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CHEMICAL AND BIOLOGICAL DEFENSE: DOD MEDICAL READINESS

HEARING

BEFORE THE

SUBCOMMITTEE ON NATIONAL SECURITY, VETERANS AFFAIRS AND INTERNATIONAL RELATIONS

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

FIRST SESSION

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CHEMICAL AND BIOLOGICAL DEFENSE: DOD MEDICAL READINESS

WEDNESDAY, NOVEMBER 7, 2001

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON NATIONAL SECURITY, VETERANS AFFAIRS AND INTERNATIONAL RELATIONS,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:04 a.m., in room 2154, Rayburn House Office Building, Hon. Christopher Shays (chairman of the subcommittee) presiding.

Present: Representatives Shays, Putnam, Gilman, Lewis, Schrock, Kucinich, Allen, Lantos and Tierney.

Staff present: Lawrence J. Halloran, staff director and counsel; Kristine K. McElroy, professional staff member; Jason Chung, clerk; Michael Bloomrose, intern; David Rapallo, minority counsel; and Earley Green, minority assistant clerk.

Mr. SHAYS. Good morning. I would like to call this hearing to order and welcome our witnesses and our guests.

The modern battleground can be a toxic and biological minefield. In far-flung deployments, indigenous diseases, parasites and environmental exposures pose unique health threats. Fighting and surviving in battle space contaminated by chemical and biological weapons demand medical countermeasures and treatment capabilities beyond those needed to deal with bullets and bombs.

To be ready to prevail on distant and increasingly dirty battlefields, the Department of Defense [DOD], is charged to recruit, train—retrain, train, equip and motivate a force capable of meeting diverse missions. One critical element of that readiness mandate is the capacity of medical personnel to protect the health of the men and women in uniform and, when necessary, treat the wounds of modern warfare.

The Gulf war brought home some hard lessons about the adequacy of medical readiness in the face of microbial as well as military assault. Baseline medical data on deployed troops was found lacking. Records on the use of vaccines and drugs against chemical and biological [CB], threats were not kept. The military services appeared to have different approaches to health surveillance, training of medical personnel, and treatment protocols.

Soon after the war, the General Accounting Office [GAO], and the DOD inspector general [IG], identified a number of shortcomings in DOD's capacity to provide medical support for the numbers of contaminated casualties anticipated. In 1996, the GAO and IG found many of those same problems persisted; so the sub-

committee requested GAO determine what the Department is doing to adapt military medical force structure and training to meet emerging CB threats. We asked GAO to assess whether DOD is augmenting medical rosters with the specialists needed to diagnose and treat CB casualties, and we wanted to know the extent all medical personnel are receiving mandatory standardized training in the treatment of chemical and biological warfare exposures.

The GAO findings released today indicate DOD has some efforts under way, but has yet to succeed in reshaping conventional medical planning to address the unique challenges of chemical and biological warfare. Training in medical management of CB casualties is limited, and treatment scenarios are almost never included in combat exercises.

One intractable aspect of the longstanding disconnect between the Department's assessment of the CB threat and medical readiness to meet it appears to be an inability or unwillingness to approach the problem jointly. The service branches cling to different assumptions about casualty estimates and evacuation rates. Based on those assumptions, each service reaches different conclusions on which and how many medical personnel will be needed to treat CB injuries.

The war against terrorism is being fought against an unconventional enemy with no compunction about using unconventional weapons. Those being sent to fight the war deserve to know medical support will be available whether they face tanks or toxins, mines or microbes. To help ensure they have that support, GAO today made several specific recommendations to clarify planning assumptions and improve medical readiness. The Department of Defense will address those proposals and describe current and planned capabilities to protect the health of deployed forces.

Our witnesses this morning bring important information and insights to our oversight of defense medical readiness. We anticipate their being here—we appreciate their being here and look forward to their testimony.

At this time I would like to recognize the ranking member, Mr. Kucinich.

Mr. KUCINICH. Thank you, Mr. Chairman.

Good morning, and let me welcome all those who will be witnesses from the General Accounting Office and the Department of Defense. I am glad you could be with us today.

Mr. Chairman, thank you for holding this hearing. The topic is extremely important. Our military has recognized a grave threat, the threat that chemical or biological agents might be used against them in the theater of war. They've made some movement toward dealing with this contingency, but as we will hear in a few moments, it appears they have not been fully able to realign and prepare the medical force for this threat.

The General Accounting Office report lays out some disturbing findings, and the Department of Defense appears to agree with the majority of them, that the Pentagon leadership is not providing adequate guidance. They should not have developed tools—they have not developed tools to determine how the medical force should be structured, and the services disagree among themselves on a host of issues. Medics are not trained sufficiently, and even those

that have received training do not feel they are proficient; that is, if the military leadership can locate them without a functioning tracking system in place.

I am glad that the Assistant Secretary is with us today to respond to these comments and provide us with his view of the steps DOD must take to overcome these challenges. In his position he no doubt will play a key role in advocating for these changes within the Pentagon.

I would highlight, however, one important observation in the GAO report. While the Assistant Secretary's commitment is essential, most exercises are controlled by those responsible for warfighting. As GAO points out, "concurrence of the military operation staff will be essential if medical participation is to be included in combat exercises and not the first they cut when it gets in the way of other goals or becomes too hard." So in addition to having a task of his own to focus on as he returns to the Pentagon, I hope the Assistant Secretary carries this additional message back with him.

Finally, Mr. Chairman, I would like to raise an issue that I believe is an urgent priority for members of this subcommittee. As you know, the administration announced last spring that it was considering reversing the previous administration by opposing the ongoing international negotiations for mandatory facility inspections under the Biological Weapons Convention. I was concerned when I heard this because I believe that inspections are the core component of these negotiations. They force proliferators to either hide their activities at legitimate locations or go underground into rudimentary and dangerous facilities. Either way their lives are made more difficult. In fact, Ambassador Mahley himself, the State Department official in charge of the negotiations, previously testified before this subcommittee in favor of inspections, and he said, "actually talking to scientists and production workers on the ground as well as observing the atmospherics at a facility are ways for experienced observers to detect anomalies. One can never discount either the whistleblower prospect of an employee or the ineptitude of a coverup of an elicit activity. While there is no way to judge the likelihood of such an outcome, the deterrence component is useful since it complicates the life of a potential proliferator."

When the new administration came in, however, Ambassador Mahley ordered an interagency review of the negotiations. According to recent press accounts, this review is what spurred the administration's reversal. Although I was concerned by the administration's reversal, I was somewhat heartened that this subcommittee will have the opportunity to conduct its oversight role and examine the rationale behind the decision.

At a hearing in July, Congressman Tierney asked Ambassador Mahley to deliver to the subcommittee a copy of the interagency review he ordered. Congressman Tierney's request would have allowed us to better understand why the administration saw no value in continuing to negotiate. Ambassador Mahley agreed to provide the report, and Mr. Tierney's request was adopted on the record without objection. Unfortunately this was 4 months ago, and we've received nothing from the administration in the meantime. And particularly in light of recent events, I would have expected

the administration to seriously have rethought its position, but from the press I've seen, it appears they're going full throttle in an effort to kill the negotiations for mandatory inspections.

Congresswoman Schakowsky also asked about this at our last hearing. While acknowledging the State Department officials were busy with counterterrorism efforts, Ms. Schakowsky rightly questioned why it had taken the Department so long to deliver the analysis. This subcommittee recognized Ms. Schakowsky's concerns and promised they would be addressed. That was over 3 weeks ago, and still the administration has not provided that information.

This issue has become even more urgent, Mr. Chairman, because the United States is about to send Ambassador Mahley to Geneva in 2 weeks to convince the world of our newly reversed position. We will be telling them that inspections are not necessary anymore, even though the United States originally called for them, and even though Ambassador Mahley himself once listed a litany of reasons we urgently needed them. We will be telling them that inspections are not necessary anymore even after September 11th attacks and even after multiple anthrax attacks.

The administration is sending the Ambassador to Geneva with a reverse foreign policy predicated on the executive analysis that Congress has had no opportunity whatsoever to review. Mr. Chairman, you are planning a December delegation to Geneva for subcommittee members to discuss these very negotiations, but without cooperation from the State Department, participation in such a delegation will be fruitless. I'm really concerned about how this committee can conduct adequate oversight of administration policies if the most basic requests are not met with cooperation. This is a vitally important issue of inspections under the Biological Weapons Convention. It definitely needs to be addressed. I hope that all members of the committee will join in demanding full cooperation from the administration, and we are certainly at a link between that and the issue of medical readiness, because if we don't do something to control the proliferation of biological weapons, all these hearings are going to be in vain because you will never be ready. We have to try to stop these weapons at their inception.

Thank you, Mr. Chairman, for your time.

Mr. SHAYS. I thank the gentleman.

[The prepared statement of Hon. Dennis J. Kucinich follows:]

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Opening Statement
Representative Dennis J. Kucinich
Ranking Member
Subcommittee on National Security,
Veterans Affairs, and International Relations

November 7, 2001

Good morning. Let me welcome our witnesses from the General Accounting Office (GAO) and the Department of Defense (DOD). I am glad you could be with us today.

Mr. Chairman, thank you for holding this hearing. The topic is extremely important. Our military has recognized a grave threat -- the threat that chemical or biological agents might be used against them in a theater of war. They have made some movement toward dealing with this contingency. But, as we will hear in a few moments, it appears they have not been able to fully realign and prepare the medical force for this threat.

The General Accounting Office report lays out some disturbing findings, and the Department of Defense appears to agree with the majority of them: the Pentagon leadership is not providing adequate guidance, they have not developed tools to determine how the medical force should be structured, and the Services disagree among themselves on a host of issues. Medics are not trained sufficiently, and even those that have received training do not feel they are proficient -- that is, if the military leadership can locate them without a functioning tracking system in place.

I am glad the Assistant Secretary is with us today to respond to these comments and provide us with his view of the steps DOD must take to overcome these challenges. In his position, he no doubt will play a key role in advocating for these changes within the Pentagon.

I would highlight, however, one important observation in the GAO report. While the Assistant Secretary's commitment is essential, most exercises are controlled by those responsible for warfighting. As GAO points out, "concurrence of the military operations staff will be essential if medical participation is to be included in combat exercises and not the first thing cut when it gets in the way of other goals or becomes too hard." So, in addition to having a task of his own to focus on as he returns to the Pentagon, I hope the Assistant Secretary carries this additional message back with him.

Finally, Mr. Chairman, I would like to raise an issue that is an urgent priority for members of this Subcommittee. As you know, the Administration announced last spring that it was considering reversing the previous Administration by opposing the ongoing international negotiations for mandatory facility inspections under the Biological Weapons Convention.

I was concerned when I heard this because I believe inspections are the core component of these negotiations -- they force proliferators to either hide their activities at legitimate locations or go underground into rudimentary and dangerous facilities. Either way, their lives are made more difficult.

In fact, Ambassador Mahley himself -- the State Department official in charge of the negotiations -- previously testified before this Subcommittee in favor of inspections. He said:

> Actually talking to scientists and production workers on the ground, as well as observing the atmospherics at a facility, are ways for experienced observers to detect anomalies. One can never discount either the "whistleblower" prospect of an employee or the ineptitude of a cover-up of an illicit activity. While there is no way to judge the likelihood of such an outcome, the deterrence component is useful since it complicates the life of a potential proliferator.

When the new Administration came in, however, Ambassador Mahley ordered an interagency review of the negotiations. According to recent press accounts, this review is what spurred the Administration's reversal.

Although I was concerned by this, I was somewhat heartened that this Subcommittee would have the opportunity to conduct its oversight role and examine the rationale behind the decision. At a hearing in July, Congressman Tierney asked Ambassador Mahley to deliver to the Subcommittee a copy of the inter-agency review he ordered. Congressman Tierney's request would have allowed us to better understand why the Administration saw no value in continuing to negotiate. Ambassador Mahley agreed to provide the report, and Mr. Tierney's request was adopted on the record without objection.

Unfortunately, this was over four months ago, and we have received nothing from the Administration in the meantime. Particularly in light of recent events, I would have expected the Aministration to have seriously re-thought its position. But from the press I have seen, it appears they are going full-throttle in an effort to kill the negotiations for mandatory inspections.

Congresswoman Schakowsky also asked about this at our last hearing. While acknowledging that State Department officials were busy with counterterrorism efforts, Rep. Schakowsky rightly questioned why it had taken the department so long to deliver the analysis. This Subcommittee recognized Mrs. Schakowsky's concerns and promised that they would be addressed. That was over three weeks ago, and still the Administration has provided nothing.

This issue has become even more urgent, Mr. Chairman, because the United States is about to send Ambassador Mahley to Geneva in two weeks to convince the world of our newly reversed position. We will be telling them that inspections are not necessary anymore, even though the United States originally called for them, and even though Ambassador Mahley himself once listed a litany of reasons we urgently needed them. We will be telling them that inspections are not necessary anymore, even after the September 11th attacks, and even after the multiple anthrax attacks.

The Administration is sending Ambassador Mahley to Geneva with a reversed foreign policy predicated on an executive analysis that Congress has had no opportunity whatsoever to review. Mr. Chairman, you are planning a December delegation to Geneva for Subcommittee members to discuss these very negotiations. But without cooperation from the State Department, participation in such a delegation would be fruitless. I am concerned over how this Subcommittee can conduct adequate oversight of Administration policies if even the most basic requests are not met.

Mr. Chairman, this vitally important issue of inspections under the Biological Weapons Convention desperately needs to be addressed. I hope members of the Subcommittee will join me in demanding full cooperation from the Administration.

Thank you, Mr. Chairman.

Mr. SHAYS. Mr. Schrock is next in line, but I understand he doesn't have a statement; so I would call on Mr. Gilman.

Mr. GILMAN. Thank you, Mr. Chairman.

Chairman Shays, I want to thank you for holding today's hearing in conjunction with the other hearings you've held on medical readiness in the event of a bio or chemical attack. We have to truly examine the overall state of the Department of Defense's ability to treat casualties resulting from any chemical or biological attack on U.S. military personnel, and we're all very much concerned about making certain our military personnel are properly taken care of as they address some of the problems confronting our Nation today.

For many years the armed services have placed, regrettably, a minimal amount of resources into training medical personnel in the treatment of chemical or biological injuries. While the possibility existed that these weapons could be used against our personnel in the field, the fact remained that such forces had not encountered the use of such agents during World War I or World War II, and ever since, regrettably and sadly, the terrible events of September 11th as well as the anthrax episode last month have sharply focused our national attention on terrorism and underscored our vulnerability to future chemical and biological attacks. Indeed the bioterrorism debate has been transformed from a question of if to the inevitability of when.

We're dealing with an evil enemy that's fanatical in its beliefs and apparently has no qualms whatsoever about using any and all weapons at its disposal, not only nuclear, but including chemical and biological agents. Given this, it makes sense for the armed services to adjust their training for medical personnel to incorporate a greater emphasis on the diagnosis and treatment of chemical and biological casualties.

Initial examinations of the services' medical structures, however, are not encouraging. None of the armed services, the Army, the Navy, the Air Force, even the Coast Guard, have updated their medical requirements—have not updated their medical requirements to include chemical/bio scenarios, and while specialized training is offered, only 37,000 of the more than 203 medical personnel have received any specialized chemical/bio warfare training in the past 4 years.

Mr. Chairman, while we cannot expect the military to overhaul its entire medical training program overnight, we would expect to see some major changes being planned in the wake of the events that have occurred since September 11th. We look forward to hearing from our witnesses today on the progress that the Department of Defense has made in this now sadly necessary new requirement as we fight a fanatical enemy.

