UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

IN RE: INVESTIGATION INTO THE DEATHS OF THOMAS MORRIS AND JOSEPH CURSEEN	)	**Misc. No. 09-402 (RCL)**

ORDER

The attached letter, in its original and unredacted form, was received in chambers on April 15, 2011. The Court subsequently filed the letter under seal and ordered that the government provide any requested redactions so that the letter can be filed on the public record. The only redactions the government suggested pertained to the privacy interests of the letter's author, as the letter and its attachments do not affect sealed material, grand jury information, or law enforcement sensitive information.

The final redactions to the letter are made herein. The letter's author did not request that his name be redacted, but requested that certain other identifying information be redacted. It is hereby ORDERED that the redacted letter attached hereto be unsealed and placed on the public record.

SO ORDERED this 22nd day of June 2011.

Royce C. Lamberth
ROYCE C. LAMBERTH
Chief Judge
United States District Court

Charles A. Cropper, MD, MPH, MS
[redacted]

30 March 2011

Honorable Chief Judge Royce C. Lamberth
United States District Court for the District of Columbia
333 Constitution Ave NW
Washington, DC 20001

RECEIVED
APR 15 2011
CHAMBERS OF
JUDGE LAMBERTH

Re: Prevention of Future Bioterrorism Attacks

Dear Chief Judge Lamberth:

My name is Charles Austin Cropper. I am a physician that specializes in Occupational Medicine and was employed for a brief period as the Competent Medical Authority (CMA) for the Biological Surety (Biosurety) program at the United States Army Research Institute of Infectious Diseases (USAMRIID). I was in this position from 21 September 2009 to 10 October 2009.

You issued an order authorizing a behavioral analysis panel to examine "the mental health issues of Dr. Bruce Ivins and what lessons can be learned from that analysis that may be useful in preventing future bioterrorism attacks". I am writing this letter to you for two key reasons: 1) to provide to you documents that I authored and tendered upon my resignation as Competent Medical Authority documenting what I consider to be severe problems with regards to Biosurety at USAMRIID and 2) to relay comments and an alternative viewpoint regarding Dr. Bruce Ivins that are not mentioned in the Behavioral Analysis Panel report ("Panel report"). Some of my confidants have considered my knowledge of USAMRIID to be grounds for a whistleblower action; I have no opinion on this point. I desire to fix the problem and not create ill will or sour grapes. Your order is targeted toward prevention and I am board certified in a preventive medicine discipline—Occupational Medicine.[1] Please take my knowledge and put it to good use.

Included Documents

Three documents are included: i) a Memorandum for Record that was my last formal attempt to rectify problems with the Personnel Reliability Program (PRP), ii) my extensive letter of concern to my supervisor at the Barquist Army Health Clinic, and iii) my resignation letter.

Please pay particular attention to items number 2, 4, 8, and especially, 11 of the letter of concern. These are all examples of systemic issues that permeate USAMRIID. Other evidence supports this notion such as the published case of glanders[2] prior to my arrival and case of laboratory-acquired tularemia[3] after my departure.

1 http://www.theabpm.org
2 http://dx.doi.org/10.1056/NEJM200107263450404
3 http://news.sciencemag.org/scienceinsider/2009/12/researcher-at-a.html

Alternative Viewpoint Regarding Dr. Bruce Ivins and Recommendations

I could discuss a multiplicity of aspects regarding USAMRIID, Biosurety, and Dr. Bruce Ivins; however, I will limit my discussion to differences between my views and the Panel report and only those relevant to prevention. I had begun a sentinel event analysis[4] of Dr. Ivins and his death prior to my departure; part of this analysis necessitated my reviewing all of the medical and psychiatric records in the Biosurety medical record regarding Dr. Ivins.

In line with recommendation 2 of Appendix II from the Panel report, I am the "...clinician ... who [has] receive[d] specific training in conducting fitness-for-duty evaluations in high-security settings". Occupational Medicine views fitness-for-duty of all medical and psychiatric illness as a core competency of medical practice. I hope to convince you that one needs a competent evaluator for all occupational settings where risk is imposed on non-consenting third persons, e.g. the public. Archetype occupations the impose risk on non-consenting third persons include airline pilots, crane operators, semi-truck drivers, power plant operators, et ceterra. Biological containment workers are merely a very special class of workers.

