Rear Admiral Bruce L. Gillingham
Surgeon General of the United States Navy

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Moderator: Welcome everyone, especially in this incredibly busy news cycle. We'll keep an eye out for late arrivals given the Pentagon press conference this morning and filing.

Welcome to our session of the Defense Writers Group. We are so honored to have Rear Admiral Bruce L. Gillingham, the Surgeon General of the United States Navy. I'm Thom Shanker, the Director of the Project for Media and National Security. And as many of you know, I conducted a poll early after I took over this job and one of the interesting findings was how many of you requested more of these sessions not only focusing on operations and policy, but more on health of the force and personnel matters. So Admiral, we are really honored that you are the first member in our expanded agenda program, sir.

RADM Gillingham: Thank you, Thom. It's a pleasure to be here.

Moderator: I'll use my role as benign dictator to ask the first question, and any of the correspondents who are on-line who want to ask questions, please drop me a note in the direct chat and I will certainly call on you.

Admiral, to start the discussion kind of at the top line level here, sir, the past 18 months have been a challenge for the medical community, in the Navy, across the armed services, quite literally around the globe. I'd be curious what lessons you are taking now as the Navy's Surgeon General of infections aboard the Roosevelt and the Kidd, how you have kept the Navy readiness at the high level that you have, and what you will do to reshape naval medicine going ahead to protect the health of the maritime service. Not just against pandemics, sir, but against the entire range of threats facing the nation and the Navy.

RADM Gillingham: What a great question.

Certainly when I came into office the 1st of November of 2019, it was very apparent to me that we faced new challenges. Certainly

the great power competition introduced new medical challenges. As the Navy Surgeon General, obviously I'm responsible for the force health readiness of both the Navy and the Marine Corps.

Before I took over I had a bit of time to think about those challenges and recognized that in a peer competition we'd be facing challenges that we did not face in the desert. Chief among them the tyranny of geography, of large distances, and frankly, the inability probably to maintain that same ability to provide surgical care immediately upon wounding that we had in the desert.

I was in Iraq in 2004 just outside of Fallujah, and many of the patients that I got not only met the golden hour but actually were there in what we called the platinum ten minutes, so we were able to respond to them immediately.

So looking at how we are able to provide medical care in that distributed maritime environment really is critical.

My job before Surgeon General was in the Pentagon developing future medical capabilities so I had a lot of time to think about that. We recognized, consistent with the CNO's guidance on distributed maritime operations and the Commandant's guidance on expeditionary advanced basing operations, that we were going to need to have smaller teams more widely distributed across the AOR. So we were able to leverage some of those small unit lessons that we learned, particularly about damage control surgery in the desert, to transport that to the shipboard environment.

So we actually have small what we call Emergency Resuscitative Teams shipboard and we will continue to work that model.

There's a gap, though, because as you know, in combat casualty care we always seek to move the patient up-echelon to definitive care as quickly as possible. In that environment, there's a gap because of those long distances and I'm excited to say that we've had the opportunity to help develop what's known as the EPF Flight 2. So really the Expeditionary Fast Transport. This is the vessel that previously was primarily used for logistics purposes. The Joint High Speed Vessel. Austal is now working on one that will have changes, significant structural changes for medical. So it will have a flight deck that will land an Osprey, for example. We'll have space to run two operating rooms, an 18-

person, 18-bed ICU, and the vessel will actually feed and berth a medical staff of about 100. So what we call a Role 2 Enhanced Medical Capability. So we're very excited about that.

Of course our hospital ships, the Mercy and the Comfort, have been our Marquis platforms. But frankly, would not be able to cover the ground or get as close to the fight, if you will, that we envision the EPF. So we think that's filling a critical gap and we're excited to work the concept of operations using that. And to work with the Marine Corps as they work on force design, to think about how we're going to provide medical care to them as they seek to be highly maneuverable, even more so than they are now, and be able to provide Role 2 care in that setting.

That's kind of an overview.

The other piece of that, and to go to your initial point, COVID taught us and reminded us that in any conflict it's disease non-battle injuries that actually produce the highest volume of casualties. So in addition to the combat casualty mission, we've got to be able to operate in that contaminated environment, if you will, and we've got to be able to take care of those individuals who are not combat wounded but who are ill or injured.

And we've learned a lot from COVID. You mentioned the Roosevelt. Our teams were on site and we actually had anticipated that TR would be at risk so we had placed a forward deployed preventive medical unit aboard that had COVID testing capability. They were actually able to identify that in fact it was SARS CV2. And so that taught us a lot about how we're going to have to augment our ships to be able to operate in that environment. I'm very pleased to say that based on the extensive outbreak investigation that occurred both on TR and the USS Kidd, that we were able to actually publish in the New England Journal last year the findings of that outbreak investigation. And that was really, to my knowledge, the first large study demonstrating that the virus' stealth weapon, its secret weapon is asymptomatic and presymptomatic transmission. So we learned a lot from that.

