INTERVIEW WITH

Dr. CRAIG VANDERWAGEN

H1N1 ORAL HISTORY PROJECT

Interviewed By Sheena Morrison

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Interview with Dr. Craig Vanderwagen
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Dr. Craig Vanderwagen: CV
Sheena Morrison: SM

Sheena Morrison: The following interview was conducted with Dr. Craig Vanderwagen. It was conducted on behalf of the National Library of Medicine for the Making History: H1N1 Oral History Project. It took place on April 13th at the National Library of Medicine in Washington, D.C., and the interviewer is Sheena Morrison.

So, as I was mentioning off record, we ended with the Enterprise Governance Board, and I wanted to start there. Again, how soon after the realization that we were in the midst of a pandemic was the Enterprise Board convened?

Craig Vanderwagen: Well, the Enterprise Governance Board had been chartered back in 2006 as a means to meet on a routine basis to make decisions, particularly with regards to acquisition medical countermeasures: should we buy this

vaccine, should we get this drug in the stockpile?--these kinds of questions. And so it was a preexisting phenomenon where we had regular participation from the appropriate optives and other departments and agencies who had a role in these kind of response activities.

And recall, also, that our planning for these activities had been going on for a number of years. And in the context of that, we developed concepts of operations for how we would approach the management of a variety of hazards. There are 15 identified hazards for the country. Pandemic was one of those. And the Department of Defense, the Department of Homeland Security, the relevant optives, as well as ASPR, had been operating to develop exercise plans, and so on.

The Enterprise Governance Board became a vehicle for monitoring our performance against plan. And recall that the planning for a pandemic had been developed around the notion of H5N1, and the assumption there was that the epidemic leading to a pandemic would begin outside the United States, probably in Southeast Asia. And so, the concept of operations for how we would approach this

started with that premise and moved forward to domestic outbreak and then all the way to pandemic.

In the event, we had disease here at approximately the same time it appeared elsewhere. And so, one of the decisions that was made, needed to be made and people made aware of the decision-making behind it was do we scrap the first 20 pages of the playbook? Because in fact, we're already to a point that's beyond what we had thought we would start with. So that the questions of providing support to WHO in attempting to quell and contain the initial outbreak and slow the progression of the pandemic--which would have involved sending people to Southeast Asia, for instance, and sending some Tamiflu and other things to Southeast Asia, screening international visitors as they came into the country, and so on--all that was already nox-nix. We had already had cases defined here in the United States.

And so I think the Enterprise Governance Board was naturally the vehicle for beginning to do the collaborative discussion to examine where we were in our concept of operations, what the real issues were that were in front of us, and how we would approach them in common, as well as

bringing in the new policy players to understand what the planning had been, what the exercising had been, where we thought we were in reality, and what the watchful next steps appeared to be.

So we started using that vehicle, I think, the first week in May as a means to really begin to assure that we were on track consistently, that all the partners and players, in the federal sector particularly, were operating from a consistent understanding of what the status of the disease was, what the challenges were, and so on.

Recognize that the National Incident Management System, which we invoked, and recall in our earlier conversation, we talked about the culture of subject-matter expertise, the culture of bureaucracy, and bringing into that an operational way of thinking about how we would respond to events that's predicated or built around what's called the National Incident Management System, and it articulates how the command and control of events will play out.

There are 15 emergency support functions articulated in the federal sector. These support functions deal with various segments of the population and the society: so you've got a

transportation one; you have one for energy; you have one for public safety, et cetera, and the public health and medical is only one of those 15.

We operated, then, bringing people up to speed on how that system was designed and how it would function. And part of the National Incident Management System assumes that the incident management is in the hands of an incident manager, not in the hands of the top political player because the political player has other issues to address, and the day-in and day-out operational reality of managing response to an event requires full-time focus.

Certainly in the case of the Department of Health and Human Services, the Secretary is our senior-most person. But, in fact, the way the National Incident Management System was developed and the way we structured a response within the Department, the ASPR is the incident manager, in effect, reports to the Secretary. The Secretary obviously can make judgment calls about things, and so on and so forth. The day-in and day-out, the functionality, is predicated on-- the Secretary deals with the political and social issues, the incident manager deals with the operational reality of

who needs to go where, when, and what supplies do we need to send, et cetera, et cetera.

This became clear during Katrina, because in Katrina, then-Secretary Leavitt was having daily meetings with all the agency heads, and it was sort of, "Boss, boss, look at me, look what I do, look what I do," and so on, as opposed to a clearly defined operation with people's roles defined, plans articulated, and processes for implementation executed and monitored. So, within the Department, I think it was clear to most folks that we needed a better way to do that, and, hence, the National Incident Management System became the mechanism for executing that.

Now, how does one keep all the policy players alert to what's going on? How does one keep the operating divisions aware of what's going on? And there were daily operational phone calls at the operator level, but the Enterprise Governance Board became the most logical vehicle for keeping folks apprised of situational awareness--here are the issues in front of us, here's what the plan has been, what we accomplished against the plan, and here's what this day's plan looks like--and offering them an opportunity to

have input to any major changes that they felt were appropriate to that process.

Meanwhile, underneath that, you had the operators doing the response. So the Strategic National Stockpile people were assuring the appropriate materials were sent, when they were needed, to the appropriate location; that you had appropriate messaging being developed, at CDC predominantly in this case because it's an infectious disease...developing appropriate messages about should we be closing schools, why are we not closing the borders, should we be wearing masks?--et cetera.

You also had surveillance activity going on as well on an operational basis. That is, the states were trying to track whether or not in fact they had influenza A H1 or whether it was some other variant of influenza. So you had a whole set of laboratory assessments to be coordinated operationally, and so on.

So this is all going on at the operational level while, at the policy level, you used the Enterprise Governance Board to keep our internal HHS partners apprised, as well as to keep our federal partners at DOD and DHS apprised as well.

It's a delicate balance to keep the policy players from trying to dabble in operations, and the Enterprise Governance Board was the vehicle for assisting in mitigating the tendency for folks to want to get involved at a level that was inappropriate for them. They didn't need to be operational or tactical. The people liked to think that at that level. People even think they've got an M.D. after their name. And so, it's a delicate balance of keeping people informed, giving them an opportunity to speak to their concerns, and have them heard and acted on where it was appropriate. And at the same time, having them stay out of the tactical and operational realities so that Rich, for instance, and his people could continue to work.

Now, Rich and, ultimately, Secretary Sebelius, once she was confirmed, had to deal with the White House, because Rich was the face of the response. He was the public messenger. And, clearly, the President and his immediate staff needed to be informed and needed to have the opportunity to vet what they thought were messages, because there you start to get into what's the political, how you advise.

I remember one phone call, for instance, that Secretary Sebelius and Rich and I had with governors. And Martin O'Malley here in Maryland wanted us to tell him, "Here's what you must do," because politically, the closure of schools was a tough political choice for him to make, and he was looking for a cover in terms of what must I do. Now, Rich and the Secretary and I never said to them, "You must do this." What we said was, "We recommend that if you have active cases documented in any particular school, then it's rational to consider closure of that school."
"So you're telling me I must close my school."
So, the political--and Rich really had to deal with that probably the most, and he'll tell you about that, I'm sure.

But, again, the Enterprise Governance Board was a way of facilitating that communication, and supporting Rich. If he was going to be our lead guy, he was out there at the tip of the spear. How do we assure that we're providing him the appropriate support so that he has comfort and doesn't have to fight a lot of backfires from people undermining him, consciously or unconsciously?