I also intend to convince you that one cannot isolate the worker from the population of workers in a working environment. This facet is the major deficit of the Panel report. Physicians characteristically pay attention to individualized factors and ignore or downplay population and environmental factors. The population at USAMRIID was unique in many ways—high levels of education, high degree of worker autonomy, and intermingling of military and civilian workers. Combining these population characteristics with a unique environment—historically USAMRIID was a bioweapons laboratory, Fort Detrick is the primary employer for Frederick Maryland, and academic work—can lead to a highly competitive and yet corrosive working culture. All of these facets are crucial and yet omitted by the Panel report.

Dr. Bruce Ivins was more of an archetype researcher than most people admit. He had strong narcissistic and obsessive traits. These traits are almost sine-qua-non with tedious academic research. Workers that are sloppy and do not care about how people perceive them will, generally, not excel at academic research. When looking at all the workers at USAMRIID, I believe that most of them exhibit some form of narcissistic and obsessive traits.

Population medicine assesses the risks differently than clinical one-on-one psychiatry.

Specifically regarding the Panel recommendations from page 18:

1) Medical records will always be tied to <u>self-disclosure</u> by the worker in question. This is part philosophical and part practical as it is always possible to go to a doctor, pay cash, and no one will ever know the interaction existed, except the worker. <u>It is much easier to punish a worker for lying on a document than for a medical or psychiatric illness they experience.</u> All effective public health and occupational health programs are modeled on this premise. Expecting an "investigator" to go fetch medical records concerning someone will not be as effective. This is why I was attempting to tighten the policies of disclosure (as evidenced in my memorandum) and making procurement of the medical records a condition of employment. Self-disclosure with follow-up consequences for lying tend to not run afoul of discrimination laws and do not predicate employment on the absence of particular illnesses at the onset. The Federal Aviation Administration medical program heavily uses this premise.
2) Agree.
3) Agree. There are many impairing states in humans, most of which are not illnesses. The CMA must take these into account. There were several workers that I had not yet reviewed at USAMRIID that had

4 http://www.ncbi.nlm.nih.gov/pubmed/6881402

disclosed psychiatric illnesses and were still allowed to work in the suites even though their illnesses raised questions of risk to others. Also, epidemiological data indicates 12 to 16 percent of the general population has a substance dependance or substance addiction problem and there is no evidence that USAMRIID workers are different from the general population in this regard. There were approximately 490 enrolled in the PRP program at the time that I was the competent medical authority. Thus, there should have been 50 or more workers under surveillance for substance abuse at any given time. None were under surveillance in actuality.

4) Agree.
5) Agree. This was not effectively being done because of conflicting interests between the Special Immunizations Program, the Barquist Army Health Clinic, and USAMRIID.
6) Agree.
7) Agree. Alcohol was never tested on civilians and the drug panel used for civilians is set by another federal agency and has not changed in almost 20 years. This is a huge problem.
8) Unclear how this would occur.
9) Agree. Conflicts of interest between the Special Immunizations Program and the Certifying Officials made this step almost impossible. I believe granting a Certifying Official the power, via Army regulations, to overrule an individual medical opinion from the competent medical authority runs afoul of many laws, customs, and fiduciary duties in the United States, especially when applied to civilians because they are autonomous humans. It is like granting an administrator or a nurse in a hospital the power of psychiatric commitment or the power to quarantine someone against their will; these are very broad powers which is why physicians exercise them and usually only in concert with a judge. Military members do not have autonomy and thus are a special case where a Certifying Official could overrule the physician. People at USAMRIID did not see this problem or the differences between military workers and civilian workers.
10) Information requests should be detailed and the worker should have a detailed job description. Independent evaluators should be used; however, the treating clinician should not be allowed to recuse themselves. The clinician, also, should never be granted immunity as a condition of releasing medical or psychiatric information; this is a professional risk that comes with practicing medicine. If the doctor does not like this fact, they should not be a doctor because they implicitly cannot tolerate the dual-agent responsibilities society has placed upon them. All doctors have an ethical duty to society as well as to the patient; it is a never-ending balancing act to judge when the risk gets elevated enough to warrant release of information. The Panel psychiatrists are confusing the responsibilities of a judge and a doctor; they are really two different roles and two different worlds.
11) Agree. See number 10.
12) Agree; although I would include other worksites that impose risks to non-consenting third persons.
13) Agree. See number 1.
14) Agree.