Thank you, Mr. Chairman.

Mr. SHAYS. Thank the gentleman.

Mr. Lantos. Not here.

Mr. Tierney.

Mr. TIERNEY. Mr. Chairman, thank you, but I'm going to put remarks on the record if I decide to do that, and we will move this along for you. Thank you.

Mr. SHAYS. Mr. Allen.

Mr. ALLEN. Mr. Chairman, I want to thank you. I'll do the same.

Mr. SHAYS. And we have Mr. Lewis.

OK. Thank you. I appreciate the Members being here. I know many of you have many other committee meetings today. Wednesday is not the day we should have hearings, frankly.

Let me recognize our witness, and we'll swear her in. Her name is Dr. Nancy Kingsbury, Managing Director for Applied Research and Methods, U.S. General Accounting Office. Is there anyone, Doctor, who would possibly be responding to a question that should stand when we swear you in? If so, that would make sense to have them do that.

Ms. KINGSBURY. Betty Ward-Zukerman and Bill Cawood, who have done a lot of work on chem/bio issues.

Mr. SHAYS. OK. Why don't we have them stand up as well, and we'll swear you all in. Raise your right hands, please.

[Witnesses sworn.]

Mr. SHAYS. Note for the record all three have responded in the affirmative. And just before I recognize you to begin your testimony, I'll take care of some housekeeping here.

I ask unanimous consent that all members of the subcommittee will be permitted to place an opening statement in the record, and that the record remain open for 3 days for that purpose. Without objection, so ordered.

I ask further unanimous consent that all witnesses be permitted to include their written statements in the record, and without objection, so ordered.

What we do, Doctor, as I think you know, is we keep the clock on for 5 minutes, and then we roll it over for another 5 minutes and hope you would finish before you get to 10.

Ms. KINGSBURY. I will plan on it, thank you.

STATEMENT OF NANCY KINGSBURY, MANAGING DIRECTOR FOR APPLIED RESEARCH AND METHODS, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY BETTY WARD-ZUKERMAN, ASSISTANT DIRECTOR, APPLIED RESEARCH AND METHODS, GENERAL ACCOUNTING OFFICE; AND WILLIAM W. CAWOOD, ASSISTANT DIRECTOR, DEFENSE CAPABILITIES AND MANAGEMENT, GENERAL ACCOUNTING OFFICE

Ms. KINGSBURY. I very much appreciate being here, Mr. Chairman and members of the committee, to share with you our work today, and I'm going to give you the very short version of the main points of our work here this morning since we have the report that's just out. Everybody can see the details.

You asked us to determine how DOD had adapted its medical personnel to emerging chemical and biological threats. Specifically we looked at two things, how DOD and the services had addressed chemical and biological threats in planning for medical personnel in their distribution across medical specialties, and the training provided to medical personnel in the treatment of chemical and biological casualties.

We found that neither DOD nor the services had systematically examined the current distribution of medical personnel across specialties with respect to their adequacy for chemical and biological defense. Although the services had begun a review of the staffing

of deployable medical units for chemical warfare scenarios, they had not done so for biological warfare scenarios. General assessments of requirements have at best roughly extrapolated from the results of modeling for other medical requirements to factor in chemical and biological warfare requirements.

As recommended by DOD studies, joint protocols for treating chemical and biological casualties have recently been completed, but agreement has not been reached among the services on which medical personnel are appropriate to provide treatment. This is important to provide integration of medical treatment in the event of an attack.

DOD officials attributed the lack of systemic efforts to several factors, including the failure to establish chemical and biological readiness as a medical priority in defense planning guidance, data and methodological constraints that complicate the task, disagreements among the services about the capacity to implement evacuation policy, and pessimism that medical personnel could effectively treat substantial numbers of chemical and biological casualties.

In general, service medical planning officials maintain that specialized training rather than systematic assessment of needed specialties is the appropriate way to address any need for additional medical skills in the military setting. However, we found that the extent of training as well as testing and exercises for medical management of chemical and biological casualties is limited. While progress has been made since the Gulf war in increasing the availability of such specialized training, the courses are voluntarily and, except for basic training and daunting chemical protective gear, not widely attended. From 1997 to 2000, as Mr. Gilman suggested, fewer than a fifth of the uniformed medical personnel completed any specialized training, and only about 2½ percent have taken the 7-day onsite medical management of chemical and biological casualties course, which is the most comprehensive training available.

We note that most training does not currently include individual proficiency testing, and in one study that we are aware of where proficiency testing was conducted, proficiency was not demonstrated in a number of key tasks, such as clearing airways or controlling bleeding. Notwithstanding these negative results, however, we think the effort to do proficiency testing is encouraging.

Even medical personnel who have been trained cannot readily be identified in the event of an emergency because tracking systems either do not exist or are not currently functioning. Thus the availability of trained personnel in a given situation is uncertain.

Another way the DOD provides combat readiness training is the conduct of field exercises. However, exercise scenarios that include chemical and biological defense elements have been almost nonexistent. For example, the last joint chemical and biological medical exercise that was completed was in 1994, and the next one is not planned until 2005. Officials told us that exercises involving medical support for chemical and biological casualties were rare because of conflicting priorities encountered by both warfighters and medical personnel and because of the difficulty and expense of conducting them. Officials also said that such exercises are not planned because of the potential that the chemical or biological elements

would overwhelm the exercise and prevent the other objectives from being achieved.

In our report we make a number of recommendations to DOD to resolve these issues, including clarification of the requirements for chemical and biological contingencies in defense planning guidance, reaching agreement among the services and joint staff about which medical personnel are qualified to provide specific treatments to ensure consistent approaches in joint activities, developing medical training requirements for chemical and biological contingencies, assessing the effectiveness of training with rigorous proficiency standards and tests, and tracking individual training and proficiency, and increased chemical and biological exercises involving medical personnel to an extent commensurate with current chemical and biological threat assessments.

Given the threat of mass casualties in a chemical and biological event, exercises should explore the extent of medical capabilities and the full consequences of scenarios that overwhelm them.

I think I will stop my statement here, Mr. Chairman. I will be happy to take your questions.

Mr. SHAYS. Short, concise, and right to the point.

[NOTE.—The report entitled, "chemical and Biological Defense, DOD Needs to Clarify Expectations for Medical Readiness," may be found in subcommittee files.]

[The prepared statement of Ms. Kingsbury follows:]

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on National Security, Veterans' Affairs, and International Relations, Committee on Government Reform, House of Representatives

For Release on Delivery
Expected at 10:00 a.m. EDT
Wednesday, November 7, 2001

CHEMICAL AND BIOLOGICAL DEFENSE

DOD Should Clarify Expectations for Medical Readiness

Statement of Nancy Kingsbury, Managing Director, Applied Research and Methods

GAO-02-219T

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to contribute to your hearing on medical preparations for chemical and biological defense. As the war on terrorism proceeds at home and abroad, the need for attention to these matters has become more urgent. My testimony today is based on our report on DOD's preparations for medical support for chemical and biological casualties.[1] In the report, which is being released today, we responded to your request that we determine how DOD had adapted its medical personnel to emerging chemical and biological threats. Specifically, we looked at how DOD and the services had addressed chemical and biological threats in the distribution of medical personnel across specialties. We also looked at the extent of training for medical personnel in the treatment of chemical and biological casualties.

Background

In June 1995, a Presidential Decision Directive declared that the United States would give the highest priority to developing effective capabilities to detect, prevent, defeat, and manage the consequences of terrorists' use of nuclear, biological, or chemical materials or weapons. In addition, the former Secretary of Defense emphasized, at his confirmation hearing in January 1997, that U.S. forces abroad face the threat of chemical and biological weapons. According to both DOD officials and U.S. government reports, chemical and biological warfare must be considered a potential threat in future conflicts.

The Office of the Secretary of Defense, the joint staff, and the armed services play distinct but interrelated roles in ensuring medical readiness. Defense planning is led by the Office of the Secretary of Defense. This office sets policy and develops Defense Planning Guidance. Based on this formal guidance, the Joint Chiefs issue a biannual Joint Strategic Capabilities Plan (JSCAP) that gives missions to the nation's unified combat commands. These commands have operational control of U.S. combat forces and are responsible for fighting and winning the nation's wars within a particular area of responsibility, usually defined by geographical boundaries. The commanders-in-chief develop war plans and requirements that specify the combat troops and support that will be needed to meet the threat and mission assigned by the Capabilities Plan.

[1] *Chemical and Biological Defense: DOD Needs to Clarify Expectations for Medical Readiness* (GAO-02-38, Oct. 19, 2001).

The services, in turn, train and equip the forces, including medical personnel, necessary to meet the needs of the commanders-in-chief. The tools available to the services for this purpose include various types of training and exercises.

DOD and the Services' Efforts to Incorporate CB Threats in Medical Personnel Planning Not Systematic

We found that neither DOD nor the services had systematically examined the current distribution of medical personnel across specialties with respect to adequacy for chemical and biological defense. This was so despite public assessments by defense officials that have emphasized the seriousness of the military threat from chemical and biological weapons. Although the services had begun to review the staffing of deployable medical units for chemical warfare scenarios, they had not done so for biological warfare scenarios. In general, DOD has not successfully adapted its conventional medical planning to chemical and biological warfare. For example, in medical planning, DOD has used software, evaluations, and review processes that address conventional threats, but that have not fully incorporated chemical and biological threats. In addition, medical planners have lacked the information on casualty rates or qualified medical personnel required to address the appropriateness of the current distribution of medical personnel across specialties. As recommended by DOD studies, joint protocols for treating chemical and biological casualties have recently been completed. But agreement has not been reached among the services on which medical personnel are appropriate to provide treatment for different casualties caused by chemical or biological agents.

DOD officials attributed the lack of systematic efforts to several factors. These included failure to establish chemical and biological readiness as a medical priority in Defense Planning Guidance (particularly for biological warfare), complex assumptions required to predict casualties, poor availability of data on the effects of particular agents, disagreements among the services about how quickly troops could actually be evacuated, and pessimism that medical personnel could effectively treat substantial numbers of chemical and biological casualties. Medical planners for the joint staff, unified commands, and the services—who are charged with addressing these issues—all expressed frustration with inaction on the part of others. For example, citing lack of input from the services, the medical planners for the unified commands had reluctantly, they said, adopted a rough method of estimating the medical support required for chemical and biological scenarios. Specifically, they had simply multiplied the medical support required for conventional scenarios by a fixed factor.

This method presumes that the individual medical units currently possess the appropriate distribution of medical personnel across specialties.

Extent of Medical Personnel Training Limited for the Treatment of CB Casualties

Following the Gulf War, both GAO and the DOD inspector general identified a number of shortcomings in DOD's capacity to provide medical treatment for the numbers of chemical and biological casualties that were predicted. In 1996, GAO observed that many of the problems identified in these reports persisted. In the review we report on today, we found that the extent of training, as well as testing and exercises, for medical management of chemical and biological casualties remains limited. Rather than adjusting the distribution of medical specialists, the services officials for medical planning maintain that specialized training in the military is the appropriate way to address any need for additional medical skills. However, while progress has been made since the Gulf War in increasing the availability of such specialized training, these courses are essentially voluntary. While training requirements for medical personnel generally incorporate instruction in such matters as donning chemical protective gear, only the Army includes an introduction to chemical and biological casualty management in training required of medical personnel. On the basis of the number of students who have taken the various specialized courses, we found that no more than a fifth of uniformed medical personnel had completed any specialized military medical training for chemical and biological casualties. Even medical personnel who had been trained could not be readily identified in the event of an emergency. This is because either the tracking systems do not exist or are not currently functioning. Except for the Army's Medic 2000 study—which found that the lowest proficiency scores among medics were for nuclear, biological, and chemical skills—the services have not defined standards for treatment of chemical and biological casualties nor tested the proficiency of medical personnel. The Army study and other indirect evidence indicate that the likelihood of chemical and biological casualties receiving proficient medical care remains low, due in part to weak or absent requirements for training, as well as testing and certification, of medical staff.

Medical planners from each of the five regional unified commands told us that, to their knowledge, no realistic field exercise of chemical or biological defense had been conducted. But the surgeons general from the services have begun integrating chemical and a few biological scenarios into their medical exercises. Additional data provided by DOD show that only two joint military exercises planned since 1993 had included both medical support activities and chemical or biological warfare. Similarly, key evaluations used to advise the President on readiness to implement the national security strategy had never set a scenario for the unified

commanders requiring medical personnel to respond to the effects of weapons of mass destruction. Officials told us that exercises involving medical support for chemical and biological casualties were rare because of conflicting priorities encountered by both warfighters and medical personnel and because of difficulty and expense.

Conclusions and Recommendations

In the years since Desert Storm, DOD and the services have not fully addressed weaknesses and gaps in planning, training, tracking systems, or tests of proficiency for the treatment of chemical and biological casualties. The resulting organization of medical personnel has not been rigorously tested for the capacity to deliver the required support. As a consequence, medical readiness for chemical and biological scenarios cannot be ensured.

Although we found efforts to plan and train for these threats, there is a wide and longstanding gap between DOD's appraisal of chemical and biological threats and DOD's medical preparedness to meet them.

We recommend that the Secretary of Defense address the gap between the stated chemical and biological threat and the current level of medical readiness by, first, clarifying DOD's expectations concerning medical preparation for chemical and biological contingencies and, second, as appropriate, incorporating biological medical readiness in Defense Planning Guidance. To the degree that DOD views chemical or biological contingencies as a serious threat and expects medical personnel to prepare for them, we also recommend additional actions:

First, the services and joint staff should conclude an agreement about which medical personnel are qualified to provide specific treatments. Without such an agreement, each service's medical model will continue to be based on different assumptions concerning which personnel are qualified to administer treatments. The results will therefore be neither comparable among the services nor readily defensible. This database should eventually be validated by proficiency testing of the identified personnel to help further refine requirements for training and distribution of medical personnel across specialties.

Second, the services should develop medical training requirements for chemical and biological contingencies, assess the effectiveness of the training with rigorous proficiency standards and tests, and track individual training and proficiency.

Third, the joint staff, commanders-in-chief, and the services should increase chemical and biological exercises involving medical personnel to an extent commensurate with current chemical and biological threat assessments. Given the threat of mass casualties, exercises should explore the extent of medical capabilities and the full consequences of scenarios that overwhelm them.

An additional recommendation and further information are included in our report.

Mr. Chairman, this concludes my statement. I will be happy to answer any questions you or Members of this Subcommittee may have.

Contacts and Acknowledgments

For further questions about this testimony, please contact Nancy Kingsbury, at (202) 512-2700. Other individuals making key contributions to this testimony include Betty Ward-Zukerman, Daniel Rodriguez, and Laurel Rabin.

Mr. SHAYS. Mr. Gilman.

Ms. KINGSBURY. I take that as a compliment, sir.

Mr. SHAYS. You should.

Mr. GILMAN. Thank you, Mr. Chairman.

We want to thank GAO for their review at a very critical time and for your very alarming review of what has been done to date. Why is chemical and biological training not mandatory?

Ms. KINGSBURY. It has not been. I am not actually sure we know.

Do we know that there have been reasons?

Mr. GILMAN. Is there any reason given to you?

Ms. KINGSBURY. I suppose there is only so much training that can be done, and you have to prioritize it.

Mr. SHAYS. I think you have chairs on either side. This way you can whisper in their ears if you want.

