Dr. Dean L. Winslow
Nomination Hearing for
Assistant Secretary of Defense for Health Affairs
Opening Statement Before the Senate Armed Services Committee

7 November 2017

Senator McCain and other members of the SASC, it is an honor to be here. It is humbling to be considered for this position and I thank Secretary Mattis and the President for placing their trust and confidence in me. Senator McCain- as a young Air Force officer going through Aerospace Medicine Primary and SERE training in the early 1980's one of your fellow POW's who spoke to our class mentioned your name as an exemplar of courage and integrity and I have always looked up to you.

I would like to acknowledge two people in the audience, my brother, Dick and my wife, Julie Parsonnet, a Stanford professor, (without whose support and love I would not be here today). Although not physically present, I would like to acknowledge the love and support of our 4 children (Lindley-a physics professor at MIT, Mary Beth- a dental hygienist in Colorado, Sam- a student at NYU, and Lauren- a student at UBC). Sammy, in particular, grew up without his dad for a total of two years during his first 11 years of life due to my 6 deployments to Afghanistan and Iraq. I'd also like to thank my 88 year old mother, who while raising us 4 kids, spent decades as a public school teacher in Dover and later in Wilmington. Lastly I would like to thank my colleagues at Stanford University for their support and encouragement over the years.

The Military Health System (MHS) is a large and vital component of our strong US military. Our charge can be summarized into 5 core missions: (1) Care for the warrior at home and while deployed. (2) Care of our military families and retirees. (3) Teaching of the next generation of MHS providers (4) Leadership in Global Health and humanitarian operations (5) Biomedical research that is essential to our future success and leadership in military medicine.

Consolidation of patient care services under the DHA creates the structure whereby we can reduce variation (a hallmark of highly functioning healthcare systems) across the services, improve quality, employ evidence-based medicine, and markedly improve the cost effectiveness of our MHS by consolidating HQ functions, thereby maximizing the "tooth to tail" ratio in our MHS. I envision helping create a high functioning integrated healthcare system on the lines of some of our country's better integrated healthcare systems, While on the topic of DHA, I'd like to acknowledge all the efforts of my predecessor, Dr. Jonathan Woodson who had the vision and vigorously championed the creation of this organization.

I will also push to increase the capabilities of our MHS, not only in war, but also in our peacetime mission of caring for our active duty military members, their families and military retirees. Rather than being "a distraction" from our primary mission of providing direct care to our warriors on the battlefield, doing high quality primary care, preventive medicine, and caring for critically ill, complicated patients in peacetime enhances our ability to do so "downrange." As a Guard flight surgeon in the field, I observed that the ongoing deep and intense experience in caring for complicated patients in civilian practices is one reason why our reserve component doctors, nurses, and medics are generally "all-stars" when they deploy. We need to leverage the capabilities of our reserve component members. We also need to work closely with the VA. The implementation of a common EHR will certainly facilitate this. If I'm confirmed, one of the first visits I'll make is to Dr. David Shulkin, Secretary of Veterans Affairs. We need to be able to care for each other's patients in a seamless manner and use each other's personnel and resources in regions interchangeably where there may be an imbalance. In the past, my impression is that various voices have encouraged the MHS to downsize and increasingly outsource care of both dependents and AD military members to the Tricare system. While Tricare will likely be one component of our care delivery for the foreseeable future, we can, under the umbrella of DHA, build a much better system. We need to re-patriate our most complicated patients and make maximum use of our MHS flagship hospitals. So, for example, a military member or dependent living on the East Coast who develops a malignancy should generally get state-of-the-art care at WRNMMC, not a civilian medical center through Tricare.

Beginning in the 1980's the MHS began a dramatic downsizing of medical facilities. While some of this made sense under larger BRAC decisions, over all I am concerned that we cut "too close to the bone." We need to make sure that we adequately resource both our primary care facilities as well as our flagship teaching hospitals and USUHS. Maintaining these "centers of excellence" is critical to training our future military physicians and for being able to deliver "state of the art" care to our military members and their families.

Secretary Mattis is known to be a strong advocate for "soft power" as well as strengthening the lethality of our military. The US military's leadership in humanitarian operations domestically and abroad has been an unqualified victory for American soft power. Our Guard, Reserve, and Active Duty response to Hurricane Katrina in Louisiana and Mississippi in 2005 and our rapid response to the Ebola outbreak in West Africa in 2014-2015 highlighted the importance our military and MHS in particular in being able to provide order in the midst of chaos and to save lives. Going back to the time of Major Walter Reed, the US has been a leader in Global Health. We need to redouble our MHS efforts to work with foreign national departments of health, foreign militaries, and NGO's in order to maintain our leadership in this arena. As an Infectious Diseases physician, I believe this to not only be a moral approach but also of great national security importance.

Lastly we need to increase our funding of military research, both weapons-related and in the biomedical sciences. We also need to be careful to not too closely prescribe strict "support of the warfighter" requirements since often the benefits of basic research are not realized for decades. Two relevant examples: (1) Most of the currently used life-saving medications for the treatment of malaria were developed by US military scientists at WRAIR and came out of basic science research programs which had been ongoing for decades and (2) 50 years ago LASERs were interesting experiments conducted by physicists with no foreseen practical applications. In about 3 decades this technology became one of the critically enabling technologies, which made PGM's possible. It also needs to be kept in mind that good science is never done in a vacuum. Therefor it is critically important that Congress adequately funds research by the NIH, NSF, CDC, DOE, and EPA. Threats are rapidly emerging and DoD cannot do this important work alone. Research is an investment in our nation's future and not adequately funding research and science education will result in an abdication of our leadership role in the world.

Finally, I would like to thank this committee for considering my appointment as ASD-HA. It was an honor to be asked by Jim Mattis and the President to take this job. Working for Jim Mattis is the dream of just about any of us who have served in uniform over the past several decades. I can't wait to start this job and begin again caring for our Soldiers, Sailors, Airmen, and Marines and their families.

Thank you, again, Mr. Chairman, and I welcome your questions.