Interview with Captain Harvey Alter, USPHS (ret)

by CAPT Jacqueline Rychnovsky (ret)

This is part one of a two-part series. Part two will be published in the December issue of Frontline.

On October 22, 2020, RADM (retired) Steven Solomon, President of the PHS Commissioned Officers Foundation for the Advancement of Public Health, and I sat down for a video interview with Captain (retired) Harvey Alter, 2020 winner of the Nobel Prize for Medicine or Physiology for his contributions to the discovery of the hepatitis C virus.

Jacqueline Rychnovsky: Dr. Alter, good afternoon. I’m Jacqueline Rychnovsky, the Executive Director of the Commissioned Officers Association and the PHS Commissioned Officers Foundation for the Advancement of Public Health. We’re joined today by a retired Admiral, Stephen Solomon, an Internal Medicine, Infectious Diseases, and Preventive Medicine physician, and President of the Foundation.

We want to just chat with you today, and first, congratulate you on your recent announcement for the Nobel prize in physiology or medicine for discovery of the hepatitis C virus. We have great admiration for the work that you do, thank you for taking time to meet with us today.

Steve Solomon: Thank you so much, Sir. I’m a longtime admirer of yours, and of your work. It has been seminal, and so much of what you’ve done affected my career, both as a young physician, and from my many years at CDC, working in the Center for Infectious Diseases. So, I’m very, very honored to have the opportunity to speak with you today.

Jacqueline Rychnovsky: Dr. Alter, you have strong ties to the NIH, starting as a clinical associate in the 1960s. Rumor has it there used to be coffee mugs that said, “Big place, lots of smart people.” Can you tell us what impact the NIH atmosphere and culture has had on your career?

Harvey Alter: Yeah, pretty much everything. I was born here ... no, not really, but I came here as a fellow out

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Words Matter

As we do each year on November 11, we celebrate Veterans Day. To the Veterans out there, I hope you had the opportunity to reflect upon the service you and others gave our Nation while wearing the USPHS uniform. As the PHS March goes, “In the silent war against disease, no truce is ever seen.” The same could be said of our never-ending battle to correct legislative and policy mistakes, because words matter.

Words matter, and when words are used incorrectly it creates confusion, can have long term implications, and lead to a chronic need to clarify and advocate to set the record straight. Take the word military and the phrase armed forces. The definition of military is “relating to or characteristic of soldiers or armed forces,” and the armed forces refers to “a country’s military forces, especially its army, navy, and air force.” When the word or phrase is used incorrectly, as occurs frequently when policy or laws are drafted or enacted, Commissioned Corps officers are inadvertently, and often unintentionally, excluded from receiving the said benefit.

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Legislative Update

Military Coalition Prepares Health Care ‘Ask’ of Congress

by Judy Rensberger

With 2021 almost upon us, The Military Coalition’s Health Care Committee is preparing a health care wish list to present to the incoming U.S. Congress on behalf of TMC’s 30 member organizations.

The committee’s goal is to “protect the value of the TRICARE health benefit by opposing any legislation or policy change that would disproportionately increase enrollment fees, deductibles, co-pays, cost shares, or the catastrophic cap.”

We want to see top-tier health benefits at the lowest possible cost. That is not easy to achieve. New TRICARE contracts are being negotiated now.

This year’s “ask” includes new requests, such as TRICARE coverage of treatment for eating disorders. It also includes requests for reversals of previous copay increases, including those for mental health services and for physical therapy, speech therapy and occupational therapy.

The committee draft objects to using increases in out-of-pocket costs to fund readiness. It chides the Defense Health Agency (DHA) for having “defied congressional intent to protect current beneficiaries from excessive fee increases.” At the same time, it leverages the findings of a recent report from the Defense Department’s Inspector General, Evaluation of Access to Mental Health Care in the Department of Defense.

The committee’s document also offers a rare compliment: it wholeheartedly supports the DHA proposal to make use of its demonstration authority before making huge untested changes to TRICARE. Thus, DHA would test regional and market-level health plan options, as well as alternative payment models (e.g., value-based care), before making major changes to TRICARE that would be difficult to undo.

The committee asks Congress to make certain that the Department of Defense does not eliminate medical billets, or reduce medical personnel, or downsize or close any military health facility, until it first presents to Congress a thorough analysis of the availability (or lack thereof) of civilian care.

see LEGISLATIVE continued on page 9
Retiree Voices: Cancer Clinical Trial

Retiree Voices is a new forum for USPHS retirees, both recently retired officers and those who retired years ago. We want this forum to be spontaneous, informal, and topical. Most of all, we want it to reflect issues of particular interest to individual USPHS retirees and to retirees as a group. Participants must be paid-up members of COA. Retiree Voices is very much a work in progress, so please share your thoughts and suggestions with Judy Rensberger at jrensberger@coausphs.org.

by CAPT Alan Echt, USPHS (ret)

When I learned I had chronic lymphocytic leukemia (CLL), I was a 50-year-old Captain with 21 years of service. I had a very worried wife, a son in veterinarian school, another son in college, and a daughter in high school.