Mr. GILMAN. Why don't you bring your assistants——

Mr. SHAYS. Hold on 1 second. We will keep the clock running. The two I swore in, would you please—whom did I swear in?

Ms. KINGSBURY. Bill.

Mr. SHAYS. Come on.

Mr. GILMAN. Don't be shy. We won't bite.

Ms. KINGSBURY. Thank you.

In the overall scheme of things, I think training is something that you spend part of your time on, and you spend part of your time on your job. It's just the way the priorities have been. We have noticed, though, that at the same time the training has been voluntary and not been done, the people who talk about the threat have been quite alarmist, if you will, quite concerned about the threat, and perhaps justifiably so as recent events have shown. So I look forward to your asking the DOD witnesses about that.

Mr. GILMAN. I note in your report that key readiness—I'm quoting from your report on page 3—key readiness evaluations used to advise the President on readiness to implement the national security strategy had never set a scenario for the unified commanders requiring medical support for weapons of mass destructions, and officials told you that CB medical support is rarely exercised because of conflicting priorities encountered by warfighters and medical staff and because it's difficult and expensive. Did you explore that any further?

Ms. KINGSBURY. I have personally had a couple of discussions about that because I think it's important to understand why that happens. My own sense of it, and I have actually been told by a couple of officials, that the serious chemical and biological scenarios are showstoppers. They stop the exercises, and so they just don't do them.

Mr. GILMAN. And you also indicate that in sum, the DOD and the services had not fully addressed weaknesses and gaps in modeling, planning, training, and tracking or proficiency testing for the treatment of CB casualties, and resulting medical structures not being rigorously tested for its capacity to deliver the required medical support.

Did you explore that with them to see what was going to be done to correct that?

Ms. KINGSBURY. Well, they have agreed with our recommendations in that regard and note in our report in their comments that

they are planning to do some additional things to try to address these issues, and I'll be happy to let them talk about that. We've been making these recommendations since 1993, and we—that's often a role that GAO plays. We make recommendations, and agencies do or don't followup on them, and this is one where I think the story is still a little disappointing.

Mr. GILMAN. Since 1993, you've been making these recommendations, and there has been no progress?

Ms. KINGSBURY. There's been some progress. I think that's fair to say. They have developed additional training. They are training more people as we go along, but we still can see gaps between what they seem to say they need and what is actually being delivered.

Mr. GILMAN. Well, my time has run, but just one last question. Why has the medical training been limited here in this area in your——

Ms. KINGSBURY. Some officials have told us it's a matter of expense. Some officials have told us it's a matter of priorities. It's been limited.

Mr. GILMAN. We gather that. All right. I hope we can explore that further.

Thank you, Mr. Chairman.

Mr. SHAYS. I thank the gentleman.

Mr. Kucinich.

Mr. KUCINICH. Dr. Kingsbury, thank you for your work on this report, and I would like to address a practical consequence of this report with this question: If we had ground troops in Afghanistan, does the Department of Defense have a medical training structure in place to adequately protect or respond to soldiers who would be injured by a biological or chemical weapon attack?

Ms. KINGSBURY. Our work predates the Afghan adventure, and I don't think I want us to talk about whether they have adequate forces in place. There are representatives in the military here to deal with that. That's a very——

Mr. KUCINICH. But you——

Ms. KINGSBURY [continuing]. Sensitive issue, and I would rather let the Department of Defense answer that question, sir.

Mr. KUCINICH. But wait a minute. You gave us a report, Dr. Kingsbury——

Ms. KINGSBURY. I did.

Mr. KUCINICH [continuing]. That says as a consequence, medical readiness for CB scenarios cannot be insured. Did you say that?

Ms. KINGSBURY. In general we support that statement, sir. I just can't speak to the situation in Afghanistan.

Mr. KUCINICH. If you say in your report that the Department of Defense and services—I am quoting directly—had not fully addressed weaknesses and gaps in modeling, planning, training, tracking, or proficiency testing for the treatment of CB casualties, wouldn't it follow that if we were to have our men and women on the ground in Afghanistan, and they were subjected to a biological or chemical weapon assault, that we might not be able to care for them given this report?

Ms. KINGSBURY. I think the phrase "we might not be able to" is a fair statement.

Mr. KUCINICH. I thank you. No other questions.

Mr. SHAYS. Thank you.

Mr. Lewis.

Mr. LEWIS. Thank you, Mr. Chairman.

Thank you, Dr. Kingsbury, for your testimony. Why do you think the medical personnel training has been limited—and the reason I ask that is because, of course, we're talking about chemical and biological here, but after all the years that we faced the threat of a nuclear attack, was there any training for medical personnel to deal with a major catastrophe in regards to the nuclear equation that could be brought around to the possibility of a chemical or biological attack?

Ms. KINGSBURY. Well, the military structure—the military medical structure serves two purposes. It serves a peacetime purpose, and it serves a wartime purpose, and I think those two things create a very difficult challenge to make sure you're prepared for the perhaps unlikely but nonetheless devastating possibilities of a chemical or biological attack. And this is made more complicated by the fact that the issues that you need to address medically for nuclear, chemical or biological are actually quite different and require different skills.

So it's a very complicated issue, and I wish we saw a really clear solution to it. We make some recommendations in our report and hope that the Department of Defense can move quickly in the right direction.

Mr. LEWIS. What are some of those steps that could bring them in a more positive direction in medical training?

Ms. KINGSBURY. Well, we address many of those in our report. We talk about the need to track who's had the training; the need to do proficiency testing and make sure that the people who are there in fact can demonstrate the skills, not just say they know it; better planning in defense planning guidance, clearer priority for this. That's what drives what the warfighters do. That's what drives what DOD ultimately thinks is going to happen on the battlefield, and I think that's where it has to start.

Mr. LEWIS. OK. Thank you.

Mr. SHAYS. Thank the gentleman.

At this time recognize Mr. Tierney.

Mr. TIERNEY. Thank you, Mr. Chairman.

Dr. Kingsbury, thank you for your testimony. In your report you conclude that the persistence of this troublesome situation has been caused by one of three factors, a disagreement about the significance of the threat, the failure of leadership, or an acceptance of a high level of risk. Can you walk us through each of those three?

Ms. KINGSBURY. Wait a minute. I've just gone blank.

Mr. TIERNEY. OK. Well, the first one was——

Ms. KINGSBURY. What page are you on?

Mr. TIERNEY [continuing]. A disagreement about the significance of the threat. The second was a failure of leadership. The third was an acceptance of a high level of risk. You know, each of those would contribute in some degree to the persistence of the situation.

Ms. KINGSBURY. Well, let's start with the threat first. I mean, I think that although there has been a great deal of commentary about the threat and obvious concern about it, if you really look in

a lot of the places we've looked across a whole spectrum of issues related to chemical and biological warfare, the resources, the training, the commitment to meet the threat doesn't seem to match the level of threat assessment that's out there, and we've been sort of puzzling about that as we've put this work together, some of the work that Bill Cawood has done and others. We really think it starts with that problem.

With respect to leadership, I point particularly to the difficulties of achieving a joint outcome here. I think it's very important because we're fighting jointly increasingly so that the services get together and reach agreement on how medical casualties in this arena need to be managed.

And with respect to risk, I think the events of the last couple of months clearly have heightened our sense that risk is real, and that the medical difficulties are a real challenge. Just identifying what's happening is perhaps one of the more real challenges.

I am encouraged actually by a byproduct of the last 2 months. I am a great believer that if you're looking for something, you're more likely to find it, and I think that the last couple of months has heightened perhaps our ability to detect these things going forward.

Mr. TIERNEY. Just as a comment, I have to say that when earlier you were talking about there being a reason for the services not addressing this gap between the appraisal of the threats and the Department of Defense medical preparedness to meet them, as some people say, it's an expense, and some people say it's the priorities, well, at $330 billion plus in that Department of Defense budget every year, I would have to say that it's a lack of responding to your priorities more so than not a lack of having the money. Or God help us if it's the other way around.

Of the three items that we just discussed on which you base your analysis, which one of those do you think is the more prominent, the primary cause of this situation?

Ms. KINGSBURY. Right now I think I need to go back to the starting point. I think it needs to be sorted out in how DOD is choosing to plan for warfare going forward. If these priorities get into the defense planning guidance, they will get fielded. They will get done. All of the services are very capable of doing things when they decide to do them. I think it's important to start there.

Mr. TIERNEY. On page 10 of your report, you said that the Army Medical Department officials said they were not authorized to structure medical care for biological contingencies. I am wondering what do these medics mean when they say they're not authorized to prepare for attacks using biological weapons?

Ms. KINGSBURY. I'm sorry, sir, where are you?

Mr. TIERNEY. Page 10. Do you—yeah. Why don't you——

Ms. WARD-ZUKERMAN. I think they were indirectly referring to the fact that preparation for biological contingencies was not something that the DPG had directed them to do.

Mr. TIERNEY. The DPG being?

Ms. WARD-ZUKERMAN. The defense planning guidance.

Mr. TIERNEY. Did you determine any reason why they hadn't been directed to do that? I mean, it's pretty amazing at this point in time to think that they hadn't been.

Ms. WARD-ZUKERMAN. We just, you know, looked at the sort of the immediate reason that they had not done it.

Mr. TIERNEY. On the question of evacuations, at least as I understand it, the faster the injured are removed or lifted from the area, the fewer medical personnel may be needed in the field. Is that a fair assessment?

Ms. KINGSBURY. Yes, sir.

Mr. TIERNEY. And in that regard what is the joint and strategic capabilities plan?

Ms. KINGSBURY. The joint and strategic——

Ms. WARD-ZUKERMAN. The joint and strategic capabilities plan is developed to provide missions to the commanders-in-chief in the various areas that DOD operates, and it follows the guidance in the defense that's put together by OSD in the form of defense planning guidance.

Mr. TIERNEY. And is there, in fact—one of the things they talk about is following that pattern of getting the people that are affected out of the area quickly so that there is less need for medics on the front line.

Ms. WARD-ZUKERMAN. We didn't specifically look at the joint strategic capabilities plan, but Army officials did cite concerns about the actual speed with which people could be evacuated.

Mr. TIERNEY. Thank you.

I see my time is up, Mr. Chairman. Thank you.

Mr. SHAYS. It's my intention to come back, but if the gentleman would like to ask questions now, he could do that if he's not coming back.

Mr. ALLEN. I could do it very quickly.

Mr. SHAYS. OK. Mr. Allen.

Mr. ALLEN. Thank you, Mr. Chairman. My questions will be—I'll try to keep this well under 5 minutes.

Based on your analysis of the availability of medical personnel in the military services, let's just imagine that the outbreak of anthrax was an outbreak of smallpox instead. How many military health care personnel are there available to treat someone infected with smallpox who's been vaccinated? I mean, is there anyone in the services among their health care personnel who can walk in and care for a smallpox victim without fear of contracting the disease themselves?

Ms. KINGSBURY. Mr. Allen, we did not specifically look at that issue, and with three very distinguished Surgeons General in the room, I would rather defer that question to them.

Mr. ALLEN. Mr. Chairman, is there a way to get an answer to that question either later, or can we bring that out?

Mr. SHAYS. Let me just ask you. Your response to the question is based on what?

Ms. KINGSBURY. Well, we did—as you well know, Mr. Chairman, we tend not to want to make observations about things that were not included in the scope of our work, and we did not specifically ask questions about the preparation to treat smallpox victims in the present moment, and I just—I don't have any basis at all for answering your question. It's not that I don't think it's a fine question.

Mr. SHAYS. But I do think that we can ask the next panel and pursue that.

Ms. KINGSBURY. I would prefer that. Thank you, sir.

Mr. ALLEN. Mr. Chairman, my point was we've been talking about training of personnel, and that's sort of one area, but having personnel who can treat patients without being themselves subject to getting the disease, it seems to me at least equally important.

Ms. KINGSBURY. I would agree with you, and it applies not only to smallpox, but any other number of biological toxins out there. I think that's an important part of the bigger picture.

Mr. SHAYS. We're going to stand at recess. We just have one vote, and we'll be back——

Ms. KINGSBURY. Yes, sir.

Mr. SHAYS [continuing]. And then we'll finish up.

[Recess.]

Mr. SHAYS. Call this hearing to order and apologize. We had two votes, not one.

What I would like to do is first state—I would like to acknowledge that there appears to be very good will between GAO and DOD and cooperation between both. And also to express appreciation that there wasn't an attempt to try to smother this report or, if there was, that it wasn't something that was pursued.

Because we're in new territory here. This is, I think, a very, very significant report but one that needs to be addressed. I think, frankly, by making sure that this is public, we have an added incentive to have people understand why resources need to be spent for DOD. I mean, we are clearly in a race with the terrorists to shut them down before they have a better system for chemical and biological weapons, nuclear waste or nuclear weapons. We're at war, and I think a lot of people in our country don't fully appreciate it.

We all have to kind of think distinctly. We have to reorient our military differently. We need to reorient how we think about foreign aid. We need to do a lot of things. I mean, I've had some in the military tell me if we had put more resources into the State Department we might have prevented some of our military from having to be in some places risking their lives.

When President Lincoln addressed Congress when—it's unbelievable to me, but we lost 10,000 men a month for 4 years in the Civil War. He addressed Congress, and he said, the dogmas of the quiet past are inadequate to the stormy present. The occasion is piled high with difficulty, and we must rise with the occasion. As our case is new, so we must think anew and act anew. We must disenthrall ourselves, and then we shall save our country.

My view is that we're all being asked to think anew. And obviously the military is part of that. So I just want to put that on the table and say that I don't have a lot of judgment as to why we're here, but I am interested in what we can do to see us think anew and act anew.

What I wanted to do was I wanted to go down, Dr. Kingsbury, the recommendations that you made and understand what each one was and understand what you think DOD's response was. I'm referring to page 47 in your report. Specific comments on rec-

ommendations made by DOD. It appears that they basically concurred with every one.

Ms. KINGSBURY. Yes, sir.

Mr. SHAYS. Is your mic on?

Ms. KINGSBURY. It is now, yes, sir.

Mr. SHAYS. Let me say that so, in your judgment, they concurred with every one. Is there any one recommendation or more than one in which you feel they qualified their response to it?

Ms. KINGSBURY. I don't think I would feel that they qualified their response. At the time they made their response they said they are taking certain actions, and the actions they described I would say were the first step necessary to actually make something happen differently. So, being GAO, we always maintain a certain healthy skepticism that this is actually going to move forward in the way it needs to, but it was certainly a positive first step.

Mr. SHAYS. What I'm going to do is do 5 minutes, then roll over for the next 5.

I missed that last sentence, I'm sorry, that last part.

Ms. KINGSBURY. The point I'm making, sir, is that they did concur explicitly with each of our recommendations. Then they described the steps that they were going to take. The first step that they were going to take, referring it to the Joint Planning Council or whatever. As I say, we will be happy to watch and make sure that something comes from that first step.

Mr. SHAYS. What I get a sense of is there's an obvious concern—I had one. I had a concern that they agreed with the criticisms, but there wasn't a sense of time line or when certain things would actually take place.

Ms. KINGSBURY. That's correct, sir.

Mr. SHAYS. You had—basically, the GAO recommended the SECDEF, which is—what is that?

Ms. WARD-ZUKERMAN. Secretary of Defense.

Mr. SHAYS. For EF? Oh, Secretary of Defense—"address the gap between the stated CB threat and the current level of medical readiness by clarifying the Department's expectations regarding medical preparation for CB contingencies and, as appropriate, by directing the Joint Staff to integrate biological medical readiness in DPG."