You know, I was thinking about this earlier. I mean, I had said in our earlier conversation that they had built up the

group B folks, you know, the consultation with stakeholders, academia and professional societies and so on, and that was good. On the other side of that, it had a certain star-chamber quality to it because they wouldn't tell us here who group B was. "Well, who are you talking to?"

"Well, we've told them we wouldn't tell anybody who they were," and so on and so forth.

And from a transparency perspective, that's a problem. And it's the same thing with the Enterprise Governance Board. I mean, we maintain full transparency as to who is participating, who is invited. In one sense, it was the more the merrier. But one has to be careful and be cautious about this notion of inside information and star-chamber type stuff where you aren't clear about who's participating and what their provenance is.

SM: Was that unusual to have the people in Team B or any other kind of advisory body, to keep it secret?

CV: Well, yeah, because FACA, the Federal Advisory Committee Act, and the sunshine laws have really promoted the notion that we have to be open about who we're consulting with. In part, because corruption from the point

of view of inside players, particularly when they are private-sector interests or academic interests with grants and so on to be awarded, the whole business of corruption of government becomes a challenge there where you don't have clear visibility on who's playing, who's advising. I mean, this is the people's business.

So there are upsides to having a Team B; there are downsides if you aren't pretty clear about who that is and what their role is in the process. And they worked through that, and we got over that hump.

You know, the tendency is sort of to have special knowledge. The public health establishment becomes a real challenge at times where people aren't willing to be upfront about who they are and what they're doing, at some level.

SM: Right.

CV: I mean, you know, as it turns out, the people that they were talking to was Harvey Fineberg over at IOM, and Andy, out at the University of Utah Society who's a major player in the Infectious Disease Society of America and so

on. So it was people you'd logically think they would be talking to. But why does it have to be secret?

So, our role in ASPR was sort of trying to keep them a little more honest about some of that stuff, not trying to tell them what to do. Again, their subject-area expertise was appropriate. In the operational reality, we needed them. But it was difficult.

And then you get into--I'm going to segue a little bit to some of the decision-making. What were some of the decisions that we had to do?

SM: Right. Well, that's where I was going. But before we go in that direction, I wanted to know whether you thought CDC would have been the lead public face, so to speak, if the Secretary had been in place. Or did this come out of the fact that there were no--

CV: No. I think that even with the Secretary in place, again, given that separation that I talked about in terms of who's the operational incident manager as opposed to who's the political leader here, obviously it's a fine line to walk at some level. Clearly, the senior-most person

needs to be perceived, in reality, to be knowledgeable and be capable of showing leadership. But I think that if it was a hurricane, for instance, clearly ASPR would be the lead player, the public face. And, in fact, every hurricane that we had from 2006 forward, I'd go over and do the press conferences with FEMA and so on, because I was the incident manager. Now, that didn't mean that Secretary Leavitt didn't opine and make some statements, and so on and so forth. And the Secretary has to be kept fully abreast. But in that case, the Secretary has to exert some discipline and not let the political desire to be the face--which is what Tommy Thompson did with anthrax, and he shot himself in the foot a few times.

So CDC, if Secretary Sebelius had been, you know, if Tom Daschle had been confirmed back in February. The operational approach to these events is such that there has to be an incident manager who's in the lead even though the Secretary is our leader. And you'll see that, for instance, in the states, where Jack Colley in Texas is the Emergency Manager for the state of Texas. It doesn't stop Perry from opining as governor and flying around and doing public events.

SM: Besides bringing up the new policy people up to speed--that's what we were going to get into--you asked about whether or not we would talk about some of the major issues.

CV: Right.

SM: So, besides bringing the new people, the new policy people up to speed, what were some of the major issues that you had to contend with?

CV: Well, as I had spoken to a little bit earlier, we had developed plans for 15 national scenarios, the pandemic being one of them, and the plans were predicated on the pandemic beginning in South Asia. And if that had been the case, we would have sent people there. We would have been at the airports doing surveillance, et cetera. You may recall the SARS event in 2003. There are 18 airports nationally where 82 percent of international travelers enter this country that fly, and so we would have executed that, et cetera, et cetera. But the fact of the matter is that by the last week in April, we already had cases defined here in the United States.

So, one of the major first questions was would we address this through border screening? Remember, border closure was an option that we had decided we were not going to pursue. I described to you in our last conversation the Global Health Security Action Group and the ministerial meeting in December 2008, where the ministers had determined that (issued a public statement)they would not close borders in the event of a pandemic, so that was not an option. But for the new folks coming on board, I mean, we needed to bring them up to speed with the rationale for why that was the case in general, and then, more specific, why we would not pursue that in this event. And our rationale, of course, was once you have the disease in the country, screening and slowing international traffic would not provide much benefit for the impact it would have economically on the airline industry and on business travel, et cetera, et cetera. It just would not provide us with much of a public health benefit. So that was a major discussion that had to occur first and foremost because a lot of political players were, "Well, when are you going to close the border?"-- particularly to Mexico.

And there were some decisions, if you will, that flowed from that as well in that within DHS, for instance, all

their employees in the border-control environment were asking the question, "Should we be wearing masks, N95s?" "Should we have Tamiflu?" "When will we get a vaccine?" et cetera. And so the discussion of mask use, particularly for those who are at the border and might encounter individuals coming across from Mexico, was another major decision point that had to be discussed, and DHS decided they were going to do it. And on the public health side, we didn't argue against it. I mean, it's prudent, but it's not absolutely required. And remember, there's not real solid scientific evidence that even an N95 mask will prevent the transmission of the virus. There's some data that suggests that it will protect, and there's some data that says it's not particularly helpful. But mask use--initially, in an occupational environment with those border-patrol folks, and then hospital and medical staff, and then finally out to the community level--is a major decision point. Were we going to recommend that people use masks?

And, in fact, a discussion with the Team B and others and internally, we had already promulgated policy for pandemic H5N1 assumption that if you're a health worker, and, again, in close proximity to individuals who had the disease, then it was reasonable to do that. And if you were a family

member of an individual with the disease, that that was a reasonable decision to use face masks.

The whole business of how many face masks were available in this country--the M95 pipeline is very, very thin. And 3M was the major manufacturer, has been operating their production lines at about 95 percent of capacity and didn't have much room to grow. And in 2008, in fact, they approached us, asking us if we would provide funding to them for more base via opening of another production line. And, as a matter of policy, the Bush administration--Secretary Leavitt--determined that no, we weren't going to provide funding support for that, that there was a business reason for them to do it, and they should act on their business reason rather than depending upon the public sector to facilitate their opening of an additional production line.

But the whole question of acquisition of raw materials for production, many of which come from offshore becomes a real challenge as well. And so there were discussions about all these things going prior to the event.

And then during the event, of course, with new policy players, where are we with that? What do we have in terms of face masks? What's our policy with regards to face masks? How do we get more, et cetera?--were all issues that had to be revisited and discussed.

And, again, the Enterprise Governance Board provided the context for that. But recall, also, that the White House was having daily videoconference calls as well with the National Security Council staff and others on their end, and with HHS and DHS primarily, but others were participants in that. So a lot of this got discussed in those contexts as well. And all the counselors--Dora and John Monahan and those folks--were participants in those; Laura Petrou, although she was, again, at that point, she was extremely busy working to get the Secretary through the nomination and hearing process for confirmation.

Other decisions that arose--so, we're not going to close borders; screening at the borders, particularly the land borders, may be rational; and sending people to a hospital environment where they appear to be ill, and how do you educate a border patrol officer as to what that is, becomes another issue. And would we mobilize public health staff

from, say, the state public health departments to assist them in that? There are over 300 land ports of entry; how do you provide coverage for those? There were not enough public health people to do that, necessarily.