The standard of care in 2011 was chemoimmunotherapy with a combination of fludarabine, cyclophosphamide, and rituximab (FCR). That therapeutic regimen was known to result in several side effects and only produced a deep remission in a subset of patients. The genetic characteristics of my cancer, a complex karyotype that included the 11q deletion, meant that FCR was likely to result in a short remission and select for a more aggressive clone which would make the CLL more difficult to treat in the future. Fortunately, my CLL progressed slowly. By the time I needed treatment, the standard of care included targeted agents, including the Bruton’s tyrosine kinase inhibitor ibrutinib. The newer drugs are more effective than FCR for people with my CLL features and have fewer side effects. The issue was that I would probably have to take ibrutinib for the rest of my life, or until it stopped working.

Ibrutinib retails for about $12,000 for a 30-day supply. The choice between chemoimmunotherapy and a long course of an expensive drug led me to look for a cancer clinical trial. Luckily, I live within 100 miles of The Ohio State University James Cancer Hospital, which is a member of the CLL Research Consortium and a leading center in CLL patient care. I was also fortunate because TRICARE covers cancer clinical trials. This meant that I was able to participate in a phase Ib/II clinical trial with the combination of three non-chemotherapy agents, obinutuzumab, ibrutinib, and venetoclax, close to home.

The TRICARE website notes the health insurance covers participation in Phase I, Phase II, and Phase III studies sponsored by the National Cancer Institute for all beneficiaries who are selected to participate. TRICARE coverage includes all testing and medical care required to assess trial eligibility, all necessary medical care during the study, including chemotherapeutics and their administration, inpatient and outpatient care, and laboratory and diagnostic testing. The regional TRICARE contractor assigned a terrific nurse case manager who contacted me to explain TRICARE coverage, answered all my questions, and contacted me periodically during the course of the study to see how I was doing and answer any questions. She explained how my hematologist/oncologist could obtain approvals quickly for unanticipated procedures. This came in handy when I needed to stay overnight unexpectedly after the first dose of venetoclax, when tumor lysis syndrome was a concern, and when I was admitted during the next dose escalation for monitoring, just in case.

I took my last doses of ibrutinib and venetoclax on March 1, 2020. Recent tests showed that I have achieved complete remission with minimal disease negativity. For me, being in a clinical trial was a positive experience that resulted in an effective treatment. While I am hoping for a durable remission, I know that the CLL is likely to return some day. I hope that a suitable trial will be available when that day comes. TRICARE coverage made it possible to be in the trial I wanted and made it less stressful. If you are facing a cancer diagnosis and you and your physician think a cancer clinical trial is right for you, know that TRICARE will be there to support your care.
Rebuilding Public Health Infrastructure

by Rear Admiral Steve Solomon, MD, FACP, FIDSA, USPHS (ret.)

This issue contains the first half of an interview we were privileged to conduct with Harvey Alter, MD, retired USPHS officer, NIH scientist and recipient of the 2020 Nobel Prize in Physiology or Medicine. The scientific community’s recognition of Dr. Alter is one more notable event demonstrating how the Commissioned Corps has brought remarkable people into uniformed service and has served as an important foundation for Federal public health.

Dr. Alter joined the Corps in the era of the Yellow Berets, when the NIH routinely brought young officers like Dr. Alter and Dr. Anthony Fauci into its clinical associate program. At that time and through the ensuing decades, as throughout the history of the Corps, those officers serving in the IHS, CDC, FDA, HRSA and many other Federal agencies both within and outside the Department of Health and Human Services distinguished themselves by their dedication and commitment to serving the public’s health. And of course, the Corps continues to attract remarkable women and men to uniformed service, especially the outstanding cadre of officers now on active duty, who have given so much of themselves to the United States’ response to the COVID-19 pandemic.

A lot has changed in the years since Dr. Alter joined the USPHS. Medical science and patient care are dramatically different. The society in which we live is changing and evolving with a speed that leaves many people with a discomfort that once was called “future shock.” It is hard to imagine the events of this past year could have demonstrated with any greater clarity that we live in a time of upheaval and uncertainty across a number of crucial areas, the public’s health and the way our nation has responded to the social compact inherent in preserving population health being prominent among those areas of concern.

In the past few months, we have seen an amplification and acceleration of trends that go back to the 20th Century. There has been a steady erosion of the public health infrastructure in the United States due to a lack of resources from legislative bodies at the local, state and Federal levels. An even greater threat may be the erosion of the trust the public invests in the agencies and the people responsible for preserving and protecting the public’s health. That loss of trust has been accelerated during the pandemic for several reasons, including attacks directed at public health personnel by some government officials.