And again DPG is——

Ms. KINGSBURY. Defense Planning Guidance.

Mr. SHAYS. That's the key document.

Ms. KINGSBURY. Yes.

Mr. SHAYS. DOD responds, concur. It says, "As the coordinating body with the services and the CINCs on issues of this nature, the Joint Staff will be requested to conduct a reexamining of CB medical training issues and provide suggested adjustments to enhance the DOD's medical readiness posture."

What does that say to you?

Ms. KINGSBURY. That says they're going to look at the issue again. It does not say what solutions they expect to come out of it.

Mr. SHAYS. OK. The second recommendation—if you just look at DOD's response and tell me what you think that's saying and if you're satisfied with that.

Ms. KINGSBURY. Well, again they're going to—they've asked the Joint Staff to address the issue of what the steps are that are going to be taken to actually get a Common User Data base established. It is not evident from this response.

Mr. SHAYS. So on the second DOD response you would want to know what steps they're going to take.

Ms. KINGSBURY. Yes, sir.

Mr. SHAYS. OK. The third one.

Ms. KINGSBURY. Oh, let's see——

Mr. SHAYS. They basically are agreeing, and we just need to know now what "agree" means.

Ms. KINGSBURY. Well, in this response they do cite certain NATO standardization agreements which are certainly steps in the right direction of this effort. But there's a great deal that needs—I would say there's a great deal that needs to be done here in terms of the planning models and so forth that don't at the moment explicitly account for chemical and biological needs except very roughly.

Mr. SHAYS. Let me just read on the next page. It says, "However, if the GAO recommendation pertains to the evacuation, EVAC, policy, DOD non-concurs."

So here we have a non-concurs. So what does it relate to?

Ms. WARD-ZUKERMAN. I think that the response that DOD gave made reference to evacuation policy, but it was our sense that the real disagreement was about evacuation capability. The Army officials specifically indicated to us that they had developed a medical force structure adjusting for the fact that they were skeptical about the actual evacuation capabilities that would be available when needed. Their response basically talks about evacuation policy which there is a policy that's written on paper that, you know, that is agreed. But the issue is more——

Ms. KINGSBURY. Implementation.

Mr. SHAYS. On recommendation 4, "the GAO recommended that the services develop CB medical training requirements and assess the effectiveness of training with rigorous proficiency metrics and standards."

What do you feel their response is there? And what's——

Ms. KINGSBURY. Well, again, it's been referred for further development, and the proof is in the pudding. The implementation of these—the actual existence of proficiency tests is what we would ultimately look for to see whether that recommendation was carried out. We would not conclude that it was until we began to see some of that——

Mr. SHAYS. OK.

Ms. KINGSBURY [continuing]. In practice.

Mr. SHAYS. When you get a concurrence, do you then in your documents respond to the concurrence? In other words, I'm kind of puzzled why we wouldn't go the next step and say the things that specifically they need to do some kind of time line to do it.

Ms. KINGSBURY. Well, we certainly continue to follow what they do. I think as a general matter, unless we have done specific work that points to a particular solution to a problem of this sort, we would not substitute our judgment for the agency's or the service's about how best to do it. We believe that's their responsibility. We would look to see what they did and whether it met either the spir-

it or the literal meaning of our recommendation, and we do track these over time.

Mr. SHAYS. The GAO recommendation 5, "The GAO recommended that the services develop and maintain information management systems to monitor completion of required CB training and track the proficiency of medical personnel, at least for the first responders and key personnel in high risk areas of operations."

Then they say they concur. How did you respond to their concurrence?

Ms. KINGSBURY. Well, they concur with the suggestion which in principle I would not disagree with which is that it might be better to actually track proficiency itself, rather than tracking training. Training is, at best, a surrogate for proficiency. If they could develop a system to actually track the proficiency of medical personnel, that would be, in fact, a better solution. That is, in our experience, probably harder to do.

Mr. SHAYS. Let me just say, for DOD's benefit here, I would love when they—and would expect that they will expound on the DOD response and give us some kind of sense of what's required and time lines of some kind, not obviously by month but give us a sense of what it's going to take to do these things.

The last one, "The GAO recommended that the Joint Staff, CINCs and services increase the realistic exercise of medical support to a level commensurate with current CB threat assessments. To the extent there is a threat of mass casualties, exercises should explore the limits of medical capabilities and the full consequences of the scenarios that overwhelm them."

What about this one?

Ms. KINGSBURY. Well, as I said earlier, we are concerned that, as we look at the conduct of exercises, that the exercise of the medical piece, particularly in the chemical and biological scenario, is rarely, if ever, addressed. And when we ask why we are often told it's because it's such a big piece of it and would get in the way of achieving the other objectives of the training.

I certainly can be sympathetic to that, but that implies that if it actually happens you couldn't deal with it, and I think if we are going to be truly prepared we would have to have some knowledge of at what point is this manageable with great effort and at what point is it not and is there anything we can do about that. Recognizing that this may be a low probability event in the overall scheme of things, it is a very high consequence of that. It seems to us that some real exercises need to be done.

Mr. SHAYS. I want your definition of low probability. Not that there would be chemical and biological attacks but they'll be massive, that they're low probability. It's not low probability that there will be an attack.

Ms. KINGSBURY. Relative to being shot at I expect it's a lower possibility, but it's perceived as higher now than before.

Mr. SHAYS. Is there—you've done an assessment——

Ms. KINGSBURY. I don't know what the actual probability is. The current threat assessments tend to describe it as a low probability, low consequence attack. That's the only place we would draw that conclusion. We're not making an independent assessment of that.

Mr. SHAYS. You didn't really look at the probability.

Ms. KINGSBURY. No, sir. We just looked at what the threat assessment said.

Mr. SHAYS. Because I just want to make sure that you're not kind of giving credibility to something I think is not true.

Ms. KINGSBURY. I would not want to do that, sir. Thank you.

Mr. SHAYS. The bottom line is you made an assumption, if there was an attack, how could we respond to it. You did not look at the threat assessment.

Ms. KINGSBURY. Well, we looked at it. We did not make an assessment of it. But I am reflecting what we were told by the people who were responsible for conducting exercises about why they did not include these scenarios in the exercises. Those descriptions were a part of those discussions.

Mr. SHAYS. Mr. Kucinich.

Mr. KUCINICH. I want to go back to something you said a moment ago that implies if it happened we wouldn't be able to deal with it. What do you mean? If what happened?

Ms. KINGSBURY. If we actually had an attack that resulted in mass casualties in the battlefield.

Mr. KUCINICH. What do you mean we wouldn't?

Ms. KINGSBURY. At this point we don't know whether we would be able to deal with it, because it has not been exercised. The people who do the exercise believe it can't be dealt with. I'm talking mass casualties here.

Mr. KUCINICH. I understand that. And today in the front page of the L.A. Times President Bush is quoted as saying the threat is that terrorists also want chemical and germ weapons, President warns, as he tries to rally support from abroad. And in the article it says that the President had not previously raised such a concern in public, that the terrorist network is seeking weapons of mass destruction.

Now, in this context which we're in, maybe not when you first started your report, we've got to look at this current context.

Ms. KINGSBURY. I completely agree with that, sir.

Mr. KUCINICH. We are in a conflict now.

Ms. KINGSBURY. Yes, sir, we are. And those weapons are probably out there.

Mr. KUCINICH. For the first time we have a President saying publicly that terrorists are trying to obtain nuclear, biological, chemical weapons; and we have the GAO saying that the Department of Defense does not have a structure in place to protect the health of the troops essentially, if I read your report correctly.

And I see from other reports, Mr. Chairman, that there's questions about whether enough vaccines are available from the private sector. There is even discussion in the government going on right now about the government itself being involved in the production of vaccines.

Now, this isn't the question you have to answer, but it's a question I want our friends from the military to get ready for, and that is, under these circumstances, how could the military possibly recommend a ground assault in Afghanistan where our men and women could be exposed to a biological or chemical weapons attack

and not have structures in place to make sure that they have some protection?

This is a very serious issue here. The context has changed from when this report first began to be worked on. And, you know, I think that we have to remember back in World War I when soldiers were met with mustard gas, they had no idea of how to deal with it. You know, the gas mask came up but still there were people dying in the trenches.

We need to be very—I think this issue that is brought to this committee of a low-probability, high-consequence effect needs to be looked at more carefully. Because if the probability increases, that means that the consequences have to increase commensurately.

So I appreciate the Chair calling this hearing. But we need to look at the very severe implications of this for not only the health care infrastructure of the Department of Defense but the linkage to military strategic analysis, planning and initiation. Thank you.

Mr. SHAYS. If the gentleman would let me followup before Mr. Putnam, you may want to followup because I may be qualifying your concern. But I want to make sure you looked force wide, correct?

Ms. KINGSBURY. Yes, sir.

Mr. SHAYS. So, you know, my recollection when I have had the opportunity, as this committee has a great opportunity to do, to be out in the field with some of our special forces, they do have capabilities that would not be force wide; and I think that we'll be able to address that later.

But your statement, if this were an all-out attack with lots of people, we'd have some real challenges. But I think, frankly, that if the numbers are small, we have that limited capability to do it.

Mr. KUCINICH. If I may, Mr. Chairman, I'm just making my statement and analysis from what's presented on the record, not from any secret information I have.

Mr. SHAYS. It's not that this report—and that's what I want to clarify. This report was a report done based on looking at the entire services. You didn't look at any specific, specific unit or did you?

Ms. KINGSBURY. No, in this work we did not. We've had other work in the past where we have.

I think it's also important to recognize in this report we only looked at how they do planning for medical resources and how they train for responding to these kinds of events. We did not look at equipment and things of that sort as a part of this work.

Mr. KUCINICH. If the Chair would just permit me to make this observation, and that is it has been broadly stated and reported in the media that the use of ground troops in Afghanistan has not been ruled out. So that's why I raise the issue. I thank the Chair.

Mr. SHAYS. I think it's very important to make that point.

Is it your intention to stay while we have the testimony of our second panel?

Ms. KINGSBURY. I'm at your disposal, sir.

Mr. SHAYS. I would welcome that. It may be that we would want you to just respond or add some clarification.

In your statement which, as I said, was short and to the point, you attribute the lack of systematic evidence to several factors, in-

cluding failure to establish chemical and biological readiness as a medical priority to defense planning guidance. There's no dispute about that. That hasn't been done. Data methodology constraints that complicate the task. Just elaborate what you mean by that.

Ms. KINGSBURY. Well, the whole question—I mean, there are models that are used and we haven't looked at them in depth to make a determination about what kinds of medical resources are needed in the various services and in the various scenarios. And the data to support those with respect to—certainly to biological and chemical areas has never been developed because they haven't actually had any experience on which to develop them. So it's a very rough kind of order of magnitude kind of analysis that goes into adding and factoring in chemical and biological.

Mr. SHAYS. Disagreements among the services about capacity to implement evacuation policy. If you could just elaborate, give it some color, so we know how to ask the—our three branches what that means. I mean, can you give me some example?

Ms. KINGSBURY. One service, if they're on the ground like the Army, needs to make certain assumptions about how many people who are casualties can be evacuated by forces provided by another service, for example, the Air Force. And those assumptions, when written in planning guidance, the officials that we met with told us that they did not believe that capacity would actually be delivered when it was implemented. So the guidance says that it will be there, but there is differences of opinion among the warfighters and the medical folks about whether that would actually happen.

Mr. SHAYS. Pessimism that medical personnel could effectively treat substantial numbers of chemical and biological casualties. In other words, even if they had a plan or because they don't? In other words——

Ms. KINGSBURY. Certainly because they don't. And, again, the way you work these things out is in planning for exercises and the like. And if you look at the possibility of an exercise and mass casualties, I think the people involved in it reach conclusions that they can't do it and it would stop the exercise. My own reaction to that is, yes, and it would stop the battle, so you really ought to think about it. But I think that's why we raised the issue in that way. It's such a big problem and everybody understands it to be a very big problem, almost so big that there haven't been the resources to try to understand it well enough.

Mr. SHAYS. And probably the thought that it wouldn't have to because people wouldn't cross that red line.

Ms. KINGSBURY. Right.

Mr. SHAYS. Which we know after September 11th there is no red line.

Ms. KINGSBURY. Doesn't appear to be.

Mr. SHAYS. No, there is no red line.

On page 3, you said, even medical personnel who had been trained could not be readily identified in the event of an emergency because tracking systems either do not exist or are not currently functioning. Thus the availability of trained personnel in a given situation is uncertain.

What we learned with the Gulf war is there were very few people in the Department of Veterans Affairs and DOD that dealt with

hazards—dealt with what toxic material that you would deal with in the workplace, and so there weren't a lot of people who had specialties. In fact, there were only—out of over 2,000 there were only like 3. And it was so stunning that it was almost incomprehensible. You couldn't comprehend it. But what you're saying is, if you have medical personnel who are trained, we don't really know where they are right now.

Ms. KINGSBURY. That's correct.

Mr. SHAYS. OK. Within the system.

Ms. KINGSBURY. That's correct.

Mr. SHAYS. Let me do this—do you have another question?

Mr. KUCINICH. No.

Mr. SHAYS. I think that your recommendations are on the record. We know what their response was. Your comment would be that they agree with the recommendations. It's really a question of what agree means. In other words, how they go about implementing the recommendations, what kind of time line they're on and so on.

Ms. KINGSBURY. And what kind of priority it has, yes, sir.

Mr. SHAYS. Well, we're going to try to give it a high priority. But I honestly don't think we need to. I think it was a real wake-up call from hell on September 11th. So thank you very much, and we'll look forward to maybe calling you back and, if we do, you have still been sworn in so we'll just remember that. Thank you.

We'll go to panel No. 2. We have one testimony from Dr. William Winkenwerder, Assistant Secretary of Defense for Health Affairs, Department of Defense; accompanied by General Paul K. Carlton, Jr., Surgeon General, U.S. Air Force; General James B. Peake, Surgeon General, U.S. Army; and Admiral Donald C. Arthur, Jr., Deputy Surgeon General, U.S. Navy.

We would welcome you to stand and swear you in. Then we'll take testimony.

[Witnesses sworn.]

Mr. SHAYS. Note for the record all four of our witnesses have responded in the affirmative.

I want to say again from the outset that what we're ultimately all interested in is how we deal with the recommendations given, that you concur with them. And we want to understand the implications. We want to know what kind of task this represents for the military and how we can be helpful in getting you to a position I know you all would like to be in. And also, candidly, the implication of what Mr. Kucinich raised as well.

So what we're going to do, Doctor, is take your testimony, and we'll roll over the clock, and invite all of you to respond to the questions. So thank you for being here.

STATEMENTS OF WILLIAM WINKENWERDER, ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, DEPARTMENT OF DEFENSE, ACCOMPANIED BY LT. GENERAL PAUL K. CARLTON, JR., THE SURGEON GENERAL, U.S. AIR FORCE, DEPARTMENT OF DEFENSE; LT. GENERAL JAMES B. PEAKE, THE SURGEON GENERAL, U.S. ARMY, DEPARTMENT OF DEFENSE; AND READ ADMIRAL DONALD C. ARTHUR, JR., DEPUTY SURGEON GENERAL, U.S. NAVY, DEPARTMENT OF DEFENSE

Mr. WINKENWERDER. Chairman Shays and distinguished——

Mr. SHAYS. Is the mic on?

Mr. WINKENWERDER. OK. Chairman Shays and distinguished committee members, thank you for inviting me to appear today before your committee.