And, really, Texas was the only state that was really aggressive at providing public health support to the border environment. But then, their cities along the border are extremely--they're mixing bowls, because Brownsville and Matamoros are part of the same suburban metropolitan statistical area, if you will, and people move, come and go. And there were a significant number of hospitalized individuals in Hidalgo County, McAllen and that area along the border. So you had the border issues.

You had the question of, would we send out, from the stockpile, Tamiflu to augment the states' intrinsic capabilities with Tamiflu? And what were the guidelines for use of Tamiflu? And in the event, we determined that we would augment them by releasing about 25 percent of the strategic national stockpile supplies of Tamiflu. And again, this had been preplanned. There was a pro rata distribution in effect, so that the question of how much goes to what state was not a real contentious issue because

this had all been worked through in the ops plans with the states. And so we sent 11 million doses out to the states. And the states, of course, had to struggle with figuring out how they were going to sub-distribute that.

And while that had been tested, North Carolina, for instance, in 2006, conducted 85 different exercises throughout the state on how to distribute and vaccinate. Each county--there are 83 counties in North Carolina--each county had run an exercise in conjunction with the state on how they were going to accomplish that. So, some states had worked it through pretty well. Other states had not. But even so, to mass distribute these kinds of things was extremely challenging. So, just with Tamiflu, there was a real challenge.

Now, leading up to this, there had been discussions in 2007 and 2008 where there was a proposal that, well, maybe we needed to develop a home flu kit for people. And they could acquire a small starter supply, if you will, of Tamiflu, and in the appropriate event, they could be told to go ahead and start using their home kit. But that was very contentious. And it never happened because many of the infectious-disease experts thought that there would be a

lot of misuse and that would lead to much more viral resistance to the drug. Others felt like there was a social justice question; that is, if you had those on the market, only middle-class people would be able to afford them, and what about the impoverished people? The answer to that, of course, is federal subsidy. And I'm a social-justice guy, so that was what I would have done to answer that problem.

And, in fact, we had field-tested antibiotic home med kits in Saint Louis around the notion of an anthrax event. So, we gave people doxycycline in a kit at home, and we said, "Don't use it until the public health officials tell you to use it." And, I mean, we hit all the socioeconomic strata: we did East Saint Louis; we did AT&T as a corporate entity; we did a variety, full social strata. And, in fact, in that event, a year down the road, when we went back, 95 percent of the people had not opened their packages. They were trustworthy. But the experts didn't feel that people were trustworthy, that if you gave it to them, they'd just use them.

Well, the data argued against that, but it didn't matter, you know. I mean, we all live with our preconceived biases. Even though we tout science, where the science challenges

our preconceived notions, we say, "Well, there's not enough data."

So, the states had that challenge of how would they sub-distribute that, and provide guidance to people on how to use it and so on. But that was not a federal directive or responsibility directly. Yes, we had some oversight responsibility of providing some rational guidance to them about which populations should use the Tamiflu, again, trying to prevent overuse leading to resistance. And our general approach then became, those who are ill, saving lives, and preventing the spread of disease. Those are the two strategic goals: save lives and prevent the spread of disease. Then those who are immediate family members would be candidates for the use of Tamiflu.

Now, the U.K., they were giving out Tamiflu to just about anybody.

SM: I remember.

CV: They had a population of 60 million. They had enough doses for everybody, essentially, and so their attitude was very aggressive: use it. And Nigel [unclear] and David

Harper and I talked about that at some length, and, again, remember, I had said in our earlier conversation, GSAG, the Global Health Security Action Group was meeting on a weekly basis as well to sort of keep each other appraised of how we were answering these questions. Will we do the border? Will we distribute Tamiflu? Who will get the Tamiflu?

SM: How was the border issue resolved in terms of screening people as they went across? You mentioned and said that only Texas provided support for border screening. What about the other states? How was that resolved?

CV: Well, I think that what they did early was different than what they did ultimately. I think, yeah, there was a lot of political pressure in all those locations to do some screening support, and so, early on, they all sort of wanted some screening activity going on. But, in general, I think the public health--Mark Horton in California, Bob Garcia in Arizona, and so on--those folks, I think, took the position that we did. That is, once you got it, the horse is out of the barn. Are you going to devote a lot of resources to that activity, or are you going to devote it to other activities that may encourage slowing the spread of disease?

So I think in California, for instance, L.A. County and San Diego County and so on, with the state's support, got a lot more aggressive within their counties with screening and school closures and monitoring congregant living circumstances, and so on and so forth, as opposed to worrying about the border. So it was pragmatic decision-making on their part. Even though there was a lot of back-and-forth the first week or two, I think they made some clear decisions about it that, you know, the culture of those states is a little different than the culture of Texas, for instance. And that's part of reality is you've got to deal with local prevailing values and concerns and where they're willing to prioritize.

SM: Were they requesting assistance from the federal government, or just guidance?

CV: Guidance and then laboratory support for testing. I think in terms of manpower, that's where the big ask was from the states was "Help us with the laboratory assessment process."

And some places in Texas got into this bind. The state ended up being a clinical laboratory for every primary care doctor in the state who had patients coming in and saying, "I think I've got influenza," and he'd draw some blood and send it off or swab them and send it off. And the state became the clinical laboratory in support of all this. And Tom Frieden, for instance, it'll be interesting to talk to him because he experienced the first three or four months of that in New York. And he had significant disease in the state of New York and in the city of New York, which was his provenance. And he had a different situation than, say, somebody in Alaska, where they really didn't have much of anything.

I mean, eventually, by mid-summer, by June and July, every state had some cases. But New York and Texas and California and so on had a much higher burden. And there was this tendency for the clinicians to want to get confirmative testing, and that put a lot of pressure on the state labs, who then made the ask to the feds, CDC, to do the testing for them.

Well, by the end of May, our position was we had enough sampling data to understand the epidemiologic character of this, and that further definitive blood testing would not

be particularly helpful from an epidemiologic standpoint--and we didn't have the manpower to do it anyway. So that was the guidance that was then pushed out. But it takes two, three, four weeks before that guidance actually has a bite at the ground level. So, by June, mid-, late June--much less testing, sampling because we had the epidemiologic picture that we needed from the data.

What we were missing was we didn't have a population denominator out there. And so, that became the next decision point that CDC had to deal with, was, do we mount some studies to just go out and do sampling in the general population to try and figure out what the denominator was like, as opposed to relying the numerator. Because [unclear] people coming in sick or thinking they're sick, asking for sampling. And that was true in the international environment too.

So, screening at the border, screening domestically, meaning laboratory assessment, were major issues. Getting Tamiflu out, we did that, like, before the first of May.

SM: I'm not sure if we spoke about this, but were you present for the meeting with Margaret Chan when she came to HHS or when she was at CDC at the onset of the pandemic?

CV: Well, when she was at HHS, yeah; at CDC, no.

SM: Well, how was she received? How was her message received? And what was her purpose for--?

CV: Well, I think there were a couple of messages that she offered. One was, she wanted the technical support experts in determining whether in fact it was a true pandemic or not. That was her ask. She wanted to convene a committee, she wanted support for that, and so on and so forth.