The public health system will be rebuilt and better supported, eventually, simply because our society has no alternative. The mounting toll of this pandemic added to the ongoing health problems present before the COVID-19 era—the opioid epidemic, obesity and poor nutrition, antibiotic resistance, and too many others to list—will only worsen the health metrics by which the United States compares poorly to other high-income countries around the world. At some point, elected officials will wake up to the need for a robust, well-funded, well-staffed public health system, and they will support the people who constitute the public health workforce not just with more money and resources, but with clear and unequivocal acknowledgement of their value and respect for their service.

Unfortunately, our nation cannot wait. The time to act is now. The COVID-19 pandemic is the public health equivalent of Pearl Harbor and 9/11/2001. This coming January, the 117th Congress should begin with actions that expand and strengthen the Commissioned Corps. Much more than that is needed, of course, but a legislative commitment to the Corps would be not just a functional response to the pandemic but also symbolic in its recognition that a uniformed cadre of officers can be a critical part of the foundation upon which to build a coordinated, integrated public health system in the United States with the capacity to serve the needs of all its people, all the time, wherever, and in whatever circumstances they find themselves.

I believe the Corps needs to be larger—at least 10,000 on active duty with a Ready Reserve of at least 2,500. The White House should elevate the role of the highest-ranking officer in the USPHS, whether the Surgeon General or the Assistant Secretary for Health, making the commandant of the Corps the director of a reconstituted Health Security and Biodefense group within the National Security Council. And Congress should give the Corps’ leadership command and control of at least a significant number
What is Gratitude and Why is it Important?

by LCDR Katrina Redman, MT(ASCP), SPOC(AACC), Chaplain (BGCT)

As we enter the season of Thanksgiving, my mind has been dwelling on the nature and importance of gratitude. I did some research online and found that gratitude means thanks and appreciation. It comes from the Latin word gratus which means thankful or pleasing. Next, I looked up grateful which means to warmly or deeply appreciative of kindness or benefits that are received.

Most belief systems teach that gratitude is necessary for worship and health. While they acknowledge the challenges of life, they note the advantages and responsibilities of this practice. Buddhism teaches that practicing gratitude turns the mind in a way that allows an individual to live into life, or more accurately, die into life. Hinduism teaches that an individual is to be grateful for what they get, and not to expect gratitude from others. Islam teaches that gratitude is for your own soul because it deactivates negative emotions such as low self-esteem, jealousy, greed, hate, stress, laziness, and arrogance which are associated with ingratitude. Judaism emphasizes that gratitude requires an honest accounting of what you do have which allows you to acknowledge the blessings which are a part of your life, and Christianity teaches that we are to give thanks for all things because our limited perspective cannot understand the positive outcomes that may result from them.

Virtue-based and non-belief systems also promote gratitude. These systems teach that life is about giving, receiving, and repaying. They stress that we are all dependent upon one another due to the nature in which we are born into the world (dependent on help from others) and how the majority of people leave the world (dependent on help from others).

How does this apply to our health though? What are the positive physical, social, and emotional effects beyond the spiritual effects? I am so glad that you asked! In psychological research, gratitude was found to be associated with greater happiness. It helps people to feel more positive emotions, relish good experiences, improve their health, build strong relationships, and deal with adversity. Thousands of quantitative studies have been performed over the last century which revealed that there are numerous positive physical health effects experienced by those who have strong religious or spiritual beliefs. These studies show that there are benefits in cardiovascular health, immunity, stress hormone levels, longevity, and that individuals are less likely to suicide, develop depression, or abuse substances.

This is fantastic news! However, it left me wondering how you would define, or characterize a gracious person. The answer stopped me in my tracks. A gracious person was defined as tactful, delicate, and generous, even when they have lost everything. Let that sink in for a minute. I did. This is a tall order.

What have you lost? What have we all lost? Can we truly say that we have been tactful, delicate, and generous when we lost something that was precious to us? It is one thing to lose a button, but it becomes totally different when you talk about lives. What if what you lost wasn’t as severe as losing someone that you love, but still represented a significant change for you. How do we embody graciousness when we are in pain, grieving, or simply frustrated? The answer is... we search for a reason to be grateful. Sometimes this searching could take seconds, and sometimes it could take us a very long time to find a reason. This could be a very difficult task indeed, especially if a person has suffered a horrific trauma. This is why I said that it stopped me in my tracks. Finding a reason to be grateful sometimes, could be a daunting and life-long challenge. However, joy and wonderment of life are the antidotes to feelings of scarcity and loss. Practicing gratitude gives us understanding which frees us from the negative aspects of life and allows us to meet our difficulties with an open heart.

This is why in 1863 President Abraham Lincoln, during the midst of the Civil War, set aside a day of Thanksgiving for the nation to restore "the full enjoyment of peace, harmony, tranquility and Union."