I'm Dr. William Winkenwerder, Assistant Secretary of Defense for Health Affairs. Today I'm going accompanied by the Surgeons General from the Air Force and the Army and the Deputy Surgeon General of the Navy.

I have already submitted a written statement, but with your permission I would like to make a brief opening statement.

As we all know, the perception of threats posed by nonconventional weapons has changed dramatically——

Mr. SHAYS. If you tilt this, bend this up. Like this. So you don't talk straight in.

Mr. WINKENWERDER. Is that OK—has changed dramatically in the last 8 weeks. As our Nation addresses this threat, DOD plays a supporting role to civilian authorities where we have the capability to do so. The Department is working closely with Federal partners for homeland and defense matters.

DOD is the primary Federal agency responsible for administering the national disaster medical system and sharing responsibilities with the Department of Health and Human Services, FEMA and the VA. We have many capabilities that can be used in support of civilian agencies to assist in both the prevention and the management of chemical and biological attacks, and these DOD assets have been used extensively in the current response to the domestic anthrax attacks.

Our focus, however, has been and continues to be our men and women in uniform, not only because their medical readiness is a critical aspect of the success of any military operation but also because they are the most important asset. I can tell you without equivocation that this is my No. 1 priority as Assistant Secretary of Defense for Health Affairs.

Since coming to this office just 2 weeks ago, I have begun to review our medical readiness training programs. It is clear to me that a solid foundation has been laid, much good work has been done in the past few years, but clearly we can do better. And I want to emphasize this, the threat is no longer theoretical. The events in the past 2 months have shifted priorities. Indeed, my mandate from Secretary Rumsfeld and Under Secretary Chu is clear, we will focus on a deliberate but accelerated process for improving our medical readiness training programs across the board to meet chemical and biological threats. Secretary Rumsfeld identified this requirement and this issue of asymmetric threats in his

Quadrennial Defense Review as he has moved the Department from a threat-based planning model to a capabilities-based model.

I will work closely with the Surgeons General to identify areas of concern and address those issues directly now.

I will outline some of the actions we plan to undertake in the Department, but first I want to identify those areas in which we already have made significant progress.

In recent years the military health system has placed increased emphasis on chemical and biological readiness. Training has increased at all levels, from individual training to the unit level. The military services have developed numerous training courses and other resources focused on the medical response to chemical and biological events.

The courses that the Department has conducted on training materials that have been distributed have been broad and substantive. We have provided educational opportunities at every skill level within the range of our medical personnel, from junior enlisted to speciality physicians. These training methods vary from in-house, multi-day courses, abbreviated exportable courses, live and rebroadcast satellite courses, Web-based courses, printed manuals, newly printed manuals and handbooks that outline chemical or biological casualty management. With the added emphasis on domestic response, both military and civilian health providers have also attended these courses, I might note.

Additionally, the Uniform Services University at the Health Sciences has robust and longstanding educational programs in the medical aspects of chemical and biological terrorism developed for our military medical students and graduate students. The university is now actively involved in adapting these programs to the civilian medical education community in both traditional and interactive Web-based formats. In this regard, I believe the value of our military medical educational institution is a national asset and a national leader in the development of education in the area of biological and chemical terrorism.

It's very appropriate that this committee ask where we are in the Department with respect to medical readiness training in the areas of responding to chemical, biological or nuclear threats. In my view, the goal of the military health system should be to ensure all medical personnel receive appropriate training commensurate with their medical skill level and that all necessary medical planning and exercises have occurred that will ensure our personnel are ready.

Since my swearing in 9 days ago, I have begun reviewing the basis upon which our military medical readiness plans have been constructed, the medical infrastructure needed to accomplish our mission, training requirements of the total medical force, active and reserve officer and enlisted, and the means by which we monitor and evaluate the training we provide.

The General Accounting Office's report is helpful. I believe it provides a road map of many actions that I and the Surgeons General and others will undertake expediently to improve our ability to respond to these acts of terrorism.

From my perspective, there are three main prongs related to medical preparedness for chemical and biological attacks: prevention, detection and response to the attack.

Prevention of disease remains the preferred course in any aspect of health care delivery. It's especially true in considering the consequences of chemical and biological warfare. With anthrax as the current biological threat and cause of disease in our citizens, DOD and the services have taken precautions for the men and women in uniform. We have ensured that both adequate supplies of antibiotics and proper guidance are available to the deployment forces.

Additionally, the Department also initiated an anthrax vaccine immunization program, as you know, to provide our service members with protection against this particular type of attack. I will be reviewing this program to ensure that it is effective for its stated goal.

The detection of a chemical and biological attack requires the logistical element of equipment and emerging technology that the Department has aggressively pursued. Detection also encompasses the medical expertise required to identify signs and symptoms at an early stage of an attack, particularly a biological event in which the awareness of the attack could be delayed for days or week.

Finally, proper medical response to an attack is essential for minimizing casualties and for sustaining our ability to fight the war. We must ensure that we have the right people to perform these missions, that these people are trained and that we know specifically who is trained at what level. To address this matter, my office and the Offices of the Surgeon General and the Joint Chiefs of Staff have already undertaken a number of initiatives.

First, let me outline that we will be conducting a comprehensive review of current chemical biomedical training, and I'm here to tell you that we will be making some level of training mandatory at all levels. If we can make mandatory training on sexual harassment, we can make this kind of training mandatory which, obviously, is of high importance.

Second, we will be standardizing medical response protocols across the services.

Third, we will be enhancing medical planning tools to include development of a Common User Data base to enable the services to conduct medical planning for contingencies involving weapons of mass destruction.

Fourth, we will be ensuring that future training and exercises include greater medical play and providing challenging and realistic scenarios that adequately assess the capabilities of our medical units to function in a chem/bio environment.

Additionally, DOD will be developing a tracking system to monitor the training and the proficiency of health personnel to function in a chem/bio environment.

Taken together, I'm confident that these actions will result in a military health system better prepared to support our military men and women in the coming months and years ahead.

I want to thank you for the opportunity to appear today. I appreciate the committee's commitment to our service members and look forward to working together to keep their safety and protection our first priority. I look forward to answering any questions you might have at this time.

Mr. SHAYS. Thank you.

[The prepared statement of Mr. Winkenwerder follows:]

CHEMICAL AND BIOLOGICAL DEFENSE:
Medical Readiness

STATEMENT BY
Honorable William Winkenwerder, Jr.
Assistant Secretary of Defense for Health Affairs

Submitted To
HOUSE COMMITTEE ON GOVERNMENT REFORM
SUBCOMMITEE ON NATIONAL SECURITY, VETERANS AFFAIRS, AND
INTERNATIONAL RELATIONS

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INTRODUCTION

Chairman Shays and Distinguished Committee Members, thank you for inviting me to appear before your Committee today to address your questions on the Department of Defense's (DOD) Chemical and Biological Defense Medical Readiness posture. I am William Winkenwerder, Jr., Assistant Secretary of Defense for Health Affairs. Today, I am accompanied by Lieutenant General James B. Peake, Surgeon General for the United States Army, Rear Admiral Donald Arthur, Deputy Surgeon General for the United States Navy, and Lieutenant General Paul K. Carlton, Surgeon General for the United States Air Force. At your request, our testimony discusses the capability of the Military Health System to support military personnel in the event of a chemical or biological attack.

THE THREAT

The United States' perception of the threats posed by chemical and biological agents has changed dramatically in light of recent events. Since September 11th and the multiple anthrax attacks, terrorism's potential to cause loss of life, disrupt missions or activities, and instill fear in daily life has been clearly demonstrated. Terrorism, specifically chemical and/or biological terrorism is an immediate threat to our security both here at home and abroad. As our nation addresses this threat to our homeland, DoD supports civilian agencies where we have the capabilities to do so. First, however, we must ensure the fitness and readiness of our men and women in uniform. That responsibility includes having our military medical personnel trained and knowledgeable in the management of biological and chemical casualties.

CHEMICAL AND BIOLOGICAL MEDICAL TRAIINING

In recent years, the Department of Defense has increased emphasis on chemical and biological (C/B) readiness in response to the heightened threat of C/B weapons of mass destruction. Training has increased at all levels—from the individual to large units -- both medical and nonmedical. We have also increased C/B medical training for health care providers. The Military Services have developed numerous training courses and other resources focused on medical response to chemical and biological events. Their leaders actively use these resources in preparing their medical personnel for handling C/B casualties. Some of the courses and publications include:

- "Medical Management of Chemical and Biological Casualties Course" (MCBC). A six and a half-day course focused on the potential threat of chemical and biological weapons, and the status and extent of preventive and treatment countermeasures available. Since Fiscal Year 1997, over 7,800 military health care professionals from all services completed the course.

- "Field Management of Chemical and Biological Casualties Course" (FCBC). A five-day course that provides detailed training in the initial management of chemical and biological agent casualties. This course is also an exportable 3-day on-site course. Since Fiscal Year 1999, over 1,700 officers and enlisted personnel have been trained from all Services.

- Satellite training courses.
  - "Biological Warfare and Terrorism: Medical Issues and Response" developed in collaboration with the Food and Drug Administration in 1997 and broadcast to over 9,000 military and civilian health professionals and first responders at 500 sites across the United States. Since then, over 22,000 military personnel have completed the course.
  - "The Medical Response to Chemical Warfare and Terrorism" developed in collaboration with the Food and Drug Administration and broadcast in 1999, and again in 2000 to over 5,500 military health care professionals.
  - "Biological and Chemical Warfare and Terrorism: Medical Issues and Response" will air live on November 28-30, 2001 with a taped rebroadcast scheduled for December 8-9.

- Handbooks and field manuals that provide guidance to health care providers for managing and treating C/B casualties include:
  - Medical Aspects of Chemical and Biological Warfare published in 1997 as part of the Textbook of Military Medicine series.
  - "Treatment of Biological Warfare Agent Casualties" was published in July 2000, as a quad-service field manual. This publication serves as a guide and a reference for health care personnel on the recognition and treatment of biological warfare casualties.
  - "Medical Management of Biological Casualties Handbook" and "Medical Management of Chemical Casualties Handbook", two pocket-sized handbooks designed to fit in the battle dress uniform (BDU) pockets, provided to health care personnel as references in the management of C/B casualties.

These publications and other medical C/B defense references and information are available on easily accessible websites.

Our Uniformed Services University of the Health Sciences has robust and long-standing educational programs in the medical aspects of biological and chemical terrorism developed for our military medical students and graduate students. The University is now actively involved in adapting these programs to the civilian medical education community in both traditional and interactive web-based formats. The University works closely with other federal agencies, the private sector, and the Association of American Medical Colleges and the American Medical Association to accomplish these important and timely

educational goals. Finally, the University will be a major contributor in the Association of American Medical Colleges' "Health Education Coalition on Bioterrorism" conference later this month.

MEDICAL SUPPLIES

Prevention of disease remains the preferred course in any aspect of healthcare delivery. It is especially true in considering the consequences of chemical and biological warfare. Antibiotics are powerful tools in the battle against diseases caused by biological weapons. With anthrax as the current biological threat and cause of disease in our citizens, DoD and the Services have taken precautions for the men and women in uniform. We have ensured that both adequate supplies of antibiotics and proper guidance on their use are available to deployed forces. This guidance has been published since March 1998, when the former Assistant Secretary of Defense for Health Affairs (ASD(HA)) issued a memo, "Policy on Issue and Use of the Antibiotic Ciprofloxacin for the Post-Exposure Treatment of Anthrax." This memo provided the recommended dosages for both ciprofloxacin and doxycycline to be used in the event of an anthrax attack.

The former Assistant Secretary subsequently issued a memo (14 July 2000) directing the Services to review their post-exposure procedures and to advise the ASD(HA) on the quantities of antibiotics on hand. The memorandum provided the latest literature references and websites on the medical management of post-exposure anthrax.

Our current Policy on Prophylaxis and Treatment for Anthrax Exposure, issued on October 19th of this year, includes direction for our providers to prescribe antibiotics in accordance with the Centers for Disease Control and Prevention guidelines.

The former Assistant Secretary requested that the Armed Forces Epidemiological Board (AFEB) provide recommendations on the most appropriate antibiotics that would be indicated for the treatment of six biowarfare threats: anthrax, plague, tularemia, brucellosis, glanders and Q-fever. The AFEB provided a matrix of the six agents, and the antibiotics of choice for post-exposure prophylaxis and treatment. In many cases, the countermeasure recommended by the AFEB had not yet been approved by the FDA for this intended use. The former Assistant Secretary met with a representative of the pharmaceutical industry association and asked the Association to work with the manufacturers of these items to see if the manufacturers would work with the FDA to get the products approved for the indications recommended by the AFEB. The Department has discussed this with The Department of Health and Human Services and Centers for Disease Control and Prevention. The Department will continue to work with and encourage pharmaceutical manufacturers to work with the FDA to get as many indications approved as appropriate to provide the maximum options possible for post-exposure prophylaxis and treatment of biowarfare agents.

SUMMARY DOD RESPONSES TO THE GAO REPORT

The Department's bioterrorism program, including the medical readiness aspects, is one of its most studied, reviewed and examined. The General Accounting Office has recommended that clarification of the Department's expectations for chemical/biological contingency medical preparedness is needed. We agree with their assessment and have begun to make improvements.

In some of the many initiatives we are undertaking, DoD doctrine for biological warfare defense has contributed to an approach to defense against bioterrorism.

- Establishing a more effective and timely medical response to a Chemical/Biological (C/B) attack and conducting a comprehensive review of current C/B medical training.
- Requiring the Joint Medical NBC Defense Readiness Working Group play a key role in standardizing medical response protocols across the Services.
- Enhancing medical planning tools, to include development of a Common User Database to enable the Services to conduct medical planning for WMD contingencies.
- Ensuring that future training and exercises include greater medical play and provide challenging and realistic scenarios that adequately assess the capabilities of our medical units to function in a C/B environment.

Additionally, the TRICARE Management Activity will develop a tracking system to monitor the training and proficiency of health care personnel to function in a C/B environment.

NATIONAL DISASTER MEDICAL SYSTEM

As you know, we work closely with the Department of Veteran's Affairs (VA) to provide a contingency hospital bed capability. These plans are also supplemented by the National Disaster Medical System (NDMS). This robust bed expansion capability will be activated subsequent to a war or national emergency requiring more than the combined resources of the DoD and VA. This joint Federal, State, and local mutual assistance organization provides a coordinated medical response in time of war, national emergency, or major domestic disaster resulting in a mass casualty situation. Patients are evacuated to designated locations throughout the United States for care that cannot be provided locally. They are placed in a national network of hospitals that have agreed to accept patients in the event of a major disaster. DoD is a primary Federal agency responsible for administering the NDMS. Other agencies sharing responsibilities with DoD include the Department of Health and Human Services (DHHS), FEMA, and the DVA. NDMS may be activated by the Assistant Secretary of Defense for Health Affairs in support of military contingencies when casualties exceed the combined capabilities of the VA/DoD Contingency Care System. The Assistant Secretary of Health (DHHS) may activate NDMS in response to a domestic conventional disaster. Under the latter

circumstances, DoD components, when authorized, will participate in relief operations to the extent compatible with U.S. national security interests.

The success of this joint venture was demonstrated immediately following the September 11th attack on the World Trade Center Towers and the Pentagon. In anticipation of receiving casualties, the Secretary of Health and Human Services activated NDMS whereupon both VA and DoD began to report bed availability to the Global Patient Movement Requirements Center (GPMRC) located at Scott Air Force Base, Illinois. However, there were no casualties evacuated as a result of this tragedy, as local resources were sufficient to handle health care commitments.