I think what was controversial or more challenging was her concern that we and the developed countries would buy up all the vaccine and there would be none available for anybody else. And so her pressure, if you will, her moral ask of us was don't buy up everything; you must think about your global responsibility elsewhere in the world, and if this becomes severe, we're going to need you to help us help them. And that means (a) that you don't buy everything up, and (b) that you're willing to donate, because they

didn't have money to buy for the Third World and developing countries, and developing countries didn't have the budget to buy this. And so it was, don't use it all up, and help us get it for elsewhere. And I think our response to her was, yes, we want to be good global citizens, and we're willing to set aside a portion of whatever we might have access to because of preexisting contract relationships, and so on and so forth. We have to think about our domestic population first, but clearly we want to be a good global citizen.

Now, a subset of that was she wanted us to think about using adjuvanted vaccines because adjuvanted vaccines would allow for a greater supply; we might be able to get away with five micrograms instead of 15 or 30. And the use of adjuvants in this country is extremely controversial. Europe's accepted it. They used and bought and used adjuvant vaccine because they believe that adjuvanted vaccines, which have been, in Europe, tested in millions of people are safe and effective. But in this country, we haven't accepted that, and the autism lobby has made vaccination such a politically hot spot, and there are good people within the science community who have some concerns

that it's still a no-go here unless we're up against the wall.

So, her recommendation to us was, "Will you guys use adjuvanted vaccines so we have a broader world supply?" And our answer was, "Probably not." Well, that wasn't very acceptable to her. I mean, what could she do? But she didn't like it.

But we were prepared to use adjuvanted vaccines in a severe event in adults. I think we were ready to go there if we needed to. But it was very controversial here in this country. And, of course, all of those decisions...

In May, we had to put money on the table, and that was a big decision point. Where's the money? And, in fact, we drew down against a special reserve fund for BioShield, which meant their out-year acquisitions for advance development got cut down because we used money that we otherwise would have used for that to acquire this vaccine. How much could we get from any given manufacturer was a question that would require negotiation. And what was the rate? And if we're not going to use adjuvanted, that made a different challenge.

And all of this had to be done in the face in inadequate science data about how fastidious this virus was going to be and how much antigen we could get from each egg, for instance, because we're still quite dependent on the egg-based approach for reasons that I talked about in our last conversation. The cell base had been invested in, but it wasn't quite ready to function.

And so these were unknowns, and yet, at the same time, we had to make some affirmative decisions about acquiring upwards of 150 million doses because we had already made determinations in our pandemic planning as to who the target populations would be for vaccination in terms of prioritization of populations. And there was no reason to move away from those other than to get greater visibility of pregnant women, which they had been in the priority group anyway, but moving them forward because of the number of deaths that we were seeing in pregnant women.

So we knew pretty much how much we needed, at least for the first wave of vaccination. But remember that we had to be cognizant of 300 million people may be demanding it, and again, where we didn't know whether the antigen requirement

was going to be 15 micrograms or 30 micrograms, one injection or two injections. That meant we had to think forward to the acquisition of 600 million doses in a world production capacity of about two million doses if we were going to answer to a hundred percent domestic requirement.

Now, it's unlikely we'd have to do that, but we had to plan for it. And we didn't have adequate data. But you had to make those decisions. I mean, the knock on HHS is they can't make decisions, and that's true. It's very difficult to get a decision in that context.

Well, you know, Robin sort of got hung out there a little bit. We told him, go full-blast, lock in whatever we can lock in. Well, that put it a little bit out front of some of the policymakers, and when the event turned out to be a little less overwhelming than we thought it might be, then it was "Wow, now it's too much." But I'm responsible for 300 million people. I've got to plan for the worst case. At the same time, I had to be aware that we needed to assure that there were supplies for others.

So it was very difficult in May because we didn't have all the data we would have liked, but we had to make decisions

because the Europeans were buying it all up. I mean, GSK's production--we used GSK in Quebec as one of our sources. But between Canada and Europe, they were only able to give us a little bit because they'd already locked in. So it's a gold rush at some level.

But being mindful of our global citizenship responsibility, being mindful of the fact that it may not be as big a problem, as severe a pandemic as we were concerned about, all those things mitigate your willingness to say, "Full steam ahead." But that's sort of what we did.

Now, how do you distribute that vaccine becomes another decision point.

SM: Now, you mentioned that the BioShield...

CV: We used BioShield money to buy it.

SM: Right. But someone called into question the National Biodefense Science Board. You were challenged by members of the group about the response actions that you took. And I think you were speaking specifically about distribution,

because one of your comments was that later, one of the members called and said--

CV: Well, this goes to that, what I was saying about home med kits versus trying to have a public distribution schema. And Andy had been one of the people who was really averse to the notion of a home med kit and fought it tooth-and-nail.

SM: Andy--

CV: Pavia [sp.].

SM: Okay.

CV: Who's on the NBS board, and he represented a point of view. It wasn't him personally. It was just Andy happened to be the spokesperson for that point of view because he definitely did not think home med kits was at all acceptable. I mean, that was just craziness. That was a Bush bizarre idea.

I was down in Panama the summer, I think it was the summer of 2008, and early morning ride to the airport. Somebody

else in the hotel got in the car with us to ride to the airport, and we started talking. Well, it turns out he used to be down at Emory. Now he's at the University of Washington, and he's a big gun in the vaccine world. He didn't know who I was, and he was just going on and on and on about, "Those stupid Bush people, they want to" you know. But then when we got into the event, and he really came to realize how difficult it was to distribute, to get it to people in a timely manner, then it was like, "Well, maybe that wasn't such a stupid idea."

SM: And this was the Tamiflu?

CV: Yeah, right. But vaccine is a similar sort of challenge because, I mean, the seasonal flu. What we ended up doing was we opted to use the seasonal flu distribution schema, which sends a lot of stuff to primary physicians' offices, and so on and so forth, because pediatricians, for instance, are using vaccine all the time. So the distribution schema that CDC has always used has been to sort of send it to the private physician groups, and so on, in addition to the states and the counties and Indian Health Service, and so on and so forth. So they had a ton of distribution imports--logistically, a very difficult

challenge because this was more than the seasonal flu. If you think about how many people actually get seasonal flu vaccinations, it's less than 100 million; it's more like 75 or 80 million. Well, here we're talking about 300 million people.

SM: Right.

CV: Fortunately, it didn't work out that... The disease wasn't severe, but you've got to plan for it. So we opted to go with their schema augmented by an expanded distribution to counties and cities. So, for instance, I got my vaccine over in East Baltimore, at the neighborhood clinic in East Baltimore. It happened to be about four blocks from Hopkins. Sue and I were over there a lot for treatment and whatnot so just walk through the 'hood, got lined up and got our shots, you know. But the private physicians in Howard County didn't have it.

I mean, this is anecdotal, but it's representative of what we discovered that the distribution schema, (a) production was slower than what we had hoped because it was a more fastidious virus and more difficult to get antigen production. But even with that, the doses that were there,

the logistics was outstripped by the process I think. But a logistical question you have to deal with is how much do you empower individual people with medication for use in an emergency--Tamiflu, antibiotics, whatever--versus the notion that experts needed control and administer it.

And we function in this country on a just-in-time mentality. I mean, that's the way business has gone in the last two or three decades. It's everything was just in time. And I saw it at the Indian Health Service because we used to run significant warehousing in Indian Health. But over the course of the '80s and into the '90s, we shut down the warehouses because people were taking advantage of the just-in-time delivery schema that were being marketed by the suppliers, by Fedex and UPS, and so on and so forth.