If you are struggling with feeling grateful or being gracious, you are not alone. Many people are finding this to be a challenge this year. Here is a link with some great ideas to help you:
https://www.virtuesforlife.com/100-ways-to-express-gratitude-and-boost-happiness/

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Joint Health Information Exchange Expands

CommonWell Connects with Federal Health Records

The CommonWell Health Alliance is now connected with a joint health information exchange (HIE) network created earlier in 2020 from the Department of Veterans Affairs, Department of Defense, and US Coast Guard. Expansion to the private sector makes joint HIE data accessible to the CommonWell nationwide system of over 15,000 hospitals and clinics.

Bidirectional transfers of electronic health records lead to greater shared understanding of patients when they shift between health care providers. Health data shared through the joint HIE includes information on prescriptions, allergies, illnesses, lab and radiology results, immunizations, past medical procedures and medical notes.

CommonWell brings a nationwide network of more than 15,000 hospitals and clinics to the 46,000 community partners already part of the joint HIE, including the Indian Health Service and Tribal Health organizations.

The joint HIE’s integration with the CommonWell network of providers is part of the overarching effort within VA, DOD and USCG to modernize and deploy a single, common federal EHR. By implementing the same EHR, care can be documented from the time the individual enters active duty service through their care as Veterans, including care they may receive in the private sector — viewable through the joint HIE.

While the joint HIE may lead to improved care for USPHS veterans, patients may opt out of the data exchange.

Remembrance of RADM Robert Harry (1940-2019)

RA DM (ret.) Robert H. Harry, Jr. D.D.S. passed away on June 25, 2019 and was laid to rest on October 2, 2020 at the Santa Fe National Cemetery in New Mexico. RADM Harry began his USPHS career with the Indian Health Service (IHS) in 1976 as a dental officer in Hugo, Oklahoma. He completed assignments as a Community Development Specialist, Chief of the Area Dental Program, Assistant Area Director for Health Program Services, and Oklahoma City Area Deputy Director culminating in his selection as Area Director in 1989. In 1996, Dr. Harry was assigned to IHS Headquarters to assist in restructuring of IHS Headquarters and served as Acting Director of the Office of Public Health. In 1999, Dr. Harry was appointed as the Executive Advisor to the IHS Director to provide leadership for highly visible American Indians and Alaska Natives initiatives. He went on to lead the Policy Review and Staff Coordination Division and led multiple initiatives to include: IHS Y2K Coordinator (1999-2000), the IHS Health Insurance Portability Accountability Act Coordinator (2001-2002) and the IHS Emergency Preparedness program (2001-2003). Subsequently, he served as the Acting Area Director of Aberdeen Area IHS (2003-2004) and as the Acting Director for the IHS Urban Program (2004-2006). He retired from active duty in 2006.

Dr. Harry moved to Tucson was soon recruited as a Clinical and Administrative Consultant for the IHS Phoenix Area. In this role he began a series of interim service unit CEO appointments including Fort Yuma (2012), San Carlos, (20012-20015) and returned to Fort Yuma (October 2015 - June 2017). In total, Dr. Harry dedicated 42 years of his life to improving and advancing the health status of American Indians and Alaskan Natives.

During his career, Dr. Harry served on several national and state councils and committees. Most notably, in 2001-2002, Dr. Harry chaired the Office of the Surgeon General’s Ready Reserve Program and was responsible for developing and implementing the USPHS Ready Reserve setting national policy and drafting legislative language to establish regulation of this program. Dr. Harry chaired the Commissioned Officers Retirement Board (2000-2006) and was a COA Life Member. A recipient of the Surgeon General Medallion, Dr. Harry received many notable honors and USPHS awards. In 2017, he was awarded the Indian Health Service Lifetime Leadership Award.

RA DM Harry is survived by his wife, CAPT (ret.) Lisa Tonrey, a member of the COA Board of Directors, daughter Rebecca, stepchildren Chris, Alex and Tiana Tonrey and four grandchildren.
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As always, the committee’s draft document argues that health care for uniformed services personnel and their families should be expanded and improved, while beneficiaries’ cost increases should be kept in check. In this ongoing debate, it is essential to develop allies in Congress. That is the ultimate purpose of this document – to help make the case and shore up the arguments.

The Health Care Committee’s document will likely ask DHA and TRICARE to:

• Reduce copays for mental health services.
• Reduce copays for physical therapy, speech and occupational therapies.
• Create incentives to encourage the use of preventive services.
• Extend coverage for dependent young adults until age 26.
• Update reimbursement policies to cover new technologies.
• Update coverage of new treatment protocols, e.g., for eating disorders.

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The Health Care Committee’s document will likely ask DHA and TRICARE to:

• Cover non-drug pain management, e.g., chiropractic, acupuncture.
• Cover laboratory-developed tests, including genetic testing.
• Adopt a tiered copayment structure for specialty care.
• Monitor and improve customer service.
• Make certain that TRICARE provider networks are large enough.
• Update and otherwise improve directories of TRICARE providers.
• Evaluate scheduling of mental health intake visits and therapy sessions.