DoD CAPABILITIES

I noted earlier that we have many capabilities that can be used in support of civilian agencies to assist in the aftermath of a chemical or biological attack. These assets include; but are not limited to:

- The WMD Civil Support Teams (WMD-CST). Full-time National Guard teams that provide advice and assessment for State and local responders.
- The Marine Corps Chemical Biological Incident Response Force (CBIRF). Unit is tailored for short notice decontamination of chemical and/or biological agents.
- The Army Technical Escort Unit (TEU). Unit is trained in chemical, biological and explosive ordinance disposal.
- The Army Medical Command Special Medical Augmentation Response Teams (SMART). Small teams organized to advise on C/B medical management, epidemiology, medical communications, preventive medicine, and more.
- The Army Medical Research Institute of Infectious Diseases (USAMRIID). Develops vaccines, drugs and diagnostics to protect U.S. military personnel from biological warfare agents.
- The Navy Medical Research Center (NMRC). Maintains biological diagnostic capability. Developed the "fly-away" portable biological agent diagnostic kit, used for United Nations' inspections, among others.
- The Air Force Civil Engineering Readiness Flights (NBC). Has the capability for chemical survey, monitoring, and mitigation.
- The Army Medical Research Institute for Chemical Defense (USAMRICD). Conducts applied research on the pharmacology, physiology, toxicology, pathology and biochemistry of chemical warfare agents.
- The Armed Forces Radiobiological Research Institute (AFRRI). Conducts applied research on the pharmacology, physiology, toxicology, pathology and biochemistry of chemical warfare agents and radiation threats.

CONCLUSION

Our focus has always been and continues to be our men and women in uniform. Medical readiness is a critical aspect of the success of any military operation—and the people they treat are our most important asset.

Thank you for the opportunity to appear before you today; we appreciate the committee's continued commitment to all our service members and look forward to working together to keep their safety and protection our first priority.

Mr. SHAYS. We'll start with Mr. Putnam.

Mr. PUTNAM. Thank you, Mr. Chairman.

Dr. Winkenwerder—did I say that correctly?

Mr. WINKENWERDER. Winkenwerder, that's correct.

Mr. PUTNAM. This is a whale of a 2 weeks for to you have started out in this position.

Mr. WINKENWERDER. An incredible time to arrive.

Mr. PUTNAM. We appreciate your presence here and your commitment to improving the level of quality of care in the health services.

According to the GAO report, between 1996 and 2000, you had over 1,300 service medical personnel take your 6½ day course. Your testimony says that, since 1997, 7,800 personnel have taken that course. Is there—how do you explain that disparity?

Mr. WINKENWERDER. Well, I would say that, due to the short notice that we had, that certainly is nobody's fault. In preparing for this hearing, the written remarks that were provided to the committee did omit a number of important preparedness activities and programs that have been undertaken by all three services in the past few years and some in just the past few months and weeks. That's why I was very much pleased that you've allowed me to have my colleagues here, the Surgeons General, to talk about some of those, that there have been more people trained than was——

Mr. SHAYS. Can you move your mic a little further away? Move it back away from you a little bit.

Mr. WINKENWERDER. There have been more people trained than has been indicated. I don't want to suggest that in my response that enough people or all the people that we want to be trained have been trained. But the numbers are something better than has been provided, and we would—thank you—and we would be glad to provide those numbers to you.

Mr. PUTNAM. OK. I would certainly appreciate that. But you're standing by at least 7,800.

Mr. WINKENWERDER. Yes.

Mr. PUTNAM. OK. You also said that 19 percent of the uniformed health service personnel have completed the specific chem/bio training and not more than a little over 2 percent of medical officers have completed the full 6½ day course and then those who have been through it we don't really have any way to track where they are to get them in a hurry. How are we addressing that issue? Why aren't the uniformed health service personnel required to take a specialized course and what steps do you have in mind as you embark on this to bump that up and increase the number who will be exposed—excuse me—who will be trained for a chem/bio event?

Mr. WINKENWERDER. Well, just in a matter of the past few days I have requested the surgeons to develop a plan that would include the level of training and courses that we believe would be mandatory for all personnel. Obviously, one size doesn't fit all here. Our goal would not be to have everybody who's a military health care provider attend a 3 or 6-day course. We need to target the level of training to the particular kind of provider or professional. But, whatever that level is, we want to make sure that everybody has the training that they need to have.

Mr. PUTNAM. I guess the part about the raw numbers of this that is a little bit disturbing is that all of us on the civilian first response side probably slept pretty well at night prior to the 11th knowing that somebody out there on the military side had a large team of people equipped to deal with these types of scenarios. I think that we're finding that there weren't quite as many people out there as we may have previously thought. So to the degree what we can help you turn that around and share some of that knowledge and training with the civilian first responders would be very helpful.

And I see that my time is up.

Mr. WINKENWERDER. We would very much like to do that.

Mr. PUTNAM. I yield back the balance, Mr. Chairman.

Mr. SHAYS. Thank you.

Mr. Kucinich.

Mr. KUCINICH. Thank you.

Mr. Secretary, it was encouraging to hear your response to the GAO report in saying that you will train, you will help personnel to become more ready. At no time in your testimony have I heard you say that the Department of Defense is ready to protect its troops in the event of a biological or chemical weapons attack. Is that correct? You did not say that, did you?

Mr. WINKENWERDER. I believe that we are prepared to protect our troops.

Mr. KUCINICH. At this very moment you're saying that we're prepared to protect our troops. And how are we prepared to protect our troops?

Mr. WINKENWERDER. Well, Congressman, protection of the troops really is a multifaceted set of activities.

Mr. KUCINICH. I understand that.

Mr. WINKENWERDER. Let me just for everyone's information talk about that for just a moment. There's issues of intelligence and intelligence on the ground. There's issues of chemical and biological detectors, early detectors in the field where we can detect agents prior to their dispersal or at the time they might be dispersed. There is the issue of protective clothing and equipment. Training, obviously, we've talked about of troops and medical personnel, antibiotics, vaccinations. So there's a whole host of things.

I don't want to minimize some of the deficiencies that have been pointed out in the area of training and planning.

Mr. KUCINICH. I understand. It's good to hear that you're trying to address this, and I understand you've only been on the job for 9 days. This report questions the readiness of the Department of Defense, the medical readiness. You know, not whether you have intelligence on the ground, not whether you have chemical or biological detectors, but whether or not there is a medical readiness. As this report says, as a consequence of their study, they're saying medical readiness for CB scenarios cannot be insured.

And the reason why I'm focusing on this, you know, we have to get our time tense straight. We are ready, which means we're ready today, or we will be ready, which means some time in the future, that we're planning on this, we're thinking about it. But the difference is, if you have men and women in the field and they're

subjected to an attack, you can't tell them we will be ready. They need to know they are ready.

So, based on that, Mr. Secretary, would you at this moment, understanding the work that needs to be done, be ready to recommend that or even be asked whether circumstances exist which would be conducive to sending troops into the field in Afghanistan without the proper medical structure in place? Would you comment on that?

Mr. WINKENWERDER. Well, in the final analysis, we rely on our commanders in the field and on the Joint Staff, I think that has been pointed out, to make the determination of overall readiness. And that includes medical readiness. I think the events of recent weeks and the perception that possibly an enemy would be willing to use certain agents may have changed the threat assessment.

Mr. KUCINICH. We're on the same team here. We're working together. Because you want to make sure that the men and women who serve are going to be protected. I know that's true of all the officers who are here. That's your life's work. I understand that. It's our life's work, too.

I just want to make sure, though, that the political imperatives which may exist somehow mesh with the realities of the medical readiness. And I'm hopeful that the Generals and the Admiral here, that somebody in the command level at the Department of Defense is going to talk to you and then that somebody is going to go over this report before we start committing troops to an invasion of a country that, given the geography is tough enough, but the medical readiness, that's what I'm concerned about. I just want to make sure that if we send our sons and daughters over to Afghanistan in order to fight terrorists that they're not going to be injured and not have a structure in place to be able to help them. That's all.

And General——

General CARLTON. I just returned from down range and looked at the medical preparedness. I believe that we are in perfect harmony with your concerns. We've addressed every known factor that we will face. We've made our point. We have hardened facilities that are in the evacuation chain.

Again, raw numbers are confusing. When we say 2 percent of the medical providers have been trained, this is a 7-day train, the trainer course; and that's about right for the people that will train ours that deploy in harms way. We have a readiness skill verification program where we certify that people are prepared to go do what they will encounter in that environment. So all of these things have stood up.

Mr. KUCINICH. General, again we all understand what a different environment you're in. And again we're working together here. This isn't an adversary proceeding at all. Because we need to make sure that our men and women are going to be safe.

Now in this report here, Mr. Chairman, staff, just on page 10 of the report, I would ask the gentlemen at the table if you would refer to page 10 of the report, paragraph 2, the middle of the paragraph. It says, "Army Medical Department officials indicated both that they were not authorized to structure medical care for biologi-

cal contingencies and that battlefield CB scenarios causing mass casualties would overwhelm current medical capabilities."

So, you know, that's the purpose of this meeting, to discuss this report.

Again, as a Member of Congress, as a fellow American, I just want to express my concern that this discussion take place in the upper echelons of the Department of Defense before any decision is made to commit to ground troops. And the reason I'm saying that is that, if that decision is made, we want to make sure that all of the areas that are covered in this report are given careful consideration so we're not in a situation after the fact where somebody comes back to any one of you and says, now what do we do. And that's why we're all here listening to this right now.

But, you know, in a few weeks from now we could be learning of mobilization of troops to Afghanistan, and I just want to make sure that our men and women, that they and their families are assured that this government is going to do everything it can to make sure that those enlisted people would be protected as best as possible under the circumstances.

So I thank the Chair for giving me this opportunity. I want to thank the witnesses for the service that each of you gives to our country.

Mr. WINKENWERDER. I can assure you that it is and will be a top priority, that these matters that are in this report and the concerns will be reviewed at the highest levels.

Mr. SHAYS. Mr. Secretary, it's pretty amazing to come into a job in 2 weeks and have to present a response to a report before Congress; and I appreciate you being here.

I would welcome the participation of the rest of your panel as well in any of these questions. Because you all have been involved in this obviously a lot longer.

On page 9 of the report it talks about, under the subheading, that DOD and the services have not systematically reviewed the adequacies of the medical specialist mix for the treatment of CB casualties. And then it says, service methods for personnel planning do not specify the personnel required to manage CB casualties.

And, page 12, I want to read to you a long paragraph. I'd like all four of you to respond, if you will.

On page 12 it says, "While maintaining that the current specialty mix is generally appropriate to these emerging threats, service planners did identify additional skills that would be key to successful medical management of CB warfare casualties."

So, in addition to this whole issue of training people for 6 days, "some Army officials expected that chemical warfare readiness would require an increase in respiratory therapy, ward nursing, and internal medicine. Others noted that the Army did not have a lot of infectious disease experts in deployed hospitals for surveillance and prevention. Similarly, Air Force officials expected that chemical warfare scenarios would require more respiratory technicians, pulmonologists, critical care nurses and intensive care beds. They stated that the threat of biological warfare would increase the need for infectious disease and preventive medical personnel as well as personnel to collect baseline, predeployment data. Air Force

and Navy medical planners both anticipated that chemical scenarios would require more emergency personnel who could recognize and respond to symptoms quickly."

Although these informal assessments vary, they imply that the current speciality mix needed revision. I'd love you to respond to that, and then I'd like each of the branches to respond.

Mr. WINKENWERDER. Let me make two general points and then would like very much my colleagues to respond as well. I think with respect to chemical and biological weapons there are two areas that come to mind that we will need to review and look at with respect to the medical personnel mix and the numbers. One is infectious disease, and the second is in the area of pulmonary medicine and the support personnel because of the way the agents work, and those would be the areas that I would expect we will be looking at and reviewing to ensure that we've got adequate numbers and adequate mix deployed in proper locations, etc. And so with that, I'll turn it over to General Peake.

General PEAKE. Sir, we have a modular structure—all of us basically have a modular structure that can be added to or taken from. The bases in our hospital situation is a combat support hospital. We have the ability to bring modules, infectious disease, laboratory and so forth to add where we see that threat, where that threat exists and as the threat changes. We have what we call smart teams, special medical augmentation response teams that reside in our medical treatment facilities that include intensive care as an example. It includes epidemiologic expertise such as that we have loaned to HHS as they look at the Capitol Hill, as a matter of fact. Those teams are available to be moved into theatre if that were required.

We rely on the commander in chief of that theater who looks at the threat, who makes those assessments, and then our Title X responsibility is to provide him trained and ready folks to deal with that. Many of those folks get their training and experience in our military treatment facilities. There was a comment by Dr. Kingsbury about the dichotomy, sir, if you would, of the peacetime health care and the go-to-war health care. Well, those infectious disease folks are—they need to be at the top of their game in their field as an example.

So I think there is a translation there and we have quality people because of our ability to have that infrastructure that takes care of patients every day, and then added to that is their expertise that they get as military physicians. We are actually kind of proud of that 2-week course. We are proud of the fact that we push those courses out.

Mr. SHAYS. There is a big difference, though, between a 2-week course for your medics and your nurses and so on, and your doctors versus someone who has an actual specialty.

General PEAKE. Yes, sir. But the infectious disease folks that—I mean, we have folks that are infectious disease specialists just as—that work in our teaching programs, that work in our hospitals and they're the same folks that come out of that and deploy as part of these specialized teams or as an internist in one of our combat support hospitals. So we have—it's a leavening of the force of quality people of their solid basis of clinical medicine, and then in addi-

tion to that, as they go through the developmental process of an Army physician as an example, come into the Army basic course and they have training in MBC. Come back to the officer advanced course, and there's hours of training associated with that.

Mr. SHAYS. You attempted to answer my question or may have. I'm not sure I fully understand why some of what of you're saying relates to this specific issue, and that's probably my fault, not yours. But the bottom line, there seems to be disagreement among the different branches from this statement and it would be—first, I will come back.

Admiral, if you would just respond to the statement and let's see what we get, and then I will make my point.

Admiral. ARTHUR. Yes. Good morning. Thank you.

Mr. SHAYS. Good morning.

Admiral. ARTHUR. I agree with much of what General Peake has said. We have our operational forces, which are——

Mr. SHAYS. Move the mic a little closer, but not as close as the doctor had it.

Admiral. ARTHUR. Have we got it calibrated now? Great. Thank you. We're staffed to provide forces in response to our lines projected operational requirements, and we have just about as many people as we need to do that and not very much in excess. We have many operational courses that we use to train people who go with our operational forces. We have people who go with the surface ships and they get a 6-week course. The flight surgeons get a 6-month course. The undersea medical officers who do the diving and submarines go to a 6-month course, and the Marines have their own course of 4 weeks, and in each of these courses there are didactic segments which deal with chemical and biological, and there are varying lengths. These are mainly physicians that I'm talking about.

Mr. SHAYS. Yes. But with all due respect, what we are learning is that you really haven't—none of the branches have seemed to adjust to this new world environment. So you're telling me the courses that you have, but are we really focused on chemical and biological? And it appears that we're not. I don't see how we can say you are when you agree with every one of the points being made in the report, and then you're telling me we're doing it, and that's why I'm confused.