Well, the problem is that leaves you with only two or three days of supplies, and what do you do in an event where the supply chain may be outstripped by the demand? And in the case of a pandemic, we're talking nationally. So you can't subsidize like we did with Katrina, for instance, where we hauled the CVS and Rite-Aid supply chains and got them focused on augmenting what was going into Louisiana and to

East Texas and Mississippi. You can't do that when a national event is tasking the supply chain throughout the whole country.

But this gets to our twentieth century, early twentieth century notions of public health, where at the turn of the twentieth century, it was a group of experts determinedly taking care of the population as opposed to empowering the population, you know, the classical... And I experienced this growing up on a res, the classical public health nurse who, "You must have thus-and-so, and I'm here to do it to you." Where's the empowerment in that?

So, the tried-and-true standard public health systems are stretched and stressed in this kind of event because there aren't enough experts and enough people to handle it on a national scale.

SM: Right.

CV: I mean, if it's a local event, well, you can pull in people from here or there. But if it's a national event, where are you going to get them? It ain't happening. So, how much have you empowered the people? And, oh, by the

way, empowerment of the people increases their resiliency, and you've got this wall. And the difference between West Louisiana and East Louisiana in the Katrina, and then Rita two weeks later, event was stark.

Here in the city, in an urban environment, people develop great dependencies: your trash pickup, your mail, your--you know, there's a store on every corner that you can walk. You don't need to keep supplies. You can walk over to the store and get it. Even if it's a 7-11 and you're being gouged, you can get it. But in an event, it ain't there.

Well, you go to West Louisiana, into a more rural environment, and people are used to doing on their own. And they make provision for the fact that you can't just run to the store tomorrow or the trash pickup ain't gonna happen. You have means for managing that. And so the standup...

I flew over to Lake Charles 12 hours after Rita went through there. I mean, it was devastating. Their hospitals were back up; they were running on a generator, but their emergency rooms were running; they fed me lunch; we had Cajun meatloaf and red-skinned potatoes--very different than what was going on in New Orleans.

Well, it's about resiliency and how you create resiliency. And in an event like this, how do we create resiliency in our population? How do we empower them to feel that they can exert control in the face of unknowns, in the face of adverse events?

So, the business of Tamiflu and a home med kit has more to it, in my view, than sort of the science concerns. Those are real, but I don't think we've seen any increased resistance in the U.K., for instance, and they were handing out Tamiflu like crazy. I haven't looked at the most recent resistance data in the last six months there, but you'd have to show me that it really did adversely affect the utility of that particular drug, because the empowerment of people in this event may be more important than a 5 percent increase in resistance.

CV: Well, anyway.

SM: So, when Margaret Chan came to HHS, you spoke about how she was received, her message, and what her purpose of the meeting was. But what were your immediate concerns at the time? I understand that she called the pandemic

operating from the International Health Regulations. How familiar were the lead responders with those regulations, and exactly what was happening during that meeting?

CV: Well, we were extremely familiar with the IHRs, in part, because many of our people contributed to the writing of the IHRs, back in 2005 and 2006 when they went through, and implementation in 2007. And ASPR is the hub for the IHR reporting, you know. Surveillance in epi, again, resides with CDC, but the IHR reporting schema involves a lot more than just us doing the epi. It involves federal partners being aware and understanding--the State Department, DHS, et cetera, et cetera. It involves engagement with the states in addition to the international dialogue with WHO.

For instance, one of our IHR notifications was we had troops flying into Qatar or Kuwait who ended up being sick. This is a group of Marines. Well, that's not a CDC issue, that was a DOD issue and a State Department issue, but the hub reporting to WHO came through us.

We actually have been doing a tremendous amount of technical assistance with Mexico--that's why the group calls me tio--trying to assist them in developing a

stronger approach to how they can affect the IHRs within their environment. I mean, they don't, for instance, have state laboratory reporting linkages, which makes it very difficult for them to... If a state lab discerns that there's something going on that's part of the IHR reportable phenomenon, that's not automatically--Mexico City may not know it. Whereas, in this country, the linkages that we have with state and municipal public health departments, in large measure through the CDC, allow us to do a more effective job for early identification of those kind of cases that are going on out in the periphery and making sure that they get in the mix in the IHRs through PAHO. We don't report to the Geneva directorate in the PAHO region, we report to PAHO. So, I mean, the IHRs were not a problem for us.

Now, there are some folks, and it's like, timeliness of reporting becomes an issue. And there are some people, if it's not absolute real-time, it's a problem; you've failed. We don't have technologies or human systems in place yet to do real-time reporting; we just don't. So, there was some concern that people had about what was the timeliness of communication, and there were a lot of people concerned

about why Mexico was slow in reporting, but less about us. So, yeah, discussion with her about IHRs.

I think the definition of pandemic is inappropriate, and they've discovered that, I think, by this exercise. Because the fact that you have 1,400 cases worldwide and you say it's a pandemic implies something that's more than the event. So WHO is going to have to think about how they recalibrate that. Keiji Fukuda and those guys are going to have to think about how they're going to do that.

Marty Cetron and the folks down at CDC who are part of the expert panel that WHO relies on are going to have to help them work through that and figure out a better way to define pandemic than just the fact that we've had a report of cases in all our regions. So what? I mean, when they say that, that implies a severity that may not exist, so they're going to figure out a way to calibrate their messaging.

But with the IHRs--Jose Fernandez, who's my guy on the IHRs, he is a killer. I mean, that guy is so solid. We have 24-hour, 7-day-a-week coverage for that deal. He was the

lead guy, but Maria and others--super people, responsible, --executing it. We're good.

SM: Okay.

CV: Now, CDC thought they should have been the hub.

SM: The IHR hub.

CV: Right, because they helped write it, and so on and so forth. But it's not an SOP thing, it really isn't. It's more about a government-to-government dialogue, and internal intra-governmental dialogue. And they have the SMEs, but there's more to it than that.

I don't know if that answered your question, but I didn't see IHRs as a problem. I embraced them, we embraced them.

SM: Okay. Well, the one thing I did want to come out of that was what were your immediate concerns at that meeting while she was there? I mean, what was going on in your head while she was sitting there and talking?

CV: I think the biggest concern was this whole decision of how do we ensure that there's a global supply of Tamiflu and vaccine? That was, what I was getting out of it. I mean, we're better than WHO by a long shot, much better.

Having said that, we also are arrogant at times, and so I was always trying to be mindful of not letting domestic demand and arrogance get in the way of hearing what she had to say. It's real easy to get, you know, "We're the best in the business."

SM: Well, you've been in the role of readying the country for influenza pandemics prior to this current outbreak. Has there been much difference in the degree of senior-level and White House involvement, say, in the response efforts when compared to the government strategy to deal with H5N1?

CV: Well, I would say we didn't see anything that we didn't anticipate, really, vis-à-vis the policy and decision-making. The fact that we had new people at the senior-most policy levels meant we were starting more from square one with education. But they're smart people, and they wanted to see the best thing done. They didn't want a

Katrina on their watch, and I get that. And they should feel that way, that they don't want a Katrina on their watch. But, you know, I didn't feel real interference at all with execution of the playbook.

I mean, there was a lot of "how many angels can dance on the head of a pin" kind of stuff. And, again, this goes to people wanting to be tactical. I mean, again, the Chief of Staff's brother is a doc, and he's here at NIH. Now we pull him down to the White House, he's a bioethicist and so on and so forth. Well, he's a doc. He wants... You know, how many angels can dance on the head of that pin, okay? But that's not unexpected. You expect that behavior. It's a question of how comfortable you can help them to become by exposing them to the information and knowing who the stakeholders of importance to them are, and bringing those stakeholders to the table to reassure them that, yes, the stakeholders that they will need then have been involved in this, and they think we're doing fine—okay, that's better.