Once finalized and approved by TMC’s member organizations, the final document will be presented to members of the relevant military and health care committees and subcommittees in both chambers of Congress. As in the past, TMC health care committee members expect to follow-up with “visits” to key congressional offices.

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In Memoriam

CDR Kenneth Boyer

Commander (retired) Kenneth Wayne Boyer, 79, COA Life Member since 1974, passed away on June 20, 2020 after a long battle with Alzheimer’s. Hailing from Hemple, Missouri, he attended a one-room schoolhouse and worked on farms to help support his family, graduating as valedictorian of his high school class. Following graduation, he enlisted in the US Navy as an electrician’s mate and earned his Bachelor of Arts in Mathematics and Bachelor of Science in Chemistry (Summa Cum Laude, Phi Beta Kappa) from the University of Kansas. After earning a PhD in Analytical Chemistry in 1974 from the University of Illinois, he transferred to the Commissioned Corps of the USPHS and was stationed at the Food and Drug Administration in Washington, DC. With his 16 years in the Navy and 10 years in the Public Health Service, he served his country for a total of 26 years. Following retirement from uniformed service he served as Director of the new Pharmaceuticals Division at Lancaster Labs, then went on to purchase Southern Testing and Research Laboratories in 1987. Ken was active in both national scientific and local community organizations. He served for many years on the Board of Directors of the Association of Official Analytical Chemists and was the author of many scientific papers and the holder of several scientific patents.

CAPT Robert Kreuzburg

Captain (retired) Robert C. Kreuzburg, MD, 82, a resident of Garden Spot Village, New Holland, passed away at home on July 24, 2020. CAPT (retired) Kreuzburg was a loyal member of COA since 1973. A graduate of Ambler High School and Juniata College, he received his Medical Degree from Temple University. Dr. Kreuzburg was a board-certified pediatrician for 36 years. He served with the USPHS for 22 years, assigned to the National Health Service Corps in Tennessee and was the maternal and child health consultant for the Indian Health Service. Following his service with the Commissioned Corps, he was in private practice Pennsylvania. He was a member of the boards of Head Start for Columbia County, the Columbia County Medical Society, the American Academy of Pediatrics, and the American Medical Association. He enjoyed gardening, model trains, and spending time with his grandkids.

CAPT Luke Howe

Captain (retired) Luke A. Howe, a Life Member of COA since 1975, passed away on July 11, 2020 at Wheelock Terrace in Hanover, New Hampshire. CAPT Howe graduated from South Royalton High School in 1944, received a Bachelor of Science from the University of Vermont in 1949, and a Medical Degree from the University of Vermont College of Medicine in 1952. After completing his medical residency at Mary Fletcher Hospital, he was recruited by Governor Stanley Wilson to start a private practice in New Hampshire. In 1964 he left the practice for an assignment as the Physician and Acting Director of Public Health for the Trust Territory of the Pacific Islands (TTP). In 1975, he joined the USPHS, serving in Virginia, Connecticut, Maryland, and the District of Columbia until his retirement in 1992. The highlight of his second tour with the PHS were his summers aboard the Coast Guard cutter, The Eagle, a cadet training vessel, which allowed him to see much of the world. He had a fulfilling retirement with his wife Pat, sharing their time between their cottage in Florida and cabin in Tunbridge, which they enjoyed until her death in 2011. They both loved singing and traveled with church choirs abroad.

CAPT Richard Malmgren

Captain (retired) Richard A. Malmgren, MD, 98, died August 16 at Ginger Cove Health Center, one day shy of celebrating his 74th wedding anniversary. He was born in Minneapolis and moved to Staten Island at the age of 10. He was an active soccer player throughout high school and worked on farms in upstate New York in the summers. With the dream of one day being a farmer, he began college at Cornell University School of Agriculture. But with World War II pressure for more doctors, he shifted into medicine and completed his medical degree at Cornell University Medical Center in New York City in three years. He interned at Grasslands Hospital, where he met his wife, Ebby. Dr. Malmgren’s strong interest in medical research led him to the National Institutes of Health where he joined the National Cancer Institute. He was decades ahead of his time in advocating immunotherapy to treat cancer. After retiring from NCI in 1972, he joined the staff at George Washington Hospital as head of the cytodiagnostic service, where he worked until 1979. Dr. Malmgren was a Life Member of COA since 1966.
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of my residency at University of Rochester. I came as a PHS officer and that was my chance of getting into NIH. And that was instrumental, because my plan was to be into clinical practice. I had no thoughts about going to research, but while here I got into a project that led me into an association with Dr. Baruch Blumberg, and together we found the Australia antigen, which later proved to be the hepatitis B virus, so that perks my interest in hepatitis viruses.

