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PROTECTING THE HEALTH OF DEPLOYED FORCES: LESSONS LEARNED FROM THE PERSIAN GULF WAR

HEARING

BEFORE THE

SUBCOMMITTEE ON NATIONAL SECURITY, EMERGING THREATS AND INTERNATIONAL RELATIONS

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

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PROTECTING THE HEALTH OF DEPLOYED FORCES: LESSONS LEARNED FROM THE PERSIAN GULF WAR

TUESDAY, MARCH 25, 2003

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

The subcommittee met, pursuant to notice, at 2 p.m., in room 2247, Rayburn House Office Building, Hon. Christopher Shays (chairman of the subcommittee) presiding.

Present: Representatives Shays, Turner, Lewis, Murphy, Janklow, Kucinich, Maloney, Bell and Tierney.

Staff present: Lawrence Halloran, staff director and counsel; Thomas Costa and Kristine McElroy, professional staff members; Robert A. Briggs, clerk, Joe McGowen, detailee; David Rapallo, minority counsel; and Jean Gosa, minority assistant clerk.

Mr. SHAYS. I would like to call this hearing to order, this hearing entitled, "Protecting the Health of Deployed Forces: Lessons Learned from the Persian Gulf War."

When the war in Iraq is over, we will mourn our dead, and a grateful Nation will welcome home legions of battle-tested men and women who fought for freedom in a far-off place. Some will be well. Some will be wounded. We may not always be able to tell the difference.

Not all the casualties of modern warfare are apparent. Injuries and illnesses linked to exposures to chemicals, pathogens, and toxins may not manifest symptoms until months or years after the victory parades. But those wounded are as much our responsibility to prevent or treat as those caused by bullets and bombs on the battlefield. Today we ask if the health of deployed forces is being effectively monitored and adequately protected against the insidious but often avoidable perils of their very hazardous workplace.

Gulf war operations in 1991 could have taught us much about the dose-response relationship between wartime exposures and delayed health effects, but essential health data was never recorded. The Department of Defense [DOD], took years to acknowledge obvious deficiencies in Gulf war-era health protections for deployed forces. Since 1997, the Pentagon has issued impressive volumes of directives and joint staff policies on improved medical recordkeeping, battlefield environmental monitoring, troop location data, and health surveillance before, during and after deployments. Ex-

ternal panels of experts have echoed those recommendations to standardize and integrate service-specific protocols and systems. The 1998 Defense Authorization Act directed the Department to implement many of the recommended improvements to medical tracking and disease prevention.

Witnesses today will describe substantial progress in applying the lessons learned during Operation Desert Storm about force health protection, but questions remain whether the ambitious plans and proposals of peacetime will be able to pierce the fog of war and yield the detailed real-time information needed to assess health effects after the battle. Do the pre and postdeployment questionnaires now being administered meet the statutory mandate for medical examinations? Will the brief, hastily administered surveys capture the data required by DOD and the Department of Veterans Affairs [VA], to reach valid epidemiological conclusions about service-connected health effects?

VA Secretary Anthony Principi recently concluded, much of the controversy over the health problems of veterans who fought in the 1991 war could have been avoided had more extensive surveillance data been collected. We agree. There should be no mysterious Iraq war syndrome after this victory. Veterans of this era should not go empty-handed into battle to prove deployment exposures caused or contributed to their postwar illnesses.

In modern warfare, smart weapons dominate the battlefield and minimize collateral casualties. By far the smartest, most complex, most elegant system we send into battle is the human body. Accurate timely information is the life-cycle maintenance log of our most precious military asset, freedom's sons and daughters, brothers and sisters, fathers and mothers. We look to those entrusted with their care to protect them.

We welcome our witnesses this afternoon, and we look forward to their testimony.

[The prepared statement of Hon. Christopher Shays follows:]

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SUBCOMMITTEE ON NATIONAL SECURITY, EMERGING THREATS,
AND INTERNATIONAL RELATIONS
Christopher Shays, Connecticut
Chairman
Room 8-372 Rayburn Building
Washington, D.C. 20515
Tel: 202 225-2548
Fax: 202 225-2382
E-mail: hr.groc@mail.house.gov

Statement of Rep. Christopher Shays
March 25, 2003

When the war in Iraq is over, we will mourn our dead and a grateful nation will welcome home legions of battle-tested men and women who fought for freedom in a far off place. Some will be well. Some will be wounded. We may not always be able to tell the difference.