From page 85, An Unreported Skin Infection:

It is not surprising to me that this occurred. In fact, while I was at USAMRIID, one of the workers had a cardiac event and honestly reported it to the Special Immunizations Program. The worker reported that the Special Immunizations Program physician complained that they were now going to "have to record it as an adverse event against their experimental vaccine". The conflicts of interest are so corrosive that no worker discloses occupational illnesses, no one expects them to be disclosed, and the culture is openly hostile to their disclosure.

From page 121, first paragraph:

The Panel states "Had this behavior been known, it would have disqualified him from the opportunity to work in the secure setting of USAMRIID under rules then in place." I have to disagree, because the psychiatrists do not understand how employment law, discrimination law, and medical practice interact with employment. There are very strict rules during the employment negotiation on what can and cannot be asked. This is why most businesses impose administrative procedures to protect against embezzlement from all workers, otherwise they would attempt to only hire "ethical" workers with no credit problems and with no medical issues. This is such an ambiguous and impossible standard that almost anyone can fail to be hired. Dr. Ivins needed a clear job description upon job offer, a clear self-disclosure form that indicated "lying on this form will guarantee termination of employment and is possibly a crime", and a medical examination from an Occupational Medicine Physician once hired to review self-disclosed problems. The physician should then have the responsibility to decide whether Dr. Ivins was medical and psychiatrically "safe" to work in the containment suites. Having these cumbersome procedures protects all parties involved—worker, employer, and the public.

From page 127, last paragraph:

This paragraph discusses a hypothetical sentinel event. Why is a mass-event through the mail treated differently? Policies at USAMRIID should have been implemented that created this proper "social response" that is mentioned, regardless of wherever and however the sentinel event occurred.

From page 130, last paragraph:

This is another example of the flagrant disregard of policy at USAMRIID. The culture tolerated policy violations with such regularity that it was one of the key reasons for my resignation.

From page 133, second paragraph:

I believe mundane population-based procedures were more likely than involuntary psychiatric commitment in preventing Dr. Ivins from harming someone else with "guns blazing". Seat-belts and clean water do this all the time. It is very difficult to see whether the attorneys, the FBI, or the doctors "saved the day". More likely it was policy and procedure that caught Dr. Ivins before he could harm someone else.

From page 159, Axis I:

I believe Dr. Ivins had Generalized Anxiety Disorder, Substance Dependance, Insomnia, and posibly, Depersonalization Disorder, and Dissociative Identity Disorder as his key diagnoses here. These are based on my reading of the Panel report and my memory of what was in Dr. Ivins biosurety medical record.

From page 160 and 164, Axis II:

I must disagree with the psychiatrists here. Dr. Ivins clearly had a Paranoid Personality Disorder and Narcissistic Personality Disorder. I do not think he had Borderline Personality Disorder; Dr. Ivins' occupational functioning was too high in my opinion. The physicians are ignoring occupational characteristics. Academic researchers have strong narcissistic and obsessive traits; these are crucial to survival in Academia. It must be remembered that Dr. Ivins was a very capable Anthrax researcher, probably one of the best in the world. This level of occupational skill must be reconciled and match the medical and psychiatric record.

From page 196, fourth paragraph:

I remember Dr. Ivins' odd answers to multiple questions as well as several question marks annotated in his biosurety medical record. There was a pattern inattentiveness and lack of follow-up regarding answers Dr. Ivins provided that should have been investigated. Interestingly, the Panel does not comment on Dr. Ivins inconsistent reporting of "back pain" through the years. This was one area where I would have done more investigation because "back pain" is a classic psychosomatic illness and often leads to more elucidation of a patient's condition.