But it also emphasized, again, in addition to the combat casualty care piece, we've got to be able to operate in a contaminated environment.

And then I will just say, a key success factor following TR, the

fact that we've been able to keep operating has been really the very close relationship that my experts and I have with the line leadership so that we can help inform guidance to help them operate in as COVID-free an environment as we can achieve. And then that we're continually updating that. Continually building on that guidance.

But fundamentally I think the key success factor has been the resilience of our sailors and marines operating in difficult conditions, operating in these additional medical restrictions that we placed, and yet still getting the job done.

Moderator: The popular press, including my alma mater, the New York Times, have been running stories saying that COVID is here to stay, at some level or another, just like seasonal flu, other illnesses and all that. So what will the Navy have to do to maintain readiness if COVID is the part of the life of everyday citizens and of all of your sailors and marines? Do we have to look at pre-deployment quarantines in a new way? Tell us how you plan for this in the mid-term and not just for tomorrow.

RADM Gillingham: I think it speaks to the absolute importance of a high vaccination level because we've found that shipboard when we have a very high vaccination level, we're not seeing significant outbreaks, and if individuals become ill, it's really more akin to a cold or a mild flu as opposed to severe illness. So I think if we continue to operate we'll make sure that our crews are highly vaccinated. Of course we have a mandate coming up which we're looking forward to, because it will just contribute to what our main job is as far as health protection. I think we'll learn what we've learned from the non-pharmaceutical interventions that we've been able to carry out aboard ship. Those will probably become standard practice. As well, I'm encouraged that I think our detection ability, our laboratory detection ability will improve so that early on when we do see elements like we did with the TR, we'll be able to diagnose early and practice those quarantine and isolation techniques that have worked thus far.

Moderator: Thanks, Admiral.

The first question from the correspondent corps is Jeff of Navy Times.

DWG: Thanks so much, and sir, thanks so much for taking time to

speak with us today.

I'm just wondering if you can offer any fresh insight into the mandatory vaccination plan for the Navy and Marine Corps, how that's going to work, what sailors or marines who still decline the vaccine might face in terms of discipline, and if you have an updated number of sailors and marines that are fully vaccinated, I'd take that as well.

RADM Gillingham: I would say that based on all that we've learned during initial vaccination operations while it's been voluntary, that we'll be in very good shape. We are confident that we're going to have an adequate amount of vaccine. We've learned how to be able to give it aboard ship and in a more remote location. So I'm confident that we'll be ready to go.

In terms of those who decide even though it's a general order and required, obviously that will be handled administratively and I will leave that up to the line in terms of how that will happen. But I think frankly, I think our sailors and marines will understand that it's at this point been deemed a mandatory readiness requirement and I don't think we're going to face significant resistance, frankly.

There's also the issue, I would just add, that we will certainly be attentive and responsive to medical exemptions. Right now because the mRNA vaccines are synthetic, I don't think we're going to see a significant number of those either.

Right now the two scenarios that I can imagine would be someone who is so severely immuno-compromised that they can't take the vaccine. That's obviously going to be a very small number in our active duty and would be handled by the physicians caring for them. The other is just a documented history of having had an allergic reaction to either the first or second vaccination.

Then in terms of where we are, I think we're doing very well. Navy is well over 72 percent immunized, that is having gotten both doses or completed a series, one dose if it's J&J. The Marine Corps has some work to do but they're making progress and I think they're in the high 50s at this point.

DWG: We're hearing from a lot of service members about what they may face. Just in your experience, and I know you're a medical guy, but do you see this being like a courts martial situation,

an NJP situation, a counseling chit. What do you think discipline, and I know you are medical but I imagine you kind of have some cognizance over how that's going to work. Can you kind of give us an expectation of what the rank and file might expect if they do in fact go against this general order?

RADM Gillingham: I think what's going to happen is we'll go back to the counseling. We'll sit down with the individual, try to understand the source of their resistance, and address that.

Ultimately I would hope that any NJP or legal proceedings would be very late in that continuum. Again, I think when they realize that yes, the Secretary of Defense has made the determination based on expert guidance that this is required for mission readiness, I do believe that those that still haven't gotten the vaccine will see the value and will proceed with getting it.

Moderator: Next will be Rick Burgess of Sea Power Magazine.

DWG: Thank you.