Not all the casualties of modern warfare are apparent. Injuries and illnesses linked to exposures to chemicals, pathogens and toxins may not manifest symptoms until months or years after the victory parades.

But those wounds are as much our responsibility to prevent, or treat, as those caused by bullets and bombs on the battlefield. Today we ask if the health of deployed forces is being effectively monitored and adequately protected against the insidious, but often avoidable, perils of their very hazardous workplace.

Gulf War operations in 1991 could have taught us much about the dose/response relationship between wartime exposures and delayed health effects, but essential health data was never recorded. The Department of Defense (DOD) took years to acknowledge obvious deficiencies in Gulf War-era health protections for deployed forces.

Since 1997, the Pentagon has issued impressive volumes of directives and Joint Staff policies on improved medical record keeping, battlefield environmental monitoring, troop location data and health surveillance before, during and after deployments. External panels of experts have echoed recommendations to standardize and integrate service-specific protocols and systems. The 1998 Defense Authorization Act directed the Department to implement many of the recommended improvements to medical tracking and disease prevention.

Witnesses today will describe substantial progress in applying the lessons learned during Operation Desert Storm about force health protection. But questions remain whether the ambitious plans and proposals of peacetime will be able to pierce the fog of war and yield the detailed, real-time information needed to assess health effects after the battle. Do the pre- and post-deployment questionnaires now being administered meet the statutory mandate for "medical examinations?" Will the brief, hastily administered surveys capture the data required by DOD and the Department of Veterans Affairs (VA) to reach valid epidemiological conclusions about service-connected health effects?

VA Secretary Anthony Principi recently concluded, "Much of the controversy over the health problems of veterans who fought in the 1991 war could have been avoided had more extensive surveillance data been collected." We agree. There should be no mysterious "Iraq War Syndrome" after this victory. Veterans of this era should not go empty handed into the battle to prove deployment exposures caused or contributed to their post-war illnesses.

In modern warfare, "smart" weapons dominate the battlefield and minimize collateral casualties. By far the smartest, most complex, most elegant system we send into battle is the human body. Accurate, timely health information is the life-cycle maintenance log of our most precious military asset – freedom's sons and daughters, brothers and sisters, fathers and mothers. We look to those entrusted with their care to protect them.

We welcome our witnesses this afternoon and look forward to their testimony.

Mr. SHAYS. At this time I'd like to call on our vice chairman of the committee.

Mr. TURNER. I don't have an opening statement. I look forward to hearing their testimony. This certainly is an important issue for us.

Mr. SHAYS. I thank the gentleman.

Mr. Kucinich, I know you just walked in. Do you have a statement you'd like to make, or shall we just swear them in?

Mr. KUCINICH. I'd like to make a statement.

Mr. SHAYS. You've got it.

Mr. KUCINICH. Thank you, Mr. Chairman. Good afternoon, Mr. Chairman. Welcome to the witnesses.

The first Gulf war was 13 years ago, but as a country, we've not yet implemented the lessons that we've learned since that time. I believe that this failure may bring harm to our troops now in Iraq, and that is unacceptable.

Part of this delay, unfortunately, was caused by a series of misstatements perpetuated by the Defense Department itself.

Mr. Chairman, as you know, it took one group of dedicated veterans over 4 years to force the Pentagon to reveal that Iraqi stocks of sarin gas at Khamisiyah had been blown up by U.S. troops, exposing over 140,000 American soldiers.

Steve Robinson, who will testify before us later, said in a recent interview, "that was the first lie. Then the Pentagon said, maybe 100 soldiers had been exposed. Then it was maybe 1,000. Lie after lie. Now it's up to 140,000."

Similar concerns were raised about depleted uranium. Again, dedicated veterans spent years filing Freedom of Information requests to obtain information about friendly fire incidents involving depleted uranium. Although the Pentagon first said only 35 soldiers were exposed, this number soon increased to 122, then to 932, and then to thousands who breathed in depleted uranium.

Unfortunately, it appears that Dr. Winkenwerder, who will also testify here today, has become part of the cycle. In January he issued a press release, which I would like to make part of the record. In the press release he made this statement, "the U.S. military is prepared to protect its personnel against the use of biological weapons." In fact, many Pentagon and White House officials have declared that troops are prepared for war in Iraq. While they understand the desire to provide assurance that a problem is being addressed, broadly claiming total preparedness in the face of evidence to the contrary is reckless.

Last year the Army's own audit agency identified what it called, "a breakdown in the Army's primary control for ensuring the maintenance and sustained operability of chemical and biological equipment." They found that 62 percent of gas masks and