So, it meant that we had to employ certain tactical approaches in the educational process and in engagement with the White House staff, and so on, and the new players that we wouldn't have had to do if they had been in place

for a year and they'd done the exercises, and so on and so forth. But it wasn't unexpected and did not delay action. They acted very smartly. They recognized that the battle rhythm is pretty high, pretty intense, and things have to move, and they couldn't slow it down. They knew that; they're smart people. I don't know if that's what you heard from Bruce Gellin.

SM: I can't recall.

CV: Bruce has a tendency to be a little more cynical than I am.

SM: Yeah. I can't recall what he said.

CV: Of course, Bruce comes from that academic environment too, so...

SM: It's been a while.

CV: I like Bruce a lot. He said to me--I saw him in a meeting a month or so ago, and he says, "God, does WHO need you!" I said, "Well, tell them that."

SM: That sounds like a comment he would make, too.

CV: Yeah, yeah.

SM: Did WHO's increase in its influenza pandemic alert change planning and response efforts during the outbreak?

CV: Not really. Again, I mean, our playbook--if you go back a year or two before this event, there was some ongoing disagreement between us and WHO about labeling of where we were in these events, and WHO had a particular set of criterion and labeling that they used. We didn't think that was appropriate necessarily, particularly after we exercised some things, and so on and so forth. It wasn't a taxonomy that was helpful to us in our decision-making in terms of when we would pull the trigger on doing X, Y, or Z. Our approach did not set up conflict with them because we could accommodate their approach. But, at the same time, our criterion were more clinical and operationally detailed and distinct for our uses. So when we called it level this or stage that, it was different in terms of the criterion that we employed than theirs, which goes to what I said: They don't offer enough criterion to distinctly understand

the severity, not just the spread, but the severity and the required action steps. We developed a more detailed and sophisticated understanding disseminated out of CDC and exercising that we did. It didn't put us in conflict with them necessarily, but it raised problems for the newbies coming in because they would see terminology with WHO that was a little different than the terminology that we were using. And so, helping them to translate and understand that we weren't moving in a way that was contrary or in conflict with WHO, but it was more appropriate and targeted for our activities domestically.

SM: Can you give me an example of an area where there appeared to be conflict that required some explaining?

CV: Well, some of it had to do with the screening, and when you made decisions about to screen or not to screen. And is it exit screening or entry screening, and so on and--?

SM: This was phase-driven.

CV: Yeah, right. And so, if you're coming in new and you're seeing WHO and you're seeing they're stage three or

stage four, and our nomenclature was a little different, you're going, "What the hell is this?" you know. "Are we in conflict with WHO?" No, we're not. It's just theirs is broader, less distinct, and less useful for us in our decision-making, but our decision-making is in concert with what they would expect us to do given their stage definitions, all right? But we were doing more, domestically.

And, again, it's sort of the level of sophistication. Because, remember, for instance, with the IHRs, it's not just reporting, it's about the establishment of a public health infrastructure, which doesn't exist in much of the developing world. And the proposed infrastructure developments under the IHR are modeled after what we have here in the U.S. And Canada has it too, in large measure. Many of the Europeans, at least the big European players, not the former Warsaw Pact countries certainly, but most of the NATO players have that capacity.

So, yeah, WHO is pitching to the lowest common denominator, and we're at a very sophisticated level, so those differences in nomenclature reflect that to a large degree.

So that was not a problem, particularly, with WHO. It was a problem internally with new federal players who were seeing certain different nomenclature being used in public statements coming from Geneva than what we were talking with them in terms of the con-ops and where we were in the playbook and what we were executing against.

SM: Okay. I just have a couple of more questions.

CV: You know, Rich could probably talk about that a little bit too, so you might want to put that in the back of your, you know.

SM: Some of the...

CV: Yeah, the differences in stages and phases between us and WHO, and was that an issue? That's one you might want to explore with him too.

SM: Okay. Well, having done this for quite some time and then actually having to implement the strategy, were there any surprises?

CV: Well, I mean, the initial surprise was that we had a novel virus with cases here before it occurred elsewhere, you know, here in North America, and then specifically, here in the U.S. That was the only big surprise. Everything else was just a variant on the playbook, really.

I mean, the messaging was prepackaged for H5N1. Okay. We modified it for H1N1 and the behavior of this particular virus. You know, the use of Tamiflu. Con-opt was there for H5 play it out. Vaccine acquisition and development, we just went right down the playbook. There were confounding details, obviously, but the basic principles in the playbook--isolate the virus, get a matching, well-matched vaccine development capability, get it to the manufacturers. Each one of those action steps, which we articulated in the playbook, we played them out.

The good surprise was that it wasn't more severe. It affected younger people, but then we were not surprised by that because, in fact, the 1918 event affected younger people more.

We couldn't quite figure out what this linkage between obesity and chronic disease and death was. We couldn't

quite figure out what the relationship to pregnancy and death was. I had one conversation down in Mexico in July with the Argentineans, because they lost a lot of pregnant women in Argentina, and I think here... Some of those details were not unexpected, but they weren't expected either. It was just sort of "play it as it comes, and what do we need to do to study this and understand it more effectively as time goes on?"

But no, I mean, I felt so good. It was a thing of beauty. (And trauma--you know, the fighting and pushing and shoving and all that crap that had gone on in the event. I was so proud.

You know, if you talk to state people, you'll get the same reaction because it played down. Yeah, yeah, we could have done better with distribution. Yeah, yeah, it would have been nicer if we had gotten vaccine quicker, and so on and so forth. But were we given anything we didn't expect? No. Did we play it? Yeah. Were we a team? Hell yes. It's just, you know, it's hard to describe to people how moving that is, because the risks are huge.

I mean, I've been in combat, and on a small scale, it's the same thing. I mean, when you execute it and you get your people home safe, it's just a tremendous emotional, it's a moving experience.

And in this event, given the scale of what we were dealing with, an international event that, certainly, we were responsible for the national implementation and assuring that we had reasonable relationships working with the international part, the scale of this was huge. And it was a thing of beauty. I loved it. But then I'm--that's the kind of stuff that's important to me.

I felt the same way in Indian Health, when we were pulling off stuff. I mean, when we responded to Red Lake--you remember that high school there in Red Lake, Minnesota, and a kid shot 10 other kids, killed 10 other kids and shot himself, our response to that was just really good.

When we had hanta virus out in Navajo and people were dying. You know, Bruce [Tempest?] figured it out after the third death, and we mobilized and we stopped that: Thing of beauty. And it's all about a team. It's about people having a common vision of what the mission is: save lives, slow

the spread of disease, and facilitate the action of others in executing against that.

I mean, if you went back and looked at our balance scorecard, the management plan for ASPR that Jerry and I put in place, it was about strengthening the partnership of the public health community, facilitating federal response to events. Those are our strategic responsibilities for ASPR and the Department writ large. ASPR is simply the tip of the spear for these events for the Department. But it takes a whole department. It takes the state. It takes the city. And when you see that all working, whew, damn, that's good, you know.

SM: I do.

CV: And you just feel part of something so good and big and human that you just can't help but be moved.

SM: Can you tell me, when did you actually pass the baton to Nicki, to Dr. Lurie, as the new ASPR?