From page 201, paragraph starting with "We support..."

As a physician that has had to make difficult judgments with many occupations, I ask the Panel, "Who would make the judgment and how can the process be kept fair?" The Panel states X must occur, and Y must not occur; they, however, never proffer a solution beyond vague musings. These problems are much more amiable to population-based approaches than individual-based approaches.

Concluding Remarks

I have condensed three weeks of experience at USAMRIID as the Competent Medical Authority and approximately nine years of formal schooling into five pages.

My key goal is to prevent the events that occurred in October 2001 from ever happening again. I also strive to prevent lesser-known events like crane accidents, subway crashes, and other occupational and public health hazards from becoming events in the future.

Population-based medicine is very different from individual-based medicine and carries very different risks to all parties involved. It should be practiced with as much or more due dilligence than regular clinical medicine.

Lastly, irreconcilable conflicts of interest were everywhere the moment I started at USAMRIID; the most dire situation is the Special Immunizations Program. I was even hearing rumors that the experimental vaccines were a "condition of employment". You are very aware that this cannot be correct; however, the more I investigated, the more concerned I became. In fact, it reminded me of the Tuskegee Syphilis Studies.[5] One can always create such a corrosive environment and culture that people do not realize how evil their everyday deeds have become.

Sincerely,

Charles Austin Cropper

5 http://www.cdc.gov/tuskegee/

DEPARTMENT OF THE ARMY
BARQUIST ARMY HEALTH CLINIC
1434 PORTER STREET
FORT DETRICK, MD 21702-9210

REPLY TO
ATTENTION OF

MCXR-FTD 07 OCT 2009

MEMORANDUM FOR RECORD

SUBJECT: This memorandum is applicable to all employees enrolled into the Personnel Reliability Program (PRP)

1. No patient physician-relationship will be created during the medical examination for the personnel reliability program (PRP). The PRP medical staff will not be responsible for care or management of conditions discovered or discussed during the medical examination. The worker will be responsible for procuring continuing care and management with their regular healthcare provider.

2. Treatment, diagnostic tests, and procedures requested for enrollment in the PRP are the responsibility of the worker (including procurement of such tests and financial consequences of such tests).

3. When enrollment in the PRP is contingent on the receipt of medical records by the PRP medical staff, it is the responsibility of the worker to procure and provide copies of such records.

4. The primary purpose of the medical examination for PRP enrollment and maintenance of PRP eligibility is to ensure physical and mental suitability of the worker; this includes limiting risks to the health and safety of other persons (e.g. other researchers, co-workers, emergency personnel, the public).

5. Point of contact for this memorandum is Charles A. Cropper, MD, MPH, MS, at commercial [redacted]

[redacted]

LTC, MC
Commander, BAHC

Charles Austin Cropper, MD, MPH, MS
Chief, Biosurety Medical Program/CMA
Barquist Army Health Clinic

10 October 2009

[redacted]
Commander
Barquist Army Health Clinic
Fort Detrick, MD

Dear [redacted]

Thank you for hiring me as the Competent Medical Authority over the biosurety medical program. I strive to work with you and rectify the challenges presented.

However, I have some grave ethical concerns that I wish to express; please read to completion.

1) I am a fully licensed and board certified occupational physician; accordingly I have a fiduciary duty to protect the worker and public. In attempting to accomplish my duties, I will render professional medical opinions regarding cases that come before me. My understanding is that the cases coming before me will usually will involve i) fitness-for-duty aspects of workers, ii) examinations to protect the health and safety of others, and iii) similar examinations that always contain conflicts of interest between the health and liberties of an individual and the countervailing safety of the public.