With the 2022 budget submission, what can the Navy and Marine Corps expect in terms of increase or decrease in capacity of medical care, including the care for families and retirees?

RADM Gillingham: I can tell you that obviously we submit our requirements and work through the POM process. Obviously since it has not been submitted as the President's budget I can't speak to specifics. But we continue to demonstrate the value that we provide to the warfighter as a critical enabler.

I mentioned at the outset the role that we'll play in distributed maritime operations. I do make the point that in this peer fight that the medical requirement for Navy will be more than they're probably used to in the sense that the Marine Corps has clearly seen the value that we provide.

So it's my job as the Surgeon General and those venues, those POM discussions to demonstrate the risk mitigation that we can provide.

I like to say that our job is to provide medical power for naval superiority and I think that's a message that resonates.

In terms of continuing to provide the family health care

benefits, obviously that's an extremely high priority for the Department of Defense and we will continue to do that as a no-fail mission.

Moderator: Next question is Rebecca Torrence of Bloomberg.

DWG: Good afternoon, sir. Happy to be here.

I have a question about booster shots in light of the Biden administration's announcement yesterday to allow boosters for fully vaccinated adults eight months after their second shot.

So given this news in the context of the DoD's vaccine mandate, how are you thinking about how booster distribution could occur throughout the Navy and Marine Corps and whether or not these boosters could be added to the mandate at some point in the future as we're seeing greater concerns floating around about breakthrough infections.

RADM Gillingham: Thanks Rebecca.

We'll obviously follow CDC guidance as we have throughout COVID. So it will simply be a timing issue. Right now as I understand Dr. Walensky's and the CDC's recommendation. It's eight months after you completed the vaccine series. The data is not out yet for Johnson & Johnson, so obviously we'll follow that guidance as it emerges. But we will use our time tested methodology for making sure people get their vaccines on time. So we'll know when they got their terminal dose of the initial series, and we'll work to create a process by which they're notified and brought in at the eight month mark.

So I don't foresee significant challenge there. In fact as we start our flu campaign in the fall, I think there will be an opportunity to be even more efficient. And for those who got the vaccine early say in January or February, to phase the booster at the same time they come in for flu, so we'll work through those details, but immunizations is something that we do very well, as you know, and I'm confident in our team.

DWG: To clarify, so you're not thinking at the moment about the potential for adding boosters to this mandate that we're seeing for mid-September.

RADM Gillingham: I think it will be semantics, Rebecca. Once a

vaccine is mandated then any additional that would naturally follow from that would be included. But we certainly, if there's clarification or guidance needed obviously I think we'll generate that.

Moderator: The next question is to Patricia Kime of Military.Com.

DWG: Thank you, Admiral.

I'm wondering if you can give us an update about the manpower requirements for Navy medicine. What is the status of the reductions that were expected out of the DHA reorganization and how many positions total have been cut, how many are going to be cut, what is the right size for that?

RADM Gillingham: To date, no reductions have occurred. You're probably aware that after the initial reductions were proposed, the NDAA language prohibited that and so Congress received significant analysis from DoD. That process is ongoing.

I would tell you that it's been very healthy within the Navy and Marine Corps, we're going back and reviewing our analysis and of course a few things have changed since that initial proposal. COVID occurred. I mentioned in the opening question that we understand and have reinforced the value of our preventive medicine, public health assets. So we're going back and taking a look at that requirement. So this will be an ongoing process.

Obviously we want to make sure that we're able to meet mission and that our leaders understand whatever risk they may incur with the proposed cuts. But we've got a very collaborative process going on within the Navy and the Marine Corps to get to the right number, but that number has not been finalized to date.

DWG: Do you foresee when you might embarking on these reductions or when the analysis will be complete?

And a follow-on for that would be where do you see maybe adding a type of providers or personnel based on what you know from the analysis at this point?

RADM Gillingham: Like I said, the analysis is ongoing. It won't be until - no reductions would occur until Congress has received and approved the analysis. So at this point that's open-ended.

As always, given that we support the Navy and Marine Corps, we tend to focus on what are known as critical wartime specialties, but we also have to acknowledge that many of our MPFs are in more remote areas. So as the Defense Health Agency assumes authority, direction, control of those MPFs, we will continue to support them to make sure that those MPFs have the full range of medical specialists that are required to meet the need in that area that can't otherwise be met either within the network or by hiring civilian professionals.

Moderator: This question is sort of out of the blue, but you talked about other risks, how to maintain the health of the force against nuclear competitors and all that. I wonder if you could speak for a minute about the sort of growing assessment that climate change is a belatedly recognized national security risk and whether you as the Navy's top medical officer are pondering the implications there. One example, I know this sounds like science fiction, but the maritime services are up around the polar ice cap. As it's melting we're reading stories about viruses that might have been frozen for eons becoming free. I know that's a science fiction scenario, but are there any real world implications for climate change on the important work that you do?