CV: Well, she was nominated in early or mid-June--I forget exactly when. I think it was late May. But June, we gave

her an office, set her up, said, "It's going to be yours, might as well get here and get your feet in it," so on and so forth. I mean, she was sworn in on the 14th of July, so that officially turned over to her. But June, early July, I was deferring to her anyway. She was coming on board, and the only rational way to deal with it was engage her, let her begin to set the tempo, the battle rhythm that she was comfortable with, and start to make those determinations for herself rather than sort of try to muck around with it and say, "I'm here until then." That's stupid. So, officially it was July 14th, but she started handing it off.

SM: And she relied on you for a lot of the sort of contextual information in terms of how to move forward. I know that you both worked together on the Rand research project, so you had a relationship previously.

CV: Well, yeah. There were two things there: One was, I mean, she had been working on a project to look at the status, preparedness at the public health department county and state level. That was a specific evaluative study that she was engaged in. And then a year ago, 18 months ago now, roughly, we also asked them to help us with the development of the national health strategy. And so where she had been

sort of looking at a more narrow slice of what's going on with pandemic preparedness at the state and county level, then that last 12 months before she was nominated and so on, she was involved with us much more on, "well, what's the broad set of policy initiatives that we need to push forward over the next four years?"

I mean, what the Pandemic and all Hazards Preparedness Act called for was the development of a national quadrennial review, in effect, of the National Health Security status, and the issuance then of a four-year plan for what are the priorities in the next four years for national health security. Well, that's the big picture.

And so, she had been working on a very focused project, which had broader implications to it, obviously. But then, more formally, we asked her organization to take on working with us on this. What is it we need to do over the next four years? So, yeah, she had a lot of insight anyway based on those regional meetings and sort of the churning of what that plan looked like and how to structure it, and so on and so forth. What are the critical strategic objectives? Then, what are the operational and tactical plans that we need to put in place to begin to achieve that in a matter

of priority? So, yeah, I mean, this was a smooth handoff, I think.

A lot of the staff, anxious as hell:

There's the usual sort of SME kind of things. That is, the operators, they're SMEs in operations, and they didn't believe that she was coming with any skill set in that arena. And they thought that her attitude was going to be, "I'm dumping you guys." So there was a lot of anxiety in that whole operational side of the house.

Over on the countermeasures side, there are a bunch of Ph.D. scientists that came out of industry, basically, and they're gung-ho, want to do this advanced development stuff. And, you know, again, when you have a change in administration, somebody's going to slow you down, and so there was a lot of anxiety there. And Gerry and I took the position that, "Look, you guys, she's been dealing with us for two or three years now. She's not coming in cold, so respect her."

And specifically in June and so on, we really went into detailed briefings with her about how the administrative

management of our organization had been set up, and HR and contracting and budget, and yada-yada-yada-yada-yada, which she hadn't been engaged in before. Why would she? So she was steep on the learning curve. But then she sort of had to step in in an environment where the political stakes were high, too, and I know that created anxiety for her.

What was it? One day I was standing at the building, it must have been late August or early September. (And I went on terminal leave the first of September--I had a couple of weeks of regular leave available to me, and when my son was diagnosed on August 15th, I just wanted to leave, and I really was only back at the building two or three times between then and the first of November.) But I remember one day I was at the building and I pulled out of the garage to leave, and she pulled out in the truck. (Danny was driving her.) We had a big U-Con car, big black Suburban type vehicle, and she was probably headed to the White House, I would think. And she was busy working on her Blackberry.

SM: She's always working on it.

CV: Right, right, right. I mean, personally, I think there's too much of that going on. You don't have time to,

you know... But be that as it may, I mean, that's her style, and that's what works for her. So, hey, go for it.

But we drove down Third Street for about three blocks, and they're right behind me, and suddenly they did a U and went back to the Humphrey Building. But the thing I noticed was she looked so stressed out. I mean, for good reasons: She was steep on the learning curve, the political risks were huge, health reform was going nowhere, so there was a lot of unhappiness in that Department. All these people would come in, policy wonks that would come from G.W. And Monahan--they were all policy wonks. They came for health reform. So, what were they doing? They're angry. They're upset, so there's a lot of tension in the building because things weren't moving. No surprise that they would feel that way, that there would be that tension, and so on and so forth.

So, you had the risks of the pandemic business going on then: "Why didn't you buy enough vaccine?" "Why did you buy too much vaccine?" "Why aren't you getting out there faster?"--you know, all the political stuff that she had to deal with just related to this in the context of a Department that was dead in the water for its policy

objectives, and frustrated. CMS was just marking time because they were waiting for the changes to come with health reform. They had that whole planning and evaluation crew that were marking time. Bill Core, marking time because what they came for wasn't happening yet--tough, tough, tough.

SM: Did you have any parting words for her, you know, the way the previous President leaves a note for the next President, was there anything that you offered her?

CV: No, because it was all part of that existential experience that we had been having together. I mean, it wasn't like that because, well, I'm an existential person anyway, but it's like life is lived, and we'd been living life together. "Just you're in it now." And it ain't theoretical at this point[Both Laugh]. I mean, Jesse used to come over and talk to me.

But I don't think you can understand it till you actually are responsible for it, for all that, until you're in the seat and you're responsible. It's hard to sort of conceptualize what that means: Three hundred million people

are depending on me. That's a lot, and you don't think that every day, necessarily.

In Indian Health, and I carried this into ASPR too, in Indian Health--I think I said this to you when we first visited--our mission was clearly stated: elevate the health status of American Indians and Alaska natives to the highest possible level. That was our goal; that was our objective; that's our strategic desire. And so on a daily basis, I would ask my staff, "What have we done today to improve the health of your people?" And I did that in Iraq, too, with the Iraqis. "It's your Health Ministry, these are your people. What have you done today to improve the health of your people?" And with ASPR, what have we done today to prepare the nation? So you don't think about that 300 million people every day in that sense, but you have to be aware: This isn't theoretical.

And, you know, we all make our accommodations for how we can deal with it personally. You know, I had a tendency to blow off the White House guys a little bit, some 30-something who's just punching a ticket to his next job, like Rajiv Ankaya. You know, I'll do what I need to do to be responsive to them. I'm not going to... But they aren't

why I'm here and why I exist. That was the way I dealt with putting off some of that pressure.

Fran Townsend [sp.] was having a cow. Go ahead, Fran, have a cow, you know. I mean, tell me what you think I need to do, I'll do it. But let's not spend a lot of emotional time and energy.

Some people will blow off the response, "Let the responders deal with it. Just keep me apprised." Some people would blow off the politics going on between BARDA and NIAID, "Look, you guys work it out. I'm not going to go to war with Tony Fauci, so you guys work it out." We all have our ways of accommodating the pressure and attending or not attending, focusing or not focusing, and she has to have her way of attenuating the weight of that, because if I worried about whether the Vice President was going to have a cow over something I was doing, and I briefed him, I can only worry about that so much, and you balance it.

And the reality is I have a family. So when I was sitting in that seat, my first grandbaby was born when I was in that chair, and that was an important event to me. I mean, I went to the 22-week ultrasound with the mom and the dad

because I wanted to see if this baby was doing fine. Now, they didn't want to know the gender, but I did, and I did but didn't tell them. They won't let me go to the next one.

But, I mean, you know, you have to have balance, and so you choose to focus and unfocus on things, and some of that has to do with what your comfort zone is with. You know, my comfort zone was more down and in because that's where the real action was, in my view. It's how those state and county people were going to react and how we can support them, and what their belief is about how we can support them. That was the most important thing to me, not whether or not somebody was having a cow at the White House over something that may or may not have been important. I mean, part of that was I started that in Katrina because they'd see something on CNN and they were calling me down in friggin' New Orleans. Okay, that's not the most important thing. I will deal with that, but it's not the most important thing.