2) Since beginning work at Fort Detrick, as a part of my assigned duties, I was required to review two cases where workers were working in BSL-3 and BSL-4 containment areas and yet had clear disease processes that jeopardized the health and safety of others; these workers had been allowed to work in the containment areas by previous Competent Medical Authorities (CMA). Why were these workers allowed to continue working? In my professional medical opinion, the affected individuals should be restricted from the BSL-3 and BSL-4 containment areas. **I received severe pressure to change my opinion from the certifying official regarding one of these cases.**

3) By being licensed to practice medicine, one of my duties is to protect the public as well as care for the individual. Nearly all medical practice statutes of the fifty states require protection of the public as a primary obligation; my licensing by [redacted] requires this as does licensing by the Commonwealth of Virginia.

4) The basic intent of the BPRP program is not being followed; attention is primarily focused upon "the regulations" and "the next inspection". I refer to both the security aspect and the medical aspect of the program. Several of the SIP physicians have indicated that they think medical restrictions (when imposed by the certifying official) are enforced voluntarily.

   By not following the basic intent of the BPRP program, I am placed in an extremely compromised ethical position. Should an event occur that endangers the public and I had rendered a preceding opinion similar to those in paragraph two above, I believe members of the public (and by extension the courts) could reasonably hold me responsible because I am the duly licensed physician rendering an individual medical opinion; I could even be responsible, irrespective of what the certifying official subsequently determines after my recommendation. I do not believe my fiduciary duties and professional responsibility can be transferred via Army Regulations to the certifying official. It would be helpful to have a complete judge advocate general opinion in this regard.

5) Concerning your comments that you "...will not tolerate a team that is not cohesive", I ask what team are you referring to? The culture in USAMRIID makes it nearly impossible to discern who is on what side or if there are "sides". I showed the memorandum that you and I completed (for which I am grateful) to [redacted] Such a negative reaction ensued that I am left with four possibilities i) they cannot clearly perceive their roles, ii) they are experiencing burnout, iii) the corrosive culture of the laboratory is affecting them, or iv) a combination of the previous three. I know burnout is a factor becaus[redacted]ave complained directly of this [redacted]ands are also quite telling of stress, there is some indication that she has neurotic excoriations around the nails of the thumbs and index fingers.

I have suggested a solution to the problem of unifying our team to you before, but you cut me off; I still strongly believe all of the BPRP medical personnel should be removed from USAMRIID and moved into the Barquist Army Health Clinic. This transition would unify our teams—occupational health and biosurety-medical in one place. It would help alleviate burnout by rotating staff into other roles. Moving the entire biosurety-medical team to Barquist would address many of the "occupational health" inspection violations by unifying i) Occupational Health and ii) biosurety-medical. More importantly, moving to Barquist would remove the BPRP medical staff from the corrosive culture inside USAMRIID. Moving to Barquist would also enable everyone to comprehend what role medical support plays within the BPRP program. If the workers inside USAMRIID refuse to come to their appointments at Barquist, such lack of attendance at appointments would become an indicator of who is not reliable under the BPRP. I suspect failure to attend scheduled appointments with the medical staff may be one of the most effective psychological screening techniques to determine reliability.

6) Many people have stated that "Dr Ivins" was "well respected in the community" and that "what happened to him and the other workers in the laboratory was traumatic". Many people also steadfastly do not believe the allegations that have been laid on Dr Ivins by the FBI. These comments are matters of concern to me because these people are assuming the role of a judge, in which case it is impossible for them to be impartial. These comments should be taken as a warning of how deep-seated the cultural problems are at USAMRIID.

7) Concerning your comment to "...not alienate anyone...", I believe that I cannot accomplish my assigned responsibilities in the current setting without precipitating some alienation, especially with regard to workers enrolled in the BPRP. By the nature of my job, I will occasionally be forced to make unpopular decisions that will upset a worker or his/her supervisor. I will endeavor to remain as objective as possible when making these decisions, but I have no control over how other people will react.

8) The USAMRIID Standard Operating Procedure MD-06-20 (Pregnancy Counseling to Prevent Workplace Hazards) violates several Federal laws and also runs afoul of a key controlling Supreme Court Case—UAW, et al. v. JOHNSON CONTROLS, INC. (499 U.S. 187). In particular, the statement that violates this ruling is "4.3.1.1 Once informed of the pregnancy status of an employee the CMA will send a Potentially Disqualifying Information (PDI) memo to the Certifying Official (CO) recommending restriction from working in a biocontaiment area." I will not enforce this requirement of the SOP because this forces me to violate the law. Pregnancy (as a "medical condition"), generally, should be ignored except to the extent that physiology dictates otherwise (e.g. preeclampsia, preterm labor, etc.). The Supreme Court case directly addressed this question.