RADM Gillingham: Obviously our new Secretary of the Navy has made that one of his four top priorities, so if he's interested we're fascinated, as you know. I think for us probably the area where, in addition to the role of potential emerging diseases as the environment changes and perhaps new pathogens appear, we'll continue to reinforce our surveillance of emerging diseases.

You may not know that our Navy medical research labs around the world are part of a global emerging infectious disease network that includes the WHO and the CDC. So we'll continue to be very vigilant there.

The other area where I think there's an overlap with Navy medicine is in our global health world and in our responses to disaster relief around the world. So if there are areas that need assistance there in which the Navy can appropriately assist, then certainly Navy medicine will support that.

Moderator: Patricia?

DWG: 43,000 sailors have contracted COVID and I'm trying to get a sense of whether they are all fully recovered, or do you have a certain percentage that really have had long COVID? And can you discuss the implications of that?

RADM Gillingham: That's a great question, and that's an area - one of the real values of having a Defense Health Agency is that we're able to kind of keep track of those folks that have sustained COVID illness.

We're seeing low numbers, long-haul COVID. I think for me, since I mentioned that obviously we're very interested in readiness, particularly the symptoms of prolonged fatigue and that can imperil someone's ability to respond to their mission. So we're making line commanders away that a sailor that has had COVID could have prolonged fatigue and that should be recognized as a valid concern, that they're aware of that.

Obviously we're following the science closely. We're making sure that we're out putting people into extreme environments before they're ready, and making sure they're medically cleared to do that.

So I think that's a great question. It does have military readiness implications and our experts are closely following the data to see where those might intersect with what we do.

Moderator: Rebecca Torrence?

DWG: A quick follow-up on that because I think it's a super interesting issue. Long COVID now can be classified as a disability under the ADA and I wonder how you're thinking about - obviously there's the issue of how these symptoms might affect a service member's ability to complete their mission, but could this be grounds for medical disqualification? Would those symptoms have to last for a certain period of time or be of a certain severity? How are you considering those issues right now?

RADM Gillingham: That's a great question. As you know, we have a well-established limited VA disability policy or standard operating procedure. So we would handle those as we would any diagnosis on a case by case basis.

As I mentioned, our medical specialists are staying on top of the

data. There are some very challenging diagnoses within long haul and it's our practice, obviously, to give the individual the appropriate amount of time to recover and return to active duty. Should that not be possible then we want to make sure that they in transitioning their care to the VA, that they'll get all of the care that they need to address those conditions.

Moderator: Admiral, this has been an extremely informative discussion. So important. I would like to return the floor to you for any final comments or thoughts you might like to share with us today.

RADM Gillingham: Thank you, Thom.

I really appreciate the interest. As you mentioned at the beginning, this has been a challenging period but if there's a silver lining I think that COVID and the challenges that we face are only accelerating our ability to be more agile and flexible in this emerging operational environment. I'll give you an example and just let you know kind of the span of things that folks are doing.

Everybody's aware that the Comfort pulled into New York Harbor. Very inspiring. The intent initially was that they would offload hospitals so that those hospitals could focus on COVID. It ended up becoming a COVID intensive care center themselves. Really tremendous work on short notice to convert a combat casualty care facility to do that.

We also sent out medical teams taken from our Expeditionary Medical Facility to support local hospitals, and we learned a lot about how to make those teams very agile. In fact just like we have a small seven-person surgical team, based on that experience, we now have a small seven-person medical intensive care team. So now as Delta has increased the demand signal on our civilian hospitals, just yesterday one of our teams was assigned and arrived in [Inaudible] to help the local hospital there. That's a three person team, based on lessons learned from those teams that have gone out earlier.

So while that - all of our folks are enormously proud of the fact that they can help their fellow Americans, but the longer term implication for us is, we're learning valuable lessons about how to be more agile as we think about future deployments in that broad based distributed environment that we may find ourselves

in.

So I'm a huge fan of high reliability organizations understanding how to achieve high reliability, and I would say that process, the process of participating in COVID operations has only accelerated that journey for us. So as challenging as it is I think when it's all said and done Navy medicine is going to be stronger, we're going to be able to project that medical power even more powerfully in support of our warfighters.

Moderator: Once again, sir, thank you for your time and for sharing your wisdom and knowledge with us. I thanks to you and your staff for all that you do. And we hope to have you back in the near future, sir.

RADM Gillingham: Thank you, Thom. I really appreciated the opportunity. And thanks to all who participated today.

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