Harvey Alter: I left NIH for a while to finish my clinical training, planning to go into practice, then did a fellowship at Georgetown and saw that I liked clinical research. I then got a call back to NIH and have been here ever since, since 1970. And everything that evolved at NIH, I don’t think could have evolved anywhere else. The atmosphere at NIH is such that you could do these long-term studies that would be very, very difficult to fund nowadays. There was no end point; it was just a lot of observation and follow-up. It’s an atmosphere that can’t be replicated anywhere, so I owe everything to NIH.

Steve Solomon: To follow up just on that point a little bit, Dr. Alter, in the Nobel Media interview that you gave, you did indicate that, as you just said … I think what you said was it was a good story of “non-directed research” and gave you the opportunity to follow an idea. And as you said, it’s a problem now, in terms of getting funding. Do you have any advice for young researchers? We have folks active duty in the Corps at NIH, at CDC, at FDA; what advice would you give them about building a successful career in biomedical research?

Harvey Alter: Yeah. It’s very difficult, and it’s much more difficult now than it was in my day. I think the advice I would give is get into the best place you can be, and CDC and NIH are up there if you want to do any kind of public health or clinical research. And as a young person, you can’t start out with a great project, usually. You need to latch on to somebody who’s a good mentor, get into something in their laboratory, and then take off from that.

I think the lessons I learned are: if you get a hint of something, keep at it. I learned that from Barry Blumberg, who was my first mentor, who went on to win the Nobel Prize for hepatitis B. And that story, the hepatitis B story, could have been dropped at any point. It was an unexpected finding that had no clinical relevance at first. And I started working with him on it, but then he kept persisting and persisting because he would raise a hypothesis and prove it or disprove it and go on to the next one. He had a wall, a whole office full of hypotheses, most of which didn’t work out, but all of which led to a new hypothesis.

I think you have to follow up leads. You must be persistent and be inquisitive. And nowadays, you particularly need to get collaborations. You can’t do it alone. The technology is too sophisticated. The knowledge you need is so extensive. You need to find people who you can work with, and who will help you do the things that you don’t know how to do.

And I was very lucky, NIH is full of those people. I was very lucky to collaborate with Bob Purcell and Steve Feinstone, a whole bunch of investigators, many of whom were in the public health service. I must say, those were big years for the public health service here in NIH, in the sixties.

Other advice I might have is to try to become an expert in something, don’t jump around from topic to topic. You have to jump around some until you find the right thing, but it’s good for you to have a particular expertise that draws people to you, that allows you to get collaborators. It can be a patient population you have, it could be a sample collection you have, it could be a particular piece of knowledge that you have, or a technology … it’s something that makes you sought after, and it allows you to collaborate.

Jacqueline Rychnovsky: Excellent. I think many of the junior officers that are in the Corps right now are going to be incredibly interested to hear your story. What drew you to the Commissioned Corps back then? And what do you remember about those early days, maybe talking to a recruiter, or those first few days of walking into the NIH as a junior officer?

Harvey Alter: Well, first of all, the background is that I was in my first year residency at University of Rochester, had been deferred from the draft up to that point ... this was back in 1960, end of 1961. Got a letter, which began, “Greetings,” and told me to report to Fort Dix for induction into the Army. At that point, I’d already applied to NIH, but I hadn’t yet been commissioned. So with a lot of help, I was able to get my commissioning moved up, and was told that if you can be commissioned and go to NIH before your draft date, which was November 27th, then the Public Health Service would take precedence.

That was life-changing because had I not been in the public health service, I would have gone into the draft. Maybe that might’ve worked out very well, but it would not have worked out towards a research career, because I wasn’t going in that direction at that time. I would have had the military experience, and then I would have gone into practice.

Jacqueline Rychnovsky: Do you remember the first day walking into the NIH, knowing everything that you’d heard about it, and what that experience was like?

Harvey Alter: Yeah, that’s a long time ago. I was actually first assigned to the Division of Biologic Standards, the predecessor of the FDA, and got to work with some people there that were really good researchers and also very collegial, so it was immediately a really good atmosphere to be in. I knew that. Eventually, went into Department of Transfusion Medicine in the clinical center, so I had a patient base, and it was that patient base that allowed us to do these prospective studies from which everything evolved.

Steve Solomon: As you indicated, Dr. Alter, the 1960s was a remarkable time. I’m sure you may have been interviewed, there’s an oral history at NIH, the Yellow Berets-
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Take a recent Department of the Interior Press Release, dated October 28, 2020 with the headline “Trump Administration Grants Gold Star Families and Military Veterans Free Entrance to National Parks, Refuges and Other Public Lands.” Secretary of the Interior David Bernhardt says, “With the utmost respect and gratitude, we are granting veterans and Gold Star Families free access to the iconic and treasured lands they fought to protect starting this Veteran’s Day and every single day thereafter.” The bulletin goes on to say that entrance fees for the National Park Service and the U.S. Fish and Wildlife Service and standard amenity recreation fees for the Bureau of Land Management and the Bureau of Reclamation sites will be waived for veterans. Free access will be granted to approximately 2,000 public locations spread out across more than 400 million acres of public lands, to allow veterans to enjoy hiking, fishing, paddling, biking, hunting, stargazing and climbing. For the veterans who are reading this, all sounds good, right? But then the bomb is dropped. For purposes of this program, they identify a veteran as “an individual who has served in the United States Armed Forces, including the National Guard and Reserves, and is able to present a Department of Defense Identification Card, a Veteran Health Identification Card (VHIC), a Veteran ID Card, or has a veterans designation on a state-issued U.S. driver’s license.” Sadly, this aligns with their policy to only allow free park access to active duty members serving in the Armed Forces.