9) There exists an embedded conflict in my position description: I am supposed to "...[r]ecommend corrective courses of action when imbalances occur in major occupational health projects....[and I have] prime responsibility for insuring the implementation of the biosurety program." Yet I "...[w]ill consult on daily issues with the Supervisory Occupational Health Nurse who establishes clinic policy, program requirements and objectives and is available for discussion on matters of a sensitive or political nature." Who is ultimately responsible? Also, I am, theoretically, responsible for "...hearing and resolving complaints from employees, referring serious matters to the next echelon..."; however, it is apparent to me that people have communicated around me directly to you; what are my responsibilities and when shall I start to act in discharging those responsibilities?

10) Am I supposed to review the determinations of the nurse practitioner CMA? What are the procedures if I disagree with her assessment? Who has the ultimate responsibility for the determinations made by a CMA: i) myself or ii) whoever signed the document?

11) As I have mentioned before, the Special Immunizations Program has three duties that result in conflicts of interest: i) research (using humans in experiments), ii) clinical care (caring for workers in experiments and workers injured in the laboratory), and iii) occupational health (protecting the health and safety of the lab as a whole – a population of workers). I believe these ethical conflicts are too great to ignore and are wholly irreconcilable. I believe I can train the physicians at Barquist to perform the occupational health functions for USAMRIID and eventually remove one of these conflicts of interest.

12) I assume someone has an obligation to accurately report and account for all work-related and occupational illnesses and injuries. I do not know who has this duty at Fort Detrick. Reports are required under the Federal Employee Compensation Act. I firmly believe these reports are not being produced (or only a small percentage are being produced) for USAMRIID workers. In order to rectify this, all workers at USAMRIID should be ordered to go to Barquist for occupational health and biosurety-medical functions prior to being evaluated by Special Immunizations Program. I do not believe that the Special Immunizations Program should be conducting the "exposure assessments" on the workers that work in the biocontainment areas until after the workers have been seen by occupational health at Barquist due to conflict of interests inherent in Special Immunization Program.

13) I am concerned that the BPRP program has resulted in isolation of USAMRIID from the rest of the Garrison at Fort Detrick. I am deriving this opinion from many unprovoked comments received in the last three weeks regarding the guards, facilities personnel, and ancillary staff.

14) The concept of "due process" should be stressed to everyone that interacts with the Biosurety program—no one should be treated differently than anyone else, including inspectors, researchers, maintenance personnel, industrial hygienists, etc.

15) To your comment of "...slow down...", please understand the following: I am greatly disturbed because these ethical problems have probably existed for decades. I do not want to be a participant in the perpetuation of these ethical dilemmas. I strongly believe you and I should execute a coordinated effort immediately to rectify and eliminate some of the gross ethical problems present via our participation as medical support in the Biosurety program of USAMRIID.

16) Finally [redacted] I need you to support me. If I do not have your one-hundred-percent support, there is absolutely no way I can perform my job.

Sincerely,

[redacted]

Charles Austin Cropper
Chief, Biosurety Medical Program/CMA
Barquist Army Health Clinic

Charles Austin Cropper, MD, MPH, MS
Chief, Biosurety Medical Program/CMA
Barquist Army Health Clinic

10 October 2009

[redacted]
Commander
Barquist Army Health Clinic
Fort Detrick, MD

Dear [redacted]

It is with great sadness that I feel I must tender my resignation from the position of Chief, Biosurety Medical Program at the Barquist Army Health Clinic. I feel that I have no choice due to the ethical constraints placed upon me.

This resignation is effective immediately.

Sincerely,

[redacted]

Charles Austin Cropper
Chief, Biosurety Medical Program/CMA
Barquist Army Health Clinic