I mean, I had this with Tom Daschle. This is why I had a relationship with Tom, was he had me to a series of hearings back in 1986 on Indian Health, and he was the inquisitor. Dan Anway [sp.] was the grand old man and he

would open it, and Tom would be the questioner. And this is a Reagan Republican administration, of course, and most of the answers were vetted by OMB--always the bane of us career people, dealing with the friggin' OMB.

But he had a series of hearings, and at the first hearing, he wanted to know why weren't we doing more for maternal and child health, yada-yada-yada-yada-yada. The next hearing was, "Why aren't we doing more for emergency rooms? Why do we have more emergency services?" and so on and so forth, in Indian Health, in Indian country. I came to the third hearing and it was about alcohol, "Why aren't we doing more?" I just said to him, "Sir, which emergency room and which MCH program do you want me to close to fund this alcohol program?--because that's my choice. And we've had three hearings now in a row where you've asked me about why for each one of these. There ain't enough money." Of course, I can't say that, I'm not supposed to say that, right?—because OMB doesn't ever want you to make a pitch for money. But you've got to call it as it is and stop playing this political game with me, beat me up over this, and then beat me over that. You know what the friggin' answer is: There ain't enough money there.

SM: Did you have similar experiences during congressional hearings for H1N1?

CV: No, not really. I mean, the challenge there was understanding science. You know, "Why can't you make this faster?" That's not about money; it's time. Money doesn't solve the problem. It's not a pure engineering problem like you have with putting a man on the moon because there's biological systems, and they function in ways that are different than mechanical systems. And sending a man to the moon is primarily a mechanical set of...it's a mechanical engineering problem. How do you make a bigger, better, faster rocket? That's a mechanical problem. How do you assure that you have a life-support system attached to this that works? That's a mechanical problem. That's very different than biology, but you know. So, no.

But where we did have some of that was more with OMB. Because, okay, you want to take this money out of the special reserve fund to fund this. That means I'm not going to be able to develop countermeasures for anthrax, for an improvised nuclear device, for emerging infectious diseases, XTR TB where I need a new broad-spectrum antibiotic or a new vaccine for TB. If we spend the money

for this, we ain't going to have it for that. So those arguments were more with OMB. It wasn't the Hill, although it's going to get to the Hill.

SM: Is there anything in hindsight that you would have done differently?

CV: I was thinking about that at 2:30 this morning. (I woke up worried a little bit about Andy. I mean, he's doing okay and all that, but I'm still a parent, so I still worry.) It was a thing of beauty. And I think--the after-action reports. There are some tactical and operational things that need fixing. There's communication things that could be fixed. But on a big-picture level, would we have done anything differently? Probably not. That's why we do after-action stuff, though. That's why we do exercises.

I mean, I'm concerned right now because, in fact, there seems to be a setting-aside of the exercise program on a national level--national-level exercises that we've been doing over the last four or five years--because of expense and wrangling and other things. I mean, there was supposed to be, for instance, a national-level exercise based in Las Vegas on an improvised nuclear device. The town fathers

were suffering from less tourist traffic and income and so on. Reached their senator and said, "We don't want this to happen because it may make Las Vegas look bad," blah-blah-blah, "so we aren't going to do it."

Well, then the whole question of "are we going to be doing exercises and learning where we're good and where we're not good," are we going to be doing that? I have some concern about that because part of the reason things went well, I think, is because we had been exercising. And, as I said to you last time, as recently as January 16th, two months ahead of this, two and a half months ahead of it, you had a major exercise. So we were familiar with each other. We were familiar with what we were going to do and the roles we were going to play, and that created trust, and trust is what you need in these kind of events. I mean, that's what didn't happen in Katrina. There was no trust whatsoever. People in New Orleans didn't trust Nagin; Nagin didn't trust the Governor; the Governor didn't trust the feds. Internally in the feds, they didn't trust each other. I mean, it was just...

And, again, the experience over in West Louisiana, I mean, part of why that went well was because they had begun to

trust. They saw what we were doing and they knew who some of the players were now because of what had gone on three weeks earlier. And so, it was easier for the locals and the state and the feds to trust each other and make it go. So we evacuated, for instance, 3,000 patients from Lake Charles, hospitals, nursing homes, et cetera, by air over 18 hours in that storm, because there was a dialogue; it worked.

And it's the same thing here. I know they've done the after-actions. And I haven't seen her, haven't asked for them. I don't know if I can. I think I can, probably, under a FOI, I could.

But three or four months from now, when I'm not on my ethical ban, I'm sure Nicki will--she and I will start talking again. I mean, we e-mail periodically, and she's referring people to me for conversations: Scotty Deitchman down at CDC just sent me a note yesterday. Nicki had said, "Why don't you talk to him about this?" But I think once I get past my ethics ban, we'll start talking more directly again, because I can do things on the outside to support her, you know, and that's what I want to do.

But the after-actions will show operational attachment things that can be improved at the big picture level, I think it went as well as it could.

SM: Me too.

CV: Yeah. So, did she, I think.

SM: Yeah.

CV: And I think the President did too, and that's important, when your boss believes that it's okay.

SM: Certainly, it wasn't a fiasco, and if you look at the news and outside the Beltway, inside the Beltway, people have issues with certain things. But I'd say overall that it went well. It was a success. You can always find something off.

CV: Sure. But I think it reflected well on the administration. I think people who are willing to look at things rationally viewed it as credible. I'm not talking about the libertarians from far north and eastern California, and the yahoos down in Mississippi or whatever,

and this friggin' stuff and the way they're demonized, just demonized. It's just so stupid.

Well, anyway, anybody other than those folks probably would say, "Yeah, the administration did a good job. Their career people stepped forward, their new political appointees did the right thing, and it was good." And that's important because people don't believe in their government much, and in a contemporary environment, that's a bigger and bigger problem. And I don't know if the friggin' Republicans realize how far they're pushing this nation to the precipice in that regard. And I'm not partisan, per se, obviously, although my values, they're where they are. But, you know, it's stupid. The lack of statesmanship and responsibility in governance just blows me away. My kids, our kids, are going to suffer for it.

SM: Can you tell me about Julie? Julie was the Director for CDC, right?

CV: Until the 20th of January.

SM: And where is she now?

CV: She's the Vice President for Vaccines, I think, for Merck.

SM: For Merck. Okay. Is there a way that I can contact her? Do you have contact...

End of Interview

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CV: That became part of our logo, and we put that on a coin with our office on it, and our motto, our objective, and that is, "A Nation Prepared." And we provided these coins to people in events where we wanted to recognize them, where we wanted to bond them to the organization, where we were just glad that they were part of us. I'm giving you one.

SM: Oh, thank you! Thank you very much.

CV: I'm also giving you my personal coin. And, again, this goes back to that Roman tradition of recognizing someone's commitment to achieving the mission that you think is important in your leadership role and your responsibilities. And Caesar, of course, had his own picture on the coin of the realm, but in this event, it's

more about the coin is representative of my career and rank and my commitments, and this coin has the flag with two stars on it because that was my rank. It's got my name. Inside the circle, it has Indian Health Service because that's my roots; that's where I came from. And outside the circle, it has various significant events that I was party to: Iraq; tsunami in Indonesia; Katrina, Rita. And on the obverse side, there's the symbol of Public Health Service and the sort of motto or objectives of the Commissioned Corps, and that is to protect, defend, and advance the health of our people. So I'm giving you that too.

SM: Thank you very much. I will keep it. I will keep it for the archives.

END OF INTERVIEW