Confusing? Yes. Wrong? Yes. There are two places in the federal code that state service in the US Public Health Service equates to military service, but we still fight this battle daily. Title 5 of the U.S. Code, Section 8331, states that military service means honorable active service in the armed forces or in the Regular or Reserve Corps of the Public Health Service after June 30, 1960. Commissioned Corps officers are considered veterans under federal law, 42 U.S. Code 213d, and “entitled to all rights and privileges thereof.”

In January 2020, COA’s then Executive Director, Colonel Jim Currie, wrote a letter to the Deputy Director of the National Park Service, David Vela, to seek clarification on why USPHS Commissioned Corps officers were not entitled to the free park benefit allowed to other active duty servicemembers. I will follow up and seek clarification on both the active duty and veteran issue. But it’s not just the National Parks. We hear from you frequently about the poor treatment you receive from airlines and the Bureau of Reclamation sites will be waived for veterans.

On another issue, COA is working with The Military Coalition to ensure an amendment is filed to Senator Duckworth’s legislation on the au pair ban to make an exception for families of uniformed servicemembers’ who have been negatively impacted by the J-1 visa ban which prevents au pairs workers from entering the U.S. The original language of the bill was written to allow military families a waiver, not uniformed servicemembers. Words matter. When we saw the language directed to “military” families we immediately requested a modification to have the word “armed forces” be struck and replaced with “uniformed services,” and that is underway.

What can you do? If you’re reading this, you are likely a COA member which means you’ve taken an important step in committing to the advocacy for the Corps and your fellow officers. Next, send a message to the Acting Director of the National Park Service, Margaret Everson, to let her know that PHS Commissioned Corps officers are active duty officers who entitled to the same benefits as those in the armed services. You can also write her at National Park Service, 1849 C Street NW, Washington, DC 20240.

If you are retired and haven’t yet applied for your Veterans ID card, I encourage you to do so. Hopefully, this card will help you access benefits and services that were created to thank you for your service. I’m going to do this today and hope you do to. If you have a Veterans ID card and have found it useful, please drop me a line to share your story.

To all Commissioned Corps veterans, thank you for your service to our Nation. This holiday started as a day to reflect upon the heroism of those who died in our country’s service. It’s now a celebration to honor America’s veterans for their patriotism, love of country, and willingness to serve and sacrifice for the common good.

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of Commissioned Corps officers, to assure and facilitate their training, career development and deployment, in consultation and cooperation with the agencies to which OSG assigns them. Those officers will serve in many Federal agencies and in assignments to local and state health agencies, as they do now. They will develop the relationships and the breadth of experience that will allow them to work through a command structure focused holistically on all aspects of a national and global response, not just to pandemics, but to the persistent public health problems that afflicted the US before the pandemic. And they can be part of an aggressive national response to the long-standing crisis of health inequity and unequal access to services that has been brought into even sharper focus by COVID-19.

These and many other ideas for rebuilding and reforming America’s public health system can be subjects of discussion, debate and dialogue. At, we’d like to hear your thoughts. Please send your ideas to frontline@coausphs.org, with the subject line “Future of Public Health,” so we can begin to think together about where public health needs to go next and how we might get there.
2020 COF Family Member Scholarship Winners
(Formerly Known as Dependent Scholarship)

by Erica Robinson, COA Director of Administration

The PHS Commissioned Officers Foundation for the Advancement of Public Health offers a scholarship program available to all high school, undergraduate, and graduate students sponsored by a member in good standing of the Commissioned Officers Association of the USPHS. The scholarships are funded by active duty and retired U.S. Public Health Service members, Local Branches of the association, and others. We thank them for their generosity.

The Foundation is proud to announce a total of $9,500 in scholarships to the following recipients:

Nam Pommier: Nutrition and Dietetics, Rowan University (LCDR Ryan Pommier) – Atlanta COA Scholarship

Kayla Jenkins: Psychology, Hampton University (LCDR Jennifer Smith-Grant) – Lessing Scholarship

Rebecca Cox: Human Science, Georgetown University (CDR Deborah Cox)

Skylar Livengood: Biology, Bryn Mawr College (CAPT Dolan Thomas)

Katarina Fiorentino: Communication Sciences & Disorders, University of Florida (CDR Douglas Fiorentino)

Sylvette Ramos-Diaz: Dentistry, University of North Carolina at Chapel Hill (LCDR Luis Ramos-Ortiz)

Shelby Bachini: Biology, Dixie State University (Steven Bachini)

Sierra Wanca: Biology, University of Alaska Anchorage (CAPT Martha Wanca)

Daniel Richardson: Biological Sciences, Arizona State University (CAPT Jeffrey Richardson)

Recipients of 2020 COF Barclay-Giel Seed Grants

by Erica Robinson, COA Director of Administration

Funded by the PHS Commissioned Officers Foundation for the Advancement of Public Health, the Barclay-Giel Seed Grants program supports community-based public health programs.

The program is named after the late Martha Barclay-Giel, a retired Captain of the Commissioned Corps of the USPHS. Captain Barclay-Giel dedicated her life’s work to advancing the health of Americans. After retiring, she generously supported COF through considerable charitable donations. Captain Barclay-Giel is a member of the John Adams Society.

The Foundation is proud to announce a total of $125,804 in 2020 funding to the following recipients:

• Benton Franklin Recovery Coalition: Benton, WA – comprehensive addiction recovery
• Boys & Girls Club of Greater Salt Lake: Murray, UT – access to behavioral health resources
• City of New Orleans Health Department: New Orleans, LA – safe routes to school
• Community Choice Action Health Partners: Wenatchee, WA – stroke/TIA hospital readmissions
• Community Health Coalition: Durham, NC – smoking/addiction behavior modification
• Healthy Alaska Natives Foundation: Anchorage, AK – rural youth ATV safety
• Morgan County Substance Abuse Council: Martinsville, IN – dangers of e-cigarettes
• North Carolinians Against Gun Violence: Durham, NC – unsecured guns and role of HCPs
• Oklahoma City Indian Clinic: Oklahoma City, OK – peri-/prenatal, newborn education
• Safe Kids Kansas: Topeka, KS – SIDS prevention
• St Mary’s Health Clinics: Saint Paul, MN – connecting patients to oral health screening
• Staten Island NFP Association, Inc.: Staten Island, NY – emergency preparedness planning
• The Village Community Garden and Learning Center: Rochester, MN – addressing hunger
• Tri-County Health Department: Greenwood Village, CO – healthy farmers markets
• Volunteers of America, Utah: Salt Lake, UT – addiction/mental illness in Wasatch Front
• Waypoint Foundation, Inc.: Sarasota, FL – grade school access to mobile dental health

We congratulate all recipients and thank each organization which applied for funding. Information about the Seed Grant program is online at www.phscof.org/seed-grants.
PHS Commissioned Officers Foundation
Donations Received, October 1, 2020 to October 31, 2020

Platinum ($1000)
CAPT John Bartko +
Mrs. Mary Gentry-Bartko +

Bronze ($100)
CAPT Francis Behan
CDR Helen Cox *

Friends (Under $100)
CAPT Mark Anderson
CAPT Maria Benke ^
Mrs. Carol Dellapenna
Mr. Stephen Daming
CAPT Stephen Lieberman
CAPT Tommy Mosely ^
CAPT George Durgin
Dr. James Kenney

^ C. Everett Koop Living Legacy Fund
+ PHS Ensemble
* Mishoe Believe Scholarship
All other donations were made to the COF General Fund

We Welcome New Members of COA, October 1, 2020 to October 31, 2020

CDR Roger Ballard
LT Joseph Douglass
LT Patricio Fuentes
LT Brad Goodwin
LCDR Vanessa Goosen
LCDR Marjorie Gray
LCDR Ross Hanson

CDR Patrick Humphries
LT Jeremy Hyrczyk
LT India Johns
LT Jueichuan Kang
LT Tiffiny McCain
LCDR Shelo Mutz
LCDR Terryl Petropoulos

CAPT Nixon Roberts
LT Patrice Smith
LT Eugene Song
Mr. Seneca Toms
LT Anita Wade
LT Ruth Widener

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Harvey Alter: Right.

Steve Solomon: ... when Dr. Fauci and Dr. Varmus and many other people also came into the Public Health Service.

Steve Solomon: It was different in those days. I started in 1981; the Commissioned Corps is a very different entity today than it was then. Did being in the Commissioned Corps have an impact on you at the time? Did you see that as something remarkable, in terms of service?

Harvey Alter: Well, I don’t know. There were a lot of us here at that time. The sixties and seventies were a very open time at NIH. The funding was not a big problem, and you could do more of what you wanted, as well as less oversight. I’m not sure whether the Commissioned Corps facilitated that, but it was good to be in it.

My salary had increased from $6,000 a year as a hematology fellow to a reasonable amount that I could really live on. It had a security; I stayed in for 30 years, and I’m reaping the benefits of that right now. The retirement is really very, very good and gives me some stability in these difficult times. So, very glad I did it. If I had not been in the Public Health Service, I probably would’ve not gotten to NIH, so that was a life-changer.

This interview will be continued in the December 2020 issue of Frontline.