Admiral. ARTHUR. Well, we're not as prepared as we now know we should be, and I think that was one of the points that Dr. Winkenwerder made. We have been awakened by the September 11th incidents in that we have an area of vulnerability that we had not recognized was of such magnitude. I would say, though, that we have to perhaps temper the discussions with enormous difficulty in retraining the staff and equipment that would be required for an all-out response to this when they're basically unused for the majority of the time and in peacetime, with the tremendous pressure we've had to deliver the health benefit in an austere funding environment.

So it's very difficult to say let's have 100 more pulmonologists that we might need, and have the health benefit in some area go wanting.

Mr. SHAYS. See, the problem is a whole host of problems exist. Our committee has had all three commissions come before us and said no one is known, we have not made a proper assessment of the terrorist threat. They said we don't have a strategy to deal with the terrorist threat, and they say we're not organized as a government to maximize our ability to be as successful as we could with our resources.

So that's what they said to your government. We saw, sadly, the military mix, the terrorist threat and the military threat, and we're kind of confusing the two, it seems to me. I mean one of the things which still have some certainty is that you're more likely to have a chemical and biological attack if the person can disguise that they actually delivered it and not have to have retribution.

So now what we've done is we've said if a terrorist is moving forward and doing these acts, we're going to hold somebody we can identify, a country, accountable; so we are going to hold countries accountable. But we don't know because we haven't done the proper threat assessment, both in the military, frankly, and the civilian threat, the terrorist threat, but it's probably less likely that you would encounter chemical or biological from a military force unless they decided to commit suicide, which obviously is a possibility as well.

I guess where I'm coming down to, though, is that as a committee, we saw the military say everybody in the military had to have anthrax vaccine and we used it all up, and we only have less than 20,000 left, and then we have 5 million that's unapproved at BioPort, some of it before they did their plan, some of it after they'd done it; so that's kind of this mess we find ourselves in and what we're trying to sort out is—what I'm trying to first sort out is, I understand now that you are doing programs you didn't do in the past, your 5-day, your 6-day, your 7-day, I'm trying to understand the quote from the GAO's report where it says either medical personnel who have been trained cannot be readily identified in the event of an emergency, because tracking systems either do not exist or are not currently functioning, lest the availability of trained personnel given the situation is uncertain. I would like just the GAO to affirm, was that basically on identifying those in the 6-day courses, in the 7-day courses, or is it also meaning doctors with specialties?

Ms. WARD-ZUKERMAN. That was with respect to training courses.

Mr. SHAYS. I want you to just get to the mic. If she could do that.

Ms. KINGSBURY. That was just with respect to tracking the people who had attended the training.

Mr. SHAYS. OK. Just the training. So it's not an issue of being able to track those with specialties. Because unfortunately at the VA, they're unable to track people very easily with specialties, the Department of Veterans Affairs. We don't have that problem in our three branches as it relates to people with specialties?

General PEAKE. We can track people with specialties. Let me just comment on in terms of tracking the training. We would like to be able to do better with tracking training. Looking at that 6-day course as an example, this morning I said pull it up, I can identify 1,747 people, 672 docs, 112 general core officers, 508 nurses that have had that training. I can pull them out of the data base by

name. So I don't think I have captured all of them. I can tell you that. There are some data issues that——

Mr. SHAYS. The question is, though, can you get that out to the field?

General PEAKE. Yes, sir. We can pull them off of mods. There was——

Mr. SHAYS. OK. Let me just go to—but the specialty issue that, wasn't a claim from GAO. General Carlton, you wanted to make—you were doing a lot of writing. Either you wanted to make a comment or you wanted to just——

General CARLTON. Yes, sir. I'd like to make a couple comments. We have been focused for the last 6 years on terrorists, specifically biological and chemical, and we've invested heavily in them. Regarding page 12, we have something called the critical care transport team that can be a ground asset or an air asset. We have more than 200 such teams that we've identified more than 150 trained to be able to fill this specific requirement. We've thought it through. We can building block those in, as General Peake indicated to you, very early. We recently certified a level 4, which the most highly infectious disease problem for air vac use, a joint Air Force/Army discussion.

Before we send people to the field, we have a readiness skills verification program that is a check, and we certify that they are certified to deploy depending on their skill level. We've been working on that for several years now. Every one of our GME institutions gives us military unique training. To answer that second piece that we'd require more emergency personnel, we train the personnel to be able to do that. One or two infectious disease people cover a medical center currently. We have been training through those infectious disease people extensively, and actually have our premier course, which starts next week, which is called a hospital-focused approach to biological weapons and toxins. It's filled up immediately and has been for 6 months.

We've really been focused on these for a long time, and I believe that as you look at these, it raises a level of concern and our approach was, yes, we can do better, which is the reason that we concurred, but I don't want you all to leave with an impression that we have not focused on this, and we are ready at this time for the expected illnesses in the bright percentages. If somebody threw me 2,000 casualties at one of my deployed locations and all need ventilators, I have a problem, but that's not the current threat.

Mr. KUCINICH. Excuse me. If I may, General, you're with the Air Force; right?

General CARLTON. Yes, sir.

Mr. KUCINICH. What does the Army say?

General PEAKE. I would say exactly the same thing. That is, we structured our force to where would see the risk. We understand the environment that our soldiers are in. We understand what their force protection capabilities are and you work with them—the maximum, you know, a credible event, and you try to structure your forces to cover that. I believe we have good—as General Carlton said, we would—there's always more things to do, but in terms of having a level of comfort of being able to care for our soldiers and being proactive about it, recently we just pumped anti-

biotics as part of our DRB, or defense division ready brigade support packages, so that, you know, we plussed them out looking at the new threat. We've done that since September 11th.

So as everybody sort of alluded to, this has been an, OK, now let's pay attention to this one a little bit more, but it's—I sort of feel a little that we probably sound a bit defensive, sir——

Mr. KUCINICH. You don't have to be because you're not under attack here. We're together.

General PEAKE. But the fact is there have been a number of things gone on. The issue of the planning tool that was mentioned, it's true, there is not one in the map, but since the early mid 1990's, we have been working with NATO to work up planning scenarios and casualty models we now have that we are investing in a tool to be able to go ahead and use the patient time test TRTA files that have been developed that was alluded to in the report. We expect we will work with the other services to move that into the medical planning tool, but we do have a desktop model that I was looking at this morning.

So there are a lot of positive things that are a part of this journey to getting better and we're along that journey, as Dr. Winkenwerder has indicated, and we will accelerate along that highway.

Mr. WINKENWERDER. Let me also add in here if I might, just in terms of the exercises, and I don't want to sound as if I'm quibbling here too much, but based on the information that these men have given me, we have had more exercises of some sort than is indicated in the report, and I'm told roughly in the range of 20, 21 in the last couple of years, many of them with civilian, we also have to look at the home front issue of how to support them. So we have an area that the military supports its civilian authorities, and so there have been exercises, tabletop. You've heard of some of them. Dark Winter and——

Mr. KUCINICH. I actually read your testimony, and I'm impressed with what you're trying to do on a domestic front, and all Americans are concerned with that. But with all due respect, you've got a lot of work to do, I would think, and hope before you get to a point of saying send the troops in, and you know, that's not a decision you're going to make, but you're going to be called upon for an evaluation of the medical readiness.

Now, Mr. Chairman I just want to ask one other question here of Admiral Arthur, and that is, you raised this report, actually touched on, and that is the question of available resources, because that's something that none of us can escape. There are financial budget issues and, as you said, whether or not you can have—you may have used a figure 100 pulmonologists and have them waiting and seeing if anything develops. I think that's one of the discussions considering this constantly changing picture. I think that's one of the discussions that you're going to have to have, and then if there is a need for additional funding, I'm hopeful that you'll come back to this Congress and inform the Members of Congress that in order to assure medical readiness that you need to—that this is what you need. We cannot hold you accountable if you don't have the resources and feel that you can't have access to the resources. So I would just say that as surgeons general, that we need

to know from you just exactly what you need in order to do the job and have a high level of medical readiness in the event that we find ourselves on the ground with a full-scale effort in Afghanistan. So that——

Admiral ARTHUR. Sure.

Mr. KUCINICH. And I just want you to know I heard you, Admiral.

Admiral ARTHUR. Yes, sir. I'd like to amplify one point, and General Carlton brought this up. They have two, for example, infectious disease specialists at a medical center. We can't have 100 like we would like. But what we do, as General Carlton said, is we cross-train a lot of people. We have a lot of people familiar with the basics. So I think we are capable, and we could never interest 100 pulmonologists in staying if they weren't truly busy. But we also train our Reserves. We train a lot of people to come in and fill in when the requirements exist, and it's different than the civilian sector where people just do their one thing because they're compensation driven. We have a system that is very much more flexible than anything in the civilian sector, and I think that's our No. 1 strength.

The No. 2 strength is this is where the expertise is for chemical and biological issues, and I think one of the ways that we can help as a service, and you can help us, is to assist us in getting out the information to our civilian sector to allow them to be more flexible when some of these issues are raised in the domestic front.

Mr. KUCINICH. I would like to ask one final question. In the report at the conclusions and recommendations on page 36, it says that the DOD has not developed comprehensive meaningful training requirements, adequate tracking system, or rigorous proficiency testing. The available evidence indicates that proficiency is low from training only a fraction of personnel to failing to conduct realistic challenging combat field exercises that include CB medical treatment, DOD has not fully responded to the threat as stated, and what you're saying today, gentlemen, is that you're moving in that direction of addressing that; is that correct?

Mr. WINKENWERDER. Yes.

Mr. KUCINICH. I want to thank the witnesses and thank all of you for your commitment and service to the country.

Mr. WINKENWERDER. Let me, if I might, just say one other thing with respect to the funding. We have put in requests that are related to the additional emergency funds that have been distributed out to the Federal Government and to DOD to lay claim to part of that for these very issues. And as we develop our plans here over the next days and weeks, we'll be coming forward inside the Department to identify the requirements that we think need to be met, and any funding or resources that are associated with that.

Mr. KUCINICH. I want to thank the Chair for allowing this opportunity to ask questions. I want to thank Mr. Putnam for his participation as well. I think this has been a productive hearing.

Mr. SHAYS. Thank the gentleman. Mr. Putnam, if you don't mind, if I could just finish. I think I'm figuring out that we're probably not going to get some answers at a hearing that we need to get because of some of it is a time line issue, and we don't have a sense of what it's going to take, but where I'm getting a little con-

cerned is I feel like we're mixing different things together. For instance, Dr. Winkenwerder, when the military is telling you that they have had training, I believe it's training on the civilian side. In other words, we're coming in and there's a challenge in the United States. My understanding is we're not going through exercises on the field with, you know, a massive chemical attack or not even a massive, or a biological attack. I don't think that's happening yet, and so I just want to be clear as to what we're saying is happening.

General, you kind of wanted to finish and I'm happy to have you finish your point, and I'd love you to address the point I just asked.

General CARLTON. Yes, sir. We added them up to find out is the criticism true.

Mr. SHAYS. I just need to know adding what up? What are you really adding up? What exercises?

General CARLTON. Military-specific exercise that included chem-bio activities in the last 2 years number 12. Civilian-specific exercises where we did things military and civilian together involving chem-bio exercises, No. 9.

Mr. SHAYS. Right. But there is a difference, there truly is a difference between the two.

General CARLTON. Yes, sir. The presentations to senior meetings in international presentations by just the Air Force staff number 1,000 in the last 2 years.

Mr. SHAYS. What does that mean? Slow down, I want to understand. In other words, there is dialog with people about——

General CARLTON. No, sir. Delivering a key note speech as I will do tomorrow in Detroit, as one of my brigadiers will do at the Southern Medical Association on Thursday.

Mr. SHAYS. And so that means that you're thinking about the issue.

General CARLTON. That means that we've addressed their civilian folks—on the military side I'm very comfortable. We've thought these through. We even planned the attack on the Pentagon and we exercised it in May. We're prospectively thinking this ahead. We planned the attack on New York City and D.C., invested in the equipment to diagnose it 3 years ago, and we have all the teams trained now. So we're thinking ahead and we're trying to get to our civilian colleague to help them understand the world's changed, and all of a sudden they're listening, and it's delightful.

Mr. SHAYS. OK. Let me just tell you now why I'm confused. You can't concur with all of the criticisms that GAO made and then say that the report isn't—doesn't reflect what is happening. That's my disconnect. I feel like I should take a lunch break and read the report again and see if I have read this report properly and your concurrences. It's not——

Mr. WINKENWERDER. Let me try to clarify it because——

Mr. SHAYS. You can do that with 2 weeks on the job——

Mr. WINKENWERDER [continuing]. I do need to speak for all of us. We concur and we agree, and agree means agree.

Mr. SHAYS. Yes.

Mr. WINKENWERDER. OK? It's very simple. We agree. That said, I think the difference of the discrepancy may be that we want to leave you with the impression that some more things have been

done, are being done than maybe the report was able to recognize because of the timing.

Mr. SHAYS. If the glass is one third full, you want me to know at least it's one third full and not empty.

Mr. WINKENWERDER. It may be a little more than one third full.

Mr. SHAYS. OK. I didn't want to use one half. Something below half. OK. You're smiling, General. Is that——

General CARLTON. No, sir. I think it's a very valid concern. I'm very comfortable with the overseas piece. I'm scared to death for homeland defense, and medically we have some work to do but we've been engaged for 6 years——

Mr. SHAYS. But you're talking as it relates to the military.

General CARLTON. As it relates to the military for our overseas pieces.

Mr. SHAYS. Right. But are you saying—are you scared here for your military or are you scared here for the civilians?

General CARLTON. I'm scared for our civilian population, that we have a lot to share with our civilian friends on what we have done in the last several years on the BWCW discussion.

Mr. SHAYS. OK. Well, you know what? I'm going to come back, but I still want this paragraph identified as to where you agree and disagree with the various points. You're basically saying respiratory and infectious diseases is your greatest need. I'm going to make an assumption, unless you correct me, that you feel you have the limited numbers of people in these specialties and you're looking to get more, I'm making an assumption if you have a limited number, that means that if you were having to defend your forces around the world, you wouldn't have enough, but if we're in Afghanistan, you can bring these resources to the field, and I make an assumption, and I would like to have a "yes" on this one, that you have the medical personnel and will have the medical personnel in the field of contention to deal with whatever bio or chemical challenge you're faced with. Is that accurate, General?

General CARLTON. Yes, sir, it is.

Mr. SHAYS. Is that accurate?

General PEAKE. Yes, sir, it is.

Mr. SHAYS. OK. Mr. Putnam. Don't even give him a clock.

Mr. PUTNAM. Thank you, Mr. Chairman. I have been listening with great interest in this, and I find myself a little bit confused about the different training portions that have been taking place.

General Carlton, you said that what keeps you up at night is fear for the civilian population, and I think that what you had implied in some earlier comments was that you have been trying to prepare some civilian health care professionals for some time, and only since the 11th, have they been particularly interested in listening to the progress that you've made? And I certainly understand that. How prepared is the civilian population and how prepared is the military for a situation that it's very conceivable 6 or 8 months from now where you have a chemical or biological attack on ground troops engaged in combat and a massive civilian incident in an urban area that would require substantial expertise from the health care community? So if you could take those couple of bites of the apple first before I go further.

Mr. WINKENWERDER. I'm going to try to speak for us as one voice here on this. I think it's not fair for us to speak for civilian preparedness across the board. I think that's really the domain of Secretary Thompson and the leadership at the Department of Health and Human Services to speak to that issue. I think we all know there's a tremendous amount of interest and training and activity going on across the civilian sector as we speak, many cities and towns across the country, people trying to learn and get up to speed on these issues, and we're here to help and support, but I think it wouldn't be fair to try to quantify or qualify how, you know, where that degraded.

Mr. PUTNAM. Is it fair to say that the military is further along in preparedness than civilian?

Mr. WINKENWERDER. I think it would be fair to say that, yeah, and everyone should hope so. I think we are.

Mr. PUTNAM. And that in many situations, these Governors and mayors are returning to their own military to help prepare their own city and State for these types of incidents?

Mr. WINKENWERDER. Well, I think they're turning to wherever the knowledge is, and that to the point that earlier brought General Peake and General Arthur is that we can be a real source of support that we want to be. We feel like one of our greatest capabilities is to train and educate and—on the civilian side and to—and we are in active discussions with the Department of Health and Human Services around concepts of, you know, protecting people, protecting populations of people, how to ensure good command and control and biological event situations and all of that.

Mr. PUTNAM. I'm not trying to box you into a position of making any comments about the preparedness or the lack thereof of civilian health care population, professional population. What I'm trying to point out is that there is a symbiotic relationship between civilian health care professionals and military health care professionals.

Mr. WINKENWERDER. Absolutely.

Mr. PUTNAM. It's been 10 years since you were engaged in a major combat situation; so you've put a number of your medical professionals in emergency rooms and trauma centers in urban areas to see what gunshot wounds are like. The civilians depend on your expertise to prepare for chem-bio-type situations and in a major incident that would occur while we are engaged in ground combat, we would have a limited number of people spread around the world and so that was really the direction I was interested in taking us which was, you know, how are we going to deal with that type of situation? How quickly can we standardize just the services much less spread it out to the civilians being able to be prepared. You have a shortage of specialists, pulmonologists and ear, nose and throat, and there's a number of others identified in the footnotes. To keep those folks sharp when we're not engaged in war they've got to be doing something else——

Mr. WINKENWERDER. That's right.

Mr. PUTNAM. So there is a very connected——

Mr. WINKENWERDER. There is.

Mr. PUTNAM [continuing]. Relationship between you and civilian population. So that was only the purpose of my question.

Mr. WINKENWERDER. Thank you.

Mr. PUTNAM. There is a recent Washington Times article that highlights your board surgical teams, the Army's board—General Peake's surgical teams, and indicates that they—attached to every brigade, the closest thing yet to battle field surgery, the article points out significant medical treatment literally is right over the hill. Are those folks prepared for a chem-bio attack? And simultaneously, let me also ask, do the benefits of having them close for conventional type of warfare put your first responders in jeopardy for this new type of asymmetric threat, General Peake?

General PEAKE. Sir, they are at—when you're putting them that close, they're at jeopardy for even conventional warfare, depending on how far forward you have to go, depending on the tactical scenario, and they are—therefore have the period defensive medical protective—chem-bio protective posture as the rest of the troops that they're supporting in terms of masks and so forth.

And so they basically share the hazards. You try to employ them so you protect them reasonably, but that's the organization's design to go far forward with the brigade. In terms of their ability to take care of chem-bio casualties, those folks, like our division surgeons as well, are folks that go get targeted to go to that course that we were speaking about before; so they have that kind of experience. We have within that unit ventilator support, a limited amount, but the idea is to stabilize folks and then transfer them further back to a more definitive facility.

Mr. PUTNAM. Mr. Secretary, you have made very clear that one of your top priorities is to eliminate any disparities between the services and the standardization of readiness.

Mr. WINKENWERDER. Absolutely.

Mr. PUTNAM. Do you feel that you are there?

Mr. WINKENWERDER. We're not all the way there, but I can assure you that we're going to be trained on to this entire issue, including that aspect of it as we speak and in the days and weeks ahead. It's my top priority.

Mr. PUTNAM. What sense of time line have you established as an objective?

Mr. WINKENWERDER. I haven't set a time line other than to set the idea in motion that it's now, we're moving, we're acting, we're doing, and I would be glad to get back to the committee at a later date in terms of if that's of interest to you with respect to what might be realistically accomplished over what period of time. We're glad to try to, you know, properly set expectations, but we're working on this. It's our top priority.

General PEAKE. Sir, there are things that are still coming about. I will give you an example. I'm going tomorrow to look at chem-bio protective shelters that are part of a Humvie that we have had in the pipeline as developmental. Our intent is to be able to put one of those board surgical teams within a chem-bio protective shelter, because we do understand the environment that changed on September 11th. That's the kind of thing that we will put on the fast track to field, and quickly put into place where we see that threat.

So we're willing to change our structure on the fly. We're required to try to meet the threat that we see evolving.

Mr. WINKENWERDER. There is one other thing that I'd like to leave the committee with, and that is the notion that much of the discussion here is focused on managing an attack once it occurs, and assuming there's casualties. I know that's not all of the discussion, but there has been a fair amount of that. It would be my plan coming into this role that we focus a great deal of effort on how to detect events at an early stage, and how we can prevent certain things from happening and how we can address things during that early phase where there's the opportunity to treat people, whether it's biological with antibiotics or even a chemical situation with antidotes and so forth, so that the whole matter of detection, the kind of equipment we have to detect and how it works, that's part of all of this and that's important and just sort of our readiness in terms of intelligence and thinking, both in the deployed situation as well as on the home front.

And let me add to that the whole area of vaccination. I think that's another issue that we've got to look at and relook at in the context of the situation that we now find ourselves in.

Mr. PUTNAM. Thank you. Thank you, Mr. Chairman.

Mr. SHAYS. We're going to get you out of here pretty soon. I'd like the counsel to ask a few questions and then I would like to ask a few and then we will be done.

Mr. HALLORAN. Thank you. With regard to proficiency testing, which is a matter the GAO raised, the training numbers, as she said, are a surrogate for how capable people actually are, what might your near-term plans be in terms of determining the proficiency of medical units in CB casualty management?

Mr. WINKENWERDER. I'm not steeped into the details of our current proficiency testing capabilities or programs, but what I'm—would plan to do is to work with the surgeons with respect to determining what levels of proficiency we ought to have for different levels of personnel and that we get rapid agreement on that and that we, sort of going along with that, have the capabilities in place to track the proficiency.

Mr. HALLORAN. You might just solve two problems at once in terms—are proficiency determinations made as a result of exercises?

Mr. WINKENWERDER. That's a good question.

General?

General PEAKE. It is one measure of proficiency. You have—you sort of have to break it down. Individual proficiency with technical expertise, hands-on expertise, cognitive expertise, those are all elements of proficiency. And then there is unit proficiency, how that unit works together internally, and then in the larger, it's the systems proficiency, the evacuation system feeding the medical system and then the further evacuations. So each of those are looked at in a little bit different way, some from the larger exercise perspective, some from the CPX nonfield training perspective to see how well you do with that. And then others are sort of the hands-on skill testing that, for instance, we are initiating as we change the military occupational specialty to 91 Whiskey in the Army, where twice a year they want to do the specific hands-on skills to prove that they can start that IV, to maintain that airway, can assess

that patient. It's not a single question, sir, it's an expanded question.

Mr. HALLORAN. Understood. Thank you. Sir.

Admiral ARTHUR. I'd like to add that the insulting agent may be different than what we're commonly seeing. For instance, it may be a chemical agent or may be a biologic agent, but the underlying pathology, the actual disease process, is common to many of the diseases and injuries and illnesses that we see every day, and I think the pathology and the skills that are existent in our health care professionals today once recognized will be able to adequately treat those same symptoms and signs that would be from chemical or naturally occurring disease.

Mr. HALLORAN. But that's good news and bad news. I mean, we're all learning everything looks like the flu in the first 48 hours.

Admiral ARTHUR. And many of them are treated symptomatically or with specific agents. Now, we have to have an awareness that we've been infected perhaps with anthrax to treat appropriately, but we have specialists who do this, and once recognized, the treatment is fairly standardized and think we're well equipped to do that.

Mr. HALLORAN. Finally, let me just change the subject. And it's not really a curve ball because I shared this with you before, but there is a report out today on the military blood tracking system that the Inspector General has found it lacking in some significant respects, and just for the record if you could comment on that, please.

Mr. WINKENWERDER. I'm going to let General Peake do that because of his responsibility.

General PEAKE. I just briefly saw the report and I haven't read it in detail, but I'd be more than happy to get back to you for the record on——

Mr. HALLORAN. Please.

General PEAKE [continuing]. On the details of it. It is an important issue to be able to track in an automated fashion the blood and that's why we put the DIB system in place. I know we have some investment that we are putting in to try to improve the product, but it's an important issue for all of us.

Mr. HALLORAN. If you would get that to the committee, I'd appreciate it.

General PEAKE. I will be happy to, sir.

Mr. HALLORAN. Thank you.

Mr. SHAYS. Dr. Winkenwerder, I appreciate the tone you set, one of, I think, just trying to be candid, and all of you. It tells me that we can work well with each other, and on that basis, what I would like is on all these—on the report which is your response where you concur, rather than just going through it in this public session, I think we will probably get a clearer response if you have time to think about it a little longer. But on page 47 and 48 of the report, it talks about the recommendation and DOD's response, and what I'd like is for you to work with the committee and give us a sense—I think it's fairly clear that GAO felt, and I would agree that the responses are somewhat general.

In other words, it's kind of like we agree and we're going to look into it or we're going to—you know, as an example, it talks about

how, just taking this as an example, with the first recommendation, concur as the coordinating body with the services in sync on issues of this nature. The joint staff will be requested to conduct a reexamination of CV medical training issues and provide suggested adjustments. You know, that's a pretty general response, and I would like to know when that's likely to happen and then what's the result of that. And so that would be—so if we——

Mr. WINKENWERDER. I will be glad to do that.

Mr. SHAYS. If we could do that, it would give us a little clearer idea as to what some of your responses mean. The second thing I want to do is just I honestly believe that there has been a lot of good work obviously to deal with this issue, but I don't want to overstate where we're at. For instance the 12 exercises, I don't—can't grasp your version of exercise versus mine or what I think of it. Can you give me an example of what kind of exercise we're talking about? Are we talking about an exercise where all of a sudden we've got, you know, 60 people who have got a chemical—been exposed to chemicals? Are we talking about 200 people who have smallpox? What are we talking about here?

General CARLTON. Yes, sir. I'm happy to do that. Alamo alert is the best example that we have. It was a mil/civ cooperation, a 3-day symposium that we put on. The first day was educational. The second day was a smallpox attack with our city leaders in place to include the mayor, the fire department chief, the police chief, etc., and they're the shot callers. And then we played the scenario based on what they responded. We had an outside company orchestrate this response. The third day, then, were the critiques of what happened on the second day.

Mr. SHAYS. This committee has participated in those kinds of exercises in what we called them, the rapid deployment—the ray teams. But how about civilians off—not the civilians. I thought the 12 was the civilians——

General CARLTON. That was a mil/civ. The example of a mil/mil was at the joint training center where we practiced our new scenarios. The Shugart-Gordon is a training range that looks like a city to most of us. Two years ago they started doing chemical scenarios involved there. It was a force-on-force discussion. Chemicals are here, how do you detect, how do you protect, how do you take care of people?

Mr. SHAYS. Was that a U.S. target?

General CARLTON. That's the U.S. Army. It is was a joint exercise down at Fort Polk, LA.

Mr. SHAYS. Is that a field exercise?

General CARLTON. It's field exercise, yes, sir.

Mr. SHAYS. And how many casualties?

General CARLTON. I'm sorry. I can't tell you. I didn't have enough time to prepare that.

Mr. SHAYS. Would it be fair to say that there have been a minimal number given the need?

General CARLTON. I can't give you the number.

Mr. SHAYS. No. I don't mean the casualties. I'm sorry. I didn't ask my question properly. We're talking—I guess I don't want to leave—I don't want to set a false impression that we aren't doing enough. I don't want to set an impression that we've been doing

these exercises, and that they have really constituted a significant military exercise, and so——

General CARLTON. Yes, sir. Pacific Warrior in February of this year was a 2,000-person exercise that was the Korean scenario that we played in Hawaii, and it involved a chem environment.

General Peake, I don't think it had a biological component to it.

Mr. SHAYS. Because what we're hearing is that there really haven't been many bio in particular. In other words, even this number of 7,800 versus the 1,718, what I'm being told is that you have onsite and you have offsite exercises, and the offsite training exercises and that the offsite have not involved the bio exposure, it's just mostly chemical.

General CARLTON. In the military exercises that I have been involved with, only three have involved biological activities. None of them were in the field. They were think tank type exercises.

Mr. SHAYS. Right.

General CARLTON. So when you start adding 17——

Mr. SHAYS. So that's really the tabletop kind of exercise?

General CARLTON. Yes, sir.

Mr. SHAYS. I guess really when I'm thinking of an exercise, I'm really thinking what you're out in the field and you're trying to expose your troops to this kind of training exercise.

General CARLTON. Yes, sir. Without exercises—some of the things that have been very exciting are surveillance systems. We had a real world exercise last summer, the summer of 2000 where we had a food borne illness break out in one of our forward deployed places. The year before we had a 60 percent casualty rate from that food borne illness. Because we had installed a new surveillance system, we had a 2.5 percent. When we could identify it quickly, it involved using the rapid pathogen identification, and so we've had some real world that we don't call exercises, but real world experiences with our equipment, with our toys that have worked beautifully.

Mr. WINKENWERDER. Mr. Chairman, if it would be helpful, we'd be glad to try to summarize these——

Mr. SHAYS. Yeah. Why don't we do that. Because I'm really left with the feeling that some of these are civilian responses to terrorist activities and some of them——

Mr. WINKENWERDER. Yeah.

Mr. SHAYS. But in other words, this isn't foreign to you, I agree, but my sense is that you do agree with this report, and the report says there is a lot that needs to happen and I'm going to kind of——

Mr. WINKENWERDER. And you deserve to know exactly what we have done here, and a little more clarification on the exercises that have taken place.

Mr. SHAYS. And Admiral Arthur, have you had many exercises in the last—on the field, not over a desktop and not in a room on bio?

Admiral ARTHUR. We've—not specifically on by bio or chemical, but we do incorporate that aspect into our training when we train specifically on the ground with the Marines, when we exercise the fleet hospitals in support of the Marines or the medical battalion in support of the Marines. We also have our shipboard casualty

drills where we do drill for chemical and biological, when we lock down the ship and we wash the ship and we——

Mr. SHAYS. That's mostly for chemical; right?

Admiral ARTHUR. Chemical and biological.

Mr. SHAYS. I'm sorry. I interrupted. So you wash down the ship and——

Admiral ARTHUR. And we have the exercises where we isolate certain portions of the ship based on contamination. So we do these exercises. We don't do much with submarines. We figure they're pretty protected.

Mr. SHAYS. All right. Is there a question that you want to ask yourself that you wished I had asked?

Mr. WINKENWERDER. I can't think of one.

Mr. SHAYS. I'd like to know if GAO would just like to make any comment before we adjourn? OK.

Well, in the spirit of the obvious need, we look forward to working with you and we'll all take a fresh start at this. We will think anew, we will act anew, and we'll disengage ourselves and try to break out of the box and in the spirit of what Mr. Kucinich said, we need to know where there are needs, and if you tell us the needs, then it's our fault if we don't respond. But if you don't tell us the needs, then it won't lie on our shoulders and we'd like to share in that responsibility. So we will adjourn this hearing and thank all four of you for coming.

[Whereupon, at 12:49 p.m., the subcommittee was adjourned.]

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