

A Yes. I've had formal epidemiology training. So you could have a report something occurred, and then it needs to be investigated and -- to see if the facts are supported.

Q And is that what would then be called a documented case of transmission?

A In my opinion, yes.

Q The second goal or the second criteria in 6130.03 is person must be "free of medical conditions or physical defects that may reasonably be expected to require excessive time lost from duty for necessary treatment or hospitalization, or may result in separation from the military service for medical unfitness."

Have I got that correct?

A Yes.

Q Does a person with well-controlled HIV pass this criteria?

MS. BERMAN: Objection. Vague. And calls for speculation.

You can answer.

BY MR. SCHOETTES:

Q Let me rephrase the question using the terms that you used. Does a person with an undetectable HIV viral load meet the standard -- the criteria that's set forth there?

MS. BERMAN: Objection. Vague. And calls for speculation.

You can answer.

THE WITNESS: Can you say one more time?

BY MR. SCHOETTES:

Q Does an individual with an undetectable viral load for HIV meet the standard -- criteria number 2?

MS. BERMAN: Objection.

You can answer.

THE WITNESS: So if we can break criteria -- question [sic] number 2 is quite long and has multiple standards, I guess you could say, or criteria in there.

Looking at the first section, which is excessive time lost from duty or for necessary treatment or hospitalization, in most cases, I would not expect that individual to require hospitalization. So that would not apply.

Necessary treatment -- lost time from duty for necessary treatment, I would need to understand the specifics of that individual's ongoing treatment. So, for instance, there are some new entry blockers that's require injectable medication. If that is a requirement, that might result in excessive time lost from duty because they would have to be transported to a place where we can provide that treatment. And so that -- that is a concern.

The second part, separation from the military service for medical unfitness, is a retention question. And that's really at the service's discretion based on the duties rate of the individual that they would be assigned to do.

So it's very a individualized decision, that second one, based on that individual's function.

BY MR. SCHOETTES:

Q However, the accession standards are not applied or determined on an individual basis, correct?

A Correct.

Q They are set based on a condition, correct?

You know, on the other hand, if you need a specialist and it's going to require a full day away every month or two, that could be more widely problematic because the specialist is not going to be available within a very large geographic region, and affect more individuals, potential population.

Q A witness for the Army has said that time required to take daily medication is not even considered time lost. Does the Department of Defense agree with that assessment?

A I would like to define daily medication. So if it's an injectable that requires -- from my Army experience, you would not carry your injectable medication in your field setting. So you would store that in as much of a controlled environment as you possibly could get, which could be a very -- which could be a hut made out of plywood at a battalion aid station. So that may require you to get care at the battalion aid station for that medication.

So depending upon what your -- what your job duties are, if you're in a combat outpost on the side of a mountain and you have to hike one day down to the battalion aid station, that could

be problematic. So it's situational-dependent, and my main concern would be injectable.

Q So for someone taking a pill or two pills or even three pills once a day, or twice a day, would that time be considered time lost?

MS. BERMAN: Objection. Compound.

THE WITNESS: If the pill is available to them, does not require any special temperature controls or controlled substance, you know, monitoring -- so for loss or theft, I would not consider that time lost.

BY MR. SCHOETTES:

Q For a deployed individual, would a visit to a medical facility within the theater of operations that requires 72 hours away from an individual's unit be considered excessive time lost?

MS. BERMAN: Objection. Vague. And calls for speculation.

You can answer.

THE WITNESS: Based on my experience as the CJTF, combined joint task force, 82nd preventive medication specialist for Afghanistan, I would say yes. In most cases, due to the ability to transport these individuals, most of

the -- in the case of combat soldiers, if they are in the outpost, to be able to transport them is time lost from a small outpost, where they may be one of a limited number of individuals available to protect that outpost -- and also transport is problematic because it puts themselves and other at risk in an environment outside, quote/unquote, the wire, with IEDs and other potential combat scenarios and more risk.

BY MR. SCHOETTES:

Q When someone is at one of these posts that you are talking about, for how long of a stretch could they potentially be at that kind of outpost?

A Could be a couple of months.

Q Is it ever six months?

MS. BERMAN: Objection. Calls for speculation.

You can answer.

THE WITNESS: I believe it has been six months.

BY MR. SCHOETTES:

Q How frequently does that happen?

MS. BERMAN: Objection. Calls for speculation.

You can answer.

THE WITNESS: I don't have data on it. It's going to be dictated by the combat situation. And -- if we look at -- right now we're talking about ground forces, so I think it occurred quite often while I was up in Afghanistan in 2007, 2008, because units were asked to extend their deployments to 15 months. So folks were there for a long time.

BY MR. SCHOETTES:

Q Would a visit to a medical facility within the theater of operations -- actually, let me back up.

The deployment policy expresses concerns with the need to transport people out of theater. So does that make your assessment -- does that influence your assessment of what is excessive time lost for purposes of obtaining treatment?

MS. BERMAN: Objection. It's outside the scope of what he's being offered for testifying about accessions, but he can talk about deployment in his personal knowledge.

THE WITNESS: Right, so I would have to look at that particular policy to see the specific wording, but there are certainly differences in

intra and inter-theater transport. The discussion we just had was intra-theater, so an individual needing to get back to their battalion aid station, a very low level of care, which would be either a physician assistant or a physician.

Within -- depending upon the particular combat environment or contingency operation, there may not even be a role two, which would be a -- more advanced medical capability to care for combat injured -- available. So the particular footprint of the operation is going to, again, define what assets are available in theater and, therefore, what would require an intra-theater evacuation for more advanced capabilities. So situational dependent.

BY MR. SCHOETTES:

Q Does every theater of operations have a role three medical facility?

MS. BERMAN: Objection. Vague.

You can answer.

THE WITNESS: Again, it's going to be contingent upon the mission and the medical support as -- determined necessary for that mission. And, in general, no. In the more recent conflicts, yes, they may have multiple

role threes, because we've -- as I stated earlier, we're currently in a mature conflict where we've been there for a while and we have kind of built up capabilities and --

BY MR. SCHOETTES:

Q And you're referring right now specifically to CENTCOM?

A No. I'm referring to Afghanistan and Iraq and Djibouti and Kuwait.

Q Which are all within CENTCOM, correct?

A Yes, unless they've changed Djibouti to AFRICOM, but I think it's still CENTCOM.

Q So what I hear you saying is that there are other theaters of operation in which there may not be a role three medical treatment facility?

A Yes.

Q Can you give me examples of those theaters of operation?

A I'm not aware of any currently in AFRICOM. And for ships at sea, there may not be one available within specific time and distance requirements. So by that, I mean, it takes a certain amount of time to evacuate a person when you're out in the middle of the ocean. And so that could vary on a day-to-day basis as ships

maneuver.

Q So to be clear, you're not aware of any role three treatment facilities in AFRICOM?

A I'm not aware of any U.S. military role three treatment facilities in AFRICOM. Djibouti is in Africa, but I believe it is part of CENTCOM. And that may be what's referred to as enhanced role two. This isn't an area that I'm currently responsible for. It would be a combatant command responsibility.

Q Does your assessment change with respect to -- let me try this again.

Would a visit to a medical facility within the theater of operations that requires 48 hours away from an individual's unit be considered excessive time lost for purposes of this criteria?

MS. BERMAN: Objection. Calls for speculation.

You can answer.

THE WITNESS: In general, I would consider that excessive time lost in a combat environment, or even in a non-combat at-sea deployment.

BY MR. SCHOETTES:

Q Would 24 hours away from -- would a visit

assessing what constitutes excessive time lost within a particular branch?

A The branches have representatives in the work group, the AMSWG, which provide their evaluation of those criteria for discussion and development of recommendations for policy.

Q And the branches each apply or interpret for themselves what constitutes excessive time lost?

MS. BERMAN: Objection. Calls for speculation.

THE WITNESS: In general, yes. It is their responsibility.

BY MR. SCHOETTES:

Q The second part of this criteria asks if the medical condition or physical defect is reasonably expected to -- I'm sorry, no, that's incorrect.

Let me go back, though, to this first section. And indeed the criteria says that it is -- it must be "reasonably expected to require excessive time lost from duty for necessary treatment or hospitalization," correct?

A 1.2c(2) states that, yes.

Q And so inherent in that standard of

"reasonably be expected" is some degree of estimation, correct?

A Yes.

Q Assessment of the likelihood of that occurring, correct?

A Yes.

Q Across the population living with this condition?

A Yes.

Q The next piece of the standard says "or may result in separation from the military service for medical unfitness."

Is well-controlled HIV a condition that may result in separation from the military service for medical unfitness?

A Well, it's going to be based on the individual case. As I stated earlier, separation is based on the individual's office, grade, rank and duties, and then of course, their particular health status.

When we interpret this statement for accession standards, we have to consider future -- the natural progression of the disease. So the answer is yes.

Q But I asked if someone has well-managed

HIV. So I'm asking you to make an evaluation as to whether someone with well-managed HIV is likely -- or may result in separation from the military service for medical unfitness?

A So the answer is, yes, they may be separated in the future.

Q And why would that be?

A Progression of disease, typically.

Q Why would the disease progress if it was being well managed?

A The disease can create additional comorbidities due to other effects of the virus as well as the treatment. The medication could have side effects. So there's additional concerns that we -- that may -- additional conditions that may occur that could result in separation.

Q What conditions may occur for someone who has well-managed HIV?

A So I'm not an infectious disease expert, so I can't answer the specifics of well managed and if there's a particular definition with well managed. Can you clarify that, please?

Q Sure. Someone who is able to maintain an undetectable viral load through the use of antiretroviral medication.

A Okay. So for our policy and interpretation of this statement, we would be concerned about cardiovascular effects mainly due to lipid alterations, we'd be concerned about renal effects, and we'd be concerned about neurocognitive effects would be my main concern.

Q And do you know what the likelihood is of cardiovascular effects rising to the level of medical unfitness and separation?

A I do not have that knowledge at this time. It would require the infectious disease specialists and epidemiologists to provide that.

Q Do you know what -- the likelihood of renal effects leading to a level of medical unfitness that would require separation?

A The same with the previous answer, I would require information from those specialists to be able to answer that question.

Q And do you know what the likelihood is of neurocognitive impairments rising to the level of creating medical unfitness and resulting in separation for a person with HIV that is well managed?

A As with my previous answer, I'd rely on the epidemiologists and the specialists to provide

MS. BERMAN: Objection. Outside the scope of what this witness is being offered for.

You can answer.

THE WITNESS: Yes.

BY MR. SCHOETTES:

Q Are members of the Armed Service, in fact, ordered to adhere to prescribed medical treatments?

MS. BERMAN: Same objection.

You can answer.

THE WITNESS: I don't know the answer to that one.

BY MR. SCHOETTES:

Q Do you know if service members living with HIV are ordered to adhere to their prescribed medical treatments?

MS. BERMAN: Same objection.

You can answer.

THE WITNESS: That's outside the scope. That would be a service responsibility.

BY MR. SCHOETTES:

Q The third criteria listed is that people accessing must be "medically capable of satisfactorily completing required training and initial period of contracted service."

And I think you just referred to this in your last answer, correct?

A Yes.

Q I'm sorry. In a previous answer, not your last answer.

Is someone with HIV medically capable of satisfactorily completing required training and initial period of contracted service?

MS. BERMAN: Objection. Calls for speculation.

You can answer.

THE WITNESS: It depends on the individual.

BY MR. SCHOETTES:

Q Is someone -- is someone with HIV, but not AIDS, medically capable of satisfactorily completing required training?

MS. BERMAN: Objection. Calls for speculation.

You can answer.

THE WITNESS: It would be dependent upon the individual's health status.

BY MR. SCHOETTES:

Q And what about their health status would make them medically -- what potentially would make

them medically incapable of satisfactorily completing required training? This is for an individual with HIV, but not AIDS.

A So I would have a couple of concerns. I'd want to make sure that the individual has no side effects or adverse effects of their medication regime, that the medication regime can be safely provided to them during initial training.

Q What do you mean by could be safely provided to them?

A So earlier in a response I talked about the entry blockers and the requirement for periodic injection. So that is a concern in a basic training environment due to the significant amount of skin bacterial diseases that we have which can result in significant morbidity and mortality, such as necrotizing fasciitis and loss of life and limb.

Q So I want to set aside injectable treatment for HIV, because it is relatively rare, as you established earlier, and ask that question again with respect to people who are either not receiving any treatment or people who are on medication ingested orally.

A Can you just state the question?

Q Sure. Is someone with HIV, but not AIDS, medically capable of satisfactorily completing required training?

MS. BERMAN: Objection. Calls for speculation.

You can answer.

THE WITNESS: It would depend on the individual and it would require individual evaluation.

BY MR. SCHOETTES:

Q And looking at it a population level for people who have HIV but not AIDS, what is it that you would be concerned about that would prevent them from satisfactorily completing required training?

A So other than injectable medication?

Q Yes.

A Certain side effects of the medication. I would be concerned with any renal effects, any mitochondrial effects and associated disorders that may put them at higher risk of injury or illness resulting from the training, such as dehydration, cardiac abnormalities that could occur in high-intensity physical exercise and

endurance. Depending upon the type of training, lack of sleep, lack of ability to eat or have access to their medication through a routine schedule.

Q And these are all concerns based on your understanding of the side effects of HIV medications?

A No. It's the side effect profile as well as the logistics and resources to ensure that they have access to the care that they need.

Q What are the concerns in the context of training in terms of access to the care that they need?

A So it's kind of a microcosm of the concerns we have in a deployed environment, which would be access to medical care, access to routine medications as needed. So if they require medication a certain time of day, they may be involved in a training evolution in the woods and they just -- in the dark and they, you know, may not have access to all of their -- all of the items they require.

So there are concerns that the initial entry training sites, in terms of the -- completing required training and follow-on

this witness is being offered to testify about.

THE WITNESS: So I mentioned a number of concerns and each one requires a separate evaluation and expert -- subject matter expertise, information that's not available to me right now to answer that question.

BY MR. SCHOETTES:

Q Would you agree that some of these risks are -- the degree of risk is speculative?

MS. BERMAN: Objection. Vague.

THE WITNESS: No.

BY MR. SCHOETTES:

Q Do you feel like we understand what the risk of neurocognitive impairment is with respect to individuals who have had HIV for a long period of time?

MS. BERMAN: Objection. Vague.

THE WITNESS: So with my epidemiology expertise, I would not say we understand the risk very well.

BY MR. SCHOETTES:

Q In terms of the acute side effects, does -- and I asked this question earlier; I don't think I got the answer to this. Given your statement that the side effects of modern HIV

treatments are generally well tolerated, does that affect your assessment as to the potential for acute side effects to influence the ability to complete required training or initial period of contracted service?

A Can you rephrase your question? Because the answer is yes.

Q Okay. How does it affect your assessment of whether the -- the fact that side effects are generally well tolerated for modern HIV treatments, how does that affect whether or not the person will be able to satisfactorily complete their required training and initial period of contracted service?

A My main concern -- so that statement informs me to understand that you can get to a point where you can have a regime of medication and treatment that currently produces a small side effect profile.

We talked a little bit about the potential for long-term effects, which is a completely separate issue. But then in the accession space, we often have to be concerned about previous treatment and what enduring effects might have occurred from that, as well as previous

non-treatment and poor control of HIV and any damage that might have occurred due to that and any residual effects.

So -- does that answer your question?

Q So -- not quite. So we're talking about the acute side effects. Can we agree that acute side effects occur shortly after initiation of a particular medication?

A In general, yes.

Q And so -- first of all, we need to be talking about someone who was starting a new regimen to have concerns over acute side effects, correct?

A Yes.

Q And so an individual who comes to the service and is already on successful treatment, there wouldn't be those concerns about acute side effects, correct?

MS. BERMAN: Objection. Calls for speculation.

You can answer.

THE WITNESS: As I stated, we'd have to look at the individual and understand any potential adverse effects and what level -- for instance, what level of renal function they have

So I would refer to a nephrologist to give you, you know, a more comprehensive answer.

Q And are the concerns around that reflected in the urinary system -- well, are the concerns that relate to the urinary system reflected in the standard, the medical standard, for accession in terms of the urinary system?

A No. We have just discussed more subtle effects based on the underlying condition. And as I stated, in cardiovascular, when we put a condition on the list as disqualifying, we don't then say all the potential problems that the condition could have with comorbidities and then list that condition in every section. We do so with an understanding of all of these aspects, and just for simplicity, put the condition down.

Q I understand. I guess what I was asking before with respect to cardiovascular, and with respect to now the urinary system, is if the standard addresses or sets a certain level of function that is required regardless of the condition. I think -- I think it comports with what you're saying is that it shouldn't matter so much what the condition is as what effect the condition is having on renal function, correct?

MS. BERMAN: Objection. Mischaracterizes the testimony.

You can answer.

THE WITNESS: I'll state it as there are -- a snapshot in time, we can assess that impact, that impairment at accession, and then there's an understanding of what might happen through the natural progression of disease that needs to be considered as well.

BY MR. SCHOETTES:

Q Is cost of treatment a basis for creating an accession standard barring individuals with a particular medical condition?

A I don't believe it's directly related, through -- it's not explicitly stated in this DODI. I would have to look more closely through every page of this extensive DODI to -- to confirm that.

Q It's certainly not part of the five criteria that guide which conditions are listed, correct?

A As I said, it's not explicitly stated, but it -- I think it is linked through some of the standards.

Q So can you point me to where you think it

is linked?

A In separation from the military service for medical unfitness. We'd have to look at the disability standard, which I'm not the expert here to testify on, but I believe there is language in there that talks about undue -- undue resources or something of that sort on the military.

Q Okay. Anything else that you think implicates cost in the criteria?

A Well, you know, it's implied in -- geographical area limitations is one factor. The availability of specialty care worldwide is a cost issue.

Q Okay. And actually, I didn't wrap this up well enough. On the last criteria, the fifth criteria, besides for the things you already identified, are there any other concerns around HIV in terms of it affecting -- aggravating existing physical defects or medical conditions by performing one's duties?

A So we covered the stressors such as biological stressors.

Q Yeah, vibration.

A And -- that's a physical stressor. Vibration is a physical stressor. The

MR. SCHOETTES: On the first page of the whole exhibit --

MS. BERMAN: Okay.

MR. SCHOETTES: -- it describes sort of what is found at tab C and may help the witness answer the question.

THE WITNESS: Yes, that's accurate on the first page of this packet, that the description of what is at tab C is the Office of General Counsel declaring this instruction legally sufficient, and it includes a copy of instruction that they reviewed.

BY MR. SCHOETTES:

Q And -- so it's a declaration from the Office of General Counsel or a memo? Is that what would be found there?

A I don't know that it requires a memo. It could be an e-mail. Some -- maybe dec- -- I don't know what the legal definition of declaration is, but there's something to indicate that they have reviewed it and provided --

Q Okay. A statement of some kind --

A Yes.

Q -- declaring this instruction legally sufficient?

A Correct.

Q All right. I think you can set that exhibit aside.

I'll ask you some questions about the work of the accessions medical standards working group. What are the responsibilities of the accession medical standards working group?

A The group meets to discuss the accessions standards and indicate if any policy changes would be recommended. We also provide some guidance to the accessions medical standards analysis and research agency, I believe it is, AMSARA -- I often say just AMSARA -- activity, I think it is -- as to what issues they should provide some research or analysis on.

Q And just to be clear, the -- AMSARA is A-M-C-A-R-A [sic] and it is the accessions medical standards analysis and research activity?

A A-M-S, as in Sam, or Sierra, A-R-A.

Q That's what I said. It might not have been audible that way.

To whom does AMSWG make these recommendations regarding changes to the accessions standards?

A The AMSWG is a work group established by

charter under the medical personnels -- medical personnel steering committee, which has both personnel and medical leadership as part of its body.

THE REPORTER: As part of its...

THE WITNESS: As part of its body of membership --

THE REPORTER: Body.

THE WITNESS: -- representatives from the personnel side, from the medical side, as well as from the services at the MEDPERS level.

BY MR. SCHOETTES:

Q And when you say "at the MEDPERS level," you are using an acronym that is capital -- all capitals, M-E-D-P-E-R-S, correct?

A Correct.

Q Are there voting and non-voting members of the AMSWG?

A Yes.

Q What's the difference between the two?

A The voting members are the services' representatives who have policy authority, as would occur when the actual policy gets staffed for concurrence, whereas as the non-voting members tend to be subject matter experts who can provide

A Both voting and non-voting?
Q Yes.
A A little over a dozen. I don't know the exact number at the top of my head.
Q And approximately how many are voting and how many are non-voting?
A About six voting and a little over six non-voting.
Q Are the people that serve on the AMSWG the same ones that are asked to comment upon 6130.03 or would those be two different groups?
A Can you specify what you mean by comment?
Q So in the comment matrix that we looked at before, you identified who would be asked to comment. And you talked about people who had authority under the DODI and those who had equities under the DODI. Is that who serves on the AMSWG or is it a different group?
A For the most part, it's the same group.
Q Okay. I'm trying to avoid us having to go through all those questions again to talk about the membership of the AMSWG.
Oh. And actually, in -- if you look back to --
A If I can clarify my statement.

Q Sure.

A So it is the same individuals who will be asked to provide input to their leadership who still retains that final authority to provide the concurrence.

Q The concurrence being their comments as reflected in the comment matrix?

A So the process is when the final -- when the policy goes for approval and it goes out for coordination, the individuals at -- the different individuals, the equity or responsibilities, will often go to their subject matter experts, which tend to be the matters of the AMSWG, and obtain their input on whether or not they should approve the document or make changes. So they will have to get their input formally approved through their chain of command before it could enter into that comment matrix.

Q If you'll turn -- go back to Exhibit 3, please, which is the 2018 report to Congress. And if you look to page 9, it describes the membership of the AMSWG. And it says, "The AMSWG is co-chaired by representatives from the Office of the Assistant Secretary of Defense for Manpower and Reserve Affairs and OASD." And then it says,

"It includes a voting representative from each of the five military services, with additional support from the following DOD components/offices: Joint staff surgeon, surgeons general of the Army, Navy and Air Force, medical officers of the Coast Guard and National Guard Bureau and personnel chiefs of the Army, Navy, Air Force, Marine Corps, Joint Staff and National Guard Bureau."

Does that accurately reflect the membership of the AMSWG?

A Yes, and it also includes consultants, which is AMSARA, and the Department of Defense medical evaluation review board, which is not specified here. They are not -- they're not voting members. They're consultants.

Q Are all of these individuals listed here voting members?

A No. Only the five military services and the two co-chairs are voting members.

Q The rest of the individuals here are -- listed here are non-voting members?

A Yes.

Q As are the consultants that you referenced?

A It's a technical issue. I don't think

expect that to be a big driver of someone joining the military.

BY MR. SCHOETTES:

Q Because they likely could get at least their HIV care free of charge or for a low charge in the United States if they did not have health care coverage?

MS. BERMAN: Same objections.

You can answer.

THE WITNESS: So my understanding of public health policy in the United States would affirm that statement, and those individuals would have to endure the rigors of military service which is usually the bar which is going to discriminate individuals coming in or not coming in.

BY MR. SCHOETTES:

Q And in some ways, if an individual was willing to go and serve in the military and put their life on the line to defend this country, would that be better than -- for the federal government fisc than providing that care for no service in return?

MS. BERMAN: Objection. This is outside the scope of what this witness is being offered to

testify about, and it also argumentative.

You can answer.

THE WITNESS: So I think that would be a personal opinion-type response. And there's other outlets for social service for individuals, Peace Corps, et cetera. So I really don't have an opinion on that one to share.

BY MR. SCHOETTES:

Q I want to talk a little bit about accessions and deployment policies for other conditions requiring daily medication.

Actually, before I do, aside from the change to the language about serological evidence of infection versus laboratory evidence of infection, have there been any changes to the accessions medical standards for people living with HIV since the -- it was established that a person with an undetectable or suppressed viral load is essentially non-infectious?

MS. BERMAN: Objection. Mischaracterizes the testimony.

You may answer the question.

THE WITNESS: I think that would probably be a compound question. If you could rephrase it, that would be helpful. If you want to ask me at a

certain date -- as of a certain date has the policy changed, I think that might be something I can answer.

BY MR. SCHOETTES:

Q When did you tell me you first read about the -- about treatment as prevention?

A I believe that was -- I might have said 2006-ish with Dr. Fucci's article in JAMA. I would have to look back to see what date popped in my head when you first asked me that question. So given 2006 onward, I'm not aware of any substantive change in the HIV policy.

Q Have there been any changes other that the one I described between -- from "serological" to "laboratory evidence of infection" since the introduction of antiretroviral therapy for HIV treatment in 1996?

A I have not reviewed the policy changes in-depth from 1996 onward. So I can't answer that from a factual basis.

Q Now I'll move to other conditions. And, I'm sorry, this is just the accessions policies with respect to these other conditions.

Are you familiar with the medical condition dyslipidemia?

A Yes.

Q What kind of treatment does dyslipidemia generally require?

A Diet, exercise and medication management.

Q What is the accession policy for individuals with dyslipidemia?

A That is listed in DOD 6130.03.

Q And in fact, it's on page 39 there.

A Okay. Thank you. So that is covered in a couple of standards, actually. The two main standards are 5.24n as well as it is related to 5.24o.

Q And 5.24n actually sets forth some criteria to judge the degree of progression of the person's dyslipidemia, correct?

A I would not use the term "progression." I would use the term, maybe, severity.

Q And it indicates that what would be disqualifying is dyslipidemia requiring more than one medication or low-density lipoprotein greater that 190 milligrams/DL on therapy; is that correct?

A That is a portion of the standard. There's additional criteria.

Q And what's the additional criteria?

A The medical management must have demonstrated no medication side effects, and there's a number of listed, for a period of six months. Also -- there's an LDL over 200.

Q Where is that indicated?

A The first line, dyslipidemia with LDL greater than 200 milligrams per deciliter or triglycerides greater than 400 milligrams per deciliter.

Q Got it.

(Discussion held off the record.)

BY MR. SCHOETTES:

Q And given that you said individuals who are accessing are likely to be new to the military, upon what do you rely to establish whether the person meets these criteria?

A In the case of accessions, it would be triggered by their medical history in the questionnaire and, based on that, if they indicate they have dyslipidemia, if they -- in order to qualify as part of the medical evaluation, they would have to provide evidence that they meet the standard, or request a waiver if they don't meet the standard.

Q How would providing that kind of evidence

condition is not military information just because we're a portion of society, and then we have to generalize it to our population and our conditions.

There is some -- there's occasionally information from military, but quite often we have to generalize from non-military populations.

Q And what I hear you saying is that you don't believe there is sufficient medical research literature regarding the effects of treatment on the individual living with HIV to set these kind of standard for HIV?

MS. BERMAN: Objection. Mischaracterizes the testimony.

You can answer.

THE WITNESS: The level of evidence is not sufficient for us to put additional specifications in the HIV criteria or HIV standard to ensure that those individuals will meet all the criteria of the accession standard which are described in -- I think it's section 1.27 which we went over in detail.

BY MR. SCHOETTES:

Q Okay. Are waivers granted for members to commission even though they do not meet the

standard for dyslipidemia?

MS. BERMAN: Objection. This is outside the scope of what this witness is being offered to testify about. Just to clarify, you said the waivers are generally at the service level.

So -- if you know.

THE WITNESS: I don't have any factual knowledge to answer that question.

BY MR. SCHOETTES:

Q Are you familiar with the condition -- medical condition hypothyroidism?

A Yes.

Q And are -- what kind of treatment does hypothyroidism generally require?

A Typically, it is managed by medication if it is of enough severity to cause symptoms.

Q And what is the accessions policy with individual with hypothyroidism? Again, this is on page 39.

A Right. So there's multiple standards that could apply with hypothyroidism. The first standard which you would apply is current hypothyroidism. This is 5.24k, as in kilo, "unless asymptomatic and demonstrated eutthyroid by normal thyroid stimulated hormone testing with

there the preceding 12 months."

And then you would also need to apply any standard that would be relevant to the cause of that hypothyroidism. So for instance, if it is secondary to cancer and, therefore, they had to remove the thyroid or ablate it through radiation, the cancer malignancy standard would apply as well. So those are the relevant standards.

Q Can you explain to me, would an individual with hypothyroidism that was unsymptomatic -- let me ask that question again.

Would a person be able to be on hypothyroidism medication and meet the standard set forth in "k"?

A Yes, given they've had the -- given they're asymptomatic and they can demonstrate through documentation that they have had normal, basically, thyroid-related hormones within the preceding 12 months.

Q And they can have created that normal function of the thyroid through medication?

A Yes. I believe so. I would have to scan through to see if there's something else that might also have to be waived, but, I mean, typically, my understanding is these individuals

would be waived if they required a waiver, but I believe medication does not require the waiver if they can demonstrate --

Q Euthyroid?

A Euthyroid, right.

Q And can you just define euthyroid for me?

A It indicates that they are no longer experiencing any adverse symptoms of hyperthyroid and their laboratory testing confirms that their levels are within normal ranges.

Q I'm assuming your answer would be the same if -- do you know if waivers are granted for members to commission even though they do not meet this standard?

MS. BERMAN: I have the same objection to scope.

But you can answer if you know.

THE WITNESS: I don't have any are factual knowledge in that specific population.

BY MR. SCHOETTES:

Q What is the accession policy for individuals with vision problems? I don't have a page number on this, but I believe it's listed under "i."

A So page 13 of DODI 6130.03 talks about

that statement effectively zero risk or essentially zero risk of transmission.

A Okay. And then what was your question?

Q If that, to your knowledge, is limited to cases of sexual transmission?

A Yes.

Q Okay. And then you discussed with counsel that there were no documented cases of -- that you were aware of of battlefield transmission of HIV, right?

A Yes.

Q Okay. Are people with HIV in the U.S. military permitted to go to the battlefield?

A Not without a waiver process.

Q Do you know of any cases where someone with a known HIV infection was in a battlefield situation?

A I'm pretty sure I remember a case when I was in the Army where the diagnosis occurred after they already deployed because of the time lag for data and laboratory testing. So he was redeployed, but not in combat.

Q Okay. And you were discussing the initial period of service. And you said that you generally consider that to be eight years. Right?

A That's my interpretation. I think most of the work group is settled on that. It's an area of discussion.

Q Okay. So counsel asked you a bunch of questions about that initial period of service, and he asked you specifically about people with well-managed HIV. Is there any way to guarantee or to know during the accessions process that someone's HIV will remain well managed throughout that initial period of service?

A I would -- based on my expertise, which is limited, I would think no, but I would want to hear that from an infectious disease specialist as well to confirm my understanding.

Q Okay.

MS. BERMAN: That's all I have.

MR. SCHOETTES: One follow-up.

FURTHER EXAMINATION BY COUNSEL FOR PLAINTIFFS BY MR. SCHOETTES:

Q Would an individual in the special forces be considered -- would an individual in the special forces be likely to be in a combat situation?

MS. BERMAN: Objection. This is outside the scope of what this witness is being offered

for.

But you can answer.

THE WITNESS: They may be put in those situations at certain times throughout their career.

BY MR. SCHOETTES:

Q Members of the special forces are expected to be able to go into a battlefield, correct?

MS. BERMAN: Same objection.

You can answer.

THE WITNESS: In general, yes.

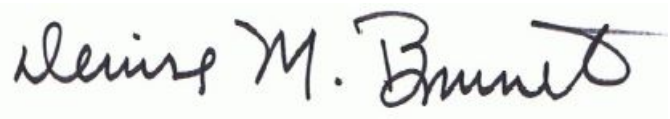
MR. SCHOETTES: That's all I have.

THE VIDEOGRAPHER: The time is 4:38 p.m., and this ends today's videotaped deposition. We're off the record.

(Whereupon, at 4:38 p.m., the deposition of PAUL CIMINERA was concluded.)

CERTIFICATE OF NOTARY PUBLIC

I, Denise M. Brunet, the officer before whom the foregoing deposition was taken, do hereby certify that the witness whose testimony appears in the foregoing deposition was sworn by me; that the testimony of said witness was taken by me stenographically and thereafter reduced to print by means of computer-assisted transcription by me to the best of my ability; that I am neither counsel for, related to, nor employed by any of the parties to this litigation and have no interest, financial or otherwise, in the outcome of this matter.



Denise M. Brunet
Notary Public in and for
The District of Columbia

My commission expires:
December 14, 2022

Veritext Legal Solutions
1100 Superior Ave
Suite 1820
Cleveland, Ohio 44114
Phone: 216-523-1313

March 20, 2019

To: Keri L. Berman, Esq.

Case Name: Roe, Richard, Et Al. v. Mattis, James N., et al.

Veritext Reference Number: 3235706

Witness: Paul Ciminera Deposition Date: 3/5/2019

Dear Sir/Madam:

Enclosed please find a deposition transcript. Please have the witness review the transcript and note any changes or corrections on the included errata sheet, indicating the page, line number, change, and the reason for the change. Have the witness' signature notarized and forward the completed page(s) back to us at the Production address shown above, or email to production-midwest@veritext.com.

If the errata is not returned within thirty days of your receipt of this letter, the reading and signing will be deemed waived.

Sincerely,
Production Department

NO NOTARY REQUIRED IN CA

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3235706
CASE NAME: Roe, Richard, Et Al. v. Mattis, James N.
DATE OF DEPOSITION: 3/5/2019
WITNESS' NAME: Paul Ciminera

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have made no changes to the testimony as transcribed by the court reporter.

_____ _____
Date Paul Ciminera

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal

this _____ day of_____, 20____.

_____
Notary Public

_____
Commission Expiration Date

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3235706
CASE NAME: Roe, Richard, Et Al. v. Mattis, James N.
DATE OF DEPOSITION: 3/5/2019
WITNESS' NAME: Paul Ciminera

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

10 April 2019
Date

Paul Ciminera

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They have listed all of their corrections in the appended Errata Sheet;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal this 10th day of April, 2019.

Notary Public
in Fairfax C., VA
November 30, 2019
Commission Expiration Date

Laurie Powell Rafferty
Commonwealth of Virginia
Notary Public
Commission No. 7642639
My Commission Expires 11/30/2019

ERRATA SHEET

VERITEXT LEGAL SOLUTIONS MIDWEST

ASSIGNMENT NO: 3/5/2019

PAGE/LINE(S) /	CHANGE	/REASON
6/14	"Mr." to "Dr."	Proper title
41/13	correct spelling is "Fauci"	
121/6	change "he have" to "may have".	Typo
141/8	spelling is "Raynaud's"	
184/13	spelling is "members'	
217/8	spelling is "Dr. Fauci"	
225/24	spelling is "euthyroid"	
225-226/25-1	change "with there" to "within"	

10 April 2019

Date

Paul Ciminera

SUBSCRIBED AND SWORN TO BEFORE ME THIS 10th

DAY OF April, 2019.

Notary Public

in Fairfax Co., VA

December 31, 2019

Commission Expiration Date

Laurie Powell Rafferty
Commonwealth of Virginia
Notary Public
Commission No. 7642639
My Commission Expires 11/30/2019

EXHIBIT 19

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Alexandria Division

NICHOLAS HARRISON, *et al.*, Plaintiffs, v. MARK ESPER, Secretary of Defense, *et al.*, Defendants.	No. 1:18-cv-641 (LMB/IDD)
RICHARD ROE, *et al.*, Plaintiffs, v. MARK ESPER, Secretary of Defense, *et al.*, Defendants.	No. 1:18-cv-1565 (LMB/IDD)

DECLARATION OF DR. PAUL CIMINERA, M.D., M.P.H.

I, Dr. Paul Ciminera, hereby state and declare as follows:

1. I am a medical doctor and a veteran of the United States Army, currently serving in a civilian capacity as the Program Director, Medical Accessions and Retention Policy for the Department of Defense, within the Office of the Deputy Assistant Secretary of Defense for Health Services Policy and Oversight. I have been in this position since December 10, 2017. As Director of Accessions and Retention Policy, I develop policy recommendations for Department of Defense Leadership in the areas of medical accessions and retention standards and other related policy areas.

2. Prior to my current position, beginning in 2015, I served as the Director of Public Health Services at the Naval Health Clinic in Patuxent River, Maryland, developing policy and providing oversight for occupational medicine, preventive medicine, environmental health, and other areas. Before that, beginning in 2011, I served as the Director for Post-9/11 Environmental Health at the Department of Veterans Affairs, providing policy development and oversight for health issues related to Post-9/11 military service. Prior to that position, beginning in 2008, I served as the Deputy Chief of Preventive Medicine at Tripler Army Medical Center in Honolulu, Hawaii, with responsibilities in occupational medicine, infectious-disease surveillance and reporting, and other areas. Before that, beginning in 2004, I served as the Army liaison to the Army Medical Surveillance Activity in Washington, D.C., providing epidemiological support to multiple Department of Defense entities.

3. At various points between 2004 and 2011, I was deployed (or deployable) in theater in a professional filler capacity as a medical specialist in the U.S. Army, as part of the 18th Medical Command, and as a preventive-medicine officer at the 121st Combat Support Hospital in South Korea. I also deployed to Afghanistan as a professional filler to the Army's 82nd Airborne Division in 2007-2008. I was originally commissioned as a Second Lieutenant, and was later promoted to Captain (in 2001) and to Major (in 2006).

4. Prior to taking on these responsibilities, I completed a three-year preventive-medicine residency at the Walter Reed Army Research Institute (WRAIR), and obtained board certification in both General Preventive Medicine/Public Health and Occupational Medicine.

5. In addition to being a medical doctor, I also hold a Masters of Public Health.

6. Through my education as a preventive-medicine doctor and public-health specialist, and through my official duties as the Program Director for Medical Accessions and

Retention Policy for the Department of Defense, I have an understanding of the Department of Defense's medical accessions policies for HIV and for numerous other diseases and medical conditions. I make this declaration based upon my own personal knowledge and upon information that has been provided to me in the course of my official duties. I submit this declaration in support of Defendants' Motions for Summary Judgment in the above-captioned matters.

Development of Medical Standards for Accession

7. The Department of Defense's primary working group to develop medical standards for accession is known as the "Accession Medical Standards Working Group" or "AMSWG" (colloquially known as and pronounced "Am-Swig").

8. The AMSWG is established under the direction of the Department of Defense Medical and Personnel Executive Steering Committee ("MEDPERS").

9. The purpose of the AMSWG is to bring together representatives from the Medical and Personnel community across the Department of Defense for the development, discussion, and recommendation of policies about accession medical standards, and to focus on oversight and revision of accession policy standards ensuring that personnel are capable of operationally performing with the best physical and medical outcomes, assuring a cost-efficient force of healthy members in service, capable of completing training and maintaining worldwide deployability.

10. Personnel and medical-action officers from each service within the Department of Defense represent their leadership before the AMSWG. Personnel officers represent the Military Service's human resource functions which possess the authority to issue enlistment contracts and officer commissions. Non-voting subject-matter experts in various relevant clinical topics are also invited to attend and provide their recommendations. The representatives of the AMSWG ultimately develop and vote on recommendations for accessions policy.

11. Final decisions on accessions policy are ultimately made by the Undersecretary of Defense for Personnel and Readiness, pursuant to Department of Defense Directive ("DoDD") 5124.02. Historically, those decisions have been heavily informed by the recommendations of the AMSWG.

12. A true and correct copy of DoDD 5124.02 is attached to this declaration as Exhibit A.

13. When developing accession standards, the Assistant Secretary of Defense for Health Affairs and the Deputy Assistant Secretary of Defense for Military Personnel Policy also follow the processes set forth in Department of Defense Instruction ("DoDI") 5025.01, which outlines the procedures for drafting, review, and issuance of Department of Defense instructions, issuances, and directives across different subject-matter areas (including accession standards). Revisions to DoDI 6130.03 are developed by the AMSWG and formally approved through the process described in DoDI 5025.01. Mandatory component coordinators are represented on the MEDPERS. The AMSWG responds to requests from MEDPERS or may request guidance regarding the standards from MEDPERS which provides a forum, as needed, for group discussion to streamline policy development.

14. Pursuant to the AMSWG charter, the voting members of the AMSWG include the following individuals (or their representatives):

- Deputy Assistant Secretary of Defense, Military Personnel Policy
- Principal Deputy Assistant Secretary of Defense, Health Affairs
- Principal Deputy Assistant Secretary of Defense, Reserve Affairs
- Surgeon General of the Army
- Surgeon General of the Navy
- Surgeon General of the Air Force
- Chief Medical Officer, U.S. Coast Guard
- Deputy Chief of Staff for Personnel, U.S. Army
- Deputy Chief of Staff for Personnel, U.S. Navy
- Deputy Chief of Staff for Personnel, U.S. Air Force

- Deputy Chief of Staff for Personnel, U.S. Marine Corps
- Chief of Personnel and Training, U.S. Coast Guard

15. In addition, the U.S. Military Entrance Processing Command, the Department of Defense Medical Examination Review Board, AMSARA (*i.e.*, the entity responsible for "Accession Medical Standards Analysis & Research Activity," which is part of the Walter Reed Army Institute of Research), and the Service Waiver Authorities also serve as non-voting "advisors" to the AMSWG.

The AMSWG's 2015 Recommendation for HIV Medical Accessions

16. In 2015, the AMSWG undertook a multi-month effort to review all medical standards established by DoDI 6130.03, *Medical Standard for Enlistment, Appointment, or Induction into the Military Services*, which ultimately took effect on May 6, 2018. No substantive changes were made to the previous HIV-related standards.

17. DoDI 6130.03 provides for certain criteria to be considered in developing medical accession standards. During the most recent AMSWG policy review, those criteria were discussed and considered at length. According to those criteria, "[i]t is DoD policy to":

> Ensure that individuals under consideration for appointment, enlistment, or induction into the Military Services are:
>
> - Free of contagious diseases that probably will endanger the health of other personnel.
> - Free of medical conditions or physical defects that may require excessive time lost from duty for necessary treatment or hospitalization, or probably will result in separation from the Service for medical unfitness.
> - Medically capable of satisfactorily completing required training.
> - Medically adaptable to the military environment without the necessity of geographical area limitations.
> - Medically capable of performing duties without aggravation of existing physical defects or medical conditions.

DoDI 6130.03, § 1.2(c).[1]

18. DoDI 6130.03 also includes specific accession standards for HIV-infected individuals.

19. On August 5, 2015, after extensive deliberations, the AMSWG ultimately agreed—unanimously—to recommend the HIV-infection standard contained in the current version of DoDI 6130.03.

20. That standard—largely unchanged from previous versions of DoDI 6103.03—lists "[p]resence of human immunodeficiency virus or laboratory evidence of infection or false-positive screening test(s) with ambiguous results by supplemental confirmation test," as a "disqualifying condition." DoDI 6130.03 § 5.23(b).

21. DoDI 6130.03 contains a waiver process.

22. This standard was unanimously agreed upon by the representatives of the various stakeholders identified by the AMSWG charter, with significant contributions from the Service Surgeons General representatives and the Service Infectious Disease Consultants. The AMSWG discussed the existing HIV accessions standards from the prior version of the Instruction with each Service's infectious-disease subject-matter expert. Each Service voted on proposed changes to the standard through their Surgeon General's representative on the AMSWG. Ultimately, each Service agreed to maintain HIV infection as a disqualifying condition for accessions. No changes to "loosen" the standard were proposed, and no dissenting votes were cast.

23. To reach its recommendation to maintain HIV infection as a disqualifying condition for accession into the Military Services, the AMSWG considered various health, logistical, and operational considerations. These considerations included (but were not limited

[1] To avoid duplication, frequently cited military policies discussed in this document are attached as exhibits to Defendants' Motion for Summary Judgment.

to): (1) the impact of a diagnosis of HIV infection on geographic assignment of service members; (2) the need for follow-up care; (3) laboratory capabilities in deployed environments; (4) the potential for well-managed HIV to become less-well-managed in the future; (5) the potential for worsening of a service member's condition and the development of co-morbidities that would impact duty performance; (6) the potential for infection of other service members through blood donation; (7) the potential for infection of other service members during medical care or in connection with a mass-trauma event; and (8) treatment costs for HIV care.

24. The AMSWG evaluates chronic conditions by considering the long-term likelihood of the individual continuing to be capable of performing their military duties compared to those applicants that do not have the chronic condition. This evaluation of the long-term prognosis includes considerations of adherence to any necessary treatment, the possibility of side effects, and potential comorbidities.

25. This analysis of the potential for successful long-term service requires consideration of the possible progression of a chronic disease over the course of a service member's career. It also requires consideration of the potential future needs of the U.S. military under a variety of potential (and necessarily difficult-to-predict) future conditions—not simply the needs of current operations under current conditions.

26. For example, with respect to HIV in particular, the AMSWG and the accessions standards do not assume that HIV will always remain well-managed during the entire length of an individual's service. There is no way to know at the time of accession whether an individual will be able to successfully manage his or her HIV infection and keep his or her viral load fully suppressed through the duration of service given the unique demands of military service, in particular the need to deploy.

27. In defining accessions medical standards, the five criteria described above and set forth in DoDI 6130.03, § 1.2(c) are considered holistically. A medical condition that fails to meet any one of these five criteria, or multiple criteria when considered together, may be a reason to deny accession.

28. A candidate for accession infected with HIV (even well-managed HIV) fails to meet each of the five criteria set forth in DoDI 6130.03, § 1.2(c), at least to some degree, when those criteria are considered holistically and in connection with the possible progression and management of the HIV infection over a longer term of service.

29. For example, with respect to the Department of Defense's policy to ensure that a service member is "[f]ree of contagious diseases that may endanger the health of other personnel," DoDI 6130.03, § 1.2(c)(1), HIV qualifies. HIV is a contagious disease, and it may infect other service members, endangering their health.

30. For example, one circumstance in which HIV-infected service members may endanger the health of other service members is during medical care. The nature of military medical care—especially in deployed environments—presents an increased risk of transmission of HIV compared to civilian medical care. Transmission can occur either from an HIV-positive patient to a caregiver, or from an HIV-positive caregiver to a patient. Unlike with typical civilian medical care, in combat medical care, both the patient *and* the caregiver may have open wounds that provide a route to blood-to-blood transmission (because the caregiver may be another service member who was also engaged in battle).

31. Because of the increased risks during combat medical care, there is a risk of HIV transmission even when the infected person has an undetectable viral load. And if an HIV-infected individual has a detectable viral load—or previously had an undetectable viral load,

but is now experiencing viral rebound, as a result of a delay in treatment or development of resistance to antiretroviral therapy—the risk of transmission would be even greater.

32. In a combat environment, a medical caregiver may not have ready access to a service member's medical records to determine his or her HIV-positive status. And because of confidentiality concerns, there may be few (if any) individuals in a deployed environment who are aware of a service member's HIV-infected status. That reality creates an increased risk that appropriate precautions will be overlooked and HIV will be transmitted during medical treatment.

33. Blood transfusions in deployed environments also present a significant risk of transmission. In civilian medical settings, blood used for transfusion is pre-screened pursuant to an FDA-approved process. In a deployed environment, by contrast, screening opportunities may be limited. The concept of the "walking blood bank"—that is, turning to other nearby service members for on-the-spot blood donations—is unique to the military context, and represents an increased risk of HIV transmission that is only present in the military setting.

34. Confidentiality concerns might also result in an HIV-positive service member donating blood—despite the presence of standing orders not to donate blood if HIV-infected—to avoid disclosing their HIV-infected status. And in exigent circumstances, such as a mass-casualty event, normal screening procedures (such as confidential checklists indicating blood should not be used for transfusion) may not be possible.

35. As an illustration of these risks, some data suggest that Vietnam-era veterans have atypically high rates of Hepatitis, and evidence indicates that some veterans received the disease during transmissions connected to combat medical care (*e.g.*, through a needlestick or similar wound), or because of blood transfusions that occurred in an environment in which the ability of military caregivers to adequately screen the blood supply for infectious diseases was limited. HIV presents similar risks.

36. The AMSWG also considers the reality of military deployment: not all orders are followed with perfect consistency. One cannot be certain that a generic standing order (issued to all HIV-infected service members) not to donate blood will actually be followed consistently, even in the normal course—but especially in connection with high-stress mass-casualty events, in an environment in which peer-pressure and the lack of widespread knowledge of HIV-infection-status (for confidentiality reasons) may lead to blood donation by an HIV-positive service member. Such a blood transfusion carries with it a high risk of transmission.

37. To be sure, the precise amount of risk presented by battlefield transmission is difficult to measure with precision. Among other reasons, that is because the military screens individuals for HIV, generally bars them from combat deployments, and evacuates individuals who acquire HIV during deployment back to the United States for medical treatment. Accordingly, there are very few, if any, individuals with HIV in combat to inform a meaningful study about the likelihood of battlefield transmission.

38. Accordingly, the members of the AMSWG generally would not assume that the lack of well-documented examples of battlefield transmission of HIV amongst deployed service members adequately demonstrates that there is no meaningful risk. And, in formulating its recommended accessions standards, the members of the AMSWG considered the fact that the risk of battlefield transmission of HIV cannot be measured with precision.

39. Members of the AMSWG must also consider the significance of possible low-frequency but high-severity events—such as transmission of incurable HIV infection from one service member to another—that could cause serious harm to the health and mission-readiness of our armed forces.

40. In addition, even virally suppressed patients on ART can experience side effects and comorbidities from either their treatment or their HIV infection. Side effects and

comorbidities can present years after HIV treatment begins and can develop and change over time, impacting the health and mission-readiness of service members.

41. Dehydration, lack of sleep, lack of regular meals, and disruptions in medications—all of which are conditions that may be experienced by service members during training or while operating in austere military environments—may also aggravate side effects of certain infections, possibly including HIV. To be sure, scientific data regarding the effects of these sorts of stressors on HIV-specific conditions is necessarily limited (including due to the lack of HIV-infected service members currently deployed), but that uncertainty itself is appropriately considered and accounted for by the AMSWG in developing recommended accessions standards.

42. Not every person on ART remains consistently adherent to their treatment regime—and even those who do sometimes develop resistance to their medication.

43. Finally, the costs of care—including direct costs like ART medication, but also indirect costs such as, for example, transportation of HIV-infected service members in and out of far-forward-deployed positions for periodic HIV viral-load testing, or HIV-specific training of medical staff—are part of the holistic consideration of the five policy criteria informing the list of medical disqualifications in DoDI 6130.03. So, for example, members of the AMSWG considered the fact that it might require the expenditure of significant resources to ensure that an HIV-infected service member continues to be able to perform his or her duties, or to prevent significant lost duty time—because of the high treatment costs of ART medication, or the logistical complexities associated with HIV viral-load testing of service members in deployed environments.

44. Based on these considerations, and the information and opinions contributed by the members of the AMSWG and relevant subject-matter experts, all members of the AMSWG

ultimately agreed that HIV-infection should remain a disqualifying condition under the medical standards of DoDI 6130.03.

45. The representatives also agreed to a technical change to the laboratory testing language to reflect advances in laboratory-testing techniques since the previous revision on the standard.

46. After reaching its unanimous agreement, the AMSWG recommendation was incorporated into the DoDI 6130.03 revision and processed according to DoDI 5025.01. This formal process did not generate any comments or recommendations to the AMSWG-recommended language. The Undersecretary of Defense for Personnel and Readiness adopted the proposal to maintain HIV as a disqualifying condition for accession, as well as the suggested language of the revised laboratory criteria.

47. All Services concurred.

Application of Accession Standards to All Individuals Seeking to Commission

48. The AMSWG also reviewed the separate requirement, *see* DoDi 6130.03 § 4.1, that the accessions standards be applied to all individuals seeking commissioning, appointment, or induction as officers in the Military Services while reviewing the Instruction for its current iteration.

49. This requirement was reviewed during the AMSWG meeting on October 8, 2015. Representatives of the Military Services supported continuing the policy for commissioning of academy cadets and for special officer accession programs, and noted that the Services may (and often do) waive standards for these individuals, if appropriate, on a case-by-case basis. The Services were again unanimous on this recommendation.

50. In the view of the members of the AMSWG, application of the accessions standards is necessary from an occupational-medicine standpoint because when service members change duties it is necessary to evaluate whether they remain medically qualified for those duties.

51. Waivers for medical accessions standards are not based solely on the medical condition of the service member, but also on non-medical criteria, including, for example, the needs of the service and the particular skills of the service member.

52. An individual with comparatively rare skills or advanced training—for example, a Pashto linguist, or an orthopedic surgeon, or a nuclear scientist—would be far more likely to receive a waiver (whether an accessions waiver or a deployment waiver) than an individual who is easily replaceable by another service member without a medical problem.

* * *

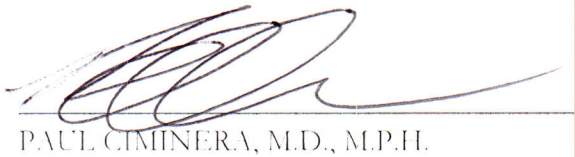
53. Finally, my understanding is that a witness in this litigation—who does not work for the military or the federal government, and who did not participate in the AMSWG proceedings—listened to "a portion of an audio recording" of certain AMSWG deliberations, and described it as follows: "my impression of the recording was that individuals in attendance started with a premise that individuals living with HIV should not be allowed accession into the military and then searched for medical justifications or facts to support that premise." Pls.' Suppl. Expert Report of Hendrix, *Roe* ECF 270-51, ¶ 21.

54. Respectfully, I disagree with that characterization. Those who participate in the AMSWG process are experienced professionals, operating in good faith, seeking only to make the best possible policymaking decisions. Their recommendations are informed by the best available medical and scientific evidence, and they are appropriately mindful of the unique medical context presented by service in the United States military and deployment to combat zones overseas.

55. In addition, the participants in AMSWG deliberations do extensive preparations and discussions before the actual meetings are held. Accordingly, a listener unfamiliar with the AMSWG process might find the discussions at the actual final meeting to be brief, but that does not at all suggest that the positions advanced and the recommendations formally adopted at that meeting were not arrived at after extensive and careful analysis and deliberation, and consideration of all relevant scientific and medical data.

* * *

In accordance with 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this third day of June, 2020.



PAUL CIMINERA, M.D., M.P.H.
Medical Officer
United States Department of Defense
Director of Accessions and Retention Policy
Office of the Deputy Assistant Secretary of Defense
for Health Services Policy and Oversight

EXHIBIT A

Department of Defense

DIRECTIVE

NUMBER 5124.02
June 23, 2008

DA&M

SUBJECT: Under Secretary of Defense for Personnel and Readiness (USD(P&R))

References: (a) Title 10, United States Code
(b) DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R))," October 17, 2006 (hereby canceled)
(c) Deputy Secretary of Defense Memorandum, "Policy Guidance for Provision of Medical Care to Department of Defense Civilian Employees Injured or Wounded While Forward Deployed in Support of Hostilities," September 24, 2007
(d) Deputy Secretary of Defense Memorandum, "DoD Drug Demand Reduction Program Policy," January 24, 2007
(e) through (aa), see Enclosure 1

1. PURPOSE

Under the authority vested in the Secretary of Defense by sections 113 and 136 of Reference (a), this Directive:

1.1. Reissues Reference (b) to update the responsibilities, functions, relationships, and authorities of the USD(P&R); incorporates References (c) and (d) and Deputy Secretary of Defense Memorandums, "Authority Delegation - National Security Personnel System (NSPS) Rate Range and Local Market Supplement Adjustments," "Guidelines for Implementation and Administration of Joint Officer Management Program Joint Qualification System," and "Transfer of Uniformed Services University of the Health Sciences to TRICARE Management Activity and Rescission of the Department of Navy as Department of Defense Executive Agent" (References (e) through (g)); and cancels References (e) and (g).

1.2. Authorizes the USD(P&R) to:

1.2.1. As a Principal Staff Assistant (PSA) reporting directly to the Secretary of Defense, promulgate DoD policy in DoD Instructions within the responsibilities, functions, and authorities assigned herein in accordance with DoD Instruction 5025.01 (Reference (h)).

1.2.2. Reissue, as necessary, the chartering DoD Directives for the Principal Deputy

Under Secretary of Defense for Personnel and Readiness (PDUSD(P&R)), the Assistant Secretary of Defense for Health Affairs (ASD(HA)), and the Assistant Secretary of Defense for Reserve Affairs (ASD(RA)) in accordance with Reference (h).

2. APPLICABILITY

This Directive applies to the Office of the Secretary of Defense (OSD), the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities in the Department of Defense (hereafter referred to collectively as the "DoD Components").

3. DEFINITIONS

The following definitions are for the purposes of this Directive only:

3.1. Armed Forces. Refers to the Army, Navy, Air Force, Marine Corps, and Coast Guard.

3.2. Reserve Components. Refers collectively to the Army National Guard of the United States, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard of the United States, the Air Force Reserve, and the Coast Guard Reserve, when the Coast Guard is operating as a Service of the Department of the Navy.

3.3. Total Force. The organizations, units, and individuals that comprise the DoD resources for implementing the National Security Strategy. It includes DoD Active and Reserve Component military personnel, military retired members, DoD civilian personnel (including foreign national direct- and indirect-hire, as well as nonappropriated fund employees), contractors, and host-nation support personnel.

4. RESPONSIBILITIES AND FUNCTIONS

The USD(P&R) is the PSA and advisor to the Secretary of Defense for Total Force management; National Guard and Reserve Component affairs; health affairs; readiness and training; military and civilian personnel requirements; language; dependents' education; equal opportunity; morale, welfare, recreation; and quality-of-life matters. In this capacity, the USD(P&R) shall:

4.1. Develop policies, plans, and programs for:

4.1.1. The Total Force and its allocation among the DoD Components, and between the Active and Reserve Components, to ensure efficient and effective support of wartime and peacetime operations, contingency planning, and preparedness. Within the Defense intelligence and security Components, the Under Secretary of Defense for Intelligence (USD(I)) exercises overall supervision and policy oversight of human capital and the USD(I) develops policies

associated with the Defense Civilian Intelligence Personnel System (DCIPS) in conjunction with the USD(P&R).

4.1.2. Reserve Component affairs to promote the effective integration of Reserve Component capabilities into a cohesive Total Force.

4.1.3. Health and medical affairs to:

4.1.3.1. Provide and maintain readiness.

4.1.3.2. Provide health services and support to members of the Armed Forces during military operations.

4.1.3.3. Provide health services and support to members of the Armed Forces, their dependents, and others entitled to or determined eligible for DoD medical care in accordance with Reference (c).

4.1.3.4. Provide oversight for the Drug Demand Reduction Program in accordance with Reference (d).

4.1.4. Recruitment, education, training, equal opportunity, compensation (including bonuses, special pay, and incentives), recognition, discipline, and separation of all DoD personnel, both military personnel (Active and Reserve Component, and retired) and civilian employees. Consistent with paragraph 4.1.1., the USD(I) exercises oversight and policy responsibilities for Defense intelligence and security Components.

4.1.4.1. Set and adjust National Security Personnel System (NSPS) rate ranges and set and adjust NSPS local market supplements in coordination with the Under Secretary of Defense (Comptroller)/Chief Financial Officer, Department of Defense (USD(C)/CFO), and the NSPS Program Executive Officer in accordance with part 9901, title 5, Code of Federal Regulations (CFR) (Reference (i)).

4.1.4.2. Perform oversight of the Defense Civilian Personnel Data System and the Defense Integrated Military Human Resources System (DIMHRS), to ensure accuracy, completeness, and timeliness of its information and data, its responsiveness, as well as its effective and efficient use of modern practices and technologies.

4.1.5. Interagency and intergovernmental activities, special projects, or external requests that create a demand for DoD personnel resources. With respect to such matters affecting personnel in intelligence positions, the USD(P&R) shall coordinate with USD(I).

4.1.6. Readiness to ensure forces can execute the National Military Strategy; oversight of military training and its enablers under DoD Directive 1322.18 and DoD Directive 3200.15 (References (j) and (k)); and oversight of Total Force personnel and medical readiness. Coordinate with other PSAs and cognizant officers in the Office of the Chairman of the Joint Chiefs of Staff and the Armed Forces on other aspects of readiness.

4.1.6.1. Perform oversight of the Defense Readiness Reporting System under DoD Directive 7730.65 (Reference (l)), to ensure accuracy, completeness, and timeliness of its information and data, its responsiveness, as well as its effective and efficient use of modern practices and technologies.

4.1.6.2. Establish safety and accident-reduction activities to prevent accidents and injuries to military and civilian personnel, as well as to contractors and visitors on DoD installations and facilities worldwide, in accordance with the guidelines of the Defense Safety Oversight Council.

4.1.7. Quality of life for U.S. military personnel (Active and Reserve Components) and their families. Areas of importance are family support, counseling services, financial planning, housing, child care, military spouse employment and career opportunities, dependents' education, schools, children's educational transitions, commissary and military exchange systems, support for victims of domestic violence, support during the deployment cycle, recreational opportunities, tuition assistance, and partnerships with states in furtherance of these areas.

4.2. Analyze the Total Force structure as related to quantitative and qualitative military and civilian personnel requirements, utilization, readiness, and support. Administer and implement controls over military and civilian personnel strengths and compositions for all DoD Components. Establish and issue guidance to be used by all DoD Components regarding manpower management, including manpower mix criteria and DoD function codes to determine workforce mix and annual commercial activities inventories.

4.3. Serve as the DoD Chief Human Capital Officer in carrying out authorities and functions under section 1402 of title 5, United States Code (U.S.C.) (Reference (m)).

4.4. Oversee the DoD Joint Officer Management Program and carry out the functions and responsibilities under chapter 38 of Reference (a) and establish and issue policy pertaining to this Program in accordance with Reference (f).

4.5. Review and evaluate the requirements of the Defense Acquisition Board's major defense acquisition programs and proposed weapons systems for personnel, training, and readiness implications, and the implications of weapons systems maintainability for qualitative and quantitative personnel requirements and for readiness.

4.6. Formulate policy for and ensure coordination of DoD Noncombatant Evacuation Operations.

4.7. Appoint and supervise the DoD Senior Language Authority in support of the foreign language capability in accordance with DoD Directive 5160.41E (Reference (n)).

4.7.1. Establish and oversee policy regarding the development, maintenance, and utilization of foreign language capabilities.

4.7.2. Monitor trends in the promotion, accession, and retention of individuals with critical foreign language skills.

4.7.3. Explore innovative concepts to expand foreign language capabilities.

4.8. Develop and provide overall policy guidance for the National Security Education Program and, pursuant to sections 1901-1912 of title 50, U.S.C. (Reference (o)), perform the duties to execute the Program, including coordination as needed.

4.9. Participate in those planning, programming, and budgeting activities that relate to assigned areas of responsibility.

4.10. Chair the Defense Human Resources Board consistent with the authorities under section 1402 of Reference (m).

4.11. Serve on boards, committees, and other groups pertaining to assigned functional areas and represent the Secretary of Defense on personnel, readiness, Reserve Component, health, compensation, and other matters related to USD(P&R) responsibilities and functions outside of the Department of Defense.

4.12. Periodically assess the DoD Executive Agent assignments under the cognizance of the USD(P&R) for continued need, currency, and effectiveness and efficiency in satisfying end user requirements, consistent with DoD Directive 5101.1 (Reference (p)).

4.13. Ensure that P&R policies and programs are designed and managed to improve standards of performance, economy, and efficiency, and that all Defense Agencies and DoD Field Activities under the authority, direction, and control of the USD(P&R) are attentive and responsive to the requirements of their organizational customers, both internal and external to the Department of Defense.

4.14. Ensure information is shared as broadly as possible, except where limited by law, policy, or security classification, and that data assets produced as a result of the assigned responsibilities are visible, accessible, and understandable to the rest of the Department, as appropriate, and in accordance with DoD Directive 8320.02 (Reference (q)).

4.15. Establish policy for, and oversee the operations of, the DoD Medical Examination Review Board (DODMERB). The DODMERB shall continue as a joint agency of the Military Departments, attached to the Air Force for administration and logistics support and operate under the policy direction of the ASD(HA). The designation of the Secretary of the Air Force as the DoD Executive Agent for administrative and logistic support to the DODMERB shall remain in effect until revoked or superseded by the Secretary of Defense.

4.16. Establish policy for the Senior Readiness Oversight Council (SROC). The SROC shall continue to advise the Secretary of Defense on matters pertaining to DoD readiness, oversee readiness-related activities, provide recommendations to the Secretary of Defense on readiness

policy matters, and provide reports on current and projected readiness issues. The Deputy Secretary of Defense shall continue as the Chair, SROC.

4.17. Establish policy for, and oversee the operations of, the Reserve Forces Policy Board (RFPB). The mission, functions, membership, relationships, and administration of the RFPB shall be consistent with sections 113(c)(3) and 10301 of Reference (a). The USD(P&R) may redelegate this authority to the ASD(RA).

4.18. Establish policy for participation in armed forces, national, and international sports activities. A Senior Military Sports Advisor may continue to be assigned for a 4-year term (terminating at the completion of each Summer Olympiad) to a Military Service Personnel Chief (or his or her designated flag/general officer representative) on a rotation basis among the Military Services in the following order: Marine Corps, Army, Air Force, and Navy. An Armed Forces Sports Committee (AFSC) may continue to be comprised of the Morale, Welfare, and Recreation Directors of each of the Military Services, or their designated representatives, and to act for the Department of Defense on matters pertaining to sports involving more than one Military Service. The Secretary of the Army may continue to provide administrative support to the AFSC Secretariat.

4.19. Serve on the Defense Business Systems Management Committee and perform the necessary reviews, certifications, approvals and other required actions in accordance with sections 186 and 2222 of Reference (a).

4.20. Serve as the co-chair of the Department of Veterans Affairs-Department of Defense Joint Executive Committee pursuant to sections 320 and 8111 of title 38 U.S.C. (Reference (r)).

4.21. Perform such other duties as the Secretary of Defense may prescribe.

5. RELATIONSHIPS

5.1. In the performance of assigned responsibilities and functions, the USD(P&R) shall serve under the authority, direction, and control of the Secretary of Defense and shall:

5.1.1. Report directly to the Secretary of Defense.

5.1.2. Coordinate and exchange information with other OSD officials, the Heads of the DoD Components, and Federal officials having collateral or related responsibilities and functions.

5.1.3. Use existing systems, facilities, and services of the Department of Defense and other Federal agencies, when possible, to avoid duplication and to achieve maximum efficiency and economy.

5.1.4. Exercise authority, direction, and control over:

5.1.4.1. The PDUSD(P&R).

5.1.4.2. The ASD(HA).

5.1.4.3. The ASD(RA).

5.1.4.4. The Deputy Under Secretary of Defense for Program Integration (DUSD(PI)).

5.1.4.5. The Deputy Under Secretary of Defense for Readiness.

5.1.4.6. The Deputy Under Secretary of Defense for Plans, through the PDUSD(P&R).

5.1.4.7. The Deputy Under Secretary of Defense (Military Personnel Policy), through the PDUSD(P&R).

5.1.4.8. The Deputy Under Secretary of Defense (Civilian Personnel Policy), through the PDUSD(P&R).

5.1.4.9. The Deputy Under Secretary of Defense (Military Community and Family Policy), through the PDUSD(P&R).

5.1.4.10. The Deputy Under Secretary of Defense (Equal Opportunity), through the PDUSD(P&R).

5.1.4.11. The Director, Defense Commissary Agency, through the PDUSD(P&R).

5.1.4.12. The Director, DoD Education Activity, through the PDUSD(P&R).

5.1.4.13. The Director, Defense Human Resources Activity, through the DUSD(PI).

5.1.4.14. The Director, TRICARE Management Activity (TMA), through the ASD(HA).

5.1.4.15. The President of the Uniformed Services University of the Health Sciences (USUHS), through the Director, TMA.

5.1.4.16. The RFPB, through the ASD(RA), on matters other than the content of the Board's advice to the Secretary of Defense.

5.1.4.17. The National Committee for Employer Support of the Guard and Reserve, through the ASD(RA).

5.2. The PDUSD(P&R) shall serve as the principal assistant to the USD(P&R) in carrying out the authorities, responsibilities, and functions of the USD(P&R) as specified in DoD Directive 5124.8 (Reference (s)).

5.3. The other OSD officials and the Heads of the DoD Components shall coordinate with the USD(P&R) on all matters under their purview related to the authorities, responsibilities, and functions assigned in this Directive.

6. AUTHORITIES

The USD(P&R) is hereby delegated authority to:

6.1. Establish and allocate civilian personnel authorizations of the DoD Components and review and approve military and civilian personnel authorization changes during program execution.

6.2. Exercise the authorities of the Secretary of Defense, whenever vested, relating to civilian personnel, whether established by law, regulation, or other action.

6.2.1. Exercise the authority to act for the Secretary of Defense to apportion costs and collect funds from non-appropriated fund (NAF) instrumentalities to cover expenditures resulting from the wage survey process that supports NAF pay schedules.

6.2.2. Exercise the authority of the Secretary to establish and approve pay schedules, salaries, wages, and other compensation for DoD civilian employees as determined pursuant to applicable laws (including but not limited to References (a), (l), (r), and title 20 U.S.C. (Reference (t)), regulations, and established policies.

6.3. Exercise the authorities of the Secretary of Defense under chapter 38 of Reference (a) related to Joint Officer Management and establish and issue policy pertaining to this program in accordance with Reference (f).

6.4. Promulgate in DoD Instructions, DoD policy within the authorities and responsibilities assigned herein, including authority to identify collateral responsibilities of OSD officials and the Heads of DoD Components. Such Instructions shall be fully coordinated in accordance with Reference (h). Further, in areas of assigned responsibilities and functions, the USD(P&R) has authority to issue other DoD Instructions, DoD Publications, and one-time Directive-Type Memorandums, consistent with Reference (h), which implement policy approved by the Secretary of Defense. Instructions to the Military Departments shall be issued through the Secretaries of the Military Departments. Instructions to the Combatant Commands normally shall be communicated through the Chairman of the Joint Chiefs of Staff.

6.5. Obtain reports and information consistent with DoD Instruction 8910.01 (Reference (u)), as necessary, to carry out assigned responsibilities and functions.

6.6. Communicate directly with the Heads of the DoD Components, as necessary to carry out assigned responsibilities and functions, including the transmission of requests for advice and assistance. Communications to the Military Departments shall be transmitted through the Secretaries of the Military Departments, their designees, or as otherwise provided in law or directed by the Secretary of Defense in other DoD issuances. Communications to the Commanders of the Combatant Commands normally shall be transmitted through the Chairman of the Joint Chiefs of Staff.

6.7. Communicate with other Government officials, representatives of the Legislative Branch, members of the public, and representatives of foreign governments, as appropriate, in carrying out assigned responsibilities and functions. Communications with representatives of the Legislative Branch shall be coordinated with the Assistant Secretary of Defense for Legislative Affairs or the USD(C)/CFO, as appropriate, and be consistent with the DoD Legislative Program.

6.8. Exercise the authorities of the Secretary of Defense to set bonuses and special and incentive pays under Reference (a) and title 37 U.S.C. (Reference (v)).

6.9. Reissue, as necessary, Reference (s), to update the responsibilities, functions, relationships, and authorities of the PDUSD(P&R), consistent with section 136a of Reference (a). In doing this, provide the PDUSD(P&R) authority, within assigned areas of responsibility, to issue instructions and communications to a Military Department, through the Secretary of the Military Department concerned.

6.10. Reissue, as necessary, DoD Directive 5125.01 (Reference (w)) and DoD Directive 5136.01 (Reference (x)) to update the responsibilities, functions, relationships, and authorities of the ASD(RA) and the ASD(HA), consistent with section 138 of Reference (a). In doing this, exercise the authority of the Secretary of Defense under section 138(c) of Reference (a), to delegate to those Assistant Secretaries authority, within the Assistant Secretaries' respective assigned areas of responsibility, to issue instructions and communications to a Military Department, through the Secretary of the Military Department concerned. Act for the Secretary of Defense, in accordance with section 115 of Reference (a), regarding increasing the authorized end strength for Reserve Component personnel. The USD(P&R) may redelegate this authority to the ASD(RA).

6.11. Exercise the authorities of the Secretary of Defense under sections 176 and 1471 of Reference (a) regarding the Armed Forces Institute of Pathology (AFIP). The USD(P&R) may redelegate this authority to the ASD(HA). The AFIP shall continue as a joint entity of the Military Departments, subject to the authority, direction, and control of the ASD(HA). The designation of the Secretary of the Army as the DoD Executive Agent for administrative support to the AFIP shall remain in effect until revoked or superseded by the Secretary of Defense.

6.12. Exercise the authority of the Secretary of Defense to conduct the business of the USUHS consistent with Chapter 104 of Reference (a), except the authority to appoint the President of the USUHS is reserved for the Secretary of Defense.

6.13. Act for the Presidential designee, the Secretary of Defense, to coordinate and implement actions that may be necessary to discharge Federal responsibilities assigned in section 1973ff of Reference (y). Establish policy for and administer the Federal Voting Assistance Program for the Presidential designee. Manage, coordinate, and perform the responsibilities assigned to the Presidential designee in section 1973ff of Reference (y). Be the sole Federal Executive Branch representative for obtaining, from each State, current voting information and disseminating it to other Federal Executive Departments, Agencies, and the DoD Components pursuant to section 1973ff of Reference (y).

6.14. Exercise the authorities of the Secretary of Defense under section 1973gg et seq. of Reference (y) regarding the National Voter Registration Act.

6.15. Exercise the authority of the Secretary of Defense under Subchapters I and II of Chapter 147 of Reference (a) regarding the Defense Commissary and Exchange Systems, with the exception of the authority under section 2488(e) of Reference (a), which is delegated to the USD(C)/CFO, and the authority of the Secretary of Defense concerning the governing board under section 2485(c)(3) of Reference (a). The USD(P&R) is designated as the DoD senior official to oversee operation of both the Defense Commissary System and the Defense Exchange System.

6.17. Exercise the authority of the Secretary of Defense under section 1034(g) of Reference (a) regarding review of final decisions of the Secretaries of the Military Department concerned on applications for correction of military records decided under Military Whistleblower Protection procedures. The USD(P&R) may redelegate this authority to the DUSD(PI).

6.18. Exercise the authority of the Secretary of Defense under 1074(c) of Reference (a) to designate by regulation individuals as eligible for healthcare services in medical treatment facilities of the Department of Defense when such designation advances an important DoD interest. This may not be re-delegated.

6.19. Exercise the authority of the Secretary of Defense to set and adjust the National Security Personnel System (NSPS) rate ranges under 9901.321-322 of Reference (i), and to set and adjust NSPS local market supplements under 9901.332-333 of Reference (i). This delegation includes the PDUSD(P&R) and may not be further delegated.

6.20. Exercise the authority of the Secretary of Defense under Executive Order 13150, "Federal Workforce Transportation," (Reference (z)) to establish transportation fringe benefit program policy and issue regulations implementing a program for the Department of Defense.

6.21. Exercise the authorities of the Secretary of Defense, whenever vested, under Chapter 61 of Reference (a), concerning retirement or separation for physical disability and Public Law 110-181 (Reference (aa)), concerning wounded warrior disability matters.

7. RELEASABILITY

UNLIMITED. This Directive is approved for public release. Copies may be obtained through the Internet from the DoD Issuances Web Site at http://www.dtic.mil/whs/directives.

8. EFFECTIVE DATE

This Directive is effective immediately.

Gordon England
Deputy Secretary of Defense

Enclosures - 1
E1. References, continued

E1. ENCLOSURE 1

REFERENCES, continued

(e) Deputy Secretary of Defense Memorandum, "Authority Delegation - National Security Personnel System (NSPS) Rate Range and Local Market Supplement Adjustments," September 27, 2007 (hereby canceled)
(f) Deputy Secretary of Defense Memorandum, "Guidelines for Implementation and Administration of Joint Officer Management Program Joint Qualification System," October 2, 2007
(g) Deputy Secretary of Defense Memorandum, "Transfer of Uniformed Services University of the Health Sciences to TRICARE Management Activity and Rescission of the Department of Navy as Department of Defense Executive Agent," November 29, 2006 (hereby canceled)
(h) DoD Instruction 5025.01, "DoD Directives Program," October 28, 2007
(i) Title 5, Code of Federal Regulations
(j) DoD Directive 1322.18, "Military Training," September 3, 2004
(k) DoD Directive 3200.15, "Sustainment of Ranges and Operating Areas (OPAREAs)," January 10, 2003
(l) DoD Directive 7730.65, "Department of Defense Readiness Reporting System (DRRS)," June 3, 2002
(m) Title 5, United States Code
(n) DoD Directive 5160.41E, "Defense Language Program (DLP)," October 21, 2005
(o) Title 50, United States Code
(p) DoD Directive 5101.1, "DoD Executive Agent," September 3, 2002
(q) DoD Directive 8320.02, "Data Sharing in a Net-Centric Department of Defense," December 2, 2004
(r) Title 38, United States Code
(s) DoD Directive 5124.8, "Principal Deputy Under Secretary of Defense for Personnel and Readiness (PDUSD(P&R))," July 16, 2003
(t) Title 20, United States Code
(u) DoD Instruction 8910.01, "Information Collection and Reporting," March 6, 2007
(v) Title 37, United States Code
(w) DoD Directive 5125.01, "Assistant Secretary of Defense for Reserve Affairs (ASD(RA))," December 27, 2006
(x) DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs (ASD(HA))," June 4, 2008
(y) Title 42, United States Code
(z) Executive Order 13150, "Federal Workforce Transportation," April 21, 2000
(aa) Subtitle D, Title XVI of Public Law 110-181, "National Defense Authorization Act for Fiscal Year 2008," January 28, 2008

EXHIBIT 20

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
ALEXANDRIA DIVISION

- - - - - - - - - - - - - - - - - - - x
NICHOLAS HARRISON and :
OUTSERVE-SLDN, INC., :
Plaintiffs, :
vs. : No. 1:18-cv-00641
JAMES N. MATTIS, In His : LMB-IDD
Official Capacity As Secretary:
of Defense; MARK ESPER, In His:
Official Capacity As the :
Secretary of the Army; and the:
UNITED STATES DEPARTMENT OF :
DEFENSE, :
Defendants. :
- - - - - - - - - - - - - - - - - - - x
RICHARD ROE, VICTOR VOE, and :
and OUTSERVE-SLDN, INC., :
Plaintiffs, :
vs. : No. 1:18-cv-01565
JAMES N. MATTIS, In His :
Official Capacity As Secretary:
of Defense; HEATHER A. WILSON,:
In Her Official Capacity as :
Secretary of the AIR FORCE; :
and the UNITED STATES :
DEPARTMENT OF DEFENSE, :
Defendants. :
- - - - - - - - - - - - - - - - - - - x

VIDEOTAPED 30(b)(6) DEPOSITION OF DEFENDANTS
GIVEN BY ANDREW WIESEN

DATE: Friday, February 22, 2019
TIME: 9:14 a.m.
LOCATION: Winston & Strawn
1700 K Street, N.W.
Washington, D.C.

REPORTED BY: Denise M. Brunet, RPR
Reporter/Notary

Veritext Legal Solutions
1250 Eye Street, N.W., Suite 350
Washington, D.C. 20005

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(Appearances continued on the next page.)

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ALSO PRESENT: Solomon Francis, Videographer

C O N T E N T S

(Exhibits continued on the next page.)

WIESEN DEPOSITION EXHIBITS: PAGE:

(*Exhibits attached to the transcript.)

P R O C E E D I N G S

THE VIDEOGRAPHER: Good morning. We are going on the record at 9:14 a.m. on February 22nd, 2019. Please note that the microphones are sensitive and may pick up whispering, private conversations and cellular interference. Please turn off all cell phones or place them away from the microphones as they can interfere with the deposition audio. Audio and video recording will continue to take place unless all parties agree to go off the record.

This is media unit 1 of the video-recorded deposition of Colonel Andrew Wiesen, taken in the matter of Nicholas Harrison and Outserve-SLDN, Inc., plaintiffs, versus James N. Mattis, in his official capacity as Secretary of Defense, et al., defendants, case number 1:18-CV-00641 LMB-IDD, and Richard Roe, Victor Voe and Outserve-SLDN, Inc., plaintiffs, versus James N. Mattis, in his official capacity as the Secretary of Defense, et al., defendants, filed in the United States District Court for the Eastern District of Virginia, Alexandria Division.

This deposition is being held at the law offices of Winston and Strawn, LLP, located at

1700 K Street, Northwest, Washington, D.C.

My name is Solomon Francis from the firm of Veritext Legal Solutions, and I'm the videographer. The court reporter is Denise Brunet with Veritext Legal Solutions.

At this time will counsel present please state their appearances and affiliations for the record.

MR. SCHOETTES: My name is Scott Schoettes. I'm here for the plaintiff.

MS. HEMMINGS: Alexandra Hemmings of Winston and Strawn, LLP, for the plaintiff.

MS. COOLEY: Lawyer Cooley of Winston and Strawn, LLP, for the plaintiffs.

MS. BERMAN: Keri Berman for the defendant.

MR. FUCCI: Michael Fucci with the Department of Defense, office of general counsel, litigation.

MR. ABBUHL: Joshua Abbuhl for the defendants.

THE VIDEOGRAPHER: At this time will the court reporter please swear in the witness and we can proceed.

WHEREUPON,

this is outside the scope of what he's being offered for as a 30(b)(6) witness, but he can answer within his knowledge.

THE WITNESS: HIV is a blood-borne pathogen which can be transmitted by blood or other bodily fluids.

BY MR. SCHOETTES:

Q And what activities can result in the transmission of HIV?

MS. BERMAN: I'm going to make the same objection, and I guess, if it's okay with you, just a standing objection for this --

MR. SCHOETTES: That sounds fine.

MS. BERMAN: -- line of questioning.

MR. SCHOETTES: Thanks.

THE WITNESS: HIV could be transmitted through sexual activity or sharing of needles, contaminated needles, or inadvertently through a contaminated blood transfusion.

BY MR. SCHOETTES:

Q Any other activities?

A There are some occupational risks, blood splash, again, all involving blood or bodily fluids, primarily semen or vaginal fluid.

Q And what bodily fluids are capable of

Q So the first one is, "Free of contagious diseases that probably will endanger the health of other personnel."

What does "probably" mean in this criterion?

A "Probably" in this criterion would mean a reasonable probability of transmission.

Q And can you define "a reasonable probability" further? Is there a number? Is there a percentage?

A So "reasonably probable" means that the individual would be -- I don't want to pin myself down to a particular number. The diseases that we would think about that might fall in this category might be something like tuberculosis. So tuberculosis, depending on how long you were in contact with another individual, you know, how close that contact was, but that would be a probability of transmission to one or multiple other people.

There are other diseases, chronic diseases, that may be in that similar category, but "probable" in that case means that, over a term of a period of time, the likelihood would be significant, so perhaps as much as -- I don't

know -- I mean, I don't want to pin myself down to an actual number, but it's certainly going to be something greater than, you know, I don't know, maybe one in a hundred.

Q So 1 percent?

A Perhaps. Again, this is -- it's difficult to pin that down. But, yes, if somebody had a 1 percent chance of transmitting a disease within a year, that would be -- that could be considered to be likely.

Q Well, but the standard isn't "likely." It's "probably," correct?

A This is -- the standard is vague.

Q But "probably" in this case doesn't mean more likely than not?

A No, it does not.

Q That's one definition of "probably" that could be used, correct?

A It could be used.

Q But that's not how the definition is -- of "probably" is being used here?

A In public health, we would not use "probably" to mean more likely than not.

Q Do service members with HIV probably endanger the health of other personnel?

undetectable, would still be possible to transmit -- as a matter of fact, likely that it would be transmitted.

So the circumstances that you're asking about do exist in forward contingency operations. They're generally not used unless they need to be used.

Q And so what it would require for a transmission to occur in this situation is for a person to be in one of those situations where the walking blood bank was required, correct?

A Yes.

MS. BERMAN: Objection. Calls for speculation.

Keep going. I'm sorry. You can -- yeah.

THE WITNESS: Sorry.

BY MR. SCHOETTES:

Q And then the person would have to be one of those people who had never been informed that they aren't to donate blood after an HIV diagnosis?

MS. BERMAN: Objection. Mischaracterizes the evidence and calls for speculation.

THE WITNESS: That's not correct. You can be informed and still do it. Informed does

not mean that that will dictate your actions.
BY MR. SCHOETTES:
Q So it would have to be a soldier in that case who was ignoring the advice/order of a -- of the military around blood donation while HIV-positive --
MS. BERMAN: Objection. Calls --
BY MR. SCHOETTES:
Q -- is that correct?
MS. BERMAN: Sorry. Objection. Calls for speculation and assumes facts not in evidence.
THE WITNESS: No, that's not correct, because you said must ignore. It didn't mean that they ignored. They could have forgotten. They could have made a value judgment that the immediate need of this individual outweighed the theoretical risk of the blood donation. There are a variety of reasons why that individual might do that.
BY MR. SCHOETTES:
Q Do you know if any service members are given a tag indicating that they cannot donate blood?
A I am not aware that people are given a tag saying you're not a blood donor.

Q During the time that you were working on notification of people living with HIV in the military, was a part of the protocol to inform them that they were not to donate blood or tissue?

A Yes, it was.

Q Under what policy was that done?

A So the notification of individuals was under AR 600-110. And there may have been other regulations that we followed. I don't recall the exact numbers, but there was a specific counseling that was given and the form was directed.

Q And at that time, you were specifically working within the Army?

A Yes.

Q And I think you've already said you're not aware of a DOD policy that requires a person be -- a service member be informed that they cannot donate blood or tissue, correct?

A I'm not aware of such a policy.

Q I'm sorry. I just need to go back and make sure I've got this clean. Setting aside sexual activity, I asked if any of the other activities -- through any of the other activities it was probable that the health of other personnel would be endangered by a person living with HIV.

You said they would not. But then you caveated that with the statement about blood donation and the walking blood bank.

Is that you saying that that is a -- that it was probable that the health of other personnel would be endangered through that scenario?

A If an individual with HIV donated blood and it was used, that would probably infect the other individual and --

Q Right. I get that.

A -- would endanger them.

Q I'm sorry. Are you finished?

A Yes.

Q But what is the probability, I'm asking? Into that calculus, doesn't -- don't you have to take what the probability is of those circumstances arising --

MS. BERMAN: Object --

BY MR. SCHOETTES:

Q -- in order to determine whether it is probable that it will endanger the health of other personnel?

MS. BERMAN: Objection. Form. And calls for speculation.

THE WITNESS: Yes, you would need to know

how likely that was. However, when we plan for personnel, we plan for exigency -- contingency operations. And so we don't know what the circumstances are going to be and we don't know when a walking blood bank or warm blood bank would be required.

So the question is, if you donated to that walking blood bank, you would endanger the health of others. If you're asking me how likely would that occurrence be, I can't answer that question because I don't know.

BY MR. SCHOETTES:

Q Well, I understand. I guess what I'm asking is, under your criterion, how do you assess whether HIV probably will endanger the health of other personnel if you're not taking into account the likelihood of that scenario arising?

MS. BERMAN: Objection. Vague. And mischaracterizes the testimony.

THE WITNESS: So you would put that into your, as you say, your calculus in terms of is this disease -- is this infectious disease or contagious disease one that would probably endanger the health of other personnel? There are circumstances in which this particular disease

would endanger the health of other personnel.
BY MR. SCHOETTES:
Q So the question becomes how probable -- in part becomes how probable are those circumstances, right?
MS. BERMAN: Objection. Mischaracterizes the testimony.
Go ahead.
THE WITNESS: Yes. You would need to do that calculation.
BY MR. SCHOETTES:
Q Because I can come up with -- and I think you said before, right, you can come up with crazy scenarios through which something is possible, but if those scenarios are highly unlikely, then they wouldn't be -- it would not be probable that they would endanger the health of other personnel. Do you agree with that statement?
MS. BERMAN: Objection. Argumentative and mischaracterizes the testimony.
THE WITNESS: No. I don't agree with that statement because when the military plans for forces, they plan for highly unlikely events. They plan for full mobilization, full contingency operations. And what might occur during full

contingency operations are much different than the experience that we have day to day.

BY MR. SCHOETTES:

Q So doesn't that transform this criterion into an any risk standard? If the basis is however unlikely something is, we -- that's what we're planning for, then, doesn't that really just vitiate the word "probably" in this criterion?

MS. BERMAN: Objection. Form. Mischaracterizes the testimony and argumentative.

THE WITNESS: It makes this criteria more subjective.

BY MR. SCHOETTES:

Q Is the probability of a person being in a situation where they would be called upon to donate as part of the walking blood bank contingent upon or affected by the role in which the HIV-positive service member is serving?

MS. BERMAN: Objection. Calls for speculation.

You can answer.

THE WITNESS: It could be.

BY MR. SCHOETTES:

Q Can you tell me -- are there some roles in which a person would not be called upon or is

highly unlikely to be called upon to donate blood as a part of the walking blood bank?

MS. BERMAN: Objection. Calls for speculation.

You can answer.

THE WITNESS: The walking blood bank would typically be used in scenarios where people were exposed to probably kinetic injuries, meaning gunfire or other explosive devices, where trauma patients would either be gathered or be encountered where blood supplies were inadequate. Those would most likely be medical units.

BY MR. SCHOETTES:

Q So the walking blood bank is most frequently used in medical units where other service members come to receive care after what you describe as kinetic injuries?

A Let me expand slightly that the individuals who come with the people who were exposed to kinetic injuries -- so from that same unit, so those experiencing the kinetic forces, generally front-line individuals, would also be used for those -- those purposes. Because in order to collect the blood and then use it for another individual requires medical support that

normally would not be found at a front-line unit.
Q So you're talking about whoever is transporting the individuals who are injured to a medical unit and anyone else who might come as a part of that transport team might be more likely to be asked to donate blood as a part of the walking blood bank?
MS. BERMAN: Objection. Calls for speculation.
THE WITNESS: Yes.
BY MR. SCHOETTES:
Q Are there some roles where it is highly unlikely that a person would be asked to donate blood as a member of the walking blood bank?
A I can conceive of roles where it would be unlikely that someone would be asked to donate blood.
Q Can you name some of those for me?
MS. BERMAN: Objection. Calls for speculation.
BY MR. SCHOETTES:
Q Or describe them.
A Are you -- exclusive of contingency operations, there are many positions that would be unlikely to need to donate blood to a warm blood

Q There are people living with HIV in Africa, correct?
A Yes.
Q Some people live in extremes of heat in Africa, correct?
MS. BERMAN: Objection. Outside the scope for a different reason of what he's been offered for.
THE WITNESS: Yes.
BY MR. SCHOETTES:
Q There's people who don't have great access to water in Africa, correct?
A Yes.
Q Is it possible that some of these things have actually been studied in populations that undergo or suffer similar types of effects as people in an austere environment in the military?
MS. BERMAN: Objection. Calls for speculation and assumes facts not in evidence.
THE WITNESS: It has not been studied in what we would consider a scientific sense.
BY MR. SCHOETTES:
Q Who would conduct that study that you're describing if not the military?
A The military could conduct said study.

They have not.

Q I'm going to go on to the next criteria, and that is, "medically capable of performing duties without aggravation of existing physical defects or medical conditions."

Are HIV-positive service members with well-controlled HIV medically capable of performing duties without aggravation of existing physical defects or medical conditions?

MS. BERMAN: Objection. Calls for speculation.

BY MR. SCHOETTES:

Q Actually, let me restate that. Are HIV-positive service members medically capable of performing duties without aggravation of their HIV?

A Under certain circumstances. And what I mean by that is that the circumstance would necessitate they be able to take their medication continuously over the period of this military duty. So if they were not able to, for whatever reason, take their medication, that would exacerbate their condition, and that is known that interrupting HIV suppressive therapy can lead to untoward effects for the individual, including

resistance to the drugs and a rebound of the infection.

Q Beside [sic] for treatment interruption, would there be any reason that a person -- service member with HIV would not be medically capable of performing their duties without aggravation of their HIV?

A There could be other reasons. I can't speak that there could not be any other reason why they wouldn't be able to.

Q But in evaluating this criteria for a service member living with HIV, would you base your decision, on other things that -- yeah. Would the decision be based on anything else or would it be based on the possibility of treatment interruption?

A If you assumed that the individual did not undergo a treatment interruption, then the question of would they be medically capable of performing duties without aggravating the medical condition of HIV, they would not. If they did not have treatment interruption, then the conditions they would need to perform should not aggravate the condition itself of HIV.

Q And we'll talk more about treatment

interruption at a later point. Okay. I'm going to go back to Exhibit 3, which is the 2018 report to Congress. Actually, we may be talking about treatment interruption right now.

If you'll turn to page 2 of this report, at the bottom. It's -- in the summation there of DODI 6490, this report states, "All service policies preclude HIV-positive service members from deploying to combat areas or in support of contingency operations due to the potential lack of access to needed medical care or medications in austere environments, as well as the military risks inherent in the mission assigned that could lead to illness exacerbation and compromise unit readiness and mission completion."

MR. SCHOETTES: I think we're on a topic now where your standing objection is no longer relevant. So if you want to make it again, please do.

MS. BERMAN: I don't think I'll have a scope objection about this part, but go ahead.

BY MR. SCHOETTES:

Q What is the effect of missing antiretroviral -- doses of antiretroviral medications on an individual living with HIV?

A So again, it depends how many, for how long, what were you taking, what was your load before and, you know, what was the resistance pattern before. It's not good to miss any doses. So the fewer doses missed, the better for that individual.

Q Once -- if an HIV-positive service member begins experiencing a treatment interruption, how long does it take on average for their immune system to become compromised as a result?

A So again, it would depend, again, on what their immune system was prior to the interruption. If the assumption you're making is that they were completely suppressed and that their immune system was relatively normal, on an individual basis, it could be as short as perhaps a month or two to as long as -- it could be much longer than that. It's an individualized response, but don't develop immunocompromise immediately once you interrupt medication.

Q So you could go for a month, I think you said, was the smallest amount of time you said, before there would be any type of compromise of the immune system as a result of treatment interruption; is that correct?

the effectiveness of suppression and the ability of the virus itself to mutate or develop resistance.

BY MR. SCHOETTES:

Q I'm sorry. That was --

A Development of resistance and effectiveness and suppression are the reasons why we generally use three drugs. Two drugs had an unacceptable rate of resistance development.

Q When all three medications are stopped at the same time, explain to me the resistance concern there.

A So if you stop all the medications at the same time -- again, the virus that survives -- even though it's undetectable, there is surviving virus -- is itself resistant to the drugs. Otherwise, it wouldn't be surviving. Right? We can't get rid of the entire infection.

And so when you stop a drug, that allows that particular virus to then replicate to higher levels. And so when you try and reinitiate the drugs against that, it's going to be likely less effective against that particular virus.

Q And that is the case, that the virus that has survived is resistant to the medications the

person was on and it is not that the virus goes into certain reservoirs where the medications are not actually getting to the virus?

A It's possible that, again, there are rests or areas where the drug penetration is less, that the virus could potentially survive. But again, the -- the patterns of resistance we see are that it's dangerous to stop drugs because it does allow -- the ones that have survived are generally more resistant to the drugs we're using than others. And so they tend to be less effective and, after an interruption has occurred and they've been reinitiated, they tend to work less well.

Q Which then could require a switch in medication for that individual?

A If one is available and tolerable by the patient, yes.

Q And the treatments today that are used most frequently by people who are naive to treatment are -- have fewer side effects and are more tolerable than the medications even from ten years ago, correct?

A The medications today are better than the medications even ten years ago and they are

generally well tolerated.

Q And they have fewer side effects?

A In general, yes.

Q In this statement on page 2, it talks about military risks that could lead to illness exacerbations. Can you explain what military risks could lead to illness exacerbation for an HIV-positive service member?

A Again, I think these would fall into the order of difficulty with either water, food, environment, or just general stress of, you know, 24/7 operations. There are a lot of psychological stressors in these military environments. And so those may exacerbate HIV or any other disease based on those -- the extreme stressors.

Q So that's something -- the things you described are applicable to many different conditions?

A Yes.

Q And even someone without a medical condition --

A Yes.

Q -- could be -- could have those military risks affect their well-being, correct?

A Yes.

Q And then this also talks about compromising unit readiness and mission completion. To what level would those military risks have to get or to what level would illness exacerbation have to get before HIV compromised unit readiness and mission completion?

MS. BERMAN: Objection. Calls for speculation.

You can answer.

THE WITNESS: So it would depend on what the role of that individual was. So if that individual were in a key position and they were disabled and it was attributable to their condition, it may not be -- that one person may compromise unit readiness. So again, it would depend on what that individual's role was within the unit.

BY MR. SCHOETTES:

Q What exacerbation of the illness would lead to the person's disability?

A When you say disability, do you mean inability to perform the mission?

Q I thought you used the term "disability." If you did not, my apologies. Yes. Before, you were describing treatment interruption potentially

resulting in, over time, a reduced -- or an increased viral load and possible resistance, and then eventually some compromise of the immune system. Would we have to get to that point before the person's HIV would compromise unit readiness and mission completion?

A So that earlier description was describing an example of harm to the individual. Right? So that was what would -- it might take to hurt the individual.

In this case, you're asking me, well -- well, I'm not even sure what you're asking me here -- is would an individual with HIV become suddenly unable to, or more rapidly unable to perform their mission because of HIV?

So I would go back to my earlier answer that we don't know, under the conditions described in these military contingency operations, how an individual with HIV on these particular medications would potentially react. It's certainly possible that those medications, in combination with the other environmental factors, may cause them to be unable to continue their missions, but that's speculation on my part.

Q Do you have any -- in that bit of

speculation, do you have some idea in mind of in what way the HIV would result in an inability to perform their duties?

A So it wouldn't be the HIV, likely. It would be the medications and the side effects of the medications, in combination with all the other things that they had to be doing or taking. And so, in general, someone who has no disease is going to start off with a higher probability of not being adversely affected than one with any other disease.

So as soon as you start adding any additional -- any medications in this case or conditions to the mix, it makes the probability of that individual suffering an inability to perform their mission higher.

Q And we just don't have any idea how much higher; is that correct?

MS. BERMAN: Objection. Mischaracterizes the testimony.

Go ahead.

THE WITNESS: There have not been studies to show whether the conditions described here or foreseen in a military contingency operation could analyze and answer that question.

seeing it. Oh, here it is. Found it.

If you go to 2(a) on page 7, it says, "In general, DOD personnel with any of the medical conditions in enclosure 3, and based on a medical assessment, shall not deploy unless a waiver is granted."

I think we've established this, but HIV is listed in enclosure 3, correct?

A Yes.

Q And even though it's listed with progressive clinical illness or immunological deficiency, it really means just HIV seropositivity, as in enclosure 3?

A Yeah, it's listed twice as both with progressive disease and then simply seropositivity.

Q And the first one is subsumed within the second category?

A Yes.

Q The next part says, "Consideration should be made for the nature of the disability and if it would put the individual at increased risk of injury or illness, or if the condition is likely to significantly worsen in the deployed environment."

I think we've talked about some of these things, but I just want to make sure that the definitions are the same in this context. So what aspect of the nature of HIV would influence the deployment waiver decision?

A Well, I -- so the nature of HIV is it's an infectious disease as opposed to some other physical limitation. So it's an infectious disease. So the nature of that is what is the risk of the infectious disease itself, first to that individual of worsening or causing a problem, and then secondly to, as we talked about earlier, transmission to others or risk to others.

Q And just in the language of this particular provision, how would a deployment put a service member with HIV at an increased risk of injury or illness?

A So again, as we discussed before, in the contingency environment, there are environmental and other stressors which may cause the disease to worsen. The interruption in treatment is a factor to consider, as well as the inability to receive normal food rations or rations that one is accustomed to, access to water, prolonged operations, psychological trauma, many other

things where those could all increase the stress on the individual and on someone taking medications already -- I guess we had already mentioned they may have to take additional medications for prevention, prophylactic purposes against malaria, may need other immunizations. There are other stressors that are going to be applied to them.

And so all of those together could cause an individual with this condition to worsen.

Q And just so I've got these categories right, there's treatment interruption, correct?

A Correct.

Q There are stressors --

A Correct.

Q -- which includes lack of food or limited rations or --

A Dehydration.

Q -- not having access to water, dehydration --

A Loss of sleep.

Q Those are all in the stressors category?

A Sure.

Q Psychological stressors, I think you said. And then there are potential drug

with HIV agents.

Q But the military does not use those?

A The military -- it's not the first-line agent for the military.

Q The folks who can't take the live virus vaccine for other reasons -- first of all, can you give me examples of what those other reasons might be?

A The simplest example for smallpox is history of eczema. So --

Q History of?

A Eczema.

Q Okay.

A E-C-Z-E-M-A, which is just a skin condition, irritable skin condition that the smallpox virus, the current one we use right now, just causes that to flare up and can be quite serious.

Q Anything else that pops into your mind?

A There are a variety of conditions, but eczema is known to occur in maybe up to 10 percent of the population, so it's fairly common and a fairly common reason for people to not get the smallpox vaccine.

Q So what do you do with those folks who

have a history of eczema in terms of deploying?

A So they're not prohibited from deploying. They simply receive a medical reason for not receiving that particular force protection measure.

Q And they don't take some other substitute or take other measures to prevent whatever the vaccine is intended to prevent?

A So, yeah, we don't have -- at this point, we don't have an alternative smallpox vaccine. It's the same one we've used since the 1940s. So, no, there isn't an alternative. I mean, we have other countermeasures in terms of, you know, using mask and, you know, our chemical protective gear, but it's more effective to use the vaccine since it's much less obtrusive.

Q So do you ask service members who have not had the vaccine because they have eczema, a history of eczema, to use those other countermeasures?

A So those other countermeasures would be used in the event of an actual smallpox attack or usage, biologic weapons usage, but there is no naturally-occurring smallpox in the world right now. So they would have to have them, but

everybody has to have those for these deployments.

Q So everybody would use those. The other folks would be protected by the vaccine as well, and these individuals with the history of eczema would be relying solely on the protective gear?

A Yes. That's correct.

Q Can you say in what deployed environment HIV is likely to significantly worsen? Or in what deployment environment is HIV likely to significantly worsen, if any?

MS. BERMAN: Objection. Calls for speculation.

Go ahead.

THE WITNESS: So the more stressors that are placed on the individual, the more likelihood that any condition will exacerbate, including HIV. So the most stressful situations that one could be deployed in would be a combination of environmental and other physical stressor factors.

So a contingency deployment in an undeveloped theater where there's limited access to the things that we normally want -- food, medicine, water, shelter -- where you're required to wear all your protective gear at all times so you're subject to heat stress and weight stress

well-established regimen, taking it for a long time with a stable dose, there are limited circumstances where you may give them up to three months of medication at a time in the United States.

Q Do you know if HIV is usually provided -- HIV medications are usually provided in a 90-day supply?

A I don't know in particular about HIV medications. It would be a candidate, potentially, for individuals who were taking a steady dose, but I don't know the particulars on that.

Q For people stationed in the United States, continental United States, what is the maximum number of days that could be supplied at one time?

A Again, these are service-specific policies, but I've personally never seen supplies exceeding 90 days.

Q For heart maintenance medications provided -- oops. Wait. Go back. Sorry.

If a service member's medications are lost, stolen or destroyed -- a service member in the United States -- are lost, stolen or

destroyed, how are they provided with a replacement supply?

A So again, it would depend on when the loss or destruction occurred, or theft occurred. If it were near the time where they were due their next refill, they would simply go and get an early refill. They could ask the pharmacy -- explain the condition to the pharmacy and the pharmacy may be willing to give them a refill, or they may refer them back to their provider for a new prescription.

Q And so once they had established that they were missing that medication, it would be resupplied through the normal pharmacy procedures in the United States?

A Pharmacy or a provision of care, yeah.

Q How are maintenance medications provided to service members stationed in Alaska, Hawaii or Puerto Rico? Any different than what we just described?

A I have not been personally stationed in those locations, but I believe they follow the same rules as the continental United States does.

Q How are maintenance medications provided to deployed service members?

A So this is where it gets a little different. So deployed service members are normally given 180-day supplies of maintenance medication. 180-day supply was chosen because it is anticipated that resupply should be available within 180 days but may not be available prior to 180 days.

The individual is then responsible for that medication and the care of that medication and proper taking of the medication until they can achieve a resupply.

Q And when are they permitted to initiate the refill, if you will, of their medication while deployed? So after 120 days, can they put in to get that medication resupplied? After 150 days? How far down do they have to be on their current supply before they can start the process of getting it refilled?

MS. BERMAN: Objection. Form.

You can answer.

THE WITNESS: So in a deployed environment, obviously things are a little bit different. The individual is going to know when and how urgent it is that they get that medication. And their individual circumstances

will be different.

So somebody who is way out front, way far away from medical, might need to start that process earlier, and they would go to their medical personnel supporting and say, I need this medication; I know it might take a while so I'm going to ask you now. I've only been here for 30 days, maybe, and they might start that process.

Somebody who is stationed at a hospital where they have that medication on hand could wait until, you know, it was due. So it really does depend on the circumstance.

BY MR. SCHOETTES:

Q If a deployed service member's medications are lost, stolen or destroyed, how would they go about securing a replacement supply?

A So they would use the medical facilities that are available to them through their unit support. So they'd go to their first level of medical support, whatever that is.

Q And in the situation where medications were lost, stolen or destroyed, so the need had arisen quickly, could the delivery of those medications to service members in theater be expedited?

MS. BERMAN: Objection. Calls for speculation.

You can answer.

THE WITNESS: So again, it would depend on the circumstances, where that individual was and how developed the theater was. It is possible under certain circumstances in a well-developed theater that medications could be expedited back to the individual, depending on the urgency of the situation as well and whether it would be more feasible to move the person to where the meds are, if they're really in need of those meds, or they could wait because the incremental harm that they would suffer by delay -- a slight delay would be insignificant.

BY MR. SCHOETTES:

Q I'm not a military guy, as you might have guessed. It's my understanding that the military can't get too far ahead of its supply lines. Is that a basic precept of military operations, that you need to move your supply lines up so that you can access them?

MS. BERMAN: Objection. Vague.

You can answer.

THE WITNESS: So in classic wartime

thinking, outstripping your supply lines is dangerous and takes risk. Unfortunately, in today's dynamic battlefield, it's sometimes forced upon us. And so we often do outstrip supply lines, and medical being one that is -- medical is a counterforce. It's not a force. It protects what we have and tries to sustain what we have, but it doesn't actually deliver the offensive blow that the forces do. So we are considered to be, you know, secondary in support. So the battle moves where the battle needs to go, and we do our best to keep up.

BY MR. SCHOETTES:

Q In this dynamic battle environment, how long could it be that a forward unit would not have ready access to medical support?

A So again, what we plan for, which is much different than what we've been doing now, is it could be a long time, as much as six months as the planning factor for us not be able to resupply people.

We do that because all of the contingencies we plan for stress our military to its limit. That's how it's set up. But we do need to be able to plan for that. So the 180 days

is a general benchmark in terms of how long we would think you could continue operations without definitive resupply of medical support.

Q Are there certain medications that are considered specialty medications within the formulary of the military?

A And specialty, could you help me understand what you're getting at?

Q So insurance plans here in the United States for civilians will sometimes have different tiers of medications within a formulary. And some of them they designate as specialty. And sometimes HIV medications -- oftentimes HIV medications fall into that specialty category.

So I'm just wondering if the military has something similar. You know, you talked earlier about -- well, let's stop there. Does the military have some similar way of classifying medications?

A So the military would classify certain categories, like scheduled drugs, as special, obviously because of their unique propensity to be misused, stolen, abused. They also have categories of the most commonly used drugs that they need the most of.

A Right. But they wouldn't be available in theater. So they are listed separately because we wouldn't carry appliances necessarily for an individual that was shaped or made for their particular needs.

Q Got it. What about glasses? For someone whose vision that requires glasses, what effect does that have on their ability to -- well, let's start with accession. Do you know what the standard is for accession in terms of vision?

A So each service has their own standards. Again, I don't remember what the exact diopters are that is automatically disqualifying. I think it's around minus 8 or so, and maybe it's as high as plus 6 or 7, but they're pretty generous for allowing people that come in.

Q And once a person is in, do those same standards apply if their vision drops below a certain level? Are they discharged?

A No. Again, so the retention standards are generally more lenient. And so, under most circumstances, it's best-corrected vision. The reason that they have certain limitations is because there are other diseases of the cornea that occur with extreme myop -- or hyperopism,

which is extreme near or farsightedness. And so they -- generally there are other conditions associated with those which is why they're disqualifying.

But if it's a simple visual refractive error, those individuals, regardless of whether their refractive error worsens during their time in service, would not be discharged unless they couldn't be corrected or they develop some other associated problem.

Q And so what's the deployment policy for people with vision problems? Do they have to be able to correct with glasses? Please explain.

A So if you're referring to people who have a refractive error, a simple refractive error, that wear glasses, essentially, the requirement is that they bring two pair of spectacles and have a mask insert. So they're responsible to bring their own with them. And the reason for the two is that in case they lose one, they will have another.

There are, as part of deployed medical sets, optical fabrication laboratories that go forward, too, because this is -- or has been in the past, a relatively common problem of people

destroying their glasses or losing their glasses. They would need to make more. So they do bring the capability in forward deployed medical assets to make glasses.

Q Can you explain to me -- I think I have an idea of what this is -- but the mask inserts. What is that?

A So there's just a special set of lenses that go inside your protective mask, which is for chemical or biological hazards, that you might have to put on and so -- that's so you can see properly through that mask because glasses in general aren't compatible with the mask because the temples of the glasses themselves would interfere with the proper seal on the mask.

Q So glasses, I think, are another example of a -- a durable device that, if you didn't have in the moment, could hinder performance of your duties. Is that accurate to say?

A It is. Glasses are considered a special class of devices which is why you have to bring two.

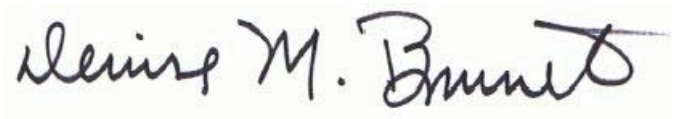
Q But if you were out doing your job and you lost, destroyed your glasses, it could seriously impact in the moment your ability to do

THE VIDEOGRAPHER: The time is 4:44 p.m. This concludes today's testimony given by Colonel Andrew Wiesen. We are now off the record.

(Whereupon, at 4:44 p.m., the deposition of ANDREW WIESEN was concluded.)

CERTIFICATE OF NOTARY PUBLIC

I, Denise M. Brunet, the officer before whom the foregoing deposition was taken, do hereby certify that the witness whose testimony appears in the foregoing deposition was sworn by me; that the testimony of said witness was taken by me stenographically and thereafter reduced to print by means of computer-assisted transcription by me to the best of my ability; that I am neither counsel for, related to, nor employed by any of the parties to this litigation and have no interest, financial or otherwise, in the outcome of this matter.



Denise M. Brunet
Notary Public in and for
The District of Columbia

My commission expires:
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March 8, 2019

To: KERI L. BERMAN

Case Name: Roe, Richard, et al. v. Mattis, James N., etc., et al.

Veritext Reference Number: 3233244

Witness: Andrew Wiesen Deposition Date: 2/22/2019

Dear Sir/Madam:

Enclosed please find a deposition transcript. Please have the witness review the transcript and note any changes or corrections on the included errata sheet, indicating the page, line number, change, and the reason for the change. Have the witness' signature notarized and forward the completed page(s) back to us at the Production address shown above, or email to production-midwest@veritext.com.

If the errata is not returned within thirty days of your receipt of this letter, the reading and signing will be deemed waived.

Sincerely,
Production Department

NO NOTARY REQUIRED IN CA

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3233244
CASE NAME: Roe, Richard, et al. v. Mattis, James N., etc.
DATE OF DEPOSITION: 2/22/2019
WITNESS' NAME: Andrew Wiesen

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have made no changes to the testimony as transcribed by the court reporter.

_____ _____
Date Andrew Wiesen

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal

this _____ day of_____, 20____.

_____
Notary Public

_____
Commission Expiration Date

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3233244
CASE NAME: Roe, Richard, et al. v. Mattis, James N., etc.
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In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

20190405 _____
Date

Andrew Wiesen

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They have listed all of their corrections in the appended Errata Sheet;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal this 5th day of April, 2019.

_____
Notary Public

04/30/2023
Commission Expiration Date

ALEXANDER M. STEIGERWALD
NOTARY PUBLIC
REG. # 7820132
COMMISSION EXPIRES
04/30/2023
COMMONWEALTH OF VIRGINIA

ERRATA SHEET

VERITEXT LEGAL SOLUTIONS MIDWEST

ASSIGNMENT NO: 2/22/2019

PAGE/LINE(S) / CHANGE /REASON

page 12, line 8 "from" to "at" clarity

page 164, line 10 "couldn't" to "could"; changes meaning

page 247, line 25 "myop" to "myopia correct medical term

____

Notary Public

Date Andrew Wiesen SUBSCRIBED

AND SWORN TO BEFORE ME THIS __________ DAY OF __________

Commission Exp~~20~~ration Date

EXHIBIT 21

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
ALEXANDRIA DIVISION
NO. 1:18-CV-00641-LMB-IDD

NICHOLAS HARRISON and
OUTSERVE-SLDN, INC.,

Plaintiffs,

vs.

JAMES N. MATTIS, in his official capacity as Secretary of Defense; MARK ESPER, in his official capacity as the Secretary of the Army; and the UNITED STATES DEPARTMENT OF DEFENSE,

Defendants.
_____/

201 North Franklin Street
Tampa, Florida
9:00 a.m. to 3:41 p.m.
March 15, 2019

VIDEO-RECORDED DEPOSITION OF KEVIN CRON

Taken on behalf of the PLAINTIFFS before Kim Auslander, RPR, CRR, Notary Public in and for the State of Florida at Large, pursuant to Notice of Taking Deposition in the above cause.

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I N D E X

* * *

E X H I B I T S

PLAINTIFF'S

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Exhibit 8	19-page document with verification	166
Exhibit 9	Court Order	195

waivers for personnel that are not affiliated to any particular service, and then appeals.

We've deferred authority to arbitrate medical waivers on medical issues -- purely medical issues -- down to the service components, so it's conceivable that they may have issued a determination on an HIV waiver without notifying us.

I had -- in order to properly advise my surgeon, I had to contact them and ensure that they had not actually done that, and additionally make sure that when we put forth our initial opinions, but for that earlier letter I mentioned, that we had not granted any waivers, I was speaking truthfully.

Q Okay. So, just to see if I understood your response, are you saying that it isn't you who would grant the waiver for someone who was HIV and seeking to deploy, it would be handled by the Service?

A We all work on behalf of the CENTCOM command surgeon. He has delegated authority to me to handle those waivers that come to the Central Command headquarters. Other waivers would go through the service components, and they would usually -- and when it's become an issue, they would contact us to notify us that they had an issue that is unusual.

However, it's conceivable that they did not,

and as a staff officer, you quickly learn that you verify your facts before you go on record, so in order to properly address the question, I was asked for my surgeon -- I had to confirm with them that they had not in fact approved any, and the response that I got back from all of them was uniformly that they did not.

Q Was there anyone else that you talked to to prepare yourself to testify on any of the topics that you were designated to address today?

A No.

Q I want to go back to the statement that you said was issued in February 2019 by CENTCOM public affairs. I don't mean to mischaracterize your testimony, so correct me if I'm wrong.

As I understood, just the gist of the statement was it was very unlikely, although possible, for someone who was HIV positive to deploy to CENTCOM, then you enumerated the concerns you had with such a deployment; is that right?

A Yes.

Q And, to the best of your recollection, what were the concerns that were enumerated in that February 2019 statement?

A Our concerns are that the service members who are HIV positive and managed on therapy are vitally

dependent upon that therapy to maintain that condition, and if their medication is lost, destroyed, or stolen, it cannot be readily replaced in a timely manner, which could result in an adverse outcome for both the service member and the mission.

Additionally, the medications themselves, while certainly improved from their earlier versions have side effect concerns which, when we see side effect profiles similar to that in other medications, we don't allow those medications into our AOR.

Then, finally, there is a concern that if a service member who is HIV positive needed to be taken to a host nation healthcare facility for care, we would be medically or ethically obligated to notify that healthcare staff that they were taking care of an HIV positive patient. Many of the nations in which we serve have statutory law against that, against an HIV positive individual.

It was felt that they would be obligated to report that to their ministry of health, and that the facility could legitimately deny care, which would potentially expose the service member to further risk.

Finally, we have, in the event of mass casualty operations, which is where the number of incoming casualties exceeds the capabilities of our

routine medical operations, we revert to doing medical care devoted to preserving what life we can.

Within that context, we have started using fresh whole blood as our resuscitation fluid of choice, and with that context, the concept of using what we would call a walking blood bank, where essentially we are directly transfusing blood from one service member -- a healthy service member into a wounded service member, is becoming more and more part of our planning process.

Within that context, even the -- even a well-controlled HIV patient would pose an amount of risk in terms of both being a potential donor, but also in terms of being a potential trauma victim.

The nature of our traumas are that we have a number of shrapnel injuries, where sharp pieces of metal, stone or, wood can become embedded in the patient and present a hazard to any surgeon working on them. Additionally, there are occasions where shards of bone become mixed into it.

It was a concern that if an HIV positive patient, even if they were not a healthcare provider, might be found in a situation where they needed to provide aid and could accidentally end up infecting either the recipient or the caregiver in such a

scenario. Those were the initial -- our initial concerns --

Q Okay.

A -- I'm not sure if we expressed it in exactly that way.

Q And the last concern that you expressed as a separate concern was the whole blood transfusion concern, is it?

A I'm sorry; could you be more clear?

Q When you were talking about the possibility of shrapnel or bone or whatever --

A That is a context that we discuss sometimes.

When we discuss the concept of a potentially healthcare transmitted blood work condition with our civilian colleagues, we sometimes end up talking past each other, because their concept of trauma is different from ours.

The traumas they usually deal with are, like, automobile crashes, where you're talking blunt forces that leave the body mostly intact. If the surgeon is careful, there's a negligeable risk of exposing themselves through either a needle stick or a laceration with a scalpel or such.

Ours differs in that regard because of the nature of our injuries. We see more penetrating trauma,

we see more mutilating trauma due to the nature of the wound patterns they encounter.

We mentioned the shrapnel because the wounds that our surgeons are working on are not clean. They are not under a controlled setting. And, oftentimes, they can't get the level of control that a domestic surgeon would be used to.

They have to move fast, they have to work in wounds that are very mutilating, may have embedded fragments, and it's entirely conceivable that they may be performing a surgery that within a civilian healthcare system would be run-of-the-mill and benign.

In that context, they could accidentally cut themselves on a piece of embedded metal or a piece of protruding bone. I can't testify as to how common that is. A lot of these surgeons are within units that have heavy levels of classification on top of them, and they met their reporting on such things.

Q Is the concern that if the surgeon cut himself, that the surgeon could then either transmit HIV if he were HIV positive?

A Correct.

And it's worth mentioning that we're not just talking about surgeons here. In the context of a mass casualty exercise, the caregiver will likely be whoever

is standing closest to the patient and can still offer care. Whoever is still standing and is able to offer care offers it to those who cannot and don't, while at the same time addressing whatever hostile force inflicted the injuries in the first place. So it's very kinetic and active, very difficult to control. So we try to manage what risk factors we can prior to even placing our service members into that environment.

Q And, just to be clear, is it a risk that the caregiver would transmit the HIV if they inadvertently cut themselves, or is it a risk that the patient could transmit back to the caregiver, or is it both?

A It is both.

(Plaintiff's Exhibit 4 marked for identification.)

BY MS. BAUER:

Q Lieutenant Colonel, the court reporter has handed you a copy of what she has marked as Cron Deposition Exhibit 4, which is a Declaration of Kevin Cron in Support of Defendants' Opposition to Plaintiffs' Motion for Preliminary Injunction in the Rowe versus Shanahan case.

I take it you've seen this document before, sir?

A I have.

Additionally, for very complicated medical conditions, once again, those 100-page files we get, a lot of times you will end up with a very equivocal case, and you will need more information, so you just say no, rather than, if you request more information, that's more information, and you will go back and forth. Meanwhile, that file is still sitting there unanswered, and then the -- it can take a long time to finalize that process. So, we will just say no; here's what we want, send it back in when it's complete, and we will move on to the next.

And those appeals usually come to us as well when the case is complete, so it's a mixture of updates, and I disagree with your decision, I would like somebody else to render a decision, please.

Q And is there any appeal from your decision if someone wants to take one?

A So, within the CENTCOM surgeon's office itself, this is not in our written policy, but it's just kind of our unspoken policy.

I recognize my limitations as a single provider. If somebody were to appeal a case from the service component to us and I issue a decision based on what I find out in my own experience, and they say, we still disagree with that, then it goes directly to the

CENTCOM surgeon, who is the senior ranking medical officer in the headquarters, and I will staff it with him and basically be; here's the situation, here's what the service component said, here's what I said.

He is the Combat and Commander's direct representative; we all operate under his authority, so he may turn around and say, well, I disagree, let's do this instead. It is his prerogative. That's an informal process.

Because, honestly, if it was that equivocal a case to begin with, I would have already talked with him about it --

Q Okay. And --

A -- and after that, if it goes past that level, then you can appeal to our chief of staff, who is a two star general, and basically at that point, once you reach that level, you've basically -- what you are saying at that point is the senior medical officer of the Combat and Command is going to what is functionally the executive officer of the Combat and Command and saying, we have a gentleman or a lady who wishes to go here to do this, the component doesn't think it's a good idea -- and when I say "component," they are usually talking to the people who are actually in the theater who would be taking care of them, so they are speaking

In my professional capacity, I would not recommend it. I don't know. We take our blood transfusion requirements from the Red Cross, so we would basically -- I would defer to my blood officers on that.

BY MS. BAUER:

Q How about HTLV; have you ever personally granted a waiver allowing someone to deploy to CENTCOM when they have HTLV?

A Not that I recall.

Q And how about, number 3 is latent tuberculosis; have you ever granted a waiver allowing someone to deploy to CENTCOM with latent tuberculosis?

A Yes.

Q On how many occasions?

A I don't know.

Q Number 4 is a history of active tuberculosis.

Have you ever granted a waiver allowing someone to deploy to CENTCOM with a history of active tuberculosis?

A Misleading. I have not -- a history of active tuberculosis and a current diagnosis of latent tuberculosis can be present in the same individual, because one becomes the other.

I would say immediately history -- if they

have active tuberculosis, we have not approved a waiver for that.

Q If they have active tuberculosis?

A If they have current or recent active tuberculosis. It's poor wording on our part.

Q Is an inability to donate blood in itself disqualifying for deployment to CENTCOM?

A Potentially.

Q What do you mean by "potentially?"

MR. NORWAY: Vague. You may answer.

THE WITNESS: As a global requirement, no. If you said, if they can go anywhere, do any job, in any place, for any time, it's fine, because there's going to be exceptions. If they are on a small team operating in a remote location, then yes, it would be.

There are -- we have operations where the ability to serve as a blood donor is a requirement to go on that mission.

BY MS. BAUER:

Q So, would it depend on what they're being deployed for, essentially?

A It would. It would be heavily dependent not only on their occupation, but also the operational environment to which they are going, what we anticipate

and would tie heavily into number 1 and 2. Number 5 might not be met, depending on the nature of their operations. Number 6 would not be met in the event of mass casualty or the situations we discussed earlier. Number 7 would be met.

I believe number 8 would be met, though I would have to defer to the infectious disease community regarding any live virus vaccines that may be required. We would be -- we would consider number 9 to potentially not be met in the event of the circumstances in number 1 or 2.

Q Let me go back to condition number 3, D3. It says:

"The condition does not require frequent clinical visits more than quarterly."

A Yes, ma'am.

Q Does that mean if a person has a chronic medical condition that requires periodic checkups but they are not more frequently than quarterly, that would be okay?

A This is the baseline standard. This is where we start the discussion.

If I ask my deployed providers, can you support this frequency, what I'm essentially asking is, do you have the resources to perform this task at the

frequency with which I've asked you to do it.

The obvious followup to that is, well, what resources do we have, and that answer is going to vary depending on where they go.

Our deployed medical apparatus is essentially designed to address acute medical needs of the deployed force with a heavy emphasis towards trauma.

As we've drawn down the force, it's been at the expense of kind of primary care or the management of chronic medical conditions with a presumption that we're going to keep most chronic medical conditions that require regular followup from going there in the first place, so you will essentially be managing things that show up, which is common in any population, and then obviously the traumas associated with kinetic operations.

So, quarterly is where we drew a line in the sand, because it's just convenient to do so. That's once every three months. That's also for controlled substances, the period they need to maintain in order to refill those prescriptions. So, it is an arbitrary standard.

If you were to, say, send us a waiver with an individual who needs to be checked twice a year, but that is in a location where I just can't spare the

ability of the local healthcare capability is either managed in place to the extent that they can, particularly in terms of kinetic operations, or evacuated to a higher level of care when it's operationally safe and feasible to do so. And if they have to be evacuated to a higher level of care, how is that accomplished.

It's typically accomplished through -- well, it's through evacuation for whatever modality is available. In the modern war, it's usually air med evac. In previous conflicts and some other theaters, it's through ground evacuation. By whatever mode of transportation is most feasible.

BY MS. BAUER:

Q What is the highest level of care that's available in CENTCOM?

A Within CENTCOM, our highest level of care would be -- it's difficult to define without using strictly military terminology, and even that is the subject of debate.

We would call it a Role 3, which is it offers some internal medicine capability. We usually have some aspect of what we would call an intensive care capability, although that would not match up exactly with the same capability in the United States. Limited

lab, limited radiology. Surgical capability, limited patient hold capability. The duration of patient hold and the amount of patient hold is one of the issues that's kind of in flux.

Once again, most of our roles of care as they are defined center around surgical capability because they are really designed around trauma care and the care of trauma victims.

Q And if someone has to be evacuated to a location that is a higher role of medical care, how long does that take?

MR. NORWAY: Objection, vague. You can answer.

THE WITNESS: It's vague, precisely true. It can take any amount of time that it takes. The challenges -- as mentioned, we move mostly by air.

The challenges to air travel in that AOR are many, including weather, operational, the urgency of the evacuation. If I have space for four people and I have five people waiting, then one person's going to have to wait for the next flight.

So, it can theoretically take many days or even weeks to move, depending on what's going on. If it's not urgent, it takes a backseat to everything that is. Things don't always go as

planned. Flight plans change, aircraft are reallocated. There are innumerable different things that could alter the plan or bump somebody from the proposed plan.

We do the best we can, and certainly those patients which are in life-threatening situations, we make every effort to move them expeditiously, but this contends with our primary concern, which is completion of remission and meeting our objectives.

BY MS. BAUER:

Q I think you told me earlier today that you've personally reviewed, you thought less than five applications for a deployment waiver for someone who's HIV positive; is that right?

A I believe --

MR. NORWAY: Objection to the extent it mischaracterizes the testimony. You may answer.

THE WITNESS: I believe so.

BY MS. BAUER:

Q I think you told me that none of those were for service members; is that right?

MR. NORWAY: Same objection.

THE WITNESS: I don't know if they were. I just mentioned that most of our HIV waivers were

A If I did, I don't recall.

Q Paragraph 12, you wrote:

"There are features of HIV which make it difficult to compare to other conditions."

Tell me what features you are referring to there.

A The features are listed further on in the paragraph.

Q Okay.

A Their medications are highly specialized and to the extent of often being individualized. They have to have a constant diligent compliance with therapy. This is a compliance which is absolutely rigid. It cannot waver. It has to be rigidly adhered to for the virus to remain adequately controlled.

One of the unique features of HIV is its ability to rapidly adapt to subtherapeutic levels of medication; so if an individual is not rigidly adherent to their regiment, not only will the virus return, it will likely become resistent to the entire class of medications with which it is being treated, and this is additionally compounded by subsequent resistence that's acquired on multiple -- if you were to try multiple regiments, it would continue to adapt and to adjust.

So, you asked earlier about daily medications

and about would a daily medication necessarily prohibit from coming to theater. Most medications have certain allowances built into them that if you miss a dose or you go on a mission or if your medications were accidentally dropped down the sink or any number of a million different scenarios, we could replace them and get them to you, and in the meantime, you may not be perfect, but you will be okay.

This is one of the conditions where that does not hold true. The medications are not something that I'm going to have on the shelf of every battalion aid station. They are not the type of medication a medic is going to have in their bag.

They are going to be a challenge to replace in an expeditionary environment, and the reasonably conceivable scenarios in which they might be lost, stolen, or destroyed are manifold.

In the event of that, it's highly possible that a virus may resurface, acquire resistence, and yet go unrecognized for the duration of the deployment, as the virus is often asymptomatic for its -- for its duration, even though it may be cellularly active, and that wouldn't be picked up until the next routine HIV test.

Q What is your understanding as to how many

Q -- is that right?

And I asked you which ones could not be met by someone with HIV, and you went through the list for me, okay?

A Yes, ma'am.

Q I want to go back to that topic. The first one is:

"The condition is not of such a nature or duration that an unexpected worsening or physical trauma is likely to have a grave medical outcome or negative impact on mission execution."

Is that right?

A Yes, ma'am.

Q And why would a person who's HIV positive not be able to meet that condition?

A So, the premise of this condition is that you have a worsening of the condition that by definition is unexpected, so this literally is to use within the context of HIV, is literally saying you have unexpected worsening of HIV, which we've only even considered it in terms of somebody who was virally suppressed.

So this would basically be somebody who was no longer virally suppressed and had active viral activity, so this would basically be somebody who had active HIV up to and including potentially AIDX.

In this case, that would be what we would consider to be a grave outcome for the service member. It would open them up to opportunistic infections, would have worsening of their condition, would expose additional service members to possibly active HIV virus through a number of conditions in the case of trauma or mass casualty event, and would be overall just a risk that would be inherent to having that condition in our theater.

Q Would the person meet Condition 1 if they were virally suppressed and compliant with the treatment regiment?

MR. NORWAY: Objection, calls for speculation. You may answer.

THE WITNESS: Once again, the premise of the condition is that their condition has worsened, so we -- in the context of this question, we have already presumed that the condition worsened; the most likely scenario of which is a failure to comply, either through deliberate negligence or through something to which the service member had no influence at all; if they were on a prolonged operation and did not make it back home in time, if they lost their meds through no fault of their own. So we have abundant scenarios where the condition

could worsen.

Additionally, even if they are maintaining proper compliance, there is a possibility that the innate stressors of the deployment could alter their native immune function to a degree where previously effective therapy might not be as effective.

However, this condition, once again, assumes that the condition is worsening. The circumstances of it worsening are speculative, but when we're asked, if we have an HIV patient that's controlled, and their condition worsens, does that present a grave outcome to the patient or risk to the force, we would say yes, it does, and plan accordingly.

BY MS. BAUER:

Q What about Condition 2? You indicated Condition 2 says:

"The condition is stable and reasonably anticipated not to worsen during the deployment in light of the physical, physiological, psychological, and nutritional effects of assigned duties and locations."

And I believe you told me that it maybe could be met by an HIV positive person, but maybe could not be met; is that right?

A Correct.

part of the routine workup, so we are not generally prepared to conclude as such.

Beyond that, the increased risk of illness is alluding to what we just discussed, where the baseline immune function of an HIV positive individual may vary from somebody who's never been infected with HIV due to the direct influence of the virus both in the acute phase of the infection and the ongoing worsening of the infection.

What that represents is hypothetical. I don't know that it's ever been examined in the military context.

Q Condition 4 says:

"There's no anticipated need for routine evacuation out of theater for continuing diagnostics or evaluation."

I believe you testified earlier this morning that whether an HIV positive individual could meet that condition, it depends, I think was your answer.

A Yes. So, once again, the reason somebody would have a routine evacuation out of theater would be to accomplish some task or test which was not available at the location they're at, or by strict definition even within the entire theater, although we take a somewhat liberal interpretation of this, in that, if I have to

fly someone from one end of my 20-country AOR to the other end of my 20-country AOR, it's still considered to be a significant effort that involves significant risk.

So, but, in this case, if we have to obtain some of these laboratory evaluations which are not readily available at the location they are at, we consider that to be concerning in this context.

Q And if you have to transfer someone because you need diagnostics or evaluations, is that always considered an evacuation?

A This would be a -- it's a curious point, actually. How you would consider them as an evacuation versus an administrative move versus a relocation for purpose X, for us, is a semantic point.

What we object to is the inherent risks of moving that person, both their loss to the unit that they're supposed to be with, the loss of the capability they represented should they have been there, and the intrinsic risk of moving that aircraft or that platform, whatever it is, through enemy territory or through controlled or uncontrolled space, the intrinsic risk of moving.

We consider evacuations to have risk attached to them beyond what you would encounter in the domestic environment, so any time we talk about movement of

equivolate a little bit.

Q Okay. Turning the page to Condition Number 6. It says:

"Individuals must be able to perform all essential functions of a position in the deployed environment with or without reasonable accommodation without causing undue hardship."

And it continues; and I think you told me that the answer to this is that this condition could not be met by an HIV positive person in the mass casualty situation we discussed this morning?

MR. NORWAY: Objection, to the extent it mischaracterizes testimony. You may answer.

MS. BAUER: I don't mean to. If I'm reading my notes wrong, tell me.

THE WITNESS: The context for the mass casualty was actually not with the first part of this paragraph but with the latter part, in that, so this is -- this language very heavily alluding to the American with Disabilities Act and some of the things we consider within that context, and here, what we really would zero in on is the last part, where it says:

"Further, the member's medical condition must not pose a significant risk of substantial harm to

the member or to others taking into account the condition, with particular consideration of areas of armed conflict within the AOR."

And, so, in that regard, as we were talking earlier, somebody called upon to render aid to a fallen comrade may themselves be bleeding, may themselves have any number of circumstances where they are either cut or are exposed to the other service member's blood, either through their own direct wounds or through embedded shrapnel, embedded foreign material in either service member, or they may be called upon to participate in a walking blood bank in a scenario in which they do not have time to do the screening that would normally be done.

Overall, it's just -- we feel it represents a hazard, so -- and then the undue hardship part of it would be more in terms of the difficulties in performing workup for routine medical conditions as we discussed earlier. It would not necessarily be hardship on part of them actually performing their duties, but actually in maintaining their health from the perspective of our healthcare team.

BY MS. BAUER:

Q Again, if we assume that the service member

was HIV positive, is virally suppressed, and compliant with their treatment regiment, would there still be problems with complying with Condition number 6?

MR. NORWAY: Objection, vague. You may answer.

THE WITNESS: There are, in that the virally suppressed individual still possesses virus within them; it's just not active.

So, in the context of a direct transfusion, i.e. my blood directly going into somebody else's body, if I'm HIV infected, even if I'm virally suppressed, my blood has virus that is incorporated into the genetic code of the remaining cells, and though that would be difficult to transmit in the context of a sexually transmitted infection or, say, a tattoo, or just kind of a transient exposure, the exposure load from a direct transfusion or from direct blood to blood contact is -- even in the context of somebody virally suppressed, it still represents a risk.

BY MS. BAUER:

Q Condition number 8 says:

"The medical condition does not prohibit required theater immunizations or medications."

Am I correct that you testified earlier this

asking for his recollection of these things. I am looking for the answer actually, so --

MR. NORWAY: I am just asking if the questions that you intend to pose are in the nature of a hypothetical.

MS. BAUER: I don't think so --

MR. NORWAY: Okay.

MS. BAUER: -- but --

MR. NORWAY: Okay.

BY MS. BAUER:

Q My first question, sir, is is a waiver required for a service member with Addison's Disease to deploy to CENTCOM?

A I'm not sure, honestly.

Q Okay.

A It's been a while since I've seen that one. I would have to look it up.

Q Would that question be answered by Tab 13 -- Tab A to Mod 13?

A I don't believe so.

Q Okay.

A I can scan for it, but I don't recall -- it's been a while since I've seen Addison's.

Q Okay. Have you been personally presented with any waiver applications for someone with Addison's

Disease to deploy to CENTCOM?

A I may have been. With the number we've done, we've seen just about everything, but I don't recall, honestly.

Q I take it you don't recall whether or not you've granted --

A No. I would need to look up exactly what it is before I could comment -- the named pathologies are difficult because it's difficult to interpret exactly what the underlying problem is.

Q How about asthma; is a person with asthma required to get a waiver before deploying to CENTCOM, a service member?

A It depends on the variant. Our standards require waivers for asthmatics who are exhibiting significant symptoms.

Asthma exists on a spectrum ranging from, had it as a kid and it's not really bothering you, to a violent reactive airway disease that happens frequently and results in multiple emergency room visits and potentially life-threatening situations.

Where an individual falls on that spectrum is extremely variable. We, by our policies, we address that on page 3 of Tab A, where we say that if they have a forced expiratory volume less than 50 percent of

predicted despite appropriate therapy, have required hospitalization in the last 12 months, or require systemic steroids, these are clinical definitions associated with moderate persistent asthma.

As a rule of thumb, we kind of assume that most asthmatics are going to become one degree worse on exposure to the AOR, just because we have a lot of particulate matter, our air quality is different than it is in the United States, so we factor that in.

Most asthmatics, when they come to us, the approved asthmatic waivers tend to be well-controlled with a simple hand inhaler, have had no difficulties in performing their duties, don't require an alternate PT test, and are more or less just noted incidentally to be asthmatic.

The disapproved asthmatic waivers, of which we have had a few, tend to be those associated with emergency room visits, requirements for advanced medications, multiple medications in order to control the condition, and are basically considered to be barely stabilized and subject to worsening, should they deploy.

Between those two there are individual circumstances that have to be considered, but those are the big discriminators for asthma.

Q If a service member had well-controlled asthma

but they took a daily medication, say an antiinflammatory to control it, that would not be disqualifying for deployment to CENTCOM?

MR. NORWAY: Objection, form. You may answer.

THE WITNESS: Depends on the daily medication.

Once again, we specifically mention the systemic steroids. Asthma is a respiratory disease by its nature, so it's able to be controlled with a respiratory agent, like an inhaler, that usually bodes well.

If we're going with a daily medication, it's already declared itself as a moderate variant of the condition. Most light variants or mild variants only require as-needed therapy, so if they are on a systemic steroid where they're taking daily medication that indicates that the disease is of a variant which is likely to become significantly worse and could potentially pose a risk to the service member.

BY MS. BAUER:

Q Does a service member need a waiver to deploy to CENTCOM if that service member has had a blood transfusion in the past?

A The transfusion by itself would not require a waiver unless it was in the immediate past and would be

deploy to CENTCOM?

A Yes, ma'am; any blood-borne infection that's potentially infectious requires a waiver.

Q And you have granted waivers for Hepatitis B?

A We have, yes, ma'am.

Q And what about Hepatites C?

MR. NORWAY: Objection, asked and answered. You may answer.

THE WITNESS: We've granted waivers for what we've termed as a history of Hepatites C since we don't routinely grant waivers for people who have active virus.

BY MS. BAUER:

Q What about HTLV?

MR. NORWAY: Objection, asked and answered. You may answer.

THE WITNESS: I don't recall seeing a waiver for HTLV. Given the number we've done, it's conceivable we may have done one.

BY MS. BAUER:

Q Sir, as you sit here today, is there anything that makes you think you would not grant a waiver for HTLV?

MR. NORWAY: Objection, speculation. You may answer if you can.

THE WITNESS: Simply its nature as a potentially infectious blood-borne agent similar to the other potentially infectious blood-borne agents.

BY MS. BAUER:

Q What about tattoo; does a service member with tattoos require a waiver to deploy to CENTCOM?

A Not for medical reasons. There are service policies governing tattoos as an administrative feature.

Q What do those policies provide?

MR. NORWAY: Objection, scope.

THE WITNESS: I am not up-to-date with them. However, they are geared around the proper military bearing. Usually tattoos that extend beyond the wrist or the neck such that they are visible when the traditional service uniform is worn, these are not health-related policies; they are geared towards appearance and military bearing.

BY MS. BAUER:

Q Okay. What about service members who have taken human growth hormone; do they require a waiver to deploy to CENTCOM?

A I would say yes. Those would be in the class of -- if you look at Tab A on the medications, we name androgens and anabolic steroids as one of our controlled

policies to bring them in line with what we're actually doing so that our deploying providers, be them uniformed or civilian, have a reasonable expectation of whether they will be approved or not, and can plan appropriately.

These are -- so we have been planning Mod 14 literally since Mod 13 was published, and we actually started drafting it about six months ago. These usually take about a year to put together and properly staff. We've not yet staffed it, so it will still be a while before it is published.

Q Is there an expectation of when it would be published, Mod 14?

A Unfortunately, we consider that the Mod 13, while flawed, is adequate, and so it is not the generation of new policy is not prioritized against more immediate things, including answering the waivers for soldiers that are waiting to deploy very quickly, so it is on my list of things to do, and we've been working on it, consulting with our different agencies and partners since about last June.

I hope to have it done soon, but we still have to staff it. It still has to be approved by both my leadership and the component surgeons, then we usually will reach out to the joint staff and to the service --

actual uniform services to ask for their input to make sure that we are basically more or less reaching a consensus.

Q Is there an average length of a deployment for a service member to CENTCOM?

MR. NORWAY: Objection, vague. You can answer.

THE WITNESS: So, the -- there is, but it's just that; it's a genuine average, in that there are those that go longer, there are those that go shorter, and the answer depends greatly on where in the AOR you want to go, and what operation you are supporting.

Typically, the answer would be nine months to a year, is the generic one size fits all answer. All that said, we do see a number of six-month deployments to certain locations, and we still see 15-month deployments.

BY MS. BAUER:

Q And is that true across services, or does the length of a deployment vary by the service?

MR. NORWAY: Objection, scope. You may answer.

THE WITNESS: It does vary by service; having more to do with operational factors than a genuine,

this is just how we do it mentality. It has to do with how rapidly we can push a force out.

There is significant disruption when we turn forces over in theater, so once we get a force successfully inserted and up and running, we like to leave them there as long as practical.

Additionally, while one unit is deployed, another unit is resting and refitting, so if you try to turn too quickly, you end up burning the candle at both ends, so to speak.

This is all operational and planning consideration. It's -- really, medical follows the rest of the force, so if the combat arms forces are moving in and out, the medical forces are moving in and out with them.

So to an extent, we don't really on the medical side have a say in that, although we will sometimes have to factor in the length of deployment, especially with surgeons with highly specialized medical personnel, as far as staffing those billets and providing those personnel to those capabilities.

BY MS. BAUER:

Q And the service members deployed to CENTCOM, do they get leave days during their deployment?

MR. NORWAY: Objection, scope. You may answer.

THE WITNESS: It's according to higher policy. Typically we like to give what we call R and R, rest and relaxation.

There are provisions; I am not familiar with the modern iterations of those provisions, and even then, it is an as allowing provision; if circumstances allow, you are supposed to do it.

If you are in sustained kinetic operations, then we're not going to cut somebody loose so they can go on leave. It's going to be -- it's really going to be up to the local commanders and more of a battlefield issue.

BY MS. BAUER:

Q And, as I understand, when a service member deploys to CENTCOM and is required to take a daily medication, they are told to take a 180-day supply with them on the deployment?

A With the exception of the controlled substances, yes.

Q And do they get one big bottle of the 180 days worth of medication or two bottles with 90 days?

MR. NORWAY: Objection, form. You may answer.

THE WITNESS: It depends on the filling

VIDEOGRAPHER: We are off the record at 3:09.

(A short recess was taken.)

VIDEOGRAPHER: We are back on the record at 3:28 p.m.

BY MS. BAUER:

Q Lieutenant Colonel Cron, can you tell me, what is the effective status of agreements on host nation restrictions?

MR. NORWAY: Objection, vague. You may answer to the extent you know.

THE WITNESS: The status of forces agreements are, to my knowledge, the agreements which we form between the United States Government and the governments of countries in which we have operations outlining to what extent their laws will affect US service members, and I believe outlining the arrangements made in the event those laws are violated.

I'm not exactly familiar. Those are planning documents usually held in high levels of security to which I'm not privy.

BY MS. BAUER:

Q Okay. The status of forces agreements are in high level --

A I believe so, yes, ma'am. And the reason for

that is that they typically delineate force placement lay down and allocation, so it's not the type of information that you would want readily available to anyone. It's very, very need to know.

Q Okay. Certainly isn't the type of information if I went to Google, I wouldn't pull up the status forces agreements?

A Absolutely not. If you do, let me know.

Q I doubt I will try.

Do you know what percent of service members who are currently deployed to CENTCOM, do you know what percentage of them are ineligible to donate blood under the Armed Services blood program medical conditions list?

MR. NORWAY: Objection, scope. You may answer to the extent you know.

THE WITNESS: I do not know.

BY MS. BAUER:

Q And do you know what percentage of the Armed Services members currently deployed to CENTCOM are ineligible to donate blood under the Red Cross' blood donation guidelines?

MR. NORWAY: Objection, scope. You may answer if you know.

THE WITNESS: I do not know, and I don't know

if that information is readily available. We only do limited screening currently prior to deployment. This is one of the things we're also discussing in terms of modifying our deployment criteria.

BY MS. BAUER:

Q Are you familiar with the HHS' current guidelines on the treatment of HIV?

MR. NORWAY: Objection, scope. You may answer.

THE WITNESS: I am not. That's outside my typical scope of practice.

BY MS. BAUER:

Q Going back to deployment waivers; do men who have sex with men require a waiver to deploy to CENTCOM?

A Not unless they required it for some other reason. We don't -- that's not considered a medical condition, and therefore we would have no reason to know that unless it was part of a medical discussion of some kind.

Q It's not information that's asked for when deployment decisions are being made?

A Not that I'm aware of.

Q Are you aware of any documented case of the transmission of HIV through wound to wound contact, as you described earlier today?

designation anymore.

BY MS. BAUER:

Q Has the new waiver authority for CENTCOM been selected?

A We have an individual who is similarly identified but not on orders for the same reasons I am not on orders, and, actually, going to an overseas lab, I actually have priority for order generation, so he's even further down the priority list than I am. I believe I have an individual; I don't want to put the name out there just yet because that's obviously subject to change.

Then, additionally, we have had a staff rearrangement at CENTCOM, such that we are having a new individual come into the staff who is an Air Force flight surgeon. We are not certain yet how those two individuals will split up the workload. That's up to the surgeon when they -- they basically just see who comes in and who's most appropriate for the position.

MS. BAUER: Thank you. I have nothing further.

MR. NORWAY: Thank you very much. We will read and sign.

VIDEOGRAPHER: This is the end of media unit number three and concludes the deposition of Kevin

Cron taken on 15 March 2019. We are off the record at 3:41 p.m.

(The taking of the deposition was concluded at 3:41 p.m.)

CERTIFICATE OF OATH OF WITNESS

STATE OF FLORIDA)
) SS:
COUNTY OF HILLSBOROUGH)

I, KIM AUSLANDER, Registered Professional Reporter, Notary Public in and for the State of Florida at Large, certify that the witness, KEVIN CRON, personally appeared before me on March 15, 2019 and was duly sworn by me.

WITNESS my hand and official seal this 15th day of March, 2019.

KIM AUSLANDER, RPR
Notary Public, State of Florida
at Large

Notary #GG286991
My commission expires: 1/10/2023

REPORTER'S DEPOSITION CERTIFICATE

I, KIM AUSLANDER, Registered Professional Reporter, certify that I was authorized to and did stenographically report the deposition of KEVIN CRON, the witness herein on March 15, 2019; that a review of the transcript was requested; that the foregoing pages numbered from 1 to 212 inclusive is a true and complete record of my stenographic notes of the deposition by said witness; and that this computer-assisted transcript was prepared under my supervision.

I further certify that I am not a relative, employee, attorney or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorney or counsel connected with the action.

DATED this 15th day of March, 2019.

KIM AUSLANDER

Registered Professional Reporter

Veritext Legal Solutions
1100 Superior Ave
Suite 1820
Cleveland, Ohio 44114
Phone: 216-523-1313

March 21, 2019

To: Robert Norway

Case Name: Harrison, Nicholas, et al. v. Mattis, James N., etc., et al.
Veritext Reference Number: 3246683
Witness: Kevin Cron Deposition Date: 3/15/2019

Dear Sir/Madam:

Enclosed please find a deposition transcript. Please have the witness review the transcript and note any changes or corrections on the included errata sheet, indicating the page, line number, change, and the reason for the change. Have the witness' signature notarized and forward the completed page(s) back to us at the Production address shown

above, or email to production-midwest@veritext.com.

If the errata is not returned within thirty days of your receipt of this letter, the reading and signing will be deemed waived.

Sincerely,

Production Department

NO NOTARY REQUIRED IN CA

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3246683
CASE NAME: Harrison, Nicholas, et al. v Mattis, James N., etc.
DATE OF DEPOSITION: 3/15/2019
WITNESS' NAME: Kevin Cron

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have made no changes to the testimony as transcribed by the court reporter.

19 Apr 2019
Date

Kevin Cron

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal this 19th day of April, 2019.

Notary Public

23 June 2022
Commission Expiration Date

Staff Judge Advocate Department of Defense NOTARY PUBLIC Title 10 US Code 1044A

BRENT W. JOHNSON, SSgt, USAF
Paralegal

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3246683
CASE NAME: Harrison, Nicholas, et al. v Mattis, James N., etc.
DATE OF DEPOSITION: 3/15/2019
WITNESS' NAME: Kevin Cron

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

19 April 2019
Date

Kevin Cron

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They have listed all of their corrections in the appended Errata Sheet;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal this 19th day of April, 20

Notary Public

23 June 2022
Commission Expiration Date

Staff Judge Advocate Department of Defense NOTARY PUBLIC Title 10 US Code 1044A

BRENT W. JOHNSON, SSgt, USAF
Paralegal

ERRATA SHEET

VERITEXT LEGAL SOLUTIONS MIDWEST

ASSIGNMENT NO: 3/15/2019

PAGE/LINE(S) / CHANGE /REASON

Attached Separately (2 pages)

19 April 2019 _____

Date Kevin Cron

SUBSCRIBED AND SWORN TO BEFORE ME THIS 19th

DAY OF April, 2019 .

_____

Notary Public BRENT W. JOHNSON, SSgt, USAF Paralegal

23 June 2022

Commission Expiration Date

Staff Judge Advocate Department of Defense NOTARY PUBLIC Title 10 US Code 1044A

Attached Errata (Page 1 of 2)

PAGE/LINE(S)	CHANGE	REASON
10/13	Should be "...Institute of Research, in Preventive Medicine, in..."	Transcription error
10/21	"preventative" should be "preventive"	Semantic change
11/5, 17, 20, 21, 25	"preventative" should be "preventive"	Semantic change
12/3	"preventative" should be "preventive"	Semantic change
12/14	"working with comp" should be "workmens comp"	Transcription error
13/10	"preventative" should be "preventive"	Semantic change
14/19	"sit" should be "sick"	Transcription error
15/5, 23	"preventative" should be "preventive"	Semantic change
15/7, 9	"Combat and Command" should be "Combatant Command"	Transcription error
24/17	"Combat and Command" should be "Combatant Command"	Transcription error
30/18	"met" should be "limit"	Transcription error
32/17	"preventative" should be "preventive"	Semantic change
33/6, 9	"preventative" should be "preventive"	Semantic change
33/22	"Combat and Command" should be "Combatant Command"	Transcription error
34/1,5,6	"Combat and Command" should be "Combatant Command"	Transcription error
35/5	"Combat and Command" should be "Combatant Command"	Transcription error
40/2	NAVCENT should be AFCENT	Error
51/7-8	"I'm here not just as" should be "I'm here just as"	Error
51/9	"Combat and Command" should be "Combatant Command"	Transcription error
58/5	"Combat and Commander's" should be "Combatant Commander's"	Transcription error
58/19, 20	"Combat and Command" should be "Combatant Command"	Transcription error
59/9-10	"Combat and Command" should be "Combatant Command"	Transcription error
59/21	"Purilla" should be "Kurilla"	Name error
60/7,11,12,13-14,24	"Combat and Command" should be "Combatant Command"	Transcription error
62/10, 11-12	"Combat and Command" should be "Combatant Command"	Transcription error
63/16,21	"Combat and Command" should be "Combatant Command"	Transcription error
66/19	"own" should be "only"	Transcription error
70/16	"Vivant" should be "Vyvanse"	Name error
79/14,15	"Combat and Command" should be "Combatant Command"	Transcription error

Signed 14 April 2019

80/20,21,22	"Combat and Command" should be "Combatant Command"	Transcription error
81/17,24,25	"Combat and Command" should be "Combatant Command"	Transcription error
82/20	"Combat and Command" should be "Combatant Command"	Transcription error
87/11,16,22	"Combat and Command" should be "Combatant Command"	Transcription error
88/5	"Combat and Command" should be "Combatant Command"	Transcription error
89/4,11,15	"Combat and Command" should be "Combatant Command"	Transcription error
90/3,8	"Combat and Commanders" should be "Combatant Commanders"	Transcription error
103/7	"win with" should be "whim of"	Transcription error
123/5	Possible missed speaker break starting with And	Possible speaker change
124/9	"remission" should be "the mission"	Transcription error
126/20	"hadn't" should be "had"	Error
126/22	"disagreement" is a bad choice of words. Should be "waiver denial"	Misstatement
127/24	"Combat and Command" should be "Combatant Command"	Transcription error
156/13	"prevents" should be "presents"	Error
162/17	"Combat and Command" should be "Combatant Command"	Transcription error
163/18	"Combat and Commander" should be "Combatant Commander"	Transcription error
164/12,14	"Combat and Commands" should be "Combatant Commands"	Transcription error
165/16	"Combat and Commands" should be "Combatant Commands"	Transcription error
170/5,12	"Combat and Command" should be "Combatant Command"	Transcription error
195/7	"bulk" should be "balk"	Transcription error
204/6,7,9,17	"Combat and Command" should be "Combatant Command"	Transcription error

Signed 19 April 2019

H Tar

EXHIBIT 22

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Alexandria Division

RICHARD ROE, et al. Plaintiffs vs. PATRICK M. SHANAHAN, et al. Defendants	Civil Action No.: 1:18-cv-01565

NICHOLAS HARRISON, et al. Plaintiffs vs. PATRICK M. SHANAHAN, et al. Defendants	Civil Action No.: 1:18-cv-00641

Deposition of
COLONEL CLINTON K. MURRAY, M.D.
Washington, D.C.
Tuesday, April 30, 2019
9:30 a.m.

Reported by: Laurie Donovan, RPR, CRR, CLR

Deposition of

COLONEL CLINTON K. MURRAY, M.D.

Held at the offices of:

Winston & Strawn

1700 K Street, NW

Washington, D.C. 20006

(202)282-5000

Taken pursuant to notice, before Laurie Donovan, Registered Professional Reporter, Certified Realtime Reporter, and notary public for the District of Columbia.

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ALSO PRESENT: Major S. Casey Biggerstaff, Esq.

EXAMINATION INDEX

E X H I B I T S

things such as diarrhea aren't, aren't capable of being used as a biological warfare agent. So you can see scenarios where someone could potentially use HIV as an instrument to deliver biological warfare agent on the battlefield.

So, for example, if I load an IED with discarded needles and blow up that roadside bomb, and the needles all fly through -- whoever is in those vehicles will get hit with those. If you're obtaining those needles from an HIV clinic, then if that's all purposefully done, then it can be used as a biological weapon.

Q To your knowledge, has it ever been used in that way?

A So IEDs loaded with needles have been used. Loaded with HIV? Not that I know of.

Q And has there ever been a documented case of HIV transmission from a found needle?

MR. NORWAY: Objection. Vague.

You may answer to the extent that you know.

THE WITNESS: So it's a little bit more complicated than that. Just a needle sitting there, no. A needle sitting there with, with blood that's not contaminated with

HIV, no, but if you transition from that needle, large quantity of HIV goes straight from one person to another, then you're starting to get the higher and higher risk of transmitting.

So it really is where are you on that continuum of nothing in the needle to a very, very fresh sample goes straight from one person to the next.

BY MR. SCHOETTES:

Q But in terms of a found needle --

A A found needle? I'd have to pull the literature to say absolutely no, but I feel comfortable the current post-exposure prophylaxis guidelines do not recommend post-exposure prophylaxis for a found needle, which just means the risk is very low.

Q And you said that HIV would not be in the top tiers of biological warfare agents; is that correct?

A Correct.

MR. NORWAY: Objection to the extent it mischaracterizes the testimony.

You may answer.

THE WITNESS: Correct.

BY MR. SCHOETTES:

Q They are unlikely?

A Correct. So these folks would set up in a tent, in an old, abandoned building. They would not be using any environment that someone would associate with a normal operating room.

Q But they do use gloves?

A Correct, but you have as many gloves as you have, so in contrast to a combat support hospital or a normal forward surgical team where your supplies on the shelf are reasonable -- limited, but reasonable -- they're going to have very limited options.

So more than one case becomes an issue. Any destruction of a glove becomes a substantial issue, because you're not going to have six and seven extra pair, and then typically you hope you're using sterile gloves. That's the goal. Those team members frequently do not all wear the same sizes, so you really are just sort of losing weight and cube again as you expand those teams out.

Q What do they use for antimicrobial protection?

A Correct. The recommended battlefield

antibiotic is ancef, cefazolin, and ertapenem. One of those is a once-a-day, so you're pretty good. The other one can be infused every eight hours. So you have enough time to work within that, and they come in incredibly small (inaudible).

Q And so those are provided to the patient, correct?

MR. NORWAY: Objection. Form.

You may answer.

THE WITNESS: They're brought in the kits at the time the patient arrives for care. They will put in an IV and infuse the antibiotics, correct, and those antibiotics are the field antibiotics, so everyone, whether you're at a forward surgical team or a combat support hospital or in these incredibly small teams, are all using the same antibiotic choices.

BY MR. SCHOETTES:

Q Do they attempt to sanitize their hands?

A They would use alcohol hand gel, but they would not have the sink where you can wash your hands for two, three minutes, which is sort of recommended pre-OR, or if you get splash on you

or a needlestick, that would not be available at all in that environment.

Q And what was your job during this two weeks of overseeing the work that was -- that you just described?

A So the Army works upon this concept called "doctrinally-based." Everything we do in the Army is doctrine-based, so the CSH is a doctrine-based organization. The forward surgical team is a doctrinally-based organization. So it's a combat support hospital forward hospital team.

This team is non-doctrinally-based, so the assessment was to see if it could be incorporated into a doctrinally-based program, and what were the constraints, limitations, strengths, weaknesses of this team was my marching orders from the two-star who told me to go to Afghanistan.

Q Can you explain to me what it means to be doctrinally-based?

A Correct. So large documents say a CSH has 498 people, it has four ORs, it has this type of equipment, it has this type of medicines, it has this many ICU nurses, so it's very regimented. When the Army says I want a CSH, they get a CSH,

asking for something that is defined by the Army.

Q Does every doctrinally-based entity, medical entity have the same formulary as the other entities within that category?

A So every area support medical company would have the same sets and kits with the same things in them. Every battalion aid station would have the same kits and the same thing in them. Every combat support hospital would have the same kits.

When you get to theater, you can ask for something unique. So, for example, the kits do not have certain anti-malarial medicine, so if I'm going to send you to Africa, there's got to be a specific plan of how I'm going to get you that drug, and how I'm going to train you on that drug, and how I'm going to train all these other folks that are going to support that event. So then it becomes that one-off conversation that we have.

Q For a particular theater?

A For a, for a specific threat or a specific capability, right. So if, if we're going to Liberia, that is a very different threat problem than to go to Kenya. The medicines are a little bit different, HIV-1 versus HIV-2, so, you

know, little subtle differences are important to recognize between those two theaters.

So if it's doctrinally-based, I can't answer both of those. Those would have to be special engagements, special requests, special logistics, special training, that whole man/train/equip/develop/sustain. So all of those pieces we talked about that commanders are responsible for go into all of these requirements that are not standard.

Q So I'm just trying to make sure I understand this, but a battalion aid station is going to have the same thing, whether it's in Iraq or Africa?

A The kit they show up with would be the same, and then I augment it with anything that is specific for that either theater, region, patient population, risk factors --

Q Got it.

A -- which in a, in a very mature environment like Iraq and Afghanistan, that's easy to do. In a very immature theater, just the words we use, injury ops, just going in like I did in Ramadi -- I mean we ran out of Motrin for six weeks and couldn't get resupplied. That's the

candy for soldiers, and we couldn't get resupplied.

It just gives you a picture contrasting what we see in Iraq and Afghanistan, absolutely not what you see early on in a fight or really in a near-peer fight, which is not what Iraq and Afghanistan are, where you really are logistically constrained. So if it's not in that kit, you may struggle actually getting it into that kit at a later date.

Q Can you explain to me the term "near-peer"?

A So near-peer currently is being referred to as Russia, China, Korea.

Q So I think I have a sense from those examples, but can you describe what you -- what the term "near-peer" means?

A So their weapon systems, their personnel, their training, their equipment is par, potentially better, potentially a little less than our training, equipping, manning, so that if there is a fight, you might not have air superiority, you may not have sea superiority, you may not have ground superiority.

You may have -- from a medical

forgot to take my malaria drugs for basically four days. So I'm an ID doctor. I should never forget to do that.

So, you know, just that environment of care just showed you what a challenge it can be to actually remember to do all the things you're supposed to do, so . . .

BY MR. SCHOETTES:

Q And that was a result of specifically the circumstance with the coup?

A Correct, to the point -- we had a dugout pool area with a fence above it, so we sat by the pool. The AK-47 rounds were going above your head, and the pool was dug out low enough that you weren't going to get shot. If you went up to your room, the AK-47s and the RPGs were flying through our windows. So you weren't necessarily going back up to your room to get anything, and there was a fair bit of stress. You just forget to sort of do things.

And then I could talk if you'd like -- so a lot of combat-related injury/infection research, which not only does it just talk about point-of-injury care and antibiotics, and then as the casualties move back to the evacuation system,

Iraq and Afghanistan to Germany, and then back to the States, what complications they had, part of all of that research was ensuring that we looked at other modalities to improve survival rate, so don't let your patient get too cold. Bad outcomes. Don't let them get too acidotic. Bad outcomes.

When I was deployed and when I came back, one of the big conversations we were having was all about fresh whole blood and the walking blood bank, so really before '03/'04, the blood bankers were -- you get component therapy, which means packed red blood cells or platelets or FFP. When we went downrange, you could get packed red blood cells. They have a shelf life of about 42 days. You want them within 14 days. That's the best for delivering oxygen. We couldn't get the packed red blood cells within 14 days, so we were trying to figure that out.

You can't actually collect -- you can't ship platelets in theater. You have to collect them locally. They didn't have a machine to collect them. So now all of a sudden, you have old packed red blood cells, you have platelets not available, and then the last part at the top that

helps mortality, because this is all bleeding out, there's something called fresh frozen plasma, which are all the clotting factors that sort of fit between the platelets so you don't bleed out. And it's frozen, so it's got to get to you frozen.

So it's got to go from Germany to these logistical hubs, from these logistical hubs, push forward to combat support hospitals, push forward from combat support hospitals down to forward surgical teams. As part of that continuum of care, we were ineffective at getting probably the right packed red blood cells, we were ineffective at getting platelets at all, and we were not getting fresh frozen plasma frozen.

So there's lots of historical literature from really The Great War, World War II-ish, where in the sense of The Great War of learning for combat casual care and then some experiences in Viet Nam with fresh whole blood was really good on the battlefield, plasma and fresh whole blood.

So a couple surgeons started using a lot of fresh whole blood, and they started doing studies that showed it was safer, better outcomes -- all retrospective studies, you can't do controlled trials here. So either you do

component therapy, which is one unit of packed red blood cells and a six-pack of platelets, which is six units put together, and then a unit of FFP. If you have all of that, that's really good, but fresh whole blood is probably still better.

So as all of that was growing and maturing, we were engaging me because of lots of trauma experience on the battlefield, lots of the surgeons that were doing the research, we were trying to figure out what do we do to make sure this is safe as possible.

So they had started using rapid diagnostic kits in the CSH in Baghdad. They just ordered them off the street, brought them back and said do these work, and Robert O'Connell, one of the infectious disease doctors, assessed those kits for hepatitis B, hepatitis C, and HIV, and showed they had sensitivities and specificities of 20 to 40 percent. So we're ineffective picking up those pathogens in a blood bank.

So lots of effort went into trying to find the right rapid diagnostic for hepatitis B, hepatitis C, to go along with building the process of fresh whole blood collection and then infusion. So you're eventually able to find a rapid kit for

each of those, at least for HIV. It is not FDA-approved for screening of personnel for transfusion, so even today it's not FDA-approved for collecting blood for donor, so it's not there.

In addition, there was lots of studies that this doctor was doing, along with other folks in the States that were showing someone that may be freshly infected and freshly initiated on therapy, but probably definitely anyone that had been on multiple regimens of HIV, those rapid kits were giving a false negative result.

So someone known to be infected with HIV, known to be on medicines, when their blood was tested, it gave a false negative. So even the current OraQuick HIV test that we use now has that same restrictions that someone that is HIV-infected, if they're on therapy, can result in false negative results.

Q From that -- I'm just going to pause you here. That's from that kit that is not FDA-approved?

A So it's FDA-approved for these things. What it's not approved for, blood donors.

Q And maybe we can pause there, because I may have some questions that I want to ask

Q If you flip to slide 30, which is the one labeled "Walking Blood Bank," there's a reference to a known transmission of HCV and one of HTLV, and then in the box at the bottom, you stated that "the HCV case was from a known HCV-infected service member who donated anyway."

MR. NORWAY: Objection.

There's no question pending.

Sorry.

BY MR. SCHOETTES:

Q How do you know that to be the situation?

A So both the hepatitis C transmission and the HTLV transmission were associated with an epidemiological look-back to figure out how that occurred. The patient -- let me pause for a second.

When that unit of blood is obtained from a soldier in a walking blood bank, it's labeled. Tubes are obtained. The unit is still given to the patient, but the tubes are sent back to a testing center in the U.S. to validate if they have the classic transfusion-transmitted complications of a unit, because you can't do that downrange.

referring to.

BY MR. SCHOETTES:

Q And so you're saying "Ever Viral Suppression" means that the people within that category have achieved viral suppression at some point after their diagnosis and being on treatment, correct?

A So there are elite controllers that might be able to suppress their virus. I can't tell you if they are in that mix or not, but yes, on the vast majority of cases, it would be diagnosed with HIV, therapy initiated, and when did their viral load get below the lower limit of detection for the assay being used.

Q And for the cohort with an HIV diagnosis between 2012 and 2016, the percentage of people who have ever achieved viral suppression is 99.8 percent; is that correct?

A Correct.

Q That means 998 out of 1,000 people who have been diagnosed with HIV during that time period would have achieved viral suppression?

MR. NORWAY: Objection. Form. Mischaracterizes his testimony.

You may answer.

THE WITNESS: Is there a question?
BY MR. SCHOETTES:
Q Yes. Does that 99.8 percent indicate that we're talking about only two out of 1,000 individuals would not have achieved viral suppression?
A Correct.
Q The next column is "Viral Suppression Within Six Months of ART Initiation."
Can you just tell us what "ART" stands for?
A Antiretroviral therapy.
Q And this shows that approximately 75 percent of people diagnosed with HIV between 2012 and 2016 achieved viral suppression within six months; is that correct?
A Correct.
MR. NORWAY: Objection.
Foundation.
You may answer.
THE WITNESS: Correct.
BY MR. SCHOETTES:
Q It says here at the bottom, "Viral suppression has occurred with 90 plus percent of service members becoming virally suppressed ever

and by one year, accounting for newer ART regimens."

First of all, did you create this entire slide, or is this data pulled from another source?

MR. NORWAY: Objection. Form.

You may answer.

THE WITNESS: So the infectious disease clinical research program is a USUHS NIH, NIAID program that looks at the care of HIV service members in our facilities. The director of that program is Dr. Agan, who provided this information to us.

BY MR. SCHOETTES:

Q And this slide says that it's "data censored February 22, 2019."

What does that mean?

A So, for example, someone that enrolled in 2002 would have 17 years' worth of data through 2019. Someone enrolled in 2016 would only have three years of data in 2019.

So when you look at outcomes, complications, errors, errors like time windows of therapy, time windows of diagnosis, you have to incorporate the bias associated with the group being followed for 17 years versus the bias of the

group being followed for three.

Q And so does that indicate that all of the people covered by this slide as having been diagnosed with HIV are still in the Army?

A No. What it means is if you were still enrolled in the study, still being followed up, then we stopped at 2019. If, on the other hand, you enrolled in the study in 2002 and you decided to not be in the study in 2011, your individual data would have nine years' worth of information in it. The "you" is the individual that got out after nine years, censored yourself at nine years.

Q So that data is still included for people who exited the study after whatever period of time, say nine years?

A Correct.

Q Did you add this statement to the bottom of this slide, or was this provided by Dr. Agan?

A That's my addition.

Q So can you tell me where the data for the "and by one year" comes from in that statement?

A So I think if you look on the next slide, the bottom right figure, if you look at the time course in months, you can see that marches

out to 12 and a half months, and you can see the various time-depicted lines for all basically at a one or close to 100 percent by one year.

Q So going back to the slide previous, is it true that not only is viral suppression at 90 plus percent for people at one year, but indeed it is almost 100 percent by first year?

MR. NORWAY: Objection. Form.

You may answer.

THE WITNESS: I would use the caveat almost as you did, so plus or minus five percent, yes.

BY MR. SCHOETTES:

Q And I don't think I heard me use "plus or minus five percent," so I'll ask you why that is the interval -- well, obviously, it couldn't be plus five percent, but why that is the interval you would use to describe it as "almost 100 percent."

MR. NORWAY: Objection. Form.

THE WITNESS: Because I can't see the data, so I, I give it a statistical error of .05 percent, which is five percent, which is my sort of pat answer for a question when you're starting to look at numbers. I think

When they sent that blood back, it was identified as hepatitis C. Occasionally those tubes of blood don't make it back, so we follow folks who get a non-FDA-approved unit of blood, which means they didn't go through the standard testing. Those patients are then monitored, and it moves a little bit, but it's mostly at three, six and 12 months after coming back.

They draw their blood, they test them for hepatitis B and C and HIV, and based upon their epidemiological risk factors, that patient may be tested for malaria, may be tested for syphilis.

So the hepatitis C patient's blood was identified as positive, the donor. The person who received it did develop hepatitis C infection. That hepatitis C soldier, when his boss -- I don't remember if it was a platoon leader or a company commander -- was injured, he was taken to a remote forward surgical team. He absolutely needed blood. They did not have enough on the shelf, so they asked for an emergency walking blood bank.

This soldier is one of his soldiers that was out with him when he had his severely traumatic injury. He and other soldiers with him

that were part of this leader's unit all donated blood.

This soldier actually knew he had hepatitis C. Somewhere it got lost in translation that you don't donate blood with hepatitis C, what hepatitis C is. The person that was receiving the unit didn't understand what was going on. So somewhere there was a break in that understanding of what hepatitis C is.

Q So let me ask a follow-up question. Does the Army knowingly deploy individuals -- let me back up.

Did the Army know that this individual had HCV?

MR. NORWAY: Objection. Form.

You may answer.

THE WITNESS: I don't know that specific question. Army regulation says no one with hepatitis B or hepatitis C can deploy without a waiver.

BY MR. SCHOETTES:

Q So that was my next question. So the Army does not deploy, without a waiver, an individual who has hepatitis C?

A However, they don't screen for hepatitis

to 95 percent are protected, so pretty much all babies get immunized against hepatitis B and have been for, gosh, a couple decades now. Soldiers entering the Army have been immunized against hepatitis B since 2002. So 95 percent, 90 to 95 percent effective vaccine, right?

If I -- say I'm not protected, vaccine didn't take, I'm part of that five to ten percent, and I get exposed to hepatitis B, 95 percent of the time I will clear it and it will not be a chronic infection.

Hepatitis C, its infection rate is higher, 30 to 70 percent. Hepatitis C is not -- hepatitis C, there's genotype 1, there's genotype 2, genotype 1b, so there's lots of subtleties. These are different across ethnicities and race. They're different across exposures.

So in addition is the infection rate is potentially different. There's now a therapy, based upon genotypes, that's 70 to 90-plus percent effective, which, again, contrasting with HIV, there is no cure, there is no vaccine. There is incredibly effective therapy, incredibly effective therapy, but the problem sets across a B to a C to an HIV are different.

Where I was, there was no one else to do it but me. I'm one deep. So if you're one deep, there is no capacity and you got a capability. So that becomes an issue when you're trying to make those decisions.

If the risk is high enough, the CDC says if you're a surgeon, you get a needlestick, you should break surgery, you should wash vigorously, you should start PEP. It also says you should call an expert in PEP, an infectious disease doctor or equivalent, for recommendations on current PEP recommendations or protocols.

What is currently recommended in the PEP system is Truvada and raltegravir, and Truvada is once a day, raltegravir is twice a day.

So now I have to know do I have those, do I have a kit that I could test this soldier that's on the table for HIV. It takes 20 minutes. Post-exposure prophylaxis says don't wait for tests. Take the drug now if you have it.

What we struggle with and historically have always struggled with is should I take the regimen of the person that I got stuck with, if their viral load is zero, then I'm likely going to keep protecting myself. Close to zero. If they

So in a place like Iraq where I got my needlesticks, and I'm inside a guy's chest cavity with my hand, and there's blood everywhere, so I feel very comfortable that there's blood now in my finger. As I look at my patient, I go I know I'm immunized against B, I'm safe. If this guy has hepatitis C, I can probably treat myself and cure myself 90 percent of the time, and if they have HIV or I'm not sure, that's the last scenario that I play in my mind before I say I'm scrubbing out, I'm going to move on, or I'm going to keep driving on.

So those were those sort of thought processes think through, either at a transfusion point, a needlestick point kind of standpoint.

Q So while we're here, what role does PEP play in your thinking in terms of the risk of HIV transmission after this relatively rare circumstance of a needlestick inside somebody's body cavity?

MR. NORWAY: Objection. Form. Objection. Foundation. Objection. Mischaracterizes the testimony.

You may answer.

THE WITNESS: I would disagree with

"rare" as a person would personally got needlesticks in a combat zone. Studies show that surgeons get sticks, nurses get sticks, large populations get needlesticks, so it is a -- I would have to define "rare," but I do not think it's rare.

BY MR. SCHOETTES:

Q Hold up just one record. All recorded?

A Mm-hmm.

Q So these are all instances that --

A No, no. I didn't tell anyone. I told no one.

Q Okay.

A And I think when you sit down and ask a surgeon, they go I rarely tell anyone I had a needlestick today.

Q Continue.

A Okay.

So yes, PEP absolutely plays a part. So if that person is there and I just got a needlestick, and I think my HIV risk is zero or close to zero, I'm going to keep going. If that risk is not zero or really close to zero, I then have to decide can I break and have someone else suture that person up.

are resistant, I probably shouldn't take their regimen. I should take someone else's.

So having an idea of what their regimen is, what their viral load is, probably what the CD4 count was, how much blood there was, hollow-bore needle, when you put all of those scenarios into the mix, you start making a decision for post-exposure prophylaxis.

And to add, so that's easy to do when you're an infectious disease doctor. That's not easy to do if you're a combat medic or a PA, because they have none of that training.

So all of these conversations we're having are very, very high-level conversations. For example, the PA, in their entire training, two years of training, gets three hours of infectious disease lectures, and that's meningitis and pneumonia, urinary tract infections, and malaria and dengue. It's not HIV.

So as you think about this problem set as an ID doctor, and then you move it off to remote units that are, that are supported by medics, these conversations are incredibly difficult and different.

Q You said that there is a recommended

course for PEP, which is Truvada and raltegravir. Isn't that the PEP regimen that's going to be used by a particular unit if it has that stocked as its PEP protocol?

MR. NORWAY: Objection. Form. Objection. Foundation.

BY MR. SCHOETTES:

Q I guess my question is: Where is the decision if there is already in place a protocol for PEP?

MR. NORWAY: Objection. Form. Foundation.

You may answer.

THE WITNESS: So that's a CDC public health recommendation. That has not been codified in Army doctrine. It wouldn't be codified in doctrine. It is not consistently codified at the facilities when you meet them and when you visit them.

BY MR. SCHOETTES:

Q Why not?

A So if the risk in your environment is low enough, that may not make it to the top of the list. Where there are so many other things you struggle with, you don't have the time to

necessarily get to everything, and it's a risk/benefit ratio.

So, for example, the four-person surgical team we talked about earlier in eastern Afghanistan, if you're going to tell them to take two bottles of medicines and be able to take them until they come home, and coming home could be two to three weeks.

Where you have a needlestick and you didn't bring the medicine or a diagnostic kit, and I can't bring you home for two to three weeks, you're buying risk. If it's a low prevalence or low area with HIV, that's a different conversation. If it becomes a higher prevalence or a known patient with HIV, then I think that conversation markedly changes.

So now I have to consider the entire logistical support, the training support, the educational support of all of those folks to make sure we do the right thing, understanding east and west Africa are different than Honduras, which is different than the Middle East.

Q And how does the viral load of the patient in this situation of potential exposure to a healthcare worker affect the analysis as to the

level of risk?

A The CDC does not talk about viral load as part of the equation for the needlestick from a known HIV-infected person.

Q When is that CDC guidance from?

A What do you mean "from"?

Q Well, you said the CDC doesn't talk about this, so in whatever you're discussing that they are talking about this in general, when is that guidance dated?

MR. NORWAY: Objection. Form.

You may answer.

THE WITNESS: So it's the most recent post-exposure prophylaxis guidelines from the CDC. I don't remember the date off the top of my head.

BY MR. SCHOETTES:

Q Is it the CDC or is it the U.S. Public Health Service?

A I think it's the U.S. Public Health Service.

Q And you say they don't talk about viral load in that document from the U.S. Public Health Service?

A When they're giving descriptions of what

that surgeon does with the needlestick.

Q But I was asking you a slightly different question. You have described all of these considerations of things that affect the risk and the analysis as to whether it is sufficient to, to warrant PEP, and I'm asking you, as the expert, how the undetectable viral load or suppressed viral load on the part of the HIV positive patient in this case would affect the risk.

MR. NORWAY: Objection. Form.

THE WITNESS: So I think we're moving through an interesting era of HIV therapy, HIV prophylaxis, HIV prevention. So if you look at the "undetectable, untransmittable" recommendation from the CDC a couple years old now, that basically said if you have someone taking their medicines as prescribed, they achieve a suppressed viral load, they maintain a suppressed viral load, then they effectively have no risk of sexual transmission of the virus to an HIV-negative partner. So huge number of caveats in that sentence.

What they don't come out and say is

for blood and body fluid, that that same conversation is applicable. So it is, it is very specific as to what the CDC's statement was in September 2017.

As such, I feel uncomfortable saying that an undetectable viral load, and even if we use the best test today, that the risk approaches zero enough not to do something with a needlestick from a known HIV-infected person; no different than sort of the pregnancy discussion of an unmeasured suppressed viral load, you're still going to get the -- the kid is still going to get treated, you're still going to maximize everything you can not to have transmission.

So I think we're in an era of the data is moving closer and closer to the transmissibility of HIV getting really unlikely in the vast majority of scenarios, but I just don't think we're there yet.

BY MR. SCHOETTES:

Q And in the case of providing PEP, it seems to me part of the calculus is the side effects are not so intolerable that it is not -- that it makes sense to provide that prevention

tool, that intervention, even if the risk is very, very, very low.

MR. NORWAY: Objection. Form. Foundation.

THE WITNESS: So there's more than just saying I put a bottle on a shelf or two bottles on a shelf to be used. You have to train folks to be able to use them, you have to maintain them, you have to sustain them, and then you have to be able to resupply them. There's an entire system --

BY MR. SCHOETTES:

Q I understand, but I'm asking a more rudimentary question, which is what you were getting to in terms of the guidance as to why you would provide PEP to someone, and your assessment that the risk isn't low enough yet to issue use of PEP. It seems to me what you're saying is, well, even if the risk is low, it may be -- you said it's approaching very, very low, we just don't know yet if it's at zero, but it seems wise to use the precaution in the meantime.

MR. NORWAY: Objection. Form. Foundation.

trying to have with the command surgeons.
BY MR. SCHOETTES:
Q So let me break this down a little bit further.
Where does the two in 1,000 for needlestick come from?
A So if you look at the site where I pulled this from, it was on there.
Q I'm sorry. The site from the page before, the slide before?
A Yeah, the Google site or the hyperlink. It's a New York City discussion of "undetectable, untransmittable," which I thought they did a very nice job of capturing really the four studies, with some subtleties within those studies, and I think they did a nice job of walking through the sharps exposure and the pregnancy discussion.
I think they were trying to do the same thing that I'm trying to do tomorrow, which is paint this broader discussion of how science, medicine, HIV is improving in the environment of a constrained or austere environment or the challenges downrange.
Q But can you now tell me what, what is the two in 1,000 or .2 percent number referring

to?

A Oh, that's transmission.

Q Transmission through needlestick in the absence of treatment?

A So the .2/.3 percent is the historical number we quote for needlestick transmission of HIV, so that's what I'm saying. So historically it's .3. Some of those folks are on therapies. Some of those folks are not on therapy. That data is very old data, '90s, so it's not been replicated. That's where that number sits.

Q Right. So then I guess what I think you're saying here is that then you would expect there to be an effect of someone on therapy and having a suppressed viral load, that would drop that to somewhere, something lower than that two in 1,000, as you've listed here?

MR. NORWAY: Objection. Form.

THE WITNESS: So that's the discussion we have. There's not enough data that backs that up. There's not enough information that backs that up. No one has gone out and said we are going to do this. You get a needlestick from a known HIV-suppressed patient. You don't have to do

anything. No one has come out and said that.
BY MR. SCHOETTES:
Q Right, and no one is ever going to do a study, right, that's going to come up with those -- you can't do a prospective study. That would be completely unethical, right, to --
A Correct. I agree with you.
Q So how do you expect to obtain data to get to the point where you would be comfortable saying the person doesn't need to use PEP after an exposure to a person with -- a needlestick exposure to a person with an undetectable viral load?
MR. NORWAY: Objection. Form.
You may answer.
THE WITNESS: So I think there's a couple of things that are going to play into that. One is: Will the various organizations out there come out and say that? So will IDSA, HIV organization, the CDC, Public Health Service, are they all going to come out and say this? Because I'm going to have to then say this is the standard across the country now, right? We have not done that. They have shifted.

broken up into this category 1 and category 2. That sort of reflects how the categories were broken up back then.

We have actually had -- I've read debates, had debates within sort of a smaller ID community of many of us who started post-exposure prophylaxis in this era, watched our patients who had a needlestick, low risk, have lots of adverse events from medicines, where those folks who were infected with HIV did not have lots of side effects with that medicine. That's been described in the literature.

So what I don't know is, as you progress forward and as you've alluded to, the drugs are less number of times per day, easier to take, less side effects, would you potentially modify this, knowing the regimens are safer than they were, easier than they were, than they were back in '08 with the regimens that were recommended.

So there's been discussions on would this get shifted today, and then you have to put on top the U equals U conversation. That's why this is, this is an incredibly complicated piece, and this is expert opinion, because we didn't walk around with blast fragments flying into folks and

randomize them into groups, so most of it ended up being expert opinion.

I will say that the casualties that we frequently see in bombings, so the Boston marathon, so a couple amputees, mostly unilateral. Our folks in Afghanistan are triple amputees. They get 250 units of blood product support within the first 24 hours, so we really are talking drastically different levels of trauma. We really are talking drastically different levels of his catastrophic injury, bone fragments flying into me. It is really different.

If you watch the images of the blast in Afghanistan or Iraq, it's truly sobering that folks live through those, but it just gives you an insight into what we're talking about from a fragment exposure issue.

Q And is there, is there the same concern around civilian populations that might blow themselves up and be of unknown HIV status?

MR. NORWAY: Objection. Foundation. Form.

You can answer.

THE WITNESS: Can you rephrase that?

carry two bottles of HIV medicines in their pocket, so it is a very different problem set out there.

If the expectation is that because that soldier is now identified as HIV-positive, and he's out on the maneuvers, that the medic -- because the medic is not always in the same vehicle they are, they can be four vehicles back, you blow up the middle vehicle, the medic can't get forward for hours, then you're buying delay, and that's not the goal. The goal is immediate.

So that's what I'm saying. This is a very complicated issue versus I have a needlestick in an OR, I walk downstairs, or I have a bombing at a marathon, and I go to two or three local trauma centers, and someone took blood from that person and it screens positive for HIV. I think those scenarios are fairly different, because the system of health in Boston is drastically different than the system of health in Ramadi.

MR. SCHOETTES: Okay. Should we take a short break?

(Whereupon, a short recess was taken.)

BY MR. SCHOETTES:

Q You can set aside what we were just looking at. I believe it's Exhibit 4, but if you would please pull out Exhibit 2, which was your expert disclosures. I'm going to ask you some questions about the topics you've identified here and what your opinions are.

The first is: What is your opinion regarding the effect of remote or austere deployed environments on the potential deployment of service members with HIV?

A I think there's some substantial constraints that impact the care of HIV-infected personnel, not only their individual care, but the system of care that supports them.

So, for example, you have to ensure that that soldier is on a regimen, is on a stable regimen, who's virally suppressed, immunologically stable, not in a window where you're still doing frequent lab follow-ups or complications associated with either the disease or medicines or behavioral health or anything else.

So I think there's criteria for them to

be successful downrange. I think there are challenges getting them downrange in the sense of ensuring they have right medicines, they have the right -- if it's a 12- or 15-month deployment, they have the right follow-up plan, whether that's follow-up personally by blood, if there's the bandwidth for communication, remote follow-up, so I think those are variable issues in the system.

And then once they're there, how do they effectively develop a similar process that allows them to be successful managing their life like they were back home, meaning it's really easy to leave your medicine next to your toothbrush so when you brush your teeth every morning, you remember to take your medicine. It's in a controlled, air-conditioned/heated room that if you run out of medicines, either you can get them back at the pharmacy you're in or they will just call them in to Walgreens, and you'll get them next door.

You've learned that your wake/sleep cycles -- when you do PT, when you go to work -- are mostly regimented until you go downrange. All those things I just described down exist downrange. So you don't have a private bath. I

literally took showers with two one-and-a-half-liter bottles for 12 months. So that system is really different, so you have to make sure they're able to manage and understand the challenges in that environment.

At the same time, they have to be able to manage their individual issues. The system has to support them. So not only does there have to be a conversation as to who is going to know their HIV status downrange, because, back home, it's their commander and probably their ID doctor and maybe no one else.

Downrange, you're going to have to decide does their immediate healthcare system support them? Do they know? Because if so, they need to have the right medicines and the right diagnostics. If it's more than their system, so the doctor and PA, is it the medic, because I'll push folks from a forward operating base to a combat outpost to something more remote to that.

So as I go down even further in the system, I go from maybe a PA to maybe a combat medic or a corpsman to no one. So what is that system of health that's going to support them? If that soldier that has HIV has any issues, who is

their reach-back system, and are they informed enough to be able to manage that care?

So whatever question comes up, can I train that -- we call them 68 whiskeys, combat medics. Can I train that 68 whiskey to manage a disease that I can tell you is barely mentioned in my internal medicine recertification book that I'm studying right now as an internist. So now I have to translate from an ID doctor to an internist to a PA to a medic.

As I'm dealing with that system, these places I've mentioned don't have electronic health records, so all of it is paper, and you don't really bring your records with you. So now there's another layer of care that is taken away, and that medic may not know what questions to ask about with Truvada and the potential renal issues with one of those drugs, in an environment where you may have two canteens a day, and that's all the water you're afforded. So in that system, he or she may not know enough to be able to effectively ask the right questions.

If I need to bring that soldier out for care, if it's a one-deep capability, someone's going to have to replace them, so now I've put

someone in the air or ground to go replace them, and someone has to wait until they come back. Same thing with the blood. You've still got to move a helicopter.

If they're a casualty, how do I communicate that they actually have HIV? That system is not there. And then each of those things I talked about are actually much more complicated. I'll give you an example.

In Ramadi, I had one soldier whose tympanic membranes were blown out because of a overpressure injury from an explosive device, and I had another soldier punch a wall because his buddy died and had a massive break in his hand. So they come and pick him up, only at night, because they wouldn't fly during the day.

Q Which one?

A Both. So two helicopters land. Both of them get into one helicopter. The other one is just there. They both take off from Ramadi, land in Fallujah. They wait there ten minutes. One takes off. It gets blown out of the sky. So you're sitting there going. The guy with the fractured hand had to leave. The person with tympanic membranes that have been blown could have

just let them heal by scarring over the next six months. Did I put someone's life at risk to move them for a non-lethal event?

So there are challenges downrange to move people or move blood that are not consistent with the U.S., and then expand that out a bit; if it's a near-peer scenario, you're not necessarily going to have air superiority, so then that whole conversation adjusts again. How would you move someone if you needed to, and how are you going to share that information across systems?

Q The last part, "share that information across systems," could you better explain that?

A So as I move those folks, I have to be able to articulate what's more important; moving this person or moving those bullets or that food, and where in that system does that priority need to be? Because it's not like I just order up an ambulance. Everything is based upon a global movement, and in Iraq and Afghanistan, global movements are okay.

So let's move off of sort of those scenarios and move to a scenario like Africa. So we have incredibly small teams that are flying across large parts of Africa, and to give you a

picture of what "large" means, so the Congo, three and a half Texases fit in the Congo, and there is no road system, so how you move in systems like that -- and because it's not Iraq and Afghanistan, they don't have the air assets that these other places do, and their resupply is measured in 10-to-14-day windows, not three to five.

So I think you just have to look at this from all of these different perspectives. You can describe similar stories for the Andes in Peru or the jungles of different countries where there's triple canopies. If there's a casualty there, how do you get them in and out of triple canopies?

Q Can you explain to me --

A Some jungles have sort of layers of craziness, and to penetrate three layers of jungles is almost impossible, so you have to sort of hike them out of a triple-canopy jungle to get them to an evacuation place. So jungles or places like this in Kenya, places like this in Congo, when you're out there walking around, trying to figure out what you're going to do with a casualty, that is a different problem set than wide open sand, a helicopter lands wherever it feels like it. I think you have to sort of put

theater, so Germany back to the States is role 4. So that's why it can be confusing.

From a hospital standpoint, the Army, the Air Force and the Navy do this a bit different. So the Army has things that are called medical centers. These are larger MTFs, typically with subspecialists, not necessarily all the subspecialists, but a pretty reasonable number of them.

And then they have something called MEDACs, and then they have large clinics and they have small clinics, so all of those systems are involved. So, for example, Walter Reed is a medical center large referral tertiary care facility. Fort Meade, 45 miles northeast of here, does outpatient surgery but no inpatient care, they have no subspecialty care, mostly primary care.

And if you go up to Aberdeen Proving Grounds, which is just north of Baltimore, 90 miles from here, a two-hour drive, they have no same-day surgery, they have limited number of personnel in uniform, and they are mostly PAs and family practitioners, with a very small pharmacy.

So my unit is at Aberdeen Proving

Grounds, so the systems of care even in the U.S. are almost sort of tiered, if we want to use that term, so sort of smaller, bigger, bigger, biggest, which is why we refer folks back to those major medical centers for their HIV follow-up every six months.

Q What percentage of service members living with HIV obtain their medications via mail-order pharmacy?

MR. NORWAY: Objection. Foundation. Objection. Form.

You may answer.

THE WITNESS: Yeah, I don't know.

BY MR. SCHOETTES:

Q Is there any reason you know of why a person who was going to deploy wouldn't be able to obtain the medications they need via mail-order pharmacy?

MR. NORWAY: Objection. Form. Foundation. Speculation.

THE WITNESS: So it depends on when you're talking about a combat zone, so for when I was there, considered entry ops, no DHL, no FedEx. We literally had mail arrive, if we were lucky, every two weeks, and they

blew up our mail truck more than once, so --
BY MR. SCHOETTES:
Q I'm asking a slightly different question. I was asking about someone, before going on deployment, obtaining their medication through a mail-order pharmacy.
A I don't know that the mail-order pharmacy will be allowed to give them 180 days worth of medicine. That may be a contract issue.
Q You think they might be limited to 90 days?
MR. NORWAY: Objection. Form. Speculation.
You can answer.
THE WITNESS: I've never used it, so I can't answer that question, but I'm not convinced they get 180 days as patients.
BY MR. SCHOETTES:
Q And you said that's by contract, you think?
A It is a DoD contract, but I can't speak much more than that.
Q But you're saying they would be able to get the 180-day supply from an actual base that had their prescription, their medications?

MR. NORWAY: Objection. Form.
You may answer.
THE WITNESS: Maybe.
BY MR. SCHOETTES:
Q So then let's go ahead and talk about the capabilities for delivery to a deployed area. Is there anything that would prevent a person with HIV from refilling, seeking a prescription refill with a large amount of cushion, if you will, so while they still have 60 days left in their medication?
MR. NORWAY: Objection. Form. Objection. Vague. Objection. Foundation.
You may answer.
THE WITNESS: So there's scenarios we're working through right now where that would not be possible for extended periods of time.
BY MR. SCHOETTES:
Q Explain what would not be possible.
A Flights of nonmilitary specific equipment into a combat zone, so --
Q For more than 60 days?
A Mail would not be being delivered for over 30 days, correct.

Q Over 30 days?
A I'm, I'm hesitant to go much further than that for other reasons. It goes back to the, the near-peer conversation of earlier.
Q But for the purposes of the hypothetical that I posed, which is could a person seek to refill their prescription with 60 days of medication left, can you explain why the potential for a 30-day delay would --
A Because we don't know what's going to happen in the next 30 days.
MR. NORWAY: Objection. Form. Speculation.
If you would just, sir, please allow me to --
THE WITNESS: Sorry.
BY MR. SCHOETTES:
Q I'm sorry. Did you finish your response?
A So the windows of time that we're discussing is -- there are certain events that have to occur that allow follow-on, less-priority supplies to get into a theater. So if the gates aren't reached in 30 days, they still may not get that after 30 days. That's what I'm saying. I

can, I can clearly describe scenarios -- not in this room -- that we're walking through that that's not an option.

Q And what is the longest period of time for which a, a delay or the lack of a flight with such supplies would be acceptable in the eyes of the military?

MR. NORWAY: Objection. Vague. Objection. Form.

I'm also going to object to the extent that you're asking him to disclose, in an unclassified environment, classified information.

THE WITNESS: So it's the same answer I gave, which is there are scenarios that we're working through for near-peer fights that would impact windows of time that medication can, as you describe, medication could be delivered, and I can't give you a far end of those days.

BY MR. SCHOETTES:

Q Because that information is classified or for some other reason?

A So classified and unknown, so it could be both.

Q So you can't put any kind of time limit on how long that delay could be?

MR. NORWAY: Objection. Form.

THE WITNESS: Correct.

BY MR. SCHOETTES:

Q Does a role 2 medical facility in a deployed environment have the capability to collect the specimens in an appropriate manner for them to be shipped elsewhere for the testing, for tests that are required by HIV follow-up care?

MR. NORWAY: Objection. Form. Objection. Foundation. Objection. Vague.

You may answer if you can, sir.

THE WITNESS: So certain tests could be done at the area support medical company, so they have, as I mentioned earlier, an ISTAT, which is sort of a hand-held device that has cartridges that could do sodium and potassium and creatinine.

There's not a good CBC test at an area support medical company. There is a dipstick for a urine, but no one would be able to sort of spin it and look at it, and they would not do lipids.

As you move off that and try to

taking care of people on the battlefield.

I mentioned earlier that if you look at what I'm reading right now to recertify in internal medicine, there is next to nothing on HIV care, current diagnosis, current therapy. The new undetectable-untransmittable, that is not in anything that I'm reading for the tests I'm taking Friday.

So to make an assumption that that knowledge is inherent in our training platforms or our sustainment platforms at an MD DO level is not currently true, because I'm living it, and as I move off where I might get a little bit of knowledge about HIV in medical school, I get even less as I move into residency, even less as I move down. The transition from MD DOs to PAs, it really starts to hit zero, and when I hit the medics, combat medics, corpsman, it really is zero.

BY MR. SCHOETTES:

Q What does "MD DO" stand for?

A Medical doctor, MD degree or a doctor of osteopathic medicine.

Q But I was asking a slightly different

question. I wasn't clear. I was talking about providing that six-month follow-up visit, which I don't think we would be asking PAs to do, or medics.

I'm talking about: Could a doctor at a role 3 medical facility who was not an infectious disease specialist provide the kind of visit necessary for that six-month follow-up?

MR. NORWAY: Objection. Form. Objection. Vague, ambiguous.

You may answer if you can, sir.

THE WITNESS: So there's no role 3 where some of our units are in Africa. There's no PA where some of our units are in Africa. There is just a medic.

BY MR. SCHOETTES:

Q I understand where some of the units are. I'm suggesting that a person could be transported to a role 3 medical facility.

Now, maybe you can tell me that there are theaters of operation in which we don't have a role 3 medical facility.

Is that, is that true?

A It is true. In addition, many of these small units are one deep, so that capability is

one deep. If that person has to be removed, that team becomes non-mission-capable and can't carry out their mission.

Q Again, I want to ask questions about that, but I guess first I just want to try to establish: Does the follow-up care -- this is a better way to ask it. Does the six-month follow-up visit require an infectious disease doctor?

MR. NORWAY: Objection. Form. You may answer.

THE WITNESS: I think it requires someone that is well-informed of the medicines, the side effects of the medicines, the laboratory assessments, the interpretation of the laboratory assessments, the issues -- you know, we can discuss neurocognition, we can discuss transmission. So all of those are part of that conversation that occurs at the six-month follow-up. It's not just let me check your labs, you're good. There's an awful lot into full body health that is involved in those follow-up appointments.

THE WITNESS: Can you, can you rephrase that?

BY MR. SCHOETTES:

Q Yeah. This helps potentially for the fact that the person is living with HIV. What type of care would you expect a medic or a PA to provide or to need to provide that they wouldn't be already equipped for?

MR. NORWAY: Objection. Form. Objection. Asked and answered.

You may answer.

THE WITNESS: So I think the PA or the medic is going to have to understand a little bit of the post-exposure prophylaxis discussion we've had, he's going to have to understand the needlestick conversation, he's going to have to understand the blood and body fluid conversation.

I think he needs to understand sexual transmission in a theater. I think he needs to understand that there can be complications from the medicines they're on that they have to maintain and monitor. I think they need to understand that there's follow-up requirements and why.

I think they need to understand if they have subtle lab abnormalities that go with that, and you have to put all of that together, because it's related to understanding the disease to be able to be successful.

BY MR. SCHOETTES:

Q So I understand the pieces about post-exposure prophylaxis. It's a little unclear to me the level at which they need to engage on that issue, but here's -- but I'm not sure. What do they need to know about the sexual transmission to provide care to this individual?

MR. NORWAY: Objection. Form.

You may answer.

THE WITNESS: So there is ongoing sexual activity downrange. We actually saw higher rates of GC and Chlamydia downrange than we did back in the States. Clearly there's pregnancy occurring downrange. We talk about this U versus U or U equals U.

If the leadership understands that there's an HIV service member downrange, there's going to be questions about all of these things, and someone is going to have to

BY MR. SCHOETTES:

Q So can you give me an example here? Are you saying that there would be sexual activity on the part of the person living with HIV, and then questions would be asked of the medic regarding whether or not he was putting other people at risk? I'm not sure I understand.

MR. NORWAY: Objection. Form. Objection. Speculation.

You may answer if you can.

THE WITNESS: Yes.

BY MR. SCHOETTES:

Q And your concern is that the medics would not understand that a person who is virally suppressed was not putting someone else at risk of HIV?

A Correct.

Q And you're saying that's a reason that you can't provide the care necessary to a person living with HIV in a deployed environment?

MR. NORWAY: Objection. Form. Objection. Mischaracterizes former testimony.

You may answer, sir.

THE WITNESS: No. What I'm saying

is there has to be a system developed that has to teach that medic and that corpsman all of the things we've been talking about. Currently that system doesn't exist.

BY MR. SCHOETTES:

Q What prevents that system from existing?

A So going back to what we talked about earlier, there has to be priorities. There's not enough time in a course to teach everything. You know, we're going to talk about how to put on a tourniquet, we're going to talk about how to do a needle decompression, we're going to talk about malaria. HIV is unlikely to bubble up to the top of that list for education.

Q What do they need to know about side effects of medications for people who are already on a viral -- have been stable on a particular regimen for some period of time? What does the -- I think you called them 68 whiskeys. What do they need to know in order to provide care?

MR. NORWAY: Objection. Form. Objection. Foundation. Improper hypothetical.

You may answer if you can.

THE WITNESS: So as we've talked

about, some of the medicines have liver toxicity, some of the medicines have kidney toxicity, some of them -- not really the ones we're using now, but it can have behavioral health issues, sleep issues, dream issues.

So they need to understand that potentially putting them on co-toxins, so a large amount of Tylenol, or putting them in a scenario where they really are having limited access to water, or putting them in incredibly stressful situations where they may not sleep for three or four days, that if that interferes with their health, they not only need to watch out for those complications in the sense of informing the patient or others that are engaged in this, but also making sure that they don't pick up any subtle events.

BY MR. SCHOETTES:

Q What do you mean when you say "events"?

A Where they really are put in a place where they're taking co-toxins that may hurt their kidneys. Dehydration and things like that.

Q And aren't the things that you described in terms of liver toxicity, et cetera, designed to

be discovered and addressed at that, at those six-month evaluations?

MR. NORWAY: Objection. Form. Foundation. Mischaracterizes the testimony.

You may answer.

THE WITNESS: As I've said, I'm now switching their scenario. Their diet is different, their sleep patterns are different, their water is different, what they drink is different, what they do on the weekend is different. Nothing is the same in a deployed environment, so to think normal in the States is normal in a deployed environment is just not the case.

BY MR. SCHOETTES:

Q Is the Army currently conducting any of those studies that I hear you saying would be necessary before the Army could deploy service members living with HIV?

MR. NORWAY: Objection. Vague. Objection. Foundation.

You may answer.

THE WITNESS: Not that I know of.

BY MR. SCHOETTES:

Q What does a unit that has one-deep

capability do when one person is killed?
MR. NORWAY: Objection. Form. Speculation.
You may answer.
THE WITNESS: They go non-mission-capable and ask for a replacement.
BY MR. SCHOETTES:
Q What was the first part of that?
A They go non-mission-capable, meaning they can't carry out their mission, and they ask for a replacement.
Q For how long could that be the situation where they are non-mission-capable?
MR. NORWAY: Objection. Speculation. Form.
THE WITNESS: Depends on the capability of the person that was lost.
BY MR. SCHOETTES:
Q How many units are one deep in capability?
MR. NORWAY: Objection. Foundation, form, speculation.
You may answer if you can.
THE WITNESS: So the small surgical

teams that I talked about earlier, every one of those is one deep, so that entire team of three to five folks is one deep. You lose one of them, I don't have a surgical team in Afghanistan.

Sniper teams are two deep. If you lose one of those two folks, you're done. EODs, explosive ordnance disposable personnel typically work in very small teams, teams of two to three, and you pull one of those folks out, it becomes non-mission-capable.

The special operations community, typically those folks are one deep. Close air support that I've seen used, that's typically one Air Force officer and a large unit. That person is out, it can have a large issue. If you're in a remote post like a combat outpost, you may have one medic. If that medic is out, you've lost your medic.

BY MR. SCHOETTES:

Q And when there is a need for a replacement into one of these units, from where does that replacement generally come?

MR. NORWAY: Objection. Vague, form, speculation.

You may answer if you can.

THE WITNESS: So, for example, if you need another medic at a combat outpost, you could reach back to a higher level of care, and frequently they have medics. So now you're going to pull one medic, put him in the air, move him over, buy some risk, and then they will do an exchange, and then that person will fly back, and then they do it again.

For other assets -- so, for example, a surgical team -- you may have someone that was in Kuwait on a CSH of three or four surgeons. They will pull that surgeon out and fly them, for example, to Syria. This has been a recent example. Lots of issues flying from Kuwait to Syria, as you can imagine, and then flying someone back, lots of issues.

So those are examples of how replacements would occur.

There's other units, special operations units that truthfully you might be getting backfill from the States, which is even longer.

compatible with deployment and may be disqualifying for deployment, absent a waiver.

A I don't think there's anything to add there.

Q Are there circumstances in which you believe a waiver for a person living with HIV to deploy to, on a contingency deployment, would be appropriate?

MR. NORWAY: Objection. Vague. Speculation.

You may answer.

THE WITNESS: Could you describe "contingency deployment"?

BY MR. SCHOETTES:

Q Probably not better than you can.

So in DoDI 6490.07, it describes conditions that are, well, that essentially require a waiver, and those deployments are called "contingency deployments." So I believe that a non-fixed medical facility is part of the description.

MR. NORWAY: Objection. Form.

Do we have a question pending?

BY MR. SCHOETTES:

Q And maybe this is a little bit better.

So it's my understanding that all of Iraq and Afghanistan are contingency deployments. That is my understanding.

MR. NORWAY: Is there a question pending?

BY MR. SCHOETTES:

Q There was.

Oh, are there instances in which you think it would be appropriate to grant a waiver to a person living with HIV to engage in a contingency deployment?

MR. NORWAY: Objection. Form.

You may answer.

THE WITNESS: So I think as I've, as I've wrestled with this question, knowing that we, as a system, might be able to develop a location that effectively has lab support and medicines, because of how we work in an operational environment, there is no guarantee that that person that has HIV won't be pushed to another location, more remote, without those assets.

So as I, as I walk through this, because we work in places, the contingency operations that are associated with moving

folks around, there were not scenarios where I couldn't come up with buying, buying risk in all these things we've been talking about because of that potential movement.

So even if, if I can walk through an incredibly safe, very, very far in the rear, and I use that term sort of loosely, knowing that folks get moved forward, I just was not able to effectively come to a place that I can put a finger on and say "waivers approved here."

BY MR. SCHOETTES:

Q I'm going to move to the next topic.

Do you have any opinions that you have not yet expressed regarding whether medical evacuations can have significant negative impacts on deployed units?

A Yeah, I think we walked through that pretty in-depth, moving folks back and forth, air/ground, lack of air/ground capability in sort of those one-deep conversations, so I think we did a pretty good job on that.

Q Is mail moved into all units?

A Not all the time.

Q Is mail moved into all units eventually?

MR. NORWAY: Objection.
Speculation.
THE WITNESS: So I've seen it take four plus weeks getting mail to Ramadi, and then mail trucks get blown up, so that mail did not make it far. Let's put it that way.
BY MR. SCHOETTES:
Q Right.
A And I think that's what folks don't absolutely appreciate is the best laid plans in RPG changes. RPG changes the best laid plans by blowing up something.
Q Well, and there was a driver driving that mail truck?
A Or two.
Q Or two, and there was some decision made that the mail needed to move forward, so that risk was worth taking, correct?
MR. NORWAY: Objection.
Foundation. Form.
You may answer.
THE WITNESS: So every decision in a combat zone is buying risk. You have to always decide which side of that conversation you want to go on, and I can tell you we quit

moving mail trucks, just like we quit moving medics for six plus weeks, because the road between Balad and Ramadi was RPG alley, and nothing moved for six plus weeks.

BY MR. SCHOETTES:

Q Do you have any opinions that you have not yet expressed regarding whether certain medical conditions, including the diagnosis and treatment thereof, may pose significant risks to military interests in the deployed environment, even if they do not require evacuation?

A So one of the things that I wrestle with a little bit is if, if you have a, so either that needlestick or that, that foreign body, and now all of a sudden it was from an HIV-infected service member, and I'm started on PEP, and now I don't have CD4 counts and viral loads to follow up within related country, what am I now doing with that PEP scenario?

So not only did I have to move the patient out, but now I have to decide for that post-exposure prophylaxis person, what is my plan for them as either an individual, and/or what is my plan with them from a blood standpoint, and knowing that even if in Iraq and Afghanistan, to

get a flight to Germany, it's about every seven days if we're sort of thinking about it on a rotational basis.

So seven days to get the lab result there, a couple days to run the lab, so you're already sort of looking at four weeks, plus some other time, until you get that viral load back, versus in any hospital in this country, I can pretty much run a viral load every day. We may batch them, but I can turn the machine on and run a viral load.

So as you think about the scenario that that individual may have expanded into a completely different conversation for a second individual, and let's say that second individual is your one of two surgeons on a forward surgical team that's in a forward operating base, you have now decreased your capacity -- if you move them out -- by 50 percent, and we don't have enough surgeons to replace them, just generically in Afghanistan right now.

So you can just see how the scenario starts to build on itself. So that gives you an example of the things that I've had to sort of think through in this scenario.

absolute constraints of that potential future fight.

BY MR. SCHOETTES:

Q And I think what I'm just trying to get at is: Given that we are talking about policies with respect to people who are already diagnosed with HIV and, in fact, people who have their HIV well-managed and under control, what the delayed presentation of HIV infection due to those considerations you just identified, how that is relevant.

MR. NORWAY: Objection. Form. Vague.

You may answer.

THE WITNESS: Can you say that a little differently?

BY MR. SCHOETTES:

Q It's listed as a topic here. The topic is that delayed presentation of HIV infection due to prolonged field care or exposure due to ongoing operations is expected.

How is the fact that someone is going to present late with their HIV infection a relevant consideration in terms of whether or not you deploy or assess people living in HIV?

MR. NORWAY: Objection. Form. Foundation. Vague.

You may answer.

THE WITNESS: So I think part of the conversation with prolonged field care is this thought process of -- although I think opportunistic infections are relatively not part of the conversation. I think the inflammatory diseases, cancer and heart disease and lung disease, kidney disease are not really the primary part of this function.

I do think prolonged field care, if you're having complications from your medicine because of all those events we talked about earlier, kidney issues because of dehydration, on top of Truvada, or liver toxicity from one of the other agents, I think those are all important.

And then when, when folks go out for operations, they typically don't take their entire set of pills with them. They will take a couple. If they're only going out for the day, they take none. The fight of the future means they may be out for longer than a day.

So now all of a sudden we're starting to miss doses when we're out in the field, and what impact -- and I think it can have substantial impact of what missing two or three doses are doing either during an evacuation chain or waiting for prolonged field care to actually occur, or as simple as just getting someone back to where their medicines are, because they were only going to go out on parole for two hours -- and we had that happen. It was a two-hour parole, and they were in a gunfight for 22 straight hours.

Life happens in a combat zone. So I think you just got of sort look through it in a slightly different lens.

BY MR. SCHOETTES:

Q So I'm going to come back to that in just a second, but I still -- I haven't heard you talk about how delayed presentation of HIV infection, which I assume is in someone who is HIV-uninfected before they present with HIV infection, how that is relevant to the policies at issue in this case.

MR. NORWAY: Objection. Form,

vague, also asked and answered, but you may answer, sir.

BY MR. SCHOETTES:

Q And if it's not and you just want to say maybe this wasn't phrased as well as it could have been --

A I'm just making sure that there was nothing else I was getting at. It's a long day, as you know.

Q Yes, yes.

A And I think I addressed it in sort of the framework I thought I meant it in.

Q Okay. Given the changing nature of modern warfare, couldn't the problem you just described with potential treatment interruption be solved by requiring a soldier living with HIV to take a three-day supply of their medication or a seven-day supply of their medication on such a patrol?

MR. NORWAY: Objection. Form. Foundation. Hypothetical.

THE WITNESS: So we can go way back to the early part of everyone minimizing the weight they're carrying going up and down the mountains of Afghanistan. Every ounce you

there may be a shift in drugs, they're going to --

BY MR. SCHOETTES:

Q And you think missing one dose of a single-tablet regimen could lead to resistance?

MR. NORWAY: Objection. Form. Foundation.

You may answer.

THE WITNESS: So I don't think the current primary integrase inhibitors that we use are going to lead to that. I'm not sure we know everyone's genetic profile to say that for sure, and I'm not sure we can say that for older regimens, and some of our patients are still on older regimens.

I think you have to be cautious saying "anyone" without just putting the caveats next to it of which regimens we're talking about and their complication history.

MR. SCHOETTES: All right.

MR. NORWAY: Let's take a break.

(Whereupon, a short recess was taken.)

BY MR. SCHOETTES:

Q Let's go back on the record.

take is another ounce you're taking. So, you know, folks are deliberate in minimizing what they take, and folks really will look at am I taking a bottle and what am I doing, and as much as I can say you're taking three pills, they don't always listen to me. They take no pills. It's just what happens.

BY MR. SCHOETTES:

Q And they would do that, you're saying, because of the weight?

MR. NORWAY: Objection. Form. Speculation. Mischaracterizes.

Go ahead.

THE WITNESS: Or forget, or "I've done this ten times, I'm not doing it the 11th," and the 11th is when it goes bad. I mean the level of complacency you can get downrange is actually impressive.

BY MR. SCHOETTES:

Q What is the effect of missing a dose of one's HIV medications?

MR. NORWAY: Objection. Speculation.

You can answer.

THE WITNESS: So I think we're,

them in or out of theater, so the battalion aid station would have a different requirement than an area support medical company, which would have a different requirement than a combat support hospital.

BY MR. SCHOETTES:

Q I still haven't heard what it is that would need to go -- so let's just start with a battalion aid company.

What would need to be in that kit that would potentially displace some other medical supply if a person living with HIV was in the field?

A So I would need the medicines, and understanding that it's not a medicine, it's numerous medicines, because there's multiple options, I would have to put multiple options of medicines in kits at a battalion aid station, if we're building this as part of a standard kit that answers the question for all places.

Q So let's assume that the person is going to get their medication, as we discussed, by taking it with them and/or obtaining a refill through the supply chain so that you don't have to have every HIV medication and every battalion aid

station. Then what supplies are we talking about?

MR. NORWAY: Objection. Form. Foundation. Improper hypothetical.

You may answer if you can.

THE WITNESS: I'm just not sure that's how we would handle it. As I've described, logistical chains may not support what you're describing. I think as a system we would have to decide if we know -- because we prepare these units for entry ops for the first 30 days. That's how we build them for equipment and sets.

So if I know that that 30 days is the biggest struggle, and if you have a potential for losing medicines or having complications and I now need to prepare for that contingency, we may need to put that into a battalion aid station kit. Those are the decisions that would need to be made at a combat developer level.

BY MR. SCHOETTES:

Q Okay. Do units that are one deep tend to have shorter deployment times?

MR. NORWAY: Objection. Form. Foundation.

You may answer if you can.

THE WITNESS: Some do. Some don't.

BY MR. SCHOETTES:

Q Is the depth of the personnel a consideration as to how long of a deployment a particular unit generally has?

MR. NORWAY: Objection. Form. Foundation.

You may answer.

THE WITNESS: It would be part of the equation, but it's not a sole decision.

BY MR. SCHOETTES:

Q How -- for those units that are one deep, can you tell me what the longest deployment would be for such a unit?

MR. NORWAY: Objection. Foundation. Speculation.

THE WITNESS: Some have gone 15 months.

BY MR. SCHOETTES:

Q And they served that entire time without anyone able to replace them in a, in a quick way?

MR. NORWAY: Objection. Form. Foundation. Mischaracterizes former testimony.

You may answer.

THE WITNESS: Correct.

BY MR. SCHOETTES:

Q If a commander needed to find three days for a service member to be absent from the unit -- setting aside the one-deep units, if a commander needed to find three days for a service member to be absent within a four-month period, would that still present a logistical problem?

MR. NORWAY: Objection. Form. Foundation. Improper hypothetical.

You may answer if you can.

THE WITNESS: It can, yes.

BY MR. SCHOETTES:

Q How -- when you say "it can," how frequently would you say it would present a logistical problem?

MR. NORWAY: Objection. Form. Foundation. Speculation.

You may answer if you can.

THE WITNESS: I think it walks through the scenarios we've talked about. Challenges in Africa are different than the challenges in Iraq and Afghanistan, which would be very different than the challenges

in a near-peer entry ops scenario. So based upon which, which scenario you're describing, there could be substantial issues trying to get folks out for windows of time.

BY MR. SCHOETTES:

Q Even with an extended period of time in which to do that?

MR. NORWAY: Objection. Form.

THE WITNESS: Even with extended times.

BY MR. SCHOETTES:

Q But you're not able to quantify that in any way?

A Correct.

Q Is there -- is the protocol for -- withdrawn.

Using the walking blood bank is not the ideal way of providing blood to a deployed unit, correct?

MR. NORWAY: Objection. Form. Objection. Foundation. Objection to the extent it mischaracterizes the prior testimony.

You may answer.

THE WITNESS: So there's something

BY MR. SCHOETTES:

Q Yes.

A Yes.

Q Do you believe that HIV is a "contagious disease that probably will endanger the health of other personnel"?

A So I think we've walked through this in numerous ways today, but yes, it has the potential to impact the health of another person.

Q But the question or the criteria is not whether it has the potential; it is whether it "probably will."

Do you believe that HIV probably will endanger the health of other personnel?

A The way you asked the question, absolutely.

Q But you can't quantify that risk in any way?

MR. NORWAY: Objection. Form. Foundation.

You can answer if you can.

THE WITNESS: So you can characterize the contagiousness of a disease, the probability of transmitting, based upon the source of that infection, the route of

infection, with variables such as viral load on therapy, all would impact the contagiousness of a disease.

BY MR. SCHOETTES:

Q And you think that -- it still doesn't give us -- can you tell me what you think the percentage risk is of someone with HIV endangering the health of other personnel? You can even make this a person who does not have a suppressed viral load.

MR. NORWAY: Objection. Form. Foundation. Improper hypothetical.

You can answer.

THE WITNESS: So it's 93 percent transfusion. 23 percent maternal fetal transmission.

BY MR. SCHOETTES:

Q And how would -- what is the likelihood of there being a transfusion that would endanger the health of other personnel? So it will be 92 percent if there was such a transfusion. What's the likelihood of such transfusion occurring?

MR. NORWAY: Objection. Form. Foundation. Speculation.

You may answer if you can.

THE WITNESS: So for your scenario, an HIV person not on medicine, donating a unit of blood downrange, will be 92 percent transmission.

BY MR. SCHOETTES:

Q And what's the possibility or the probability, I should say, of there being such a transmission?

MR. NORWAY: Same objection.

BY MR. SCHOETTES:

Q You're assuming the -- I'm sorry on such a transfusion, you are assuming that the transfusion has occurred. I'm asking you: What is the probability that such a transfusion would actually occur?

MR. NORWAY: Objection. Form. Foundation. Improper hypothetical.

You may answer if you can.

BY MR. SCHOETTES:

Q Wouldn't it require someone who was living with HIV to ignore the order that they have been given, the counseling that they have been given, and choose to donate blood nonetheless, in order for the transfusion to even occur that would

complications we see with HIV, whether it be heart disease, cancers. Kidney disease could be part of the drugs or part of the virus.

So I think those are interrelated to the point there's ongoing discussions of is HIV an independent risk factor for heart disease, irrespective of diabetes, smoking and cholesterol, and I think that again is likely reflective of inflammation.

I don't think HIV is like other pathogens, like Chlamydia, where it actually may be sort of involved in plaque development. I don't know that I've actually read enough to know that answer, but I think that inflammation is sort of going on all the time, because that immune response is continually occurring.

Q How well does antiretroviral therapy treat a person's viral load?

A I think it's outstanding, truthfully. I think appropriate therapy, especially the integrase inhibitors, are able to maximally virally suppress an incredibly large percentage of folks, and not only do they suppress them, it's also durable, so it's sort of a lasting impact. So if they're adherent with their medicines,

they're making good life decisions, they're not getting a lot of comorbidities, they're going to live a very, very long life.

Q How well does antiretroviral therapy impact the activation of an individual's immune system by HIV?

A So I feel a little uncomfortable being able to clearly state that an integrase inhibitor is going to be responsible for turning on a CD4 count which is associated with inflammation. Although the drugs are inside the cell, they're interacting with mitochondria, they're interacting with the DNA, I'm not sure I feel comfortable saying what the impact that has on immune inflammation. The answer is probably out there, but I do think the virus impacts the CD4 count in the CD4 cell, and immune cell CD8, it has an impact there. That's sort of my thoughts.

Q And what kind of impact is it?

A It increases the immune response and the inflammation that we've been talking about.

Q Okay. So the immune response, even in somebody who is taking antiretroviral therapy, is greater than a person who is not?

MR. SCHOETTES: Objection to the

six or seven folks is O, we could say O negative, but I think that's less relevant, but O-AB low titer is my HIV service member, then I've just lost one out of my universal donor where there would have been one if they were not a soldier with HIV.

So when you're, when you're talking about locations where you have relatively large footprints of personnel, you can find probably enough O-AB negatives for your donor pool. As you shrink that pool smaller and smaller, everyone on that team becomes more and more relevant to this conversation.

The Rangers have done a really good job of building this program. We are actively building this program in Korea, so this is now going to be a much broader conversation, and this housing of a walking blood bank then starts moving into other databases. So now we know you have O. What other transmitted infections might you have or not have that you have to worry about? So there's just this broad building in this program, but from a operational small-unit standpoint, you're limited by who goes out with you.

Q And below that, you have "tyranny of

distance." Can you explain to me what that refers to?

A I was involved in building a seven-person team for east Africa, and five of those people were positioned in Kenya. Three of those -- the other three were stationed in Djibouti, and what we had to figure out how to do was do damage control surgery as well as movement across Africa.

Their operational space went from Kenya all the way through about half of the Congo. As I said earlier, the Congo is three and a half Texases. If you look at a map of Africa, the U.S. doesn't even fill the top section. We're not even talking about sliding it down to where we're talking about.

So the distance of moving people is incredibly difficult. The evacuation times for a C130 were, from Djibouti, for where most of the ops, operations were going, was 12 to 15 hours. So if something happened, it was going to take 12 to 15 hours for evacuation to occur, presuming you had the bird, the C130 release.

So these two teams, the intent, the design was the surgical team would be

prepositioned with the special operators who were going to have a mission to, if something happened, they had immediate surgery, so again one surgeon on the team. The other three folks were the ones involved in moving, so they would be on the back of C130, coming to pick them up, and then from there, they would go to Germany.

So being able to work in that distance, we really have had to think about blood product support, low titer of blood, what medicines were they going to have on their back, because it really was backpack requirements. To fit folks that are doing the operation into a helicopter, plus five more people, four more people, plus their backpacks is really difficult.

So you've pretty much got to bring sort of a fanny pack equivalent of who you are and everything you need, because the rest is a regular backpack with all your surgical instruments, and that's the challenge of those environments.

Q So there are space and weight requirements?

A Correct.

Q The decision to -- is it fair to say the decision of what capabilities and assets to bring

at any particular level of the medical system is a combination of medical knowledge and operational experiences rolled together into a risk equation?

A To include a capability and capacity conversation.

So the constraints environmentally that are built around a capability and capacity to carry out the support that's required of the operator on the battlefield, so the ultimate is who's the one pulling the trigger or knocking down the door. Everyone else is supporting them. You're sharing -- I'll use bandwidth in the sense of logistical support, movement of people, movement of equipment, movement of medical is all moving onto this piece.

So that's the constraint that you're dealing with, a very complicated problem set, because someone up here is going to say you get two feet by two feet. That's all the space you get in the back of the bird. Everything else is going to bullets and water and everything else, so they're going to constrain you, and you have to work within that.

Q Who is the decision-making authority for constraints in operations like that?

A If it's a special operations, it will be special operations command for that region, so, for example, if it's Africa, it's special operations command Africa. If they work outside of that, then they would have to go to the African combatant commander, so elevating it up to a four-star. Typically that can be delegated down to a two-star, and if it's small enough operations, down to an 06, but it's still a very high-level discussion.

Q Is it fair to say it's a military decision?

A Absolutely. So we are staff officers giving advice, and then they put that into the context of the operation and what risk we hope we have articulated appropriately that they then put into their risk equation and then make a decision from that.

Q Thank you.

I think it's time to take a break.

(Whereupon, a short recess was taken.)

BY MR. NORWAY:

Q Let's go back on the record.

Sir, do you remember when you were

testifying earlier about some impacts on like the training environment that HIV might have?

Do you recall that testimony?

A I do, mm-hmm.

Q That training environment you were discussing, was it the initial entry training, basic training?

A So most of this type of training would not occur in basic training. This would occur in either what's called AIT or advanced individual training, which is where we train our medics. For PAs, it would be at their PA school, so that's a two-year program. For physicians it would be part of whichever educational program they have if you could fit it into those places.

So TRADOC is the governing body for what would go into any enlisted training, which would be the combat medics. What their position is is that you have a block of time you can train with them. You don't get any more, and we can take it away, but we don't want to. If you want to put any new training in there, something has to come out for you to put something new in.

So to introduce that into that program, it's just not something the medical community can

do. That's something TRADOC -- so big Army four-star level command would be responsible for approval of any changes, so that's substantial.

The PA program, their first year is sort of book-learning, and their second year is clinical. They mostly follow the PA curriculum that's driven on high, because they have to pass their boards, understanding they still have to train military unique issues, so they, too, have limited windows of time.

So as I alluded to earlier, they have a three-hour total block in that first year to address all of the infectious disease challenges in a, in a routine medical environment, like in the States, as well as all the challenges in Africa, southeast Asia, South and Central America. It's incredibly difficult to do all that, so again, they would have to prioritize the requirement of training something new inside that block of time.

Q So that military official would need to make a decision to provide priority training for the treatment of HIV individuals over some other training?

A Correct. I used to teach that course.

We spent most of our time talking about key infections that they need to recognize at the bedside: Meningitis, pneumonia, malaria, dengue, those kind of diseases. Even the three hours we were given was nowhere adequate to cover the things we just highlighted, so it would be difficult to add much more in there.

The other way you can do training is something called "just in time" training, which is, you know, try to figure out how to do this as they go out the door. So for our personnel who went to Liberia, that was me spending about four weeks on the road, and I had to go to Fort Bragg, I had to go to Fort Campbell, I had to go to Fort Benning, I had to go to Fort Hood to train those folks up, and that included delivering sort of the entire challenges from an infectious disease standpoint for Liberia to everything from a whiskey to a PA to a doctor.

So that's really difficult to do. It completely took me out of my day job, but a FORSCOM four-star, General Milley, said this is going to happen, so that trickled down to I was there doing it. The commander back at the hospital canceled my clinics. I wasn't training

fellows, I wasn't doing substantial research or teaching, because that was my mission set.

So that was to get a relatively small number of medical personnel to Liberia. To do that, to scale in quality is really, really difficult. In the Army we have 40 ID doctors, so to be able to spread that out and do everything else we're required to do would be really difficult.

So although we can do just-in-time training, it is, it is difficult, because you then also have to work -- so, for example, the Liberia experience, the teams didn't know how to do malaria diagnosis, they didn't actually have the stains to do the diagnosis, so we had to start at the most basic for something that absolutely was lethal and fix that first before we moved on to other things. So not that anything is impossible, but there's constraints that would make this difficult.

Q Are there logistical constraints to treating individuals with HIV both in the deployed setting and undeployed setting?

A We talked about this a little bit. We talked about the different levels of providers,

So as the senior physician, you're correct. The R.P.G. Alley got so bad, we could not get Motrin from the major combat support hospital equivalent. It's an Air Force, different name, but same thing. We could not move Motrin to Ramadi, because it was so unsafe.

Q If you -- during that time, were you confronted by any situation where a soldier was presented with an injury that required a medication, a lifesaving medication?

A Frequently. We had -- we continued to have casualties during that time. Some of those casualties had to be intubated, so to intubate a patient, you have to sort of paralyze them, put a tube down their throat, and you've got to breathe for them. So the medicine that's involved in a rapid-sequence intubation is required of all of that.

In addition, in an area support medical company, although you're logistically pretty well supplied, we had a 43-person MASCAL one day, or 42, and the logistical constraints on moving those people, but just the supply demand, was overwhelming. We pretty much ran out of everything, and it took us about two weeks to

start resupplying.

So we almost -- well, we actually were non-mission-capable for a fair bit of time, because we just couldn't take care of the next patient who walked through the door.

Q When you took care of that 43-person mass casualty event, was there time during that event to change your gloves?

A No. So we started about at 1:00 on a Sunday afternoon, and it ended at about 8:00 that evening, and about four hours in is when I realized I had the same pair of gloves on, despite putting test tubes in folks, doing central veins to infuse medicine, fluids.

As an ID doctor, you sort of cringe at that statement, but it didn't even enter your mind to do that. The constraints in that environment, we were not using blood, for lots of reasons we didn't use blood, but to do what we normally do with trauma, such as X-rays, infusing antibiotics, doing stability labs, all of that stuff stopped, because you were just trying to get to the next patient.

So understanding the challenges and the decisions you would make when you're managing

42 -- and just to clarify, so there was two convoy briefs (?) occurring, and mortars landed between the two of them, and that's the reason 42 casualties happened. So just understanding the constraints and an environment like that, we put mathematical modeling onto scenarios in other near-peer fights that will dwarf what that 42-person experience was.

Q During that mass-casualty event, were you able to stop and check patients' medical records?

A We didn't have electronic health records, so there was nothing you could check. As they were unconscious, you got no information. Dog tags have less than no useful information on it. Despite folks supposedly wearing their allergy either tags or bracelets, most folks take them off and don't wear them.

So none of that really happens, and even if you were going to go to the electronic record, trying to find the piece that says what's wrong with them previously, our electronic records struggles at best, so pulling out labs or a key note with a key diagnosis just isn't useful in our, our MTF electronic medical record, and the

downrange is not better than that.

Q Sir, you're familiar with the pool of infectious disease doctors in the United States Army, correct?

A Correct.

Q How many individuals would you say who are infectious disease doctors in the United States Army have your level of operational experience?

A None.

Q Sir, to add a capability to a unit, even at a very low treatment level, would that addition require changes to doctrine, organization, equipment deploying or the array of forces and training?

MR. SCHOETTES: Objection. Form.

THE WITNESS: So the process for changing an organization's footprint and what that loosely means is personnel, equipment, maintenance, vehicles, training, or use this dot-mil PFP, which is doctrine organization, manpower -- I always have to look it up, but it's all of these different assets to make a unit successful.

What happens is within TRADOC,

and we think that's a priority, then it is a broader system you have to fix.

BY MR. NORWAY:

Q So there are many more decisions that need to be made besides just medical decisions?

MR. SCHOETTES: Objection. Form. Go ahead.

THE WITNESS: Correct. So an ID consultant would not be able to say yes, we absolutely should have this inside a medical kit, let's make it happen tomorrow. Just not going to happen.

MR. NORWAY: All right. Thank you, sir. I think I'll turn the witness back over.

FURTHER EXAM BY COUNSEL FOR PLAINTIFFS

BY MR. SCHOETTES:

Q I have a few questions, but we'll get out of here fairly quickly.

Going backwards, is a person's blood type on their dog tag?

A There is, but studies have shown it's frequently inaccurate.

Q Why would that be?

A Because I get to say what my blood type

is, and then someone types it in wherever they make dog tags. There's no confirmation. No one looks it up in a computer system. No one -- literally I go "I'm O negative," and the next thing I know, I get dog tags that say O positive.

Q That seems like a risky system to have for such important information. Why would there not be a more sound system for identifying blood type on dog tags?

MR. NORWAY: Objection. Form. Objection. Foundation. Speculation.

You may answer.

THE WITNESS: I can't answer that question. I think many folks have asked the exact same question. I have found dog tags less than helpful. The places that frequently soldiers and Marines put their dog tag is actually the shoestring down at the bottom. The number of folks that have come in without a foot so that I couldn't find a dog tag is not inconsequential. The number of folks that don't like to wear them around their neck or it falls off or when you get blown up in a vehicle and everything is shifting around, you lose it, so it's been

infrequent that I've used dog tags to help drive a conversation.

Again, I write down whatever -- we now use DoD ID numbers instead of Social Security numbers, so I get to tell you what to write. No one confirms that it's really my DoD ID number. They're just something I struggle trusting. I think you'd get your name right, but I've seen folks add their pet name to their dog tags.

BY MR. SCHOETTES:

Q I think you said that a person with type B blood can't be a donor?

MR. NORWAY: Objection. Form. Objection to the extent it mischaracterizes the testimony.

You may answer.

THE WITNESS: So for the O, low titer O blood, that's your primary donor, and then A is your next donor. If you have time inside of CSH, and you're B minus and the patient needs B minus, then I can do that, but that adds complexity, and it also is not a universal donor unit, so now it really is the B minus person walks in the door, is

done.

MR. NORWAY: Great. Thank you very much, Scott.

MR. SCHOETTES: Thank you.

MR. NORWAY: We will read and sign.

THE REPORTER: Do you want a rough draft?

MR. NORWAY: Yes, please.

MR. SCHOETTES: Yes, please.

THE REPORTER: Normal turnaround? Two weeks?

MR. NORWAY: Yes.

(Signature having not been waived, the deposition of COLONEL CLINTON K. MURRAY, M.D. was concluded at 8:13 p.m.)

ACKNOWLEDGEMENT OF WITNESS

I, Colonel Clinton K. Murray, M.D., do hereby acknowledge that I have read and examined the foregoing testimony, and the same is a true, correct and complete transcription of the testimony given by me, and any corrections appear on the attached Errata sheet signed by me.

29 May 2019 _____ (DATE)

(SIGNATURE)

ACKNOWLEDGED before me
this 28 day of MAY 2019
by _____
KIRK LAMONT KNOCKETT
NOTARY PUBLIC STATE OF MARYLAND
My Commission Expires 9/26/2020

Job #3308250

E R R A T A S H E E T

IN RE: RICHARD ROE, ET AL VS. PATRICK SHANAHAN

WITNESS: COLONEL CLINTON K. MURRAY, M.D.

PAGE	LINE	CORRECTION AND REASON
15	1	HTLV not HTLP
49	18	Medical Corps not W Corps
122	22	era(s) not error(s)
139	12	insert chronic before infection

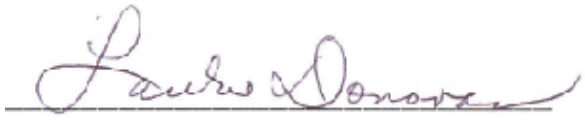
Job #3308250

CERTIFICATE OF SHORTHAND REPORTER -- NOTARY PUBLIC

I, Laurie Donovan, Registered Professional Reporter, Certified Realtime Reporter, and notary public for the District of Columbia, the officer before whom the foregoing deposition was taken, do hereby certify that the foregoing transcript is a true and correct record of the testimony given; that said testimony was taken by me stenographically and thereafter reduced to typewriting under my supervision; and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand this 14th day of May, 2019.

My Commission Expires: March 14, 2022



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LAURIE DONOVAN
NOTARY PUBLIC IN AND FOR
THE DISTRICT OF COLUMBIA

EXHIBIT 23

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Alexandria Division

RICHARD ROE, ET AL.,)
) CIVIL ACTION
Plaintiffs,) NO. 1:18-cv-01565
v.)
)
PATRICK M. SHANAHAN,)
ET AL.,)
)
Defendants.)
---)
NICHOLAS HARRISON,) CIVIL ACTION
ET AL.,) NO. 1:18-CV-00641
)
Plaintiffs,)
v.)
)
PATRICK M. SHANAHAN,)
ET AL.,)
)
Defendants.)
---)

Friday, July 26, 2019

30(b)(6) Deposition of the Secretary of the U.S. Department of Defense, Secretary of the Army & U.S. Department of Defense, by and through its designee, Colonel Scott Frazier, taken at the offices of Winston & Strawn, LLP, 1700 K Street N.W., Washington, D.C. beginning at 11:32 a.m., before Nancy J. Martin, a Registered Merit Reporter, Certified Shorthand Reporter.

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ALSO PRESENT:
MAJOR ADAM WOLRICH
DAN REIDY, LEGAL VIDEOGRAPHER

I N D E X

E X H I B I T S

E X H I B I T S
(CONTINUED)

NUMBER	DESCRIPTION	MARKED
Exhibit 6	Army Regulation 600-110, Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus, NH-23 - NH-85, 63 pages	25
Exhibit 7	Army Regulation 40-5-1, Standards of Medical Fitness, 131 pages	68
Exhibit 8	Army Staffing Form, US25518 - -25540, 24 pages	70
Exhibit 9	Memorandum dated April 30, 2015, US1136, 1 page	81
Exhibit 10	DOD Instruction 1332.45, Retention Determinations for Non-Deployable Service Members, Effective July 30, 2018, US3507 - 3526, 20 pages	98
Exhibit 11	Letter dated November 9, 2018, Memorandum for See distribution, US5451 - 5452, 2 pages	104

MS. COOLEY: Yes.

Q. But I was also asking -- I was going to get to the readiness posture aspect of it next, but it says, "and." So presumably there must be some other effect on Army units.

A. So the reason why I believe that the statement reads the way it does, so the overall impact of infected personnel in Army units and on readiness posture is because within the Department of Defense readiness is measured at both the individual level and the unit level. So it was necessary in the statement to clarify that when we measure readiness relative to soldiers, we are assessing individual readiness of the individual soldier, which is measured one way, and then we are assessing the readiness posture of the unit that they are a part of, which is a more macro level view.

Q. So this statement is about readiness?

A. Yes.

Q. Okay. So what is your understanding of the overall impact of infected personnel on both individual and unit readiness?

A. So for individual readiness, as the current policy stipulates, they are not unrestricted worldwide deployable. And so as a result of their restricted ability to be utilized, their readiness relative to an uninfected soldier is less.

At the unit level, if they are a member of a unit and they have a restricted deployability code, then it also reduces the relative readiness of that unit because, especially if they perform a function that is vital to the functioning of that unit and the unit is asked to go to a location that the HIV positive soldier is restricted from deploying to, then the unit is compelled at the last minute to find another qualified substitute for that soldier so that the function performed within the unit can continue.

And that situation is compounded if the soldier is in a leadership position and the unit relies upon that soldier in terms of providing guidance and instruction. Then you're forced to develop a whole new leadership team at the last minute.

Q. When you say they're not worldwide

deployable, does that mean not worldwide deployable without a waiver, or there are certain locations where they are not deployable even with a waiver?

A. So the determination of whether or not a soldier could receive a waiver in terms of entering an AOR is up to each combatant command. And as a result of the process by which they have to request a waiver, the department is in a position of in order to maintain unit readiness for units that are required to deploy no notice or with a very short deployment time line, the waiver process is not responsive enough to meet the needs of those types of units in terms of timeliness of turning around decisions.

And so the impacts of soldiers who are HIV positive to those types of units means that it is not conducive or supportable to have them assigned to those types of units and wait out the individual decisions of combatant commands at time of need.

If you think of it in the context of calling 911 for the fire department and then asking the department to go through a medical waiver process before that fire truck is allowed to leave the station

and respond to the fire because an individual fireman has a medical condition that may preclude them responding to that particular type of fire. You don't have that type of time.

Q. So the impact that HIV positive service members have on readiness is a result of the DoDI waiver process?

A. The impact is a combination of their lack of ability to be worldwide deployable unrestricted, meaning that they require a waiver before they can deploy. The other aspect of readiness would be relative to their requirements to be supported in specific environments, unlike other soldiers. And that's in excess to care issues that I believe we've already discussed.

Q. And on the last factor, what is your understanding, as the designated representative of the Army, of the risk that HIV infected personnel pose to the safety of the military blood supply?

MS. BERMAN: Objection. This is beyond the scope of what this witness is being offered for to the extent you're asking for medical information.

You can answer.

THE WITNESS: So I am not a blood program officer. It is my understanding, from our medical professionals that we use in the field, a process called the "walking donor program," which means that if I do not have access to fresh, whole blood that has been processed through a normal blood donor center, then they use a process in the field to gain access to whole blood by tapping directly into other service members who are literally walking around, and they do transfusion directly from that individual into a bag and then from the bag directly into another individual.

Because it's done in oftentimes austere environments, this means that they don't have ready access to the same type of diagnostic capabilities that would be available in a blood collection activity in the continental United States through a normal blood donor center.

BY MS. COOLEY:

Q. And this poses a risk to the blood supply?

A. Because as we discussed earlier, an HIV

positive soldier, even if they are successfully suppressed under ART therapy, does not mean that there is no circulating virus in the blood. It simply means that it's circulating at a very low level to which the previous blood test did not detect its presence.

As you transfer units of blood, you are also incrementally increasing the risk that virus in that blood is being transferred to another individual.

Q. Are service members living with HIV told that they cannot donate blood?

A. It is my understanding that the counseling statement that they receive from public health and from their unit commander contains that language, yes.

Q. Are they ordered not to donate blood?

A. I believe the regulation orders them not to donate blood.

Q. Is it assumed that service members will follow orders?

A. Are you asking my personal opinion or the department's position.

Q. The department's position.

A. The department's position is that if a law

order is given, that soldiers in uniform will follow lawful orders.

Q. So then how does HIV infected personnel pose a risk to the safety of the military blood supply if they've been ordered not to donate blood?

MS. BERMAN: Objection. This is beyond the scope of what this witness is being offered for, but also calls for speculation.

THE WITNESS: So are you asking me to speculate?

BY MS. COOLEY:

Q. I'm asking you to answer the question.

A. So in circumstances where there is no ability to provide a walking donor capability and a service member is faced with watching one of their peers, a friend, a battle buddy die if they do not receive blood, then they may elect to take actions that may be contrary to what the regulation has prescribed. That would be my speculation.

And we know that, in combat environments, that the extreme circumstances that service members are placed under, they are oftentimes asked to make

difficult choices. That does not absolve them from being subject to the Uniform Code of Military Justice, but it nevertheless means that there are sometimes circumstances that the regulation is unable to account for.

Q. Please turn to Page 3. I'm sorry. Page 4. Subsection f states, "HIV infected active duty Soldiers, including" --

A. I'm sorry. Are we talking 1-16 F, because there's two F's on Page --

Q. Yes. I'm sorry. 1-16 F.

A. Okay.

Q. States, "HIV infected AD soldiers" -- I assume that's active duty?

A. Yes.

Q. -- "including AGR" -- what is "AGR"?

A. Active guard reserve.

Q. -- "will be limited to duty within the United States (including Alaska, Guam, Hawaii, Puerto Rico, and the U.S. Virgin Islands)"; correct?

A. Is that what the statement says? Yes.

Q. And then also please turn to Page 22.

MS. COOLEY: Okay. That's all I have.

MS. BERMAN: Okay.

THE VIDEOGRAPHER: This concludes today's deposition. The time on the video is 2:03 p.m. We are off the record.

(Witness excused.)

(Deposition concluded at 2:03 p.m.)

C E R T I F I C A T E

I do hereby certify that the aforesaid testimony was taken before me, pursuant to notice, at the time and place indicated; that said deponent was by me duly sworn to tell the truth, the whole truth, and nothing but the truth; that the testimony of said deponent was correctly recorded in machine shorthand by me and thereafter transcribed under my supervision with computer-aided transcription; that the deposition is a true and correct record of the testimony given by the witness; and that I am neither of counsel nor kin to any party in said action, nor interested in the outcome thereof.

Nancy J. Martin, RMR, CSR

Dated: July 28, 2019

(The foregoing certification of this transcript does not apply to any reproduction of the same by any means, unless under the direct control and/or supervision of the certifying shorthand reporter.)

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July 29, 2019

To: Ms. Berman

Case Name: Harrison, Nicholas, Et Al. v. Shanahan, Patrick M., et al.

Veritext Reference Number: 3463821

Witness: Col. Scott Frazier Deposition Date: 7/26/2019

Dear Sir/Madam:

Enclosed please find a deposition transcript. Please have the witness review the transcript and note any changes or corrections on the included errata sheet, indicating the page, line number, change, and the reason for the change. Have the witness' signature notarized and forward the completed page(s) back to us at the Production address shown above, or email to production-midwest@veritext.com.

If the errata is not returned within thirty days of your receipt of this letter, the reading and signing will be deemed waived.

Sincerely,

Production Department

NO NOTARY REQUIRED IN CA

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3463821
CASE NAME: Harrison, Nicholas, Et Al. v. Shanahan, Patrick M., et al.
DATE OF DEPOSITION: 7/26/2019
WITNESS' NAME: Col. Scott Frazier
In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.
I have made no changes to the testimony as transcribed by the court reporter.

_____ _____
Date Col. Scott Frazier
Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal

this _____ day of_____, 20____.

_____
Notary Public
_____
Commission Expiration Date

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3463821
CASE NAME: Harrison, Nicholas, Et Al. v. Shanahan, Patrick M., et al.
DATE OF DEPOSITION: 7/26/2019
WITNESS' NAME: Col. Scott Frazier

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

_____ _____
Date Col. Scott Frazier

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They have listed all of their corrections in the appended Errata Sheet;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal this _____ day of_____, 20____.

_____
Notary Public

_____
Commission Expiration Date

ERRATA SHEET

VERITEXT LEGAL SOLUTIONS MIDWEST

ASSIGNMENT NO: 3463821

PAGE/LINE(S) / CHANGE /REASON

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Date Col. Scott Frazier

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____

DAY OF _____, 20_____ .

_____

Notary Public

_____

Commission Expiration Date

EXHIBIT 24

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Alexandria Division

NICHOLAS HARRISON, *et al.*, Plaintiffs, v. MARK ESPER, Secretary of Defense, *et al.*, Defendants.	No. 1:18-cv-641 (LMB/IDD)

RICHARD ROE, *et al.*, Plaintiffs, v. MARK ESPER, Secretary of Defense, *et al.*, Defendants.	No. 1:18-cv-1565 (LMB/IDD)

DECLARATION OF COLONEL CLINTON MURRAY

I, Colonel Clinton K. Murray, hereby state and declare as follows:

1. I am a colonel in the United States Army and a medical doctor specializing in infectious diseases. I am presently assigned to United States Forces Korea (USFK) in the Republic of Korea. In July 2020, I am scheduled to take command of the Walter Reed Army Institute of Research (WRAIR).

2. In the exercise of my official duties, I have been made aware of these lawsuits by counsel from the Department of Defense Office of General Counsel.

3. I submit this declaration in support of Defendants' Motion for Summary Judgment. I base this declaration on my personal knowledge, and on my expertise infectious disease medical care in the

military, and my expertise on the military's operational environment.

Background and Expertise

4. My current role is the USFK Command Surgeon and the United Nations Command Surgeon, responsible for Health Services Support and Force Health Protection for the Korean Theater of Operation. I have been in this position since July 15, 2019.

5. Since 2016, I have also served as the infectious disease consultant to the U.S. Army Surgeon General. In that role, my responsibilities include: assisting with the manning, organization, training, and talent management of infectious disease physicians across the Army; assessing the equipment, including labs and medication, that are included in deployable medical facilities and unit equipment packages for the battlefield for a given type of operation ("sets"); providing subject matter expert opinions on infectious diseases that affect the Army; and advising on the development of policies concerning infectious diseases.

6. Additionally, since 2011, I have been a full professor of medicine at the Uniformed Services University of the Health Sciences ("USUHS").

7. From 2017 to 2019, I provided inpatient care, including treating people living with the human immunodeficiency virus (HIV), at Walter Reed. I also was the commander of the First Area Medical Lab, an operational unit designed to enter a combat zone to conduct laboratory confirmation of biological warfare agents, chemical warfare agents, nuclear agents, and endemic diseases. As a commander, I was responsible for manning, equipping, sustaining, and leading that unit.

8. From 2015 to 2017, I was the Deputy Corps Chief for the Medical Corps, overseeing approximately 4,500 medical officers. In that role, I was also responsible for reviewing regulations and policies for manning, training, and equipping the Army medical system, including policies related to accession and retention. From 2011 to 2015, I was the infectious disease service chief at Brooke Army Medical Center ("BAMC"). In that role, I managed a research program focusing on operational medicine, combat casualty care related to infections,

travel medicine, and HIV. I provided care to service members and healthcare beneficiaries with HIV on an inpatient and outpatient basis. Additionally, from 2011 to 2105, I also served as the Army service chief for infectious disease service, while continuing to manage patients with HIV and teaching state of the art care to infectious disease fellows.

9. From 2005 to 2012, I was a practicing clinician at BAMC while also serving as the infectious disease fellowship program director for the combined Army/Air Force program. From 2002 to 2005, I was the Chief of the BAMC infectious disease clinic.

10. From 1999 to 2002, I completed an infectious diseases fellowship at BAMC. From 1996 to 1999, I was a resident in internal medicine at Walter Reed. From 1992 to 1996, I attended the Uniformed Services University of the Health Sciences (USUHS) medical school in Bethesda, Maryland.

11. I have deployed to combat zones several times:

a. From 2003 to 2004, I deployed to Iraq as a general medical officer, responsible for primary care and damage control stabilization of trauma patients before evacuation. Medical care under these circumstances was complicated by transportation constraints, including lack of evacuation assets, supply constraints (including lack of basic medications), and unreliable communication systems and logistical infrastructure. It was not possible to obtain labs and other medical tests or to reliably consult with experts.

b. In 2012, I deployed to Afghanistan to assess U.S. and allied nations' military medical facilities for infection prevention and control. That deployment revealed the challenges of providing care for standardized HIV, Hepatitis B/C, and other infections at deployed facilities in close proximity to combat. These facilities had a limited supply of medications, and did not have the current stock of HIV post-exposure prophylaxis (PeP) despite policies requiring that they be available at those locations. The PeP medications that would have been used if there was a risky blood and/or body fluid exposure through a needle stick or high volume blood included only 2 medication in some locations while 3 were indicated or did not have the

currently recommended medication despite it being formal theater policy to have the medications available. Also rapid diagnostic testing for HIV, Hepatitis B and Hepatitis C was not universally available.

c. In 2013, I returned to Afghanistan to help the Afghan National Army build a residency program in preventive medicine and infectious diseases. In an operational environment, the U.S. frequently relies on our multinational partners to provide logistical and medical support. Because our multinational partners do not require the same type of medication and treatment regimens as does the U.S. military, inconsistent standards of care affect both resupply and care at the point of injury. We cannot always rely on our partners to provide us with the medications or equipment we use to treat our service members, or provide point of injury care for our service members in the manner we require.

d. In 2015, I deployed to Afghanistan to assess surgical teams' support to special operations forces. This deployment highlighted the challenges of providing medical support to small teams in remote areas where logistical support and the ability to evacuate service members are extremely constrained. The limitations of supplies and equipment greatly limited what medical personnel carried focusing on life saving damage control surgery and medications such as HIV PeP were not included.

12. I have also performed research on tropical and operational medicine in locations across South and Central America, Africa, and Southeast Asia. These experiences provided me with insight on the unique culture of, and logistical constraints in, those regions.

13. I have extensive clinical experience in the treatment, care, and management of individuals living with HIV. My experience ranges from providing care for individuals living with HIV in clinic and hospital settings, to developing Army and Department of Defense (DOD)-level policies concerning HIV. Having practiced medicine since 1992, my perspective on HIV treatment and policy is informed by my first-hand experiences in changes in how HIV is perceived and managed in both the military and in civilian communities.

14. My experience in the care of HIV also includes participating in collaborative research on transfusion associated infections, needle stick risks, sexually transmitted infections, and deployment-associated complications in deployed settings.

15. A true and correct copy of my curriculum vitae is attached to this declaration as Exhibit A.

Summary

16. Based on my experience, I am able to compare how HIV is treated in the U.S. by the civilian and military health care systems to how it would be treated under the constraints of operational and austere military environments. Operational environments can range from kinetic conflict, fighting with bullets, mortars, and missiles, to stability operation, securing safe environments by providing essential governmental services, emergency infrastructure reconstruction, and humanitarian relief. Unlike the typical civilian health care position, kinetic and stability operations may not have a stable supply of personnel, medicine, and equipment because of both short and long lines of resupply, and limited logistical support that does not allow for even the most basic laboratory support, particularly in the less mature or more forward areas of operations.

17. My opinion is based on: (1) my medical duties, experience, training, and knowledge of the proper standard of care for individuals with HIV, including the current recommended standards of care of the DOD, the World Health Organization ("WHO"), the Center for Disease Control and Prevention ("CDC"), and the U.S. Department of Health and Human Services ("HHS"); (2) the knowledge I have gained in the course of my official duties, my experience and training as a medical doctor and expert in infectious diseases, including HIV, and as a military officer who has served in the U.S. military's operational environment for more than twenty years, leading a combat medical facility in combat, and working in several continents; and (3) my knowledge of the constraints of providing medical care in operational and austere environments, which is informed by my experience with the care of routine infectious diseases, other communicable diseases, and other complications associated with operational medicine, especially in environments with limited supply lines in which transportation is difficult or

dangerous and each deployed service member is essential for mission success.

18. I have read the deposition testimony of Dr. Hardy and Dr. Hendrix, their expert reports, and the Supplemental and Rebuttal Expert Reports of Dr. Hendrix. Generally, they are incorrect in assessing some of the unique challenges of providing HIV care in a deployed setting. In particular the reports' analyses lack consideration of conflicts with near peer competitors[1] and a proper understanding of military operational constraints, which include: the potential lack of air superiority, adequate resupply, and medical laboratory support; incomplete medication supplies at the ready; inability to consult effectively with subject matter experts due to unreliable or disrupted communications systems; and lack of consistent training of all healthcare personnel to manage service members with HIV. Additionally, I believe that the doctors' opinions on the standard of care and prognosis for HIV patients require further explanation and qualification to understand the unique risks of deploying service members with HIV.

Deployment of HIV-Positive Service members to Contingency Operations

19. Based on my training and experience, I believe the DOD should prohibit the deployment of service members with HIV to certain operational settings around the world. Deployment to combat zones directly impacts how the U.S. military fights its wars and must be informed by professional assessment of risk, including known conditions in recent and current theaters of operation and unknown conditions of future battlegrounds that may pose, different, unique, and greater challenges. Such battlegrounds may include enemies with near peer capabilities in theaters without mature infrastructure.

20. The fact that HIV-positive service members are willing to accept risk and put themselves in harms' way for their country when they go downrange (to a deployed environment) does not relieve the military of its obligation to minimize the risk of harm to them, to other personnel, or to mission success.

[1] "Near peers" are adversaries over which the U.S. military may not have military superiority.

21. The risks of deploying HIV-infected service members is distinguishable from the risk of deploying service members with other chronic diseases. HIV is an incurable communicable disease, and lack of care not only places the service member at risk, but also risks the health of other service members. Service members with known infections of communicable diseases, such as tuberculous or blood borne diseases like Hepatitis B and C, are also barred from contingency deployments, even though the risks are lower because there are vaccines and cures for those diseases.

22. My risk assessment is informed by a consideration of multiple interrelated factors. No single factor is determinative; rather, I have assessed numerous considerations, discussed below, in reaching my conclusion.

Health and Well-Being of HIV-Positive Service Members

23. The military has an obligation to ensure every service member is provided the appropriate level of care for their conditions.[2] The required care for a patient with HIV varies from individual, and depends of several factors, including the service member's medicine regimen, HIV viral load, and immune profile. It also depends on the service member's adherence reports, which document historical compliance with a medication regimen under normal non-deployed conditions. The time course of the disease is also relevant because timely initiation of therapy allows control of the infection and recovery of any lost immune response. Antiretroviral therapy (ART) typically limits the impact of acute infection and allows the infection to be treated as a chronic condition. Additionally, appropriate care also depends on the extent of the service member's knowledge of HIV management.[3] Level of knowledge informs a provider with key information concerning: 1) whether service members understand the importance of their medication; 2) the possibility of transmitting

[2] For HIV care, the military generally adheres to the Clinical Guidelines available from HHS. *See* HHS AIDS Info, Clinical Guidelines, https://aidsinfo.nih.gov/guidelines (last visited May 26, 2020)

[3] *See generally* HHS AIDS Info, What to Start: Initial Combination Regimens for the Antiretroviral-Naive Patient (Last Updated Dec. 18, 2019), https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv/11/what-to-start (last visited May 26, 2020); HHS AIDS Info, Management of the Treatment-Experienced Patient: *Optimizing Antiretroviral Therapy in the Setting of Virologic Suppression* (Last Updated Dec. 18, 2019), https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv/16/optimizing-antiretroviral-therapy-in-the-setting-of-virologic-suppression (last visited May 26, 2020).

the infection to others through blood exposure, blood donations, pregnancy/delivery/breast feeding, or sexual activity; 3) the importance of safety labs such as liver and kidney tests; 4) the potential consequences of discontinuing treatment[4] —viral rebound, immune decompensation, and clinical progression; and 5) whether service members can communicate their disease states to other healthcare providers.

24. ART medicine regimens vary, and can range from one pill once a day to multiple pills numerous times a day. Some medications must be taken with a certain kind of food or fluid, or at a specific time during the day, and a small number of these medications require temperature control settings.[5] Even a service member on a one-pill a day regimen with a history of viral suppression needs laboratory support, access to medication, and other medical care that might not be present in certain operational settings.

25. Initial care involves ensuring a person is on the right regimen to clear the vast majority of circulating virus although there are still sites of virus not completely eradicated by ART. Stopping viral replication prevents the infection from causing ongoing complications and generally allows the patient to recover lost immune function. The right regimen also prevents the infection from progressing without causing damage due to medication toxicity although there is some data that supports ongoing systemic inflammation of the body even while maximally virally suppressed on the right medication that might lead to excess cardiac disease and cancers.[6]

26. Although it is generally accurate to say that "A person who is diagnosed with HIV in a timely manner and adheres to their prescribed ART regimen has nearly the same life expectancy as a person who is not living with HIV," Hardy Rep. ¶¶ 10, 20, Pls.' MSJ Ex. 20; Hoppe Rep. ¶ 25, this

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[4] *See* HHS AIDS Info, Management of the Treatment-Experienced Patient: *Discontinuation or Interruption of Antiretroviral Therapy* (Last Updated Apr. 8, 2015), https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv/18/discontinuation-or-interruption-of-antiretroviral-therapy (last visited May 26, 2020).

[5] AHHS AIDS Info, Drugs, https://aidsinfo.nih.gov/drugs (last visited May 26, 2020).

[6] *See generally* HHS AIDS Info, Initiation of Antiretroviral Therapy (Last Updated Dec. 18,2019), https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv/10/initiation-of-antiretroviral-therapy (last visited May 26, 2020).

statement must be qualified. First, average outcomes are not the same as *all* outcomes. Treatment interruptions, side effects, and comorbidities that can occur in some patients reduce life expectancy. Further, because effective treatment has only been available for the last two decades, we are still studying long term health outcomes. In short, we continue to learn about HIV, including HIV-associated mortality based on complications an *individual* may experience, and morbidity and mortality associated with persons infected with HIV as they remain on their treatments for prolonged periods of time.

Resources are Limited in Deployed Environments

Availability of ART Re-Supply During Deployments

27. Service members who deploy carry with them a sufficient amount of medication for a limited amount of time downrange (typically six months). However, deployments may exceed six months, or service members may need resupply because of loss or destruction of medications, and deployments can be extended from six months to potentially 12 or even 15 months or longer. Like all other supplies, medication can be destroyed in combat, and service members lose medication for several reasons, including the unique stresses of austere environments and battlefield conditions. Thus, resupply of medication is essential.

28. With an increasing number of available ART regimens and patients on different regimens, it would be logistically difficult in a combat operation to support every deployment set with the required medications for all therapies as there are constraints on type and quantity of medications needed and ART will not be on the priority list above many other required equipment and supplies. Although the military can plan to supply specific facilities downrange with specific medications, the military would be unable to ensure that these medications are reliably provided to deployed service members in all combat environments.

29. In combat operations, large movements of troops occur frequently, and supply chains are disrupted. No amount of planning can sufficiently anticipate combat operations to ensure the right medications will always be readily available to service members who have been moved to a different

location, are in the process of being moved, or are in combat. In addition, where someone is supposed to be assigned within a combat theater that frequently is not the location they ultimately end up being located. As such, all the associated preplanning might not be able to support personnel in remote areas with prolonged supply distances.

30. In contingency operations, resupply is frequently delayed and disrupted. This occurs even in more mature and developed theaters, such as Afghanistan. Adversaries target flights and ground convoys transporting supplies. I experienced the delay of prescription resupplies as the senior physician of a medical unit in Iraq, when rocket-propelled grenade attacks prevented the supply of Motrin to our soldiers for six weeks. On another occasion in Iraq, my unit ran out of medical supplies after suffering a mass casualty event ("MASCAL"). In the two weeks it took before we were resupplied, we were unable to take care of soldiers seeking medical assistance.

31. Because the extent of supply chain disruption depends largely on the air and ground capabilities of our adversary, in a future battleground against a near-peer adversary, the level of disruption to logistics would dwarf current experiences. In that case, it might be impossible to deliver supplies for months, leaving service members with HIV in a combat environment without their medication if their medicine is lost or destroyed or if their deployment length exceeds their initial supply of medicine.

32. Even if, hypothetically, there were a location in a deployed environment that had the lab support, medicines, and knowledgeable providers to appropriately support an HIV-positive service member, my analysis would not change because conditions during deployment are always changing. The same system that fully supports the healthcare needs of a service member with HIV one day, due to battle conditions or logistical problems, might not be able to do so the next. Service members might be moved to a different locations, which occurs frequently in deployed environments based upon mission requirements.

33. If service members with HIV are deployed, then the military would be required to provide downrange medical personnel with the right equipment and medication (and, as discussed, training)

for HIV treatment and to mitigate the risk of potential HIV transmission to other service members. Thus, in addition to ART, supplies of PeP would also be necessary to mitigate transmission risks after exposures. PeP and ART drugs are not typically provided to medical personnel during contingency operations. This would require a diversion of resources because there is a limit to logistics—because resources are limited in deployed environments, if PeP and ART drugs were required for contingency operations, components of deployment sets that are presently considered necessary would be unavailable.

34. Such a diversion of resources, itself, adds risk to the success of the mission. If the medication and equipment needed for HIV treatment is moved to the top of the priority list, despite the limited operative population, other things fall off the list. Because some medical supplies or equipment that are presently considered essential downrange would not be made available, some service members would not be able to receive the treatment they require and may be unable to fulfill their required roles in the mission.

35. At each level of medical care, there are limits of what can be carried. At the point of injury, the medic only has an aid bag. At the next level of care (called a Role 1 medical facility), providers have access to limited medication and a limited ability to conduct trauma stabilization, but there are no labs or robust laboratory support. The next level of care (called a Role 2 medical facility) has minimal lab and x-ray capability, and occasionally surgical care capability designed to be mobile and provide approximately eight core life-saving surgeries. Each of these levels of care is very limited by space and weight for their supplies. Even a more robust field hospital (such as those found at a Role 3 medical facility), which contains a pharmacy and laboratory, cannot support performing all the labs required of HIV-associated care and still are constrained in their ability to order and stock medications. At each level of care, the decisions on which medications and supply to stock are deliberately and carefully made. Additionally, these decisions are complicated by the possibility, especially in a near-peer conflict, that supply lines will be disrupted. Each level of care must not only have a sufficient supply of medications needed to treat the conditions commonly encountered in a

deployed setting, but enough medication to account for the possibility of an extended duration of time without resupply. The current approach is to stock medical facilities with medications it needs for common complications in a combat zone in the interest of preserving the overall strength of the force. The removal of any item presently deemed necessary at any level of care to make room for HIV medication (either ART or PeP) will have a significant effect on capabilities and capacities at that level of the medical care system. Displacing that medication with HIV medication would result less ability to adequately manage the wounded, ill, and/or injured.

Deployed Medical Providers are Not Trained in HIV Care

36. The military is currently unequipped to ensure that the deployed medical care providers are properly trained to care for service members with HIV. The medical providers that we rely on in the battlefield are not necessarily doctors. They may be physician assistants (PA), nurse-practitioners, combat medics, or corpsmen. Medics and corpsmen receive no training on HIV care, and PAs receive very limited training. They are trained to encounter common conditions in the deployed setting, and their curriculum cannot be modified to include training on HIV—an infrequently encountered disease—without removing other training the military has determined is necessary. This is also true for management of complications of other infectious diseases, such as Hepatitis B and C therapy.

37. Even if the medical training were modified to include initial training on HIV care, the military is unequipped to sustain the training, knowledge, skills, and abilities in the care of service members with HIV.

38. Without proper training in HIV care, service members with HIV could be treated by someone unable to provide the correct treatment or detect symptoms associated with viral rebound that could render the service member contagious in the field. A military internist or family physician can manage routine HIV-associated care if adequately trained but not complicated and/or atypical care requirements. However, they typically do not manage personnel with HIV given the small numbers among Military Health System beneficiaries or in the active services. This is more complicated with

you consider reserve and national guard healthcare providers that have different experience and knowledge bases than those in the active components. But particularly in the battlefield, the military doctors and medical care providers do not have the necessary training in the nuances of HIV care that might be required to detect treatment interruption and make the necessary modifications to the course of treatment.

39. Additionally, the ability of providers to provide the correct care is further limited because quick and reliable access to medical histories and medical records are not always available in deployed settings. Deployed service members do not bring hard copies of their medical files downrange. Rather, the military relies on an online system that might have reduced capability in a remote environment or if disrupted during combat.

HIV Care During Deployments

40. If the military were to implement the minimum necessary changes to provide HIV care in deployed operations, there would be a risk that the military still would be unable to provide the requisite standard of care in all theaters and environments. In all contingency operations, but especially those in remote or austere environments, the military simply is not equipped to provide a healthcare system—that ensures the provision of the right medicine, the right diagnostics, and the right personnel with the right training—to service members with HIV.

Clinical and Viral Load Monitoring

41. We plan for near-peer engagements in which "deployments" might not be limited to a set time period. Even now, circumstances may change requiring service members to stay downrange for months longer than a planned deployment, such as the six-to-eighteen month deployment periods to which we have become accustomed over the past twenty years. For these reasons, prior to deploying a service member, the military considers the consequences of an extended disruption of required medication and clinical care.

42. All HIV treatment requires lifelong care and laboratory monitoring. The military continues to have the obligation to provide this adequate, individualized standard of care in a deployed

environment. The military's Joint Trauma Care guidelines for deployment reflect that, the goal is to provide the same standard of care in both the deployed and home stations whenever possible.[7] Our current capabilities do not provide for this standard of care in the deployed environment.

43. The current National Institute of Health AIDS guidelines indicate that the viral load of patients on ART should typically be measured every three to four months for the first two years.[8] After two years of consistent viral suppression, the viral load monitoring can be extended to every six months. The military standard of care is to provide viral load monitoring every six months, consistent with HHS guidelines. I understand that some civilian providers perform monitoring every 12 months or longer, however, such deviations of standard of care are based on an individual medical provider's experience with a specific patient including long-term adherence to medication, response to treatment, and personal behavior patterns. The military program is designed to provide the recommended standard of care to its entire population of patients, even if a medical provider finds deviation in an individual circumstance might be warranted. Because deployments often exceed 6 months, the military would have to alter its operations to meet the accepted standard of care required to maintain the health of its service members during deployments.

44. Clinical monitoring, including viral load monitoring, plays an important role in ensuring that the patient maintains viral suppression and does not experience side effects. The unique stresses of a deployed environment, which could result in treatment interruption or exacerbated side effects, makes regular monitoring necessary and counsels against extending the period of time between viral load tests and clinical monitoring given the unknowns in individual responses in this environment.

45. If a service member experienced a prolonged interruption of his treatment, such as loss of medication, the service member would need a follow up viral load test. If a service member's medication regimen changes, because a different regimen was available in theater to continue

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[7] *See generally* Joint Trauma System Clinical Practice Guidelines (Last Updated May 28, 2020), https://jts.amedd.army.mil/index.cfm/PI_CPGs/cpgs (last visited May 28, 2020).

[8] *See* HHS AIDS Info, Laboratory Testing (Last Updated May 1, 2014), https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv/458/plasma-hiv-1-rna--viral-load--and-cd4-count-monitoring (last visited May 25, 2020).

treatment, the guidelines indicate that a viral load test should be performed within two to eight weeks after changing therapy.[9]

46. Service members with HIV require follow up care from providers who are well-informed about HIV care specifically, including the medicines, laboratory assessments, interpretation of laboratory assessments, potential complications of the medicines, and the history of their patients. Providers of follow up care must also understand the interplay of their patients' disease with adherence to medication, behavioral health issues, and stresses associated with deployment. In a deployed environment, there are simply not enough providers with this level of expertise, and communication bandwidth limitations in some environments limits the usefulness of telemedicine.

Adherence to ART During Deployment

47. The conditions of a deployed environment constrain service members' ability to engage in personal care of their disease. Personal care is a combination of medication, medical care, and measures to ensure people are living a healthy lifestyle that avoids excess stress on the body. In order to control their disease, service members with HIV must manage their lives as successfully as they do at home, however, deployment is very different. Downrange, diet and sleep patterns change. A deployed service member may experience many hours of sleep deprivation on patrol or in combat, or may be required to work nights. Deployed service members, tired, far from home, and constantly aware of the threat of attack, generally experience more stress. These factors make it more likely that service members will forget to take their medication. The risk to the service member (and to others) increases with missed doses. In general, the same conditions that constrain self-care (diet change, fatigue, lack of sleep) as well as others in a deployed environment (extreme weather) might increase negatively affect all deployed service members' immune system, and therefore presents a unknown risk it could exacerbate potential side effects of any medication, including ART.

48. Even when service members have access to their medication (with a sufficient supply and

[9] *See* HHS AIDS Info, Table 3: Laboratory Testing Schedule for Monitoring People with HIV Before and After Initiation of Antiretroviral Therapy, https://aidsinfo.nih.gov/guidelines/htmltables/1/7267 (last visiting May 28, 2020)

reliable resupply), it is important to consider that they might not adhere to ART regimens consistently. Although service members have an excellent history of adherence at home, due to the conditions of deployment, their adherence downrange may be less consistent. An extended ART disruption increases the risk of a service member becoming immunocompromised, more infectious, or resistant to the current regimen (which could require a regimen shift). Further, when these individuals experience viral load rebound due to ART interruption, the risk of transmission to other service members increases, endangering the health of the fighting force.

49. Plaintiffs' expert, Dr. Hendrix, appears to rely on a study of U.S. Naval personnel serving on operational assignments that had high rates of adherence to medications to dismiss adherence concerns. Pls. Ex. 49, Hendrix Supl. Rep. ¶ 29. However, the conclusions from this small study cannot be extended to ground-based contingency operations. Personnel on naval vessels adhere to strict routines and are unlikely to lose their medication or have their medication destroyed in battle. Large vessels also have hospital-like medical facilities that can store all necessary prescription medication for resupply. These conditions are not comparable to contingency ground operations especially those in austere environments or those with prolong supply lines.

50. Finally, the current guidelines indicate viral rebound typically occurs within days to weeks after cessation of therapy, and has been observed to occur as early as three to six days after stopping treatment; however, the minimum level of adherence has not been determined with certainty, especially with more recently developed daily dosing regimens.[10]

Transmission Risk to Other Service Members

Wound to Wound Contact

51. Battlefield transmission of HIV through wound to wound contact or catastrophic injury (for example, the detonation of an explosive device causing infected blood or tissue to penetrate an uninfected service member, or a bleeding soldier applying emergency medical care to another

[10] HHS AIDS Info, Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV at F-3, *available at* https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv/548/antiretroviral-therapy-to-prevent-sexual-transmission-of-hiv---treatment-as-prevention-

bleeding soldier) potentially can occur. Undetectable viral load does not mean no viral load, and the larger quantities of blood increase the likelihood of transmission. However, there is limited data regarding this subject.

52. Because service members with HIV are kept off the battlefield, the lack of documented cases of battlefield transmission is unsurprising. However, I disagree with Dr. Hendrix's conclusion that the risk of battlefield transmission is so low to present no danger to a service member's comrades on the battlefield. *See, e.g.*, Hendrix Expert Rep. ¶¶ 50-51. Dr. Hendrix minimizes the risk of this transmission modality, arguing that "blood splashes" and "wound-to-wound contact" that occur in civilian settings—which have not been documented as routes of transmission—are comparable to battlefield conditions. They are not. The type of "blood splash" or "wound-to-wound contact" that may typically occur in a civilian setting do not reflect the severity of, and amount of blood associated with, catastrophic battlefield injuries. I also disagree with Dr. Hendrix's conclusion that no service member is likely to have multiple exposure incidents in a year. Service members may engage in daily, if not more, kinetic events in the course of a deployment, and in a single kinetic event, multiple wounded service members may provide emergency medical aid to several other wounded service members. The lack of a documented case of transmission does not mean there is no possibility of transmission. Based on what we know about how HIV carried and transmitted, that there is a potential although low risk of transmission. We owe our service members transparency and informing the person that was exposed is required of a health care provider to allow the patient to make an informed decision themselves regarding their ongoing medical care.

53. If a battlefield medical provider is aware of a service member's potential exposure to HIV through wound to wound contact with a service member whose viral load was undetectable, the provider should take several steps. First, the provider should make the potentially-exposed service member aware of the risk of transmission, no matter how slight, and the availability of prophylactic treatment. Second, the provider must be able to provide PeP and support laboratory testing on request. If the service member were exposed to the blood of an individual experiencing a previously

undetected or unreported viral load rebound, the provider would take the same steps, but more strongly recommend prophylactic treatment. Regardless of the likelihood of transmission in either scenario, the military must be able to fully address this risk and the concerns of the exposed service member, including ensuring the availability of PeP in the field. This would also lead to loss of anonymity of the service member with HIV.

Walking Blood Bank

54. The walking blood bank is the process of having deployed personnel donate their blood for immediate use. It can include a prescreened population that should pose minimal risk of transfusion-associated infection risk; however, in a MASCAL, donors are often not prescreened and their blood is immediately provided. For small units, caregivers prefer to transfuse O low antibody titer blood, but that blood type is only present in a relatively small percentage of donors. Consequently, in a small unit, every person's blood, and especially those with unique blood types, is key. If someone with HIV is part of a small unit where everyone is needed to be a donor, this places a risk to the unit. Some units are less than 12 person units when engaged in combat operations so every person is potentially a donor.

55. When a unit of blood is obtained from a soldier for an emergency blood bank, the blood is labeled and tubes containing the blood are obtained. Although the unit of blood is still given to the patient, the tubes are sent back to a testing center in the U.S. to validate that the transfused blood did not contain any pathogens. Though rapid test kits for use before transfusions may sometimes be available, there may not the 10-20 minutes required to use to use them in medical emergencies in which blood is needed immediately. The rapid testing kits also sometimes produce false negatives in cases of virally suppressed patients whichmeans that a service member might be provided infected blood without the service member's or provider's knowledge.

56. Although service members with HIV are instructed not to donate blood, it is possible they will misunderstand or disobey those orders by deciding the need for blood is too great or out of concerns for confidentiality of their HIV status. Also peer pressure to donate can be a very strong

influencer for someone to donate blood. Although service members should fully understand and obey all orders, based on my decades of experience in the military, I know this not to be true. I am aware of a soldier with Hepatitis C donating blood despite being instructed not to do so. The Hepatitis C was only detected after the transfusion, when the blood was sent back for testing.

Occupational Exposure Risk to Deployed Providers

57. In deployed settings, regardless whether they are treating battle casualties, service members comprising the health care system who would support personnel with HIV would be at risk of infection from occupational exposures, such as needle stick injuries. If there is a needle stick injury, the standard procedure is to report the injury and then assess if the person that was stuck knows the source and if that source can be tested. The person stuck would then have safety labs and then offered therapy if in a high risk exposure environment. We know an undetectable viral load renders the virus untransmittable from sexual intercourse. But, we do not know whether an individual with an undetectable viral load can transmit the virus through needle stick injuries or blood exposure. We know that even with an undetectable viral load, there is at least some risk of transmission through blood transfusion.

58. Battlefield medical providers do not take universal precautions in all circumstances. In a kinetic environment, and particularly during a MASCAL event, although medical providers try to adhere to the best standard of care for universal precautions, in reality that does not occur. Medics managing a bleeding casualty while returning fire would not put on their gloves, but instead would quickly apply a tourniquet and continue firing. I speak from experience. When I treated wounded soldiers in a 40+ person MASCAL — given the severity of their injuries, there was no time to change gloves between patients, and I would not have stopped managing my patients even if I incurred a needle stick injury

59. Further, many of service members we treated during the MASCAL were unconscious. Their dog (identity) tags revealed only unconfirmed information concerning their blood type, and we did not know whether we were treating soldiers with HIV. There was, in fact, no way to acquire that information as we treated our patients: we did not have access to medical records, and we were

unable to quickly identify, let alone communicate with, the wounded soldiers' medical providers or commanders who might have known the injured service members' medical conditions. There is no feasible system to protect the confidentiality of a service member's HIV status while allowing that information to be disseminated to providers under battle conditions. If one of the soldiers we treated had HIV, we might have evacuated him out of theater without the proper medication. If one of my providers had been exposed to infection during treatment, we would not have known. This is the type of scenario that must be considered in assessing the risk of deploying service members with HIV to austere and highly kinetic environments. Although this scenario can occur in today's conflicts, it would occur more frequently in a near-peer fight.

60. If a medical provider experienced an occupational exposure, there are multiple logistical hurdles that pose challenges in operational settings. First, without knowing the patient has HIV, a provider might not even seek PeP treatment. As discussed, there is no system in place that informs all providers in an operational setting of their patients' HIV status while protecting their patients' privacy. Second, many deployed locations do not have rapid HIV diagnostic kits and/or PeP medications, given their deployment medical supplies focus on issues likely encountered in an deployed setting. Third, due to the limited of weight and space available in small units and in austere environments, ensuring the availability of PeP would necessarily limit the unit's ability to bring supplies of greater necessity, such as food, water, and ammunition. Fourth, transporting personnel (or their blood for testing after potential exposure to HIV) to, within, or out of theater incurs additional risk to their safety as well as to those required to transport them. Fifth, those providers would also very likely experience heightened anxiety due to their potential exposure to HIV, affecting their well-being and their ability to provide care for those who rely on them. And finally, as discussed in more detail below, removing a provider from theater could reduce or fully negate mission capability.

Viral Load Rebounds Can Increase Transmission Risk

61. Viral load rebound is not common among service members, but the military must consider the

risk of rebound based on the combination of the several factor already discussed that could contribute to this scenario: treatment interruptions, supply chain problems; conditions on deployment that constrain self-care; and lack of sufficient medical expertise in HIV treatment downrange. Increased viral loads mean that HIV transmission risk increases across all transmission paths, and when viral load becomes detectable, the disease becomes transmittable sexually. In assessing risk, the military does not consider just the most likely scenario, it must also consider the most dangerous scenario based on all factors contributing to risk. Thus, the concern regarding the likelihood of transmission in the battlefield is heightened when viral load rebound is considered. Additionally, because sexual activity does occur down range (despite orders and policies to limit or restrict this behavior), viral load rebound adds the risk of transmission through sexual intercourse.

Other Considerations to Mission Success

62. Deploying HIV-positive service members also burdens the military's ability to prepare for deployments and adds risks to mission execution once deployed.

Pre-deployment Preparations

63. Preparing for deployment is often a robust process with many steps, from ensuring the service member has a will and a power of attorney, to conducting pre-deployment medical and dental evaluations. Sometimes, however, a service member will have a matter of days to prepare for a deployment with little or no time to complete the necessary medical and administrative steps. This can occur because someone was unable to deploy, and a rapid replacement was needed. Or a service member might be needed for a new operation that did not have personnel already in place for support. Little or no-notice deployments could negatively affect service members' ability to deploy with adequate medications, obtain all the required laboratory testing (to not need additional testing for six months), and see an infectious disease physician prior to deployment (especially if they are not located at the same base, which is common).

64. An essential part of pre-deployment preparation is ensuring that deploying service members are medically fit. At the very minimum, to medically clear service members with HIV for deployment,

providers would have to ensure that they are on a stable medication regimen, are virally suppressed for a minimum amount of time, have an undetectable viral load, are immunologically stable (stable labs for a sufficient duration), and do not require frequent follow ups for any issue related to HIV, including ongoing infectious complications, history of recurrent infections of unclear etiology, or associated behavior health conditions. Because reserve and National Guard service members receive their HIV care from the civilian health care system, there is no system in place to provide this level of screening for members of those components, who frequently deploy.

65. Provided these service members are medically cleared to deploy, the military would then have to ensure they have right amount of the right medicine. There are fifteen possible first-line regimens, and the military would have to ensure that every location from which a service member may deploy is stocked with a sufficient supply of the right drugs. This would be the only option to ensure service members deploy with the right medication because mail-order pharmacies are not available in certain locations downrange. The military does not have a system in place for this. Because these medications are not part of the deployment medical set ups that are standardized across the military services, the military would be required to redesign these medication packages. That would typically result in removing something from the packages that the military has determined to be necessary. Additionally, the cost of re-designing deployment medical set-ups would be significant given the scope and scale of the U.S. military's operational requirements across the services, and the requirement to maintain and continually adjust the set ups over time as new HIV-specific medications are introduced into clinical care.

During Deployment

66. Once deployed, the presence of personnel with HIV could add risk to the mission. If a service member with HIV requires treatment that cannot be provided in theater, that service member must be moved out of theater. At minimum, this will likely require movement for regular clinical monitoring, in addition to any additional care required if they experience a treatment interruption. Although the same is true for any service member requiring treatment, most common chronic

conditions have laboratory services available in theater or the follow up window is more extended. These personnel should also not deploy to austere small unit locations with limited supply chains for similar reasons to a patient with HIV. But even then, these other conditions are not communicable, like HIV. Providers or non-medical personnel who might have been exposed to HIV (or their blood) would also have to be moved. Any movement in a deployed environment risks the lives of those being transported and those who transport them. I have experienced medical evacuation assets fired upon by rocket-propelled grenades; some were hit and destroyed with all those on board. Also, because movement requires taking assets away from another area of an operation, it might delay the overall goal in a combat zone.

67. Moving service members away from their assigned location for care can render a team non-mission capable. For example, if a team is "one-deep," it has no redundancies. Each service member on that team has specific responsibilities, and the team cannot carry out its mission without that individual. "One-deep" teams, which include sniper teams, certain surgical teams, and EOD (explosive ordnance disposal) are frequently employed in operational environments. Generally, there are very limited redundancies downrange. Every deployed service member has a designated purpose, and even if a team or unit is not "one-deep," the absence of a single service member can have significant adverse effects on a mission. For example, the removal of one combat medic from a forward operational post could render the mission incapable. Finding a replacement is not simple, and also incurs risk. The right replacement has to be identified. For certain operations, to secure a service member with the requisite skill set, the military must reach back to the United States. Second, once identified, the replacement has to be moved in theater, which incurs risk and is subject to frequent and often extensive delays due to battle conditions. While a service member is stuck in transit for weeks, the receiving unit will continue to experience degraded capabilities or possibly be non-mission capable.

68. The effect on the unit of having to remove a service member unexpectedly for treatment or monitoring for an unknown amount of time is very different than allowing a service member to go

to "R&R," rest and recuperation. The timing of each personnel who is approved to go on R&R is planned; that is, the command decides well in advance which and how many personnel may leave theater at a given time. The military does not use R&R to provide necessary medical care, and the command will not approve R&R if doing so would jeopardize the mission or render it incapable of accomplishing its mission. If transport out of theater for R&R is dangerous, the command can reschedule it. The removal of a service member from theater for medical treatment, on the other hand, is neither planned nor a vacation that can be rescheduled. Any unplanned amount of time in which the service member is unable to perform his duties is excessive and jeopardizes the unit's ability to accomplish its mission. In future conflicts, especially in a near-peer conflict, it is important to note that there might not be R&R.

Conclusion

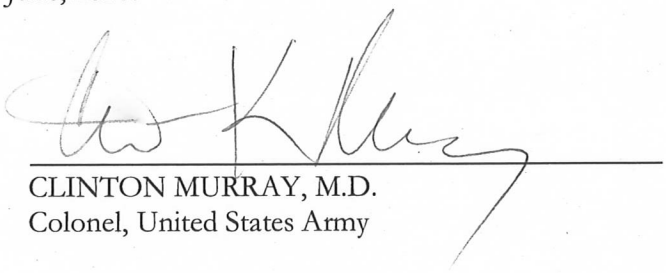
69. Deploying HIV-positive service members to contingency operations in remote or austere environments poses unique medical challenges and results in an unacceptable risk both to those service members and the success of the mission. There are significant differences between the types of deployments, which may occur in different environments, entail different missions, and involve adversaries with varying levels of capability; however, deploying service members with HIV to any of these environments creates additional risk. Each of these deployment environments would have to ensure appropriate laboratory support, pharmacy support, and the ability to move people for treatment. But the military can only provide limited medical resources, personnel, and expertise to a given location. Changing who the military deploys affects more than simply the composition of the fighting force. It would change what the military can—and cannot—decide to bring with it to a conflict; it would introduce a new level of both known and unknown risks to service members and their commanders; and it would add additional requirements and challenges making it more difficult for commanders to focus on their primary objective of accomplishing the mission.

70. Although the military must incur great risk to its service members when it is necessary, the military must mitigate risk when it is possible. Mitigating risk is essential in protecting the safety of

our service members, our mission, and our nations' security. Considering the combination of risks, the resources likely to be available in theater, and the changes of operations that would be required to mitigate the risks, my conclusion is the military's judgment that HIV-positive service members should not deploy to contingency operations is reasonable.

* * *

In accordance with 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 2nd day of June, 2020.



CLINTON MURRAY, M.D.
Colonel, United States Army

EXHIBIT A

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Colonel, Medical Corps, US Army

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Personal
Home Address:
Cell:
E-mail:

Education

Master of Strategic Study, U.S. Army War College Distance Education Program, Carlisle, PA	2013-2015
Fellowship, Infectious Disease (ID), San Antonio Uniformed Services Health Education Consortium (SAUSHEC), Brooke Army Medical Center (BAMC), Ft. Sam Houston (FSH), TX	1999-2002
Residency, Internal Medicine, Walter Reed Army Medical Center (WRAMC), Washington, DC	1996-1999
MD, Uniformed Services University of the Health Sciences (USUHS), Bethesda, MD	1992-1996
BS (Biochemistry), Summa Cum Laude, Texas Tech University (TTU), Lubbock, TX	1988-1991

Professional Positions and Appointments

Command Surgeon, United States Forces Korea (USFK), United Nations Command, Combined Forces Command — 2019-current
Camp Humphreys, Republic of Korea
Coordinates and Synchronizes Heath Service Support and Force Health Protection across the Korea Theater of Operations in support of USFK, United Nations Command, and Combined Forces Command.

Commander, 1st Area Medical Laboratory — 2017-2019
Aberdeen Proving Ground, MD
Responsible for the operation unit designed to deploy around the world for rapid assessment of chemical, biological, radiological, and nuclear events.

Deputy Corps Chief — 2015-2017
U.S. Army Medical Corps
Joint Base San Antonio, FSH, TX
Responsible for representing the Medical Corps Chief (2-Star) in all aspects regarding the Medical Corps.

Corps Specific Branch Proponent Officer (CSBPO) — 2015-2017
U.S. Army Medical Corps
Joint Base San Antonio, FSH, TX
Responsible for integration of the Medical Corps (MC) in all proponent categories (branch, functional, specified and personnel) that affect individual and collective AMEDD Corps; develop policy direction for the AMEDD with an integrated Army-wide health service system for peace, war and operations other than war.

ID Consultant, U.S. Army Surgeon General — 2016-2020
ID Consultant, Southern Regional Medical Command — 2009-2015
ID Consultant, Great Plains Regional Medical Command — 2008-2009
Southeast US, Central US
Coordinated the Infectious Disease personnel and programs across the Army. Provides expert ID recommendations.

Professor — 2011-current
Associate Professor — 2007-2011
Assistant Professor — 2002-2007
Instructor in Medicine — 2001-2002
Teaching Fellow in Medicine — 1997-1999

Department of Medicine
USUHS, Bethesda, MD

Adjunct Professor	2012-2017
Clinical Associate Professor	2006-2012
Clinical Assistant Professor	2002-2006

Medicine and ID
University of Texas Health Science Center at San Antonio (UTHSCSA), San Antonio, TX

Chief	2011-2015
Acting Chief	2007-2011(2+yr)
Assistant Chief	2003-2007
Officer In Charge, ID Clinic	2002-2008

ID Service
San Antonio Military Medical Center (SAMMC)/BAMC, San Antonio, TX
Managed a staff of 60+ US Army and Air Force, government service, contractor, and research employees that produced ~25,000 RVUs/year with an annual research and clinical budget in excess of $2.5 million.

Director 2008-2015
Multiply-drug Resistant Bacteria Molecular Epidemiology Referral Laboratory
SAMMC/BAMC, FSH, TX
Developed and implemented an international program evaluating multidrug-resistant bacteria.

Acting Chief 5-9/2014, 2012, 2011 (6+ months)
Department of Medicine
SAMMC/BAMC, San Antonio, TX
Directed and managed 900+ personnel and 12 services at the DoD largest Military Treatment Facility.

Program Director 2005-2011
U.S. Army and U.S. Air Force ID Fellowship
SAUSHEC, San Antonio, TX
Managed a program of up to 12 U.S. Army and Air Force Infectious Disease Fellows.

Director 2004-2008
Department of Defense (DOD), Global Emerging Infections Surveillance and Response System (GEIS) Center of Excellence for Leptospirosis
BAMC, FSH, TX
Directed an international research program assessing leptospirosis diagnostics and therapeutics.

Certification and Licensure

Infectious Disease, American Board of Internal Medicine, Certificate #: 189133	2012, 2002
Internal Medicine, American Board of Internal Medicine, Certificate #: 189133	2019, 2009, 1999
Travel Medicine Certification by the International Society of Travel Medicine	2003
United States Medical Licensing Examination (Step 1,2,3), Certificate number: 4-037-137-9	1998
District of Columbia Medical License #MD30897	1998-current

Professional Membership

Infectious Disease Society of America (IDSA) (Fellow 2006)	1999-current
American College of Physicians (ACP) (Master 2016, Fellow 2005)	1997-current

Editorial and Grant Reviewing Activities

Journal Editorial Board

Burns	2010-2015
Journal of Special Operations Medicine	2006-2011

Journal Supplement Editor

Military Medicine	2018
Army Medical Department Journal	2015
Journal of Trauma	2011, 2007

Journal Reviewer

American Journal of Critical Care, American Journal of Tropical Medicine and Hygiene, Annals of Emergency Medicine, Annals of Tropical Medicine and Parasitology, Burns, Central European Journal of Medicine, Central European Journal of Medicine, Clinical Infectious Disease, Clinical Microbiology and Infection, Clinical Orthopaedics and Related Research, Diagnostic Microbiology and Infectious Disease, Emerging Infectious Diseases, European Journal of Clinical Investigation, European Journal of Clinical Microbiology and Infectious Diseases, Expert Review of Anti-Infective Therapy, Expert Review of Molecular Diagnostics, Future Drugs Ltd, Hospital Physicians, Indian Journal of Medical Sciences, Infection, Infection and Drug Resistance, Infection Control and Hospital Epidemiology, Intensive Care Medicine, International Journal of Occupational and Environmental Health, International Journal of Infectious Diseases, JAMA, Journal of Antimicrobial Chemotherapy, Journal of Clinical Microbiology, Journal of Emergencies, Trauma and Shock, Journal of Infection, Journal of Orthopaedic Trauma, Journal of Rehabilitation Research and Development, Journal of Travel Medicine, Microbial Drug Resistance, Military Medicine, PLoS (Public Library of Science) Neglected Tropical Diseases, Scandinavian Journal of Infectious Diseases, The Lancet, The Lancet Infectious Disease, Transplant Infectious Disease, Travel Medicine and Infectious Disease

Grant Reviewer

Global Health Engagement Research Initiative through the Office of the Assistant Secretary of Defense for Health Affairs, Defense Health Agency and USUHS	2019
Institute for Integration of Medicine and Science/Clinical and Translational Science Award, UTHSCSA	2010, 2009
Czech Science Foundation	2009
The Wellcome Trust- Pathogens, Immunology and Population Health Grants	2009
Member, ID Joint Programmatic Committee- Congressionally Directed Medical Research Program, (FY08 Congressional War Supplement for “Battle Casualty and Psychological Health” $273.8 million)- Military ID Intramural and Extramural Granting Committee	2008
Member, Orthopaedic Trauma Research Proposal, US Army Institute of Surgical Research	2007, 2006
British Society for Antimicrobial Chemotherapy	2006

Military Awards

Legion of Merit, 1st Bronze Oak Leaf Cluster (2nd award)	2019
Legion of Merit	2017
Meritorious Service Medal, Silver Oak Leaf Cluster (6th award)	2016
Meritorious Service Medal, 4th Bronze Oak Leaf Cluster (5th award)	2015
Meritorious Service Medal, 3rd Bronze Oak Leaf Cluster (4th award)	2015
International Security Assistance Force (ISAF) Operation NATO Medal	2013

Afghanistan Campaign Medal	2012
Army Superior Unit Award- 2nd Bronze Oak Leaf Cluster (2nd award)- BAMC	2011
Meritorious Service Medal, 2nd Bronze Oak Leaf Cluster (3rd award)	2011
Army Achievement Medal, 1st Bronze Oak Leaf Cluster (2nd award)	2009
Meritorious Service Medal, 1st Bronze Oak Leaf Cluster (2nd award)	2008
Army Superior Unit Award- BAMC	2006
Combat Action Badge	2004
Joint Meritorious Unit Award- 1st Brigade Combat Team, 1st Infantry Division	2004
Army Valorous Unit Award- 1st Brigade Combat Team, 1st Infantry Division	2004
Meritorious Service Medal	2004
Overseas Ribbon	2004
Bronze Star Medal	2004
Army Commendation Medal, 3rd Bronze Oak Leaf Cluster (4th award)	2004
Iraqi Campaign Medal, Bronze Star (2nd Award)	2004
Iraqi Campaign Medal	2003
Army Commendation Medal, 2nd Bronze Oak Leaf Cluster (3rd award)	2002
National Defense Service Medal	2001
Army Commendation Medal, 1st Bronze Oak Leaf Cluster (2nd award)	1999
Army Commendation Medal	1999
Army Achievement Medal	1998
National Defense Service Medal	1992
Army Service Ribbon	1992
Outstanding Battalion Cadet, TTU	1990
Outstanding Company Cadet, TTU	1990
Department of the Army Superior Cadet Decoration Award, TTU	1990

Honors and Recognition

Honorary Membership, The Korean Military Medical Association	2019
Master of the American College of Physicians	2016
2016 USU Alumni Association's School of Medicine Award, Graduate of the Year	2016
Healthcare-Associated Pneumonia Among United States Combat Casualties, 2009-2010. Mil Med Selected as the 2016 Military Medicine Article of the Year	2016
The Surgeon General's Award for Military Academic Excellence (Lewis Aspey Mologne Award)	2015

Outstanding Faculty Medicine Clerkship, UTHSCSA Medical School Class	2014, 2013, 2012, 2011, 2007, 2006
Outstanding Teaching Staff of the Year, Transitional Intern Class, BAMC/SAUSHEC	2013, 2012, 2009
Outstanding Teaching Service, Department of Medicine, BAMC/SAUSHEC	2017, 2016, 2015, 2014, 2012, 2009
Outstanding Staff Teacher, Internal Medicine Residency, Department of Medicine, BAMC/SAUSHEC	2012, 2009, 2006
Experience monitoring exposure to Ebola and health of United States military personnel deployed in support of Ebola control efforts Liberia, 2014. MMWR. Recognized in Infectious Disease News 2015	2015
Faculty Development Certificate in Medical Education, USUHS	2014
The epidemiology of *Staphylococcus aureus* blood and skin and soft tissue infections from 2005-2010 in the US Military Health System. JAMA Featured Article by Journal Watch Infectious Diseases- July 4th edition Highlighted in ACP Internist Weekly- 12 July 2012 Journal Watch- Infectious Diseases Top Stories of 2012	2012
8H Skill Identifier, Clinical Investigation and Research Regulatory Oversight	2012
Winner, Gold Headed Cane Award, San Antonio Military Health System	2012
Winner, COL John D. Roscelli Outstanding Program Director Award, SAUSHEC	2011
Selected to present the best Army Research Paper, Military Health System Conference	2011
Master Teacher Award, Army Chapter ACP	2010
Finalist, Gold Headed Cane Award, SAMHS	2011, 2010
US sponsor, American Society of Microbiology International Affairs Fellowship and Professional Recipient- Dr. Ahmed Samir Mohamed Cairo University, Egypt	2009-2010
US Army Medical Corps “A” Proficiency Designator in ID	2009
Excellence Award in Military Clinical Practice- V Pan-American Congress of Military Medicine, San Antonio, TX	2008
The Order of Military Medical Merit	2006
James J. Leonard Award for Excellence in Teaching IM, USUHS, Department of Medicine	2006
William Crosby Superiority in Research Award, Army Chapter ACP	2006
Surgeon General’s Physician Recognition Award, top US Army Medical Corps Major	2005
First place- Commander’s Award Fellow in Basic Science/Animal Model, SAUSHEC	2002
Finalist, General Graves B. Erskine Award, WRAMC	1999
Finalist, Bailey K. Ashford Award, WRAMC	1999
Alpha Omega Alpha, USUHS	1995
Number 1 Graduate, College of Arts and Science, TTU	Dec-1991

Committee Member

National (Department of Defense/Military)

Synchronizer, AMEDDC&S/HRCoE/Corps/Joint- Medically Ready Force	2015-2017
Chair, Iron Major Selection Committee- Medical Corps	2016, 2017
Chair, CJ Reddy Selection Committee- Medical Corps	2016, 2017
Chair/Member, Steering Committee for the Infectious Disease Clinical Research Program	2016-2020
Chair/Member, ID Clinical Research Program- Scientific Review Board, USUHS, Bethesda, MD	2007-2014
Chair, U.S. Army Infection Prevention and Control Advisory Panel	2011-2014
Chair, Combat-related Infections, Extremity Team, Prevention and Management of Combat-related Infections: Clinical Practice Guidelines Development Workshop, FSH, TX	2011, 2007
Member, Joint Program Committee- 2/Military Infectious Diseases	2016-2020
Member, Military Tropical Medicine Curriculum Committee	2016-2020
Member, GEIS Antimicrobial Resistance Steering Committee	2016-2020
Member, Customer Representative, Diarrheal Diseases Prevention Research Program Steering Committee, Military ID Research Program (MIDRP)	2014-2020
Member, USUHS Committee on Appointments, Promotions and Tenure, Bethesda, MD	2015-2019
Member, Readiness Resource Management Decision Committee	2016-2017
Member, Wolf Pack Award Selection Committee	2015-2017
Member, Order of Military Medical Merit Selection Committee	2015-2017
Member, MEDCOM Memorialization Board	2015-2017
Member, DoD Gastrointestinal Management Clinical Practice Guidelines Committee	2016-2017
Member, Prolonged Care IPAT	2016-2017
Member, Planning Committee for International State-of-the-Science Meeting, Blast Related Injury Infections	2016
Member, State of the Science Meeting: Systems Biology of Drug-Resistant Infectious Diseases	2016
Member, Graduate Medical Education Review Committee	2015-2016
Member, Army Surgeon General Senior Talent Management Council	2015-2016
Member, Medical Reorganization Action Planning Team (MRAP)/Essential Medical Capability Team	2015-2016
Member, Corps Synchronizing Element (CSE) Workgroup	2015-2016
Member, O5A Branch Immaterial AMEDD Committee	2015
Member, Army Surgeon General Awards Committee	2016, 2015
Member, Military Health System Army Female Physician Junior and Senior Leader Award Selection Committee	2015

Proponent Officer, Mologne and The Surgeon General Medical Corp Awards	2015
Member, IDCRP Concept Scoring Panel- USUHS, Bethesda, MD	2014-2016
Member, DoD ID Ebola CPG Working Group	2014-2015
Member, Dengue Rapid Diagnostic Device Development Effort	2012-2014
Member, Defense Threat Reduction Agency, Joint Science and Technology Office (DTRA JSTO) Hand Held Rapid Diagnostic for Pre-hospital and Healthcare Point-of-Entry	2011-2014
Member, Joint Biological Agent Identification and Diagnostic System (JBAIDS) Clinical Advisory Panel, Washington DC	2008-2013
Member, Military ID Research Program-Trauma Wound Infection Program, Washington DC	2008-2013
Member, Medical Corps 'A' Designator Board, FSH, TX	2013
Member, AFHSC-GEIS Antimicrobial Resistance and Surveillance Steering Committee	2012-2013
Member, Biopsy and Treatment of Invasive Fungal Infection in War Wounds, Clinical Practice Guideline, Joint Trauma System	2012
Member, US Army Leadership Development Working Group	2011-2012
Subject Matter Expert, Congressionally Directed Medical Research Programs U.S. Army Medical Research and Materiel Command, Peer Reviewed Orthopaedic Research Program	2010
Member, Expanded Joint Technology Coordinating Group, Washington DC	2009-2010
Member, Telemedicine & Advanced Technology Research Center (TATRC), Product Line Review: ID, Fredrick MD	2009
ID Representative to the Internal Medicine Services Manpower and Requirements Criteria, Washington DC	2009
Program Liaison, ID- Congressionally Directed Medical Research Program, FY08 Congressional War Supplement for "Battle Casualty and Psychological Health"	2009
Member, Multidrug-resistant Organism Repository and Surveillance Network, Washington DC	2008-2010
Member, 2008 Deployment Related Medical Research Program (DRMRP) Joint Program Alignment Peer Review Program (JPAPRP)	2008-2009
Member, Intramural ID Joint Planning Committee (Programmatic Review) for the FY09 War Supplemental Program (DHP funding for Battle Casualty and Psychological Health)	2008-2009
Army Representative, DoD Clinical Guidelines for Combat Theater Management of Pandemic Influenza, Washington, DC	2006
Voting Member, Brigade & Division Surgeons Critical Task Selection Board, FSH, TX	2006

National (Civilian)

Member, Antibacterial Resistance Leadership Group (ARLG) Special Populations Special Emphasis Panel	2013-current
Member Protocol Steering Committee, Major Extremity Trauma Research Consortium (METRC) Bioburden Study	2009-current

POvIV Study
Oxygen Study

Member, Accreditation Appeals Panel, Internal Medicine- ID, Accreditation Council for Graduate Medical Education (ACGME) 2011-2017

Member, IDSA ID Training Program Directors Committee 2011-2014
Medical Scholars Award sub-Committee Member 2012-2014

Member, Clinical and Laboratory Standards Institute Carbapenem Ad Hoc Working Group 2012-2013

Member, Hospital Medical Management Focus Group, Robert Wood Johnson University Hospital "Evidence-based best practices for explosive/incendiary incidents: translating the Israeli experience for use in the US military and civilian pre-hospital and hospital health care systems" 2010

Advisory Board, Intercell AG- IC43 Pseudomonas Vaccine, Austria 2008-2009

Military Decision Brief- Lead Presenter

NDAA 2017, Sec. 708/709- Joint Trauma System and Civilian Training Model Senior Leader Meeting 2017

Responsive Medical Force (Officer/Enlisted) KSAs, The U.S. Army Surgeon General's Senior Medical Readiness Forum 2016

Point of Injury Antibiotic- Reanalysis. Tactical Combat Casualty Care (TCCC) Committee 2016

Sustainable Readiness Model: Responsive Medical Capability at the Surgeon General's Command Team Leader Development and Training Session 2016

Infection Control and ID CETCOM AOR After Action Review with focus on Personnel/Training, Logistics, Standardization, and Communication 2012

Point-of-Injury Antimicrobial Use- continue current regimens based upon US Ranger experience, TCCC Committee (no change in current policy except to enforce training) 2011

Point-of-Injury Antimicrobial Choice- use of IV/IM Ertapenem versus other agents, TCCC Committee (ertapenem selected as the field choice) 2005

Regional/Local

Chair, Medical Advisory Infectious Disease (MAID) Lookback Committee 2011-2015

Co-Chair, BAMC Ebola Response Team 2014-2015

Chair, Awards Committee, William Crosby Superiority in Research Award, Army Chapter ACP 2012-2015

Chair, Updating Graduation Awards Committee, SAUSHEC 2010

Director of Integration, BRAC integration of BAMC and WHMC ID Services 2006-2011

Member, Clinical Competency Committee (Key Clinical Faculty), SAUSHEC IM Residency 2005-2017

Member, Clinical Competency Committee (Key Clinical Faculty), SAUSHEC ID Fellowship 2002-2017

Member, AMEDD Captains Career Course Curriculum Review 2015

Member, SAUSHEC Research Working Group Subcommittee 2014-2015

Member, Clinical Risk Management Committee, BAMC/SAMMC 2012-2015

Member, Gold Headed Cane Selection Committee, SAUSHEC 2013-2019

Member, Resident Primary Care Manuscript Commanders' Research Award Committee	2013
Member, COL John D. Roscelli Outstanding Program Director Award Committee	2012
Member, Awards Committee, Master Teacher Award, Army Chapter ACP	2011
Member, Awards Committee, William Crosby Superiority in Research Award, Army Chapter ACP	2010, 2009
Member, Awards Committee, COL John Roscelli Outstanding Program Director Award, SAUSHEC	2010
Consulting Panel, Guidelines for Texas First Responder immunization for U.S. Gulf-Coast Hurricane Response	2009
Member, Educational Value Units, BAMC Department of Medicine	2006-2007
Member, BAMC- JCAHO Oryx Committee, FSH, TX	2005-2008
Primary/Alternative Member, Nuclear, Biological, Chemical SMART Team, FSH, TX	2002-2008
Member, BAMC Institutional Review Board (IRB), FSH, TX	2002-2007

Community Activities

Mentor, Alamo Heights United Methodist Church New Zion Jr/Sr High Choir Mission Trip	
Flagstaff, Arizona	2016
Nashville, Tennessee	2015
Estes Park, Colorado	2014
Little Rock, Arkansas	2013
Albuquerque, New Mexico	2012
Jackson, Mississippi and Knoxville, Tennessee	2011
New Orleans, Louisiana	2010
Hemet, California	2009
Member, BioMed San Antonio, ID Subcommittee	2011
Triathlon	
Trifecta, Olympic Distance Possum Kingdom Lake, TX, benefits YMCA Camp Grady Spruce	2016, 2015, 2014, 2013
Ironman 70.3, Buffalo Springs Lake, TX	2015
Community Board Member, Biomedical Research Foundation of South Texas, Inc. Audie L Murphy Veterans Administration Hospital, San Antonio, TX	2005-2011
Member, Administrative Board, Alamo Heights United Methodist Church, San Antonio, TX	2005-2006

Military Experience

Colonel, Selected Below the Zone, US Army	2013-current
Joint Senior Medical Leaders Course, Falls Church, VA	2019
Army Medical Department Precommand Course, FSH, TX	2017
Joint Senior Leader Course: A focus on countering WMD and CBRN Defense	2017
Brigade Command Tactical Commander's Developmental Program, Ft Leavenworth, KS	2017
Expeditionary Health Readiness Platform- Site Visit, Honduras	2016
Brigade Pre-Command Course, Ft Leavenworth, KS	2016

Senior Officer Legal Orientation (SOLO) Course, Charlottesville, VA	2016
Expeditionary Surgical Assessment Team- Forward Surgical Team/Golden Hour Off-Set Treatment-Mission Review, Special Operations Command, Afghanistan	2015
Senior Service College- Army War College Distant Education Program, Carlisle, PA Program Research Project- The Defense Health Agency Leadership Role in Global Health Security	2013-2015
Developer and Director, MEDCOM Military Treatment Team (MTT) Clinical, Tropical and Deployment Medicine Training for Operation United Assistance Deploying Medical Personnel, West Africa Ebola Response	2014-2015
Team Leader, Graduate Medical Education Subject Matter Expert In-theater Consultant to Afghan National Army ID/Preventive Medicine Residency Training Program, CENTCOM, NATO Training Mission-Afghanistan (NTM-A), Kabul, Afghanistan	2013
Lieutenant Colonel, US Army	2008-2013
ID/Infection Control Subject Matter Expert In-theater Review of Role 2 and 3 US, Coalition and Afghanistan National Facilities, CENTCOM	2012
US Army Recruiting Command Accession Board, Member	2009
Command and General Staff Officer Course (Intermediate Level Education)	2006
Senior Physician- C-Company, 101st Forward Support Battalion, 1st Brigade Combat Team, 1st Infantry Division, Ar Ramadi, Iraq, Operation Iraqi Freedom	2003-2004
Professional Filler System (PROFIS)- Senior Physician- C-Company, 101st Forward Support Battalion, 1st Brigade Combat Team, 1st Infantry Division, United States Army, Ft. Riley, KS	2003-2005
Joint Operations Medical Managers Course, San Antonio, TX	2003
Major, US Army	2002-2008
Special Medical Augmentation Response Team- Nuclear, Biological, Chemical (SMART-NBC)	2002-2003, 2004-2006
Officer Advance Course, AMEDD, FSH, TX	2002
Medical Effects of Ionizing Radiation, FSH, TX	2000
Medical Management of Chemical and Biological Casualties, MD	1999
Tropical Medicine Field Experience, Peru	1998
Tropical Medicine Course, USUHS, Bethesda, MD	1998
Captain, US Army	1996-2002
Bushmaster, USUHS, Camp Bullis, TX	1996
Airborne School, Ft. Benning, GA	1993
2nd Lieutenant, US Army	1992-1996
Officer Basic Course, AMEDD, FSH, TX	1992
ROTC, TTU	1990-1991

Educational Activities

Teaching Activities

Instructor, AMEDD C&S, Basic Officer Leaders Course and Captains Career Course, "The Role of the Army Medical Corps Officer" and "Professionalism," FSH, TX (200+/year, 20+ sessions/year)	2015-2017
Instructor AMEDD C&S, Brigade Healthcare Team Course, "Humanitarian Assistance, Security Assistance and Medical Readiness Exercise," FSH, TX (30/year, 2 sessions/year)	2015-2017
Preceptor, 3rd Year USUHS Medicine Clerkship, WHMC/BAMC, San Antonio, TX (2-4 students/yr)	2002-2015
Attending, 3rd Year UTHSCSA Medical Students, BAMC, FSH, TX(4-8 students/yr)	2002-2015
Attending, ID Consult Service, BAMC/WHMC/SAMMC, FSH, TX (2-4 months/yr); weekly fellow lecture	2002-2017
Attending, Internal Medicine In-patient Service, BAMC, FSH, TX (0.5-3 months/yr)	2002-2015
Instructor, Global Medicine Course, Brooks City Base, TX/Wright Patterson, OH	2000-2017
Instructor, Preparing for Global Health Work, Malaria lecture, UTHSCSA	2010-2017
Instructor, Defense Institute of Medical Operation, HIV In-Country Course- Democratic Republic of Congo, Africa	2006
Instructor, Tropical Medicine and International Health, UTHSCSA, San Antonio, TX	2002-2010
Instructor, Introduction to Clinical Sciences, UTHSCSA, San Antonio, TX	1999-2003
Instructor, Interservice Physician Assistant Program, AMEDD C&S, FSH, TX	1999-2003

Course/Conference Development/Director

Developer and Director, AMEDD at War: Lessons Learned conference, 3-day course, ~200 attended, San Antonio, TX	2015
Developer and Director, Operation United Assistance, Healthcare Provider Military Training Team (MTT), 3-dayTropical, Ebola, and Deployment Medicine to West Africa Training, Ft Campbell, KY; Ft Hood, TX; Ft Bragg, NC; Ft Benning, GA (6 sessions over 230 trained)	2014-2015
Conference Co-Developer and Co-Director, Guidelines for the Prevention of Infection Following Combat-related Injury, FSH, TX	2011, 2007
Co-Developer and Co-Director, MEDI 4150- Tropical Medicine and International Health, UTHSCSA, San Antonio, TX (30-50 students per yearly 6-week course)	2002-2009
Developer and Director, Operational Medicine Review Course (5-day didactic and hands-on course to 3 graduating Army Residency classes), Graduating Internal Medicine Residents, BAMC, FSH, TX (30+ trained)	2005-2007
Assistant Director, Global Medicine Course, Brooks City Base, TX	2005-2007
Coordinator, Army ACP ID Plenary and Breakout Session, San Antonio, TX	2005
Developer and Director, ID Review Course (3-day review course for clinicians and special operations forces), Roosevelt Roads, Puerto Rico (20+ trained)	2003

Symposium and Workshop Director/Moderator

Director, GME Plenary, MC Consultant Training Symposium, Ft Myer, VA	2015
Chair, Program Committee, Military ID Research Program (MIDRP) and DHP, Wound Symposium	2011
Member, Program Committee, Extremity War Injury VIII- Sequelae of Combat Injuries	2013

Moderator, Extremity Team, Prevention and Management of Combat-related Infections: Clinical Practice Guidelines Development Workshop, FSH, TX — 2011, 2007

Meet-the-Professor Moderator- Trauma associated infections: current knowledge and gaps. 48th Annual Meeting of the ID Society of America, Vancouver, Canada — 2010

Moderator, Fellows Symposium- Oral Presentations/Basic Science Poster Session, Meeting of the Texas ID Society, San Antonio, TX — 2010

Co-Moderator, AFIDS/IDCRP Multidrug Resistant Gram Negative Bacterial Infection Symposium, AFIDS Spring Meeting, Gettysburg, PA — 2007

Co-Chairman- Leptospirosis Symposium, ASTMH 54th Annual Meeting, Washington, DC — 2005

Director, Trauma Symposium, Ar Ramadi, Iraq — 2004

Houstestaff Awards and Recognition

Mentored Fellow's Travel Grants (n=25)

Mentored Fellows' / Residents' SAUSHEC Research Awards (n=21)

Mentored Fellows' and Residents' Presentation Award/Recognition (n=16)

Mentored Staff Awards and Recognition: (n=6)

Grants

Primary Investigator, DoD, GEIS/Armed Forces Health Surveillance sponsored research "Continued Development of a Multiply-drug Resistant (MDR) Bacteria Molecular Epidemiology Referral Laboratory", total of $954,000 over 5 competitive yearly renewals — 2009-2013

Primary Investigator, OTRP sponsored research- "Repository of Bacteria Isolated from War Wound Injuries" $170,000 — 2007

Primary Investigator, USAISR sponsored research- "Investigation of Wound Infections and Infectious Organisms" $31,500 — 2007

Director, Department of Defense (DOD), Global Emerging Infections Surveillance and Response System (GEIS) Center of Excellence for Leptospirosis, total of $500,000 over 5 years — 2004-2008

Overseas Activities

Command Surgeon, Korea — 2019-2020

CBRNE evaluation of Korea and Japan — 2018

Expeditionary Health Readiness Platform- Site Visit, Honduras — 2016

Invited Guest Lecturer, Seoul, Korea — 2005, 2016

Expeditionary Surgical Assessment Team- Review of Forward Surgical Teams and Golden Hour Off-Set Treatment Team (GHOST-T), Antonik, Dahlke, Bagram, Kabul, Afghanistan — 2015

Team Leader, Afghan National Army ID/Preventive Medicine Residency Training Program, Kabul, Afghanistan — 2013

ID/Infection Control Subject Matter Expert Review- Kandahar, Bastion, Bagram, Jalalabad, Salerno, Mazar-E-Sharif, Gazni, Shank, Sharana, Kabul, Afghanistan — 2012

Invited Guest Lecturer, European Regional Medical Command, Sonthofen, Germany — 2008

Leptospirosis Field Site Evaluation, Lima, Iquitos, Peru	~2007
Leptospirosis Train the Trainer, Cairo, Egypt	~2007
Instructor, HIV In-Country Course, Kinshasa, Democratic Republic of Congo	2006
Leptospirosis Animal Field Study, Cairo, Alexandria, Egypt	~2006
Invited Guest Lecturer, European Regional Medical Command, Sonthofen, Germany	2005
Leptospirosis National Meeting Presentation, Chiang-Mai, Thailand	2005
Leptospirosis Global Collaboration and Field Site Evaluations, Peru, Egypt, Kenya, Thailand	2005
Senior Physician- Ar Ramadi, Iraq	2003-2004
ID Review Course, Roosevelt Roads, Puerto Rico	2003
Malaria Immunologic Assessment, Field Site Review, Nairobi, Kisumu, Kericho, Kenya	2001
Malaria Rapid Diagnostic Device Field Testing, Sangklaburi, Mae Sot, Bangkok, Thailand	2000
Malaria Rapid Diagnostic Device Field Testing and Fever Study, Sangklaburi, Mae Sot, Bangkok, Thailand	1999
Tropical Medicine Field Experience, Lima, Iquitos, Peru	1998

Extramural Presentations (data upon request)

Invited Lecture

International/National (n=18)

Regional/Military (n=87)

Oral Research Presentations

National/International (n=13)

Local/Regional/Military (n=31)

Poster Research Presentations

National/International (n=133)

Local/Regional/Military (n=25)

Media Interviews (12)

Publications (*mentored internal medicine, surgical, orthopedic residents, and ID fellows)

Peer-reviewed

1. **Murray CK**, Wortmann GW. Trovafloxacin induced weakness secondary to a demyelinating polyneuropathy. South Med J 2000;93:514-515.
2. Roop SA, **Murray CK**, Pugh AM, Phillips YY, Bolan CD. Operational medicine experience integrated into an internal medicine residency curriculum. Mil Med 2001;166:34-39.
3. **Murray CK**, Walter EA, Crawford S, McElmeel ML, Jorgenson JH. *Abiotrophia* bacteremia in a patient with neutropenic fevers and antimicrobial susceptibility testing of *Abiotrophia spp.* isolates. Clin Infect Dis 2001;32:e140-142.
4. Hospenthal DR, **Murray CK**, Beckius ML, Green JA, Dooley DP. Persistence of pigment production by yeast isolates grown on CHROMagar Candida medium. J Clin Microbiol 2002;40:4768-4770.
5. **Murray CK**, Joyce MP, Longfield RN. Short report: treatment failure in Hansen 's disease. Am J Trop Med Hyg 2003;68:233-234.

6. Wongsrichanalai C, **Murray CK**, Gray MR, Miller RS, McDaniel P, Liao WJ, Pickard AL, Magill AJ. Co-infection with malaria and leptospirosis. Am J Trop Med Hyg 2003;68:583-585.
7. **Murray CK**, Beckius ML, McAllister CK. *Fusarium proliferatum* superficial supperative thrombophlebitis. Mil Med 2003;168:426-427.
8. Horvath LL, Hospenthal DR, **Murray CK**, Dooley DP. Direct isolation of *Candida* spp. from blood cultures on Chromogenic Medium CHROMagar Candida. J Clin Microbiol 2003;41:2629-2632.
9. Forney JR, Wongsrichanalai C, Magill AJ, Craig LG, Sirichaisinthop J, Bautista C, Miller RS, Ockenhouse CF, Kester KE, Aronson NE, Andersen EM, Quino-Ascurra HA, Vidal C, Moran KA, **Murray CK**, DeWitt CC, Heppner DG, Kain KC, Ballou WR, Gasser RA. Devices for rapid diagnosis of malaria: evaluation of prototype assays that detect *Plasmodium falciparum* histidine-rich protein 2 and a *P. vivax*-specific antigen. J Clin Microbiol 2003;41:2358-2366.
10. Hospenthal DR, **Murray CK**. *In vitro* susceptibility of isolates from seven *Leptospira* species to traditional and newer antibiotics. Antimicrob Agents Chemother 2003;47:2646-2648.
11. Horvath LL, **Murray CK**, DuPont HL. Travel health information at commercial travel websites. J Travel Med 2003;10:272-278.
12. Horvath LL, Hospenthal DR, **Murray CK**, Dooley DP. Detection of simulated candidemia by the BACTEC™ 9240 with Plus Aerobic/F and Anaerobic/F blood culture bottles. J Clin Microbiol 2003;41:4714-4717.
13. Horvath LL, George BJ, **Murray CK**, Harrison LS, Hospenthal DR. Direct comparison of BACTEC 9240 and BacT/ALERT 3D automated blood culture systems for *Candida* growth detection. J Clin Microbiol 2004;42:115-118.
14. **Murray CK**, Hospenthal DR. Broth microdilution susceptibility testing for *Leptospira* spp. Antimicrob Agents Chemother 2004;48:1548-1552.
15. Hepburn MJ, Dooley DP, **Murray CK**, Hospenthal DR, Hill BL, Nauschuetz WN, Davis KA, Crouch HK, McAllister CK. Frequency of vaccinia virus isolation on semipermeable versus nonocclusive dressings covering smallpox vaccination sites in hospital personnel. Am J Infect Control 2004;32:126-130.
16. Ellis MW, Hospenthal DR, Dooley DP, Gray PJ, **Murray CK**. Natural history of community-acquired methicillin resistant *Staphylococcus aureus* colonization and infection in soldiers. Clin Infect Dis 2004;39:971-979.
17. **Murray CK**, Hospenthal DR. Susceptibility of 26 *Leptospira* serovar to 24 antimicrobial agents by a broth microdilution technique. Antimicrob Agents Chemother 2004;48:4002-4005.
18. Regules JA, Dooley DP, Hepburn MJ, Van De Car DA, Davis KA, McAllister KC, Hospenthal DR, **Murray CK**, Fofaria R, Ekstrand JR, Crouch HK. The effect of semipermeable dressings on smallpox vaccine site evolution. Am J Infect Control 2004;32:333-336.
19. Pickard AL, McDaniel P, Miller S, Uthaimongkol N, Buathong N, **Murray CK**, Telford SR, Parolal P, Wongsrichanalail C. A study of febrile illness on the Thai-Myanmar border: predictive factors of rickettsioses. SE Asian J Trop Med Public Health 2004;35:657-663.
20. **Murray CK**, Dooley DP. Bullis Fever. Mil Med 2004;169:863-865.
21. **Murray CK**, Ellis MW, Hospenthal DR. Susceptibility of *Leptospira* serovars to antimalarial agents. Am J Trop Med Hyg 2004;71:685-686.
22. **Murray CK**, Reynolds JC, Schroeder JM, Harrison MB, Evans OM, Hospenthal DR. Spectrum of care provided at an Echelon II medical unit during Operation Iraqi Freedom. Mil Med 2005;170:516-520.
23. **Murray CK**, Roop SA, Hospenthal DR. Medical problems of detainees after the completion of major ground combat during Operation Iraqi Freedom. Mil Med 2005;170:501-504.
24. **Murray CK**, Beckius ML, Green JA, Hospenthal DR. Use of chromogenic media in the primary isolation of fungi from clinical specimens. J Med Microbiol 2005;54:981-985.
25. **Murray CK**, Hospenthal DR, Holcomb JB. Antibiotics use and selection at the point of injury in tactical combat casualty care for casualties with penetrating abdominal injury, shock or unable to tolerate an oral agent. J Special Op Med 2005;5:56-61.
26. Humberd C, **Murray C**, Stuart S, Reeb B, Hospenthal D. Enumerating leptospires using the coulter counter. Am J Trop Med Hyg 2005;73:962-963.
27. Horvath LL*, **Murray CK**, Dooley DP. Effect of maximizing a travel medicine clinic's prevention strategies. J Travel Med 2005;12:332-337.
28. Hospenthal DR, Beckius ML, Floyd ML, Horvath LL, **Murray CK**. Presumptive identification of *Candida* species other than *albicans*, *krusei*, and *tropicalis* with the chromogenic medium CHROMagar Candida. Ann Clin Microbiol Antimicrob 2006;5:1.
29. **Murray CK**, Hospenthal DR, Dooley DP. Guide to prevention of infectious diseases during military deployments. J Special Op Med 2005;5:17-34.

30. Ellis RD, Fukuda MM, McDaniel P, Welch K, Nisalak A, **Murray CK**, Gray MR, Uthaimongkol N, Buthaong N, Sriwichai S, Phasuk R, Sriwichai Y, Phasuk R, Yingyuen K, Mathavarat C, Miller RS. Causes of fever in adults on the Thai-Myanmar border. Am J Trop Med Hyg 2006;74:108-113.
31. Griffith ME*, Horvath LL, Mika WV, Hawley JS, Moon JE, Hospenthal DR, **Murray CK**. Viability of *Leptospira* in BacT/ALERT MB media. Diag Microbiol Infect Dis 2006;54:263-266.
32. Moon JE*, Ellis MW, Griffith ME, Hawley JS, Rivard RG, McCall S, Hospenthal DR, **Murray CK**. Efficacy of macrolides and telithroymcin against leptospirosis in a hamster model. Antimicrob Agents Chemother 2006;50:1989-1992.
33. Griffith ME*, Ceremuga J, Ellis MW, Hospenthal DR, **Murray CK**. *Acinetobacter* skin colonization in US Army Soldiers. Infect Control Hosp Epi 2006;27:659-661.
34. **Murray CK**, Yun HC, Griffith ME, Hospenthal DR, Tong MJ. *Acinetobacter*- what was the true impact during the Vietnam conflict? Clin Infect Dis 2006;43:383-384.
35. Yun HC*, **Murray CK**, Roop SA, Hospenthal DR, Gourdine E, Dooley DP. Bacteria recovered from patients admitted to a deployed U.S. military hospital in Baghdad, Iraq. Mil Med 2006;171:821-825.
36. **Murray CK**, Roop SA, Hospenthal DR, Dooley DP, Wenner K, Hammock J, Taufen N, Gourdine E. Bacteriology of war wounds at the time of injury. Mil Med 2006;171:826-829.
37. Chinevere TD, **Murray CK**, Grant Jr E, Johnson GA, Duelm F, Hospenthal DR. Prevalence of glucose-6-phosphate dehydrogenase deficiency in United States Army personnel. Mil Med 2006;171:905-907.
38. Albrecht M, Griffith M*, **Murray C**, Chung K, Horvath E, Ward J, Hospenthal D, Holcomb J, Wolf S. Impact of *Acinetobacter* infection on the mortality of burn patients. J Am College Surg 2006;203:546-550.
39. **Murray CK**, Reynolds JC, Boyer DA, Koops MK, Van de Car DA, Zanders TB, Hospenthal DR. Development of a deployment course for graduating military internal medicine residents. Mil Med 2006;171:933-936.
40. Mody RM*, **Murray CK**, Dooley DP, Hospenthal DR, Horvath LL, Moran KA, Muntz RW. The remote diagnosis of malaria using telemedicine or e-mailed images. Mil Med 2006;171:1167-1171.
41. Ismail T, Wasfy M, Abdul-Rahman B, **Murray C**, Hospenthal R, Abdel-Fadeel M, Abdel-Maksoud M, Samir A, Hatem M, Klena J, Pimentel G, El-Sayed N, Hajjeh R. Retrospective serosurvey of leptospirosis among acute febrile illness and hepatitis patients in Egypt. Am J Trop Med Hyg 2006;75:1085-1089.
42. Moon JE*, Rivard RG, Griffith ME, Ressner RA, McCall S, Reitstetter RE, Hospenthal DR, **Murray CK**. Effect of timing and duration of azithromycin therapy of leptospirosis in a hamster model. J Antimicrob Chemother 2007;59:148-151.
43. Hawley JS*, **Murray CK**, Griffith ME, McElmeel ML, Fulcher LC, Hospenthal DR, Jorgensen JH. Susceptibility of *Acinetobacter* isolated from deployed US military personnel. Antimicrob Agents Chemother 2007;51:376-378.
44. **Murray CK**, Horvath LL. An approach to prevention of infectious diseases during military deployments. Clin Infect Dis 2007;44:424-430.
45. Myint KSA, Gibbons RV, **Murray CK**, Rungsimanphaiboon K, Supornpun W, Sithiprasasna R, Gray MR, Pimgate C, Mammen MP, Hospenthal DR. Leptospirosis in Kamphaeng Phet, Thailand. Am J Trop Med Hyg 2007;76:135-138.
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EXHIBIT 25

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Alexandria Division

NICHOLAS HARRISON, *et al.*, Plaintiffs, v. MARK ESPER, Secretary of Defense, *et al.*, Defendants.	No. 1:18-cv-641 (LMB/IDD)

RICHARD ROE, *et al.*, Plaintiffs, v. MARK ESPER, Secretary of Defense, *et al.*, Defendants.	No. 1:18-cv-1565 (LMB/IDD)

DECLARATION OF MS. MARTHA P. SOPER

I, Martha P. Soper, do hereby state and declare as follows:

1. I am the Assistant Deputy, Health Policy for the Assistant Secretary of the Air Force for Manpower and Reserve Affairs. The Assistant Secretary is responsible for overseeing all Air Force Personnel, Health, and Readiness policies. My office is located within the Deputy Assistant Secretary (Reserve Affairs and Airman Readiness) office, which is responsible for manpower and readiness issues. I have served in this position for 5 1/2 years. Prior to this position I served on active duty in an Active Guard Reserve position. I served in the Air Force Reserve as a flight nurse for 23 years. I retired in 2014 in the rank of Colonel. I have been made aware of this lawsuit by counsel from the Department of Defense's Office of General Counsel.

2. I submit this declaration in support of Defendants' Motion for Summary Judgment. The information in this declaration is based upon my personal knowledge and upon information made available to me in my official capacity. This declaration supplements the declaration I previously submitted in this case, filed on January 25, 2019.

The Structure of the Disability Evaluation System (DES)

3. Department of Defense Instruction (DODI) 1332.18 is the primary policy governing the Disability Evaluation System (DES). The DES is "the mechanism for determining fitness for duty, separation, or retirement of Service members because of disability." DODI 1332.18, 3b.

4. The Air Force has implemented the requirements of DODI 1332.18 through several Air Force Instructions (AFIs), including AFI 36-3212, *Physical Evaluation for Retention, Retirement, and Separation*. To avoid duplication, military policies discussed in this declaration are attached as exhibits to Defendants' Brief in Support of their Motion for Summary Judgment.

5. For ease of explanation, the DES can be broken down into four phases: 1) the pre-Integrated Disability Evaluation System (pre-IDES)[1] phase; 2) the Medical Evaluation Board phase; 3) the Physical Evaluation Board (PEB) phase; and 4) an appellate phase conducted by the Secretary of the Air Force Personnel Council (SAFPC).[2] Each phase is discussed below.

Phase 1: Pre-IDES

[1] The DES and IDES are generally synonymous. The IDES is "integrated" because it allows Service members to have their conditions rated by the Department of Veterans' Affairs for disability benefits prior to separation or retirement from the military. In rare cases that are not relevant for purposes of this declaration, Service members may be evaluated through the "Legacy Disability Evaluation System" (LDES), in which the Physical Evaluation Board provides the disability ratings for the Service member's unfitting conditions. The plaintiffs in this case were evaluated through the IDES.

[2] In light of changed DOD policy, the Air Force no longer provides a right to appeal to the SAFPC for cases that were referred to the DES after March 1, 2020. Cases that had been referred to the DES prior to this date are still afforded the right to this appeal.

6. The mere diagnosis of a medical condition does not require Air Force members to be evaluated by the DES. AFI 36-3212, para. 1.3. Rather, Service members are referred to the DES who: "(1) [h]ave one or more medical conditions that may, individually or collectively, prevent the Service member from reasonably performing the duties of their office, grade, rank, or rating," "(2) [h]ave a medical condition that represents an obvious risk to the health of the member or safety of other members," or "(3) have a medical condition that imposes unreasonable requirements on the military to maintain or protect the Service member." DODI 1332.18, Enc. 3, App. 1, ¶ 2(a).

7. The Air Force has designed several mechanisms to ensure that cases are properly referred to the DES. Every Air Force installation has a Deployment Availability Working Group (DAWG). The DAWGs meet on a monthly basis to determine whether, for personnel with medical conditions, those individuals' medical conditions may affect their ability to reasonably perform their duties, including deploying. If the airman is fully able to perform all duties, including deploying without restriction, the DAWG will dismiss the case and return the member to duty. However, if the airman's condition affects their ability to reasonably perform their duties including by limiting deployment, the DAWG will refer the case to the Air Force Personnel Center's Medical Retention Standards Office.

8. The Medical Retention Standards Office performs a similar review of every case. This review, called an Initial Review in Lieu of a Medical Evaluation Board (IRILO) screens out cases which will likely result in a return to duty finding later on in the DES process. The IRILO may then return the airman to duty or refer the airman to a full Medical Evaluation Board. If the Medical Retention Standards Branch returns an airman to duty, it may also place the airman on an Assignment Limitation Code (ALC). ALCs are codes placed in an Air Force personnel system that alert personnel managers to long term constraints on assignments or utilization of airmen. Airmen with ALCs require waiver approval prior to deployment, overseas assignment, or assignment to remote locations in the United States in order to ensure their medical needs can be met.

9. In 2018, the Medical Retention Standards Office reviewed the cases of 31 airmen who were newly diagnosed with HIV. Ten of those individuals were returned to duty by the IRILO process, and 21 were referred into the DES.

Phase 2: The Medical Evaluation Board (MEB)

10. The MEB consists of a minimum of three physicians and documents the medical conditions that may cause him or her to be unfit for military service in accordance with the criteria set forth in DODI 1332.18, Enc. 3, App. 2. The MEB bases its findings upon the airman's medical records, a narrative summary of the potentially unfitting medical conditions, an assessment provided by the airman's commander of how the injury or illness impacts the airman's ability to perform his or her duties, and other information as required on a case-by-case basis. The MEB can recommend either a return to duty or referral to the Informal Physical Evaluation Board (IPEB). After receiving the results of the MEB, an airman may request an impartial medical review of their case from a medical provider who did not participate in the MEB, and may submit a written rebuttal which is reviewed by both the MEB and all subsequent DES adjudicators.

Phase 3: Physical Evaluation Boards:

11. All DES cases which do not result in a return to duty decision by the pre-IDES process or the MEB are evaluated by the Informal Physical Evaluation Board (IPEB). The IPEB consists of at least two members, one of whom must be a physician, and applies the same criteria as the previous layers of review in determining whether the airman's medical conditions cause him or her to be unfit for continued service. *See* DODI 1332.18, Encl. 3, App. 2. The IPEB's review is based solely upon the record created through the MEB process, and the airman is not provided an opportunity to appear or submit evidence or argument to the IPEB. In the IDES, in parallel, the Department of Veterans' Affairs issues a disability percentage rating that determines the type and amount of disability compensation that the airman will receive if he or she is separated or retired due to the medical

condition. If the IPEB finds an airman fit, there is no right to an appeal. However, if the IPEB issues an unfit finding the airman is permitted to appeal to the Formal Physical Evaluation Board (FPEB). The FPEB has three members, one of whom must be a physician. It considers the complete case file assembled through the MEB and IPEB stages. An airman is allowed to appear in person before the FPEB, may present evidence and arguments, and are provided counsel at no expense.

Phase 4: Appeal to the Secretary of the Air Force Personnel Council

12. If an airman disagrees with the FPEB's findings, he or she may submit a written rebuttal to the Secretary of the Air Force Personnel Council (SAFPC). The Air Force Personnel Board (AFPB) is a component of the SAFPC and is the final administrative appeal available before separation or retirement. An airman is not entitled to an in-person hearing before the AFPB, but may submit additional written evidence.

Standards Applied During the DES Process

Criteria for Making Unfitness Determinations

13. After a Service Member is referred into the DES, the standards set out in DODI 1332.18, Enc. 3, App. 2, ¶ 2 govern whether he or she may be found unfit. A Service member may be found unfit if one of the three following criteria apply: (1) "the member, due to disability, is unable to reasonably perform duties of his or her office, grade, rank or rating," (2) "the Service member's disability represents a decided medical risk to the health of the member or to the welfare or safety of other members," or (3) the "Service member's disability imposes unreasonable requirements on the military to maintain or protect the Service member." The plaintiffs in this case were found "unable to reasonably perform duties of his or her office, grade, rank or rating."

Reasonable Performance of Duties

14. DODI 1332.18 provides further guidance to assist in determining whether a Service member is "unable to reasonably perform duties of his or her office, grade, rank or rating." DODI

1332.18, Enc. 3, App. 2, ¶ 4(a), sets out a non-inclusive list of factors that must be considered in determining whether a Service member is reasonably able to perform his or her duties, which are:

a. "(1) Common military tasks. Whether the Service member can perform the common military tasks required for the Service member's office, grade, rank, or rating . . . . Examples include routinely firing a weapon, performing field duty, or wearing load-bearing equipment or protective gear."

b. "(2) Physical Fitness Test. Whether the Service member is medically prohibited from taking the . . . required fitness test. . . ."

c. "(3) Deployability. Whether the Service member is deployable individually or as part of a unit, with or without prior notification, to any vessel or location specified by the Military Department. . . ."

d. "(4) Special Qualifications. For Service members whose medical condition disqualifies them for specialized duties, whether the specialized duties constitute the member's current duty assignment; the member has an alternate branch or specialty; or classification or reassignment is feasible."

15. With respect to the fourth factor set out in DODI 1332.18, Enc. 3, App. 2, ¶ 4(a) ("Special Qualifications") the DES must consider "whether the specialized duties constitute the member's current duty assignment; the member has an alternate branch or specialty; or reclassification is feasible." The phrase "special qualifications" refers to unique training beyond that required to be a member of the Air Force in a particular Air Force career field. Special Operations personnel, for instance, may be subject to heightened medical and fitness requirements due to the nature of their positions. If these personnel are unable to meet the heightened Special Operations requirements, but are able to meet the standards attendant to a non-Special Operations position for which they are already qualified, DES adjudicators may retain the individual in the non-Special Operations position. Similarly, airmen with special qualifications who are medically disqualified from their current duty

assignment, but who are qualified in a different career field, are considered for retention in all career fields for which they are qualified. For example, a flight nurse who is unable to meet the medical requirements for flight duty may be considered for retention as a general nurse. Finally, adjudicators will consider whether retraining or reclassification is feasible for those who are disqualified from their special qualifications.

16. However, the additional procedures for those with "special qualifications" set out in DODI 1332.18, Enc. 3, App. 2, ¶ 4(a)(4) apply only to Service members who possess special qualifications. Airmen who lack special qualifications are not considered for retraining or reclassification by the Air Force as part of the DES process.[3] The ability to deploy, or to deploy to Central Command, is not a special qualification that requires the Air Force to consider retraining or reclassification. As a matter of policy, with a discrete exception for those with special qualifications, the Air Force does not consider whether an airman can be retrained into a non-deployable position when they are evaluated through the DES.

Deployability in General

17. The ability to deploy is a cornerstone requirement for almost all military service. The retention of personnel who are unable to deploy disrupts the Air Force's ability to accomplish its mission and increases burdens upon those who are able to deploy. While many non-deployable individuals who are processed through the DES are ultimately retained because their positions do not require frequent deployment, for those in highly deployable career fields, deployment is a duty that

[3] Airmen are generally able to request retraining or reclassification at various points in their career progression. But retraining or reclassification decisions are made on a competitive basis outside of the DES process. Retraining or reclassification for individuals without "special qualifications" is not considered within the DES process because otherwise DES adjudicators would have to engage in speculation to determine whether any particular individual would be approved for reclassification or even whether there were non-deployable billets available for which the individual in questioned was qualified.

must be fulfilled. Therefore, individuals whose medical conditions preclude them from deployment are typically found unfit for continued service through the DES.

18. When discussing deployability, it is crucial to understand the separate roles assigned to the individual Armed Services (e.g., the Air Force) compared to the Combatant Commands, such as the United States Central Command ("Central Command" or "CENTCOM"). The Air Force does not itself conduct military operations, but rather it supplies necessary resources (e.g., manpower and equipment) to the Combatant Commands, which are the entities that actually conduct military operations. To assist in carrying out their missions, the Combatant Commands may promulgate policies setting out eligibility requirements for individuals deploying to their respective areas of operations. Because it is the Air Force's role to maintain a dependable supply of manpower that will be useful to the Combatant Commands, the Air Force necessarily considers whether an airman can satisfy deployment restrictions imposed by the Combatant Commands when deciding whether to retain the airman. Just as it would strain financial resources for the Air Force to maintain weapons systems that Combatant Commands do not use, it strains manpower resources, which are subject to Congressionally mandated end-strength limitations, to retain personnel whose positions require them to deploy to Combatant Commands, but whom the Combatant Commands may not accept due to medical conditions.

19. The strains on manpower caused by non-deployable personnel are different for the Air Force than the other Services. Whereas the other Services may deploy entire units as a group, the Air Force does not make deployment decisions this way. Rather than ordering a currently non-deployed unit to deploy as a group, the Air Force fills the roster of a deployed unit by drawing individuals from numerous units across the Service. This distinction is important because it has the effect of making non-deployable individuals less effective to the Air Force than they might be for other Services. While other Services may have enough billets available to absorb non-deployable members, the Air Force is not in a position to do the same. Retaining non-deployable personnel thus

offers no benefit to the Air Force while at the same time limiting its flexibility in meeting its mission and manpower requirements.

20. As noted above, DODI 1332.18, Enc. 3, App. 2, ¶ 4(a)(3) permits the Air Force to specify locations where airmen are able to deploy in assessing their fitness for service. Over 80 percent of Air Force deployments in the past 20 years have been to Central Command. Thus, the Air Force has given particular weight to an airman's ability to deploy to Central Command in its adjudication of DES cases. While an individual's deployability to other locations or commands is considered, it makes little sense for the Air Force to retain individuals who are unable to deploy to the location where the overwhelming majority of deployed billets are located. Thus, Central Command's limitations on the deployability of HIV-positive individuals plays a large role in retention decisions for HIV-positive personnel.

Deployability of HIV-Infected Personnel:

21. DODI 6490.07, Deployment Limiting Conditions, Enc. 3, ¶ e(2) provides that "the cognizant Combatant Command surgeon shall be consulted in all instances of HIV seropositivity before medical clearance for deployment." Central Command's Modification 13, Tab A, ¶ C(2), provides that confirmed HIV infection is disqualifying for deployment. Although Central Command policy leaves open the possibility of a waiver being approved, Central Command has never approved a waiver for an HIV-positive person to deploy, and the Air Force was aware that it was unlikely that HIV-infected personnel would be granted a deployment waiver to CENTCOM. That determination has weighed against retention of those who are in positions that require frequent deployment to Central Command, are relatively early in their career, are unlikely to have unique skills needed in CENTCOM, and who are easily replaceable with individuals who do not have deployment-limiting conditions.

Deployment Waivers

22. There is no process by which an individual Service member may request a deployment waiver as part of the DES process, such a process is not required by regulations, nor is it practically feasible, for several reasons, discussed below.

23. First, individuals do not have a right to unilaterally request deployment waivers on their own behalf. DODI 6490.07, Enc. 2, ¶ 3 provides: "If a commander or supervisor of DOD personnel . . . wishes to deploy an individual with a medical condition that could be disqualifying . . . , the commander or supervisor must request a waiver."

24. Second, seeking hypothetical waiver determinations for individuals as they are processed through the DES would be impracticable. Waiver determinations require waiver authorities to know the "position to be placed in, any known specific hazards of the position, anticipated availability and need for care while deployed, the benefit expected to accrue from the waiver, [and] the recommendation of the commander or supervisor[.]" DODI 6490.07, Enc. 2, ¶ 3(a). This information cannot be compiled unless there is a known location and position by which it can be determined if appropriate medical care is available, specific hazards exist, or whether the benefit of approving the waiver outweighs the risk that is posed by deploying the member.

25. Were waiver authorities required to consider hypothetical waiver requests from every service member with deployability in question, the waiver authorities would be required to consider an unmanageable number of hypothetical waiver requests every year. This would unduly overburden the Combatant Command's medical personnel, whose primary focus must be on accomplishing their medical mission in a combat theatre, not on resolving hypothetical questions of deployability in order to facilitate adjudication by the DES.

26. Due to these issues, Air Force DES adjudicators must utilize their own knowledge of contingency deployment conditions, their knowledge of whether particular conditions are likely to be waived, and the likelihood that a waiver request would be approved. It would be impractical to disallow DES adjudicators from making such judgments. The Combatant Commands may always

waive medical requirements they set themselves if they believe a waiver is required for mission success based on the particular risk and benefit to the mission of the deployment. Thus, the DES must exercise this judgment in thousands of cases each year in assessing airmen with any medical condition that is subject to CENTCOM deployment restrictions.

The Air Force's Interpretation of Military Policies Relating to HIV

27. Until approximately 2017, the Air Force did not refer individuals with asymptomatic HIV for evaluation through the DES, despite the fact that the condition causes deployment restrictions. Instead, the Medical Retention Standards Branch issued return to duty findings for members with asymptomatic HIV and assigned Assignment Limitation Codes (ALCs) to prevent the members from being assigned to locations that were unable to treat their medical condition.

28. However, in approximately 2017, the Air Force conducted a policy review of DODI 6485.01, *Human Immunodeficiency Virus (HIV) in Military Service Members*, which was last approved on June 7, 2013. During that review, the Air Force Personnel Center considered the language in that instruction stating that "an AD Service member with laboratory evidence of HIV infection will be referred for appropriate treatment and a medical evaluation in the same manner as a Service member with other chronic or progressive illnesses[.]" DODI 6485.01, Enc. 3, ¶ 2(c).

29. Airmen with other chronic or progressive illnesses that limit deployability are routinely referred to the DES for retention determinations. There are multiple conditions that – like asymptomatic HIV – may not interfere with an airman's ability to perform common tasks such as firing a weapon, or impede their ability to take a physical fitness test, but which do result in unfit findings because of an inability to deploy. *See* DODI 1332.18, Enc. 3, App. 2, ¶ 4(a)). Insulin-dependent diabetes is one such disease. Many insulin-dependent diabetics are able to perform their duties without restriction in an in-garrison environment, and many score highly on physical fitness exams, as do many individuals with HIV. However, insulin-dependent diabetics are barred from all

deployments without a waiver, and waiver requests for insulin-dependent diabetes have almost never been approved by Central Command. Thus, insulin-dependent diabetics are often separated from the Air Force through the DES. Thus, in order to treat HIV in the same manner as other chronic or progressive illnesses the Medical Retention Standards Office began referring some HIV-infected individuals into the DES.

30. The decision to begin referring HIV-infected airmen was closely considered within the Air Force. These discussions led to the publication of three separate policy memos concerning whether airmen with asymptomatic HIV could be referred to the DES. The first two memos were published on October 11, 2017 and June 6, 2018. A true and correct copy of these memos are attached as Exhibit A and Exhibit B, respectively.

31. After the second memo was written, it became apparent that SAFPC and the Physical Evaluation Boards (the IPEB and FPEB) were interpreting the memo inconsistently, with the Physical Evaluation Boards and the Medical Retention Standards Office continuing to believe that DOD policy required them to refer HIV-positive individuals to the DES if they were in positions that were likely to require deployment, and the SAFPC often returning those individuals to duty. This led to further policy discussion, during which SAFPC was informed that CENTCOM was unlikely to approve a waiver request for a service member with asymptomatic HIV. As a result of these policy discussions, a third policy memo was distributed on September 26, 2018. A true and correct copy of the memo is attached at Exhibit C. The memo stated: "[t]he phrase 'asymptomatic HIV alone is not unfitting for continued Service' in [the June 6, 2018 memo] is not a policy statement that asymptomatic HIV airmen are not to be referred into the DES." Rather, airmen with asymptomatic HIV may be retained or separated following the normal procedures set out in DODI 1332.18.

32. After the September 26, 2018 memorandum was published, the SAFPC began issuing more unfitness determinations for airmen with asymptomatic HIV who were relatively likely to be ordered deployed. In [redacted], the SAFPC decided ten cases of members with asymptomatic

HIV, finding six of those individuals unfit, including the cases of Roe and Voe. The other four individuals were returned to duty. All ten cases [redacted] had support from their command for retention. Of those who were found unfit, all belonged to career fields in which a given individual had a greater than 20% chance of deployment in fiscal year 2018, and had at least a 20% likelihood of deployment between fiscal years 2015 and 2017. Three of the six airmen who were found unfit were in situations unlike Roe and Voe, two were unable to be medically cleared for special flight duties, and one airman was found to have an unstable condition. The four airmen who were retained and returned to service had a lower likelihood of deployment, as the highest likelihood of deployment in this cohort was only 12.8% in fiscal year 2018 and 17.1% between fiscal years 2015 and 2017.

33. There have been 16 DES cases involving airmen with HIV that have reached a final decision since the last policy guidance was issued in September 2018, including the ten referenced above from [redacted]. Of these 16 cases, one resulted in a return to duty finding by the FPEB and four resulted in return to duty findings from SAFPC. There were five cases in which the member was found unfit by the IPEB and elected to accept the IPEB's recommendation. These five service members accepted a voluntary separation pursuant to the modification in the injunction. There have been six cases, including plaintiffs Roe and Voe, in which the member was found unfit by the SAFPC. Of the six members who received unfit findings, four were recommended for discharge with severance pay, one was recommended for medical retirement, and one member who was originally recommended for discharge was administratively separated due to misconduct unrelated to his medical condition. The four service members who were recommended for discharge with severance pay have been retained in their current position under the court's preliminary injunction.

34. There are 7 airmen with HIV who have been referred to the DES that have not yet received a final fitness determination.

Roe and Voe's DES Evaluations

35. In determining that Roe, Voe, and other individuals with asymptomatic HIV were unfit because of deployability considerations, it was not necessary for the SAFPC to consider anew whether an individual would be granted deployment waivers to CENTCOM. Instead, after the policy discussions leading to the September 26, 2018 memo, SAFPC in all cases relied on its knowledge that CENTCOM was not likely to approve deployment waivers for individuals with asymptomatic HIV.[4] The SAFPC's knowledge of the low likelihood of CENTCOM waivers for HIV was based on the discussions that led up to the September 2018 policy memorandum. An airman that may have a greater likelihood of receiving a waiver from CENTCOM because they have a rare or irreplaceable skill of substantial value to the military, will likely be retained by the DES regardless of deployability concerns, so it would likely be unnecessary to consider whether they would receive a waiver.

36. After Plaintiff Roe was diagnosed with HIV, he was referred to the DES by the Medical Retention Standards Branch.[5] His MEB was conducted [redacted] and the MEB referred his case to the IPEB. The IPEB concluded that Roe's condition prevented him from "reasonably performing the duties of his office, grade, rank, or rating" and recommended that he be discharged. [redacted]. The IPEB further found that Roe's HIV caused deployment restrictions that prevented him from becoming fully worldwide qualified for deployment and from deploying without a waiver.

37. Roe appealed to the FPEB. [redacted]

[4] The SAFPC also considers all arguments an individual airman raises in its appeal. If such an airman, with any medical condition, affirmatively argues that the PEBs were incorrect in suggesting that he or she is unlikely to receive a medical waiver for deployment, the SAFPC would evaluate that claim on an individual basis.

[5] To avoid duplication, key documents from Roe and Voe's DES proceedings are attached as exhibits to Defendants' Brief in Support of their Motion for Summary Judgment.

[redacted]

38. Roe appealed to the SAFPC. The SAFPC concluded that Roe's HIV caused him to be unfit. [redacted], Roe was unable to reasonably perform the duties of his "office, grade, rank, or rating" and found him unfit for continued service in accordance with DODI 1332.18.

39. After Plaintiff Voe was diagnosed, he was referred to the DES by the Medical Retention Standards Branch. His MEB met on [redacted] and referred him for evaluation by the IPEB. The IPEB found that Voe was unable to reasonably perform his duties, due to limits on

[6] The Air Force labels job categories as "career fields." Career fields are further divided into skill levels, which in effect describe a member's training and experience. Generally, the skill levels in order from least skilled to most skilled are: helper, apprentice, journeyman, craftsman, and superintendent.

his deployability and recommended that he be discharged. Voe then appealed to the FPEB which similarly found his HIV to be an unfitting condition because he [redacted] Voe then appealed to the SAFPC.

40. The SAFPC initially considered Voe's appeal on [redacted]. The panel voted to return Voe to duty at that time and a memo was drafted and signed by the Director of the SAF Personnel Council which directed that Voe be returned to duty. However, because there was ongoing confusion concerning whether airmen with asymptomatic HIV were to be referred to the DES, the SAFPC did not issue Voe's decision at that time. Instead, it held the decision while it awaited further policy clarification.

41. The decision to hold Voe's initial board decision was consistent with past practices of the SAFPC. While there is no regulatory guidance which definitively states when an SAFPC decision is final, the consistent practice of the Board has been to treat decisions as final only once they are delivered to the respondent. The SAFPC has, on several occasions, revisited decisions upon receipt of new information about cases, and then reconsidered decisions in light of the new facts. Because it was not definitively understood whether the Air Force was categorically exempting airmen with asymptomatic HIV from DES processing, the SAFPC held Voe's decision and reconsidered based upon the policy clarification dated September 26, 2018.

42. After receiving the policy clarification the SAFPC ultimately determined that Voe was unable to reasonably perform his duties, given the deployment restrictions on HIV-positive individuals, the SAFPC's knowledge that CENTCOM was unlikely to grant deployment waivers for individuals with HIV, the high deployment rate of members of Voe's career field, and his career point. [redacted]. Accordingly, the SAFPC directed Voe's discharge.

* * *

In accordance with 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 03 day of June, 2020.

MARTHA P. SOPER
Assistant Deputy, Health Policy
Office of the Deputy Assistant Secretary
(Reserve Affairs and Airman Readiness)

EXHIBIT A

DEPARTMENT OF THE AIR FORCE
WASHINGTON DC

11 Oct 17

MEMORANDUM FOR AFPC/CC

FROM: HQ USAF/A1P

SUBJECT: Retention of Airmen with Asymptomatic HIV

Airmen with asymptomatic HIV infection, defined as laboratory evidence of Human Immunodeficiency Virus (HIV) infection without the presence of progressive clinical illness or immunological deficiency, shall be referred to Air Force Personnel Center (AFPC) Medical Standards Branch in the Medical Service Officer Management Division (DP2NP) for a case review.

AFPC/DP2NP will determine if the Airman may be returned to duty with an Assignment Limitation Code (ALC-C) or if medically necessary, be referred to the Integrated Disability Evaluation System (IDES). Asymptomatic HIV alone is not unfitting for continued service.

Airmen with laboratory evidence of HIV infection and with the presence of progressive clinical illness or immunological deficiency shall be referred into the IDES.

Our points of contact are Lt Col Matthew Huibregtse, AF/A1PPP (703-571-0827, matthew.j.huibregtse.mil@mail.mil) and Col Patrick Danaher, AFMOA/SGHM, (210-395-9140, patrick.j.danaher6.mil@mail.mil).

ROBERT D. LABRUTTA
Major General, USAF
Director, Military Force Management Policy

cc:
AFMOA/CC

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A-00341

EXHIBIT B

DEPARTMENT OF THE AIR FORCE
WASHINGTON DC

OFFICE OF THE ASSISTANT SECRETARY

JUN 0 6 2018

MEMORANDUM FOR AIR FORCE PERSONNEL CENTER/CC
AIR FORCE MEDICAL STANDARDS BRANCH
AIR FORCE MEDICAL OPERATIONS AGENCY/CC

FROM: Assistant Secretary of the Air Force (Manpower and Reserve Affairs)

SUBJECT: Appropriate Evaluation of Fitness for Continued Service for Airmen with Asymptomatic Human Immunodeficiency Virus (HIV)

This memo will provide guidance for the Air Force Personnel Center (AFPC) Medical Standards Branch in the Medical Service Officer Management Division (DP2NP) for the evaluation for fitness for Airmen with asymptomatic HIV.

In order to treat every Airman equitably and with dignity and respect, the appropriate treatment and medical evaluation of fitness for continued service for asymptomatic HIV Airmen will be accomplished in the same manner as any Airman with a chronic and/or progressive disease, and IAW with DoDI 6485.01, *Human Immunodeficiency Virus (HIV) in Military Service Members,* dated 7 June 2013. Asymptomatic HIV alone is not unfitting for continued service. Airmen will not be referred into IDES unless the criteria for referral, in accordance with DoDI 1332.18, *Disability Evaluation System*, Enclosure 3, Appendix 1, paragraph 2, are met.

Our point of contact is Col Karen Downes at karen.m.downes2.mil@mail.mil or 703-697-8822.

Shon J. Manasco
Assistant Secretary
(Manpower and Reserve Affairs)

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A-00338

EXHIBIT C

DEPARTMENT OF THE AIR FORCE
WASHINGTON, D.C. 20330-1000

SEP 2 6 2018

OFFICE OF THE ASSISTANT SECRETARY

MEMORANDUM FOR AIR FORCE REVIEW BOARDS AGENCY
AIR FORCE PERSONNEL CENTER
AIR FORCE MEDICAL STANDARDS BRANCH
AIR FORCE MEDICAL OPERATIONS AGENCY

FROM: Assistant Secretary of the Air Force (Manpower and Reserve Affairs)

SUBJECT: Airmen with Asymptomatic Human Immunodeficiency Virus (HIV) Disposition

References: (a) Department of Defense Instruction 1332.18 *Disability Evaluation System,* dated 5 Aug 2014, Incorporating Change 1, 17 May 2018
(b) Department of Defense Instruction 6490.07, *Deployment –Limiting Medical Conditions for Service Members and DoD Civilian Employees,* dated 5 Feb 2010
(c) Department of Defense Instruction 6485.1 *Human Immunodeficiency Virus (HIV) in Military Service Members,* dated 7 June 2013
(d) *Appropriate Evaluation of Fitness for Continued Service for Airman with Asymptomatic Human Immunodeficiency Virus (HIV) Memorandum,* dated 6 June 2018

1. This memo provides additional guidance for the evaluation of fitness for duty for Airman with asymptomatic HIV.

2. Airmen identified with asymptomatic HIV will be evaluated through the Medical Retention Standards office (AFPC/DP2NP) and, based on the determination of DP2NP, will either be referred to the Integrated Disability Evaluation System (IDES) or returned to duty with an assignment limitation code.

3. When evaluating Airman with any chronic and/or progressive condition (to include HIV), the decision authority or boards will use the criteria in DoDI 1332.18, Enclosure 3, Appendix 1 and 2 as well as an assessment of the current career point of the Airman. Additionally, further evaluate the disability to see if it (1) represents a decided medical risk to the health of the member or to the welfare or safety of other members; or (2) the Airman's disability imposes unreasonable requirements on the military to maintain or protect the Service member.

4. Airmen with Asymptomatic HIV may be retained or separated on a case by case basis in accordance with DoDI 1332.18, *Disability Evaluation System* and DoDI 6485.1 *Human Immunodeficiency Virus.*

5. The phrase "asymptomatic HIV alone is not unfitting for continued Service" in Reference (d), is not a policy statement that asymptomatic HIV Airman are not to be referred into DES.

A-00339

Referral into the DES system requires a further determination that the member is unfit for continued Service under the criteria in DoDI 1332.18.

6. Our point of contact is Col Karen Downes at 703-697-8822 or via email at karen.m.downes2.mil@mail.mil.

Shon J. Manasco
Assistant Secretary
(Manpower and Reserve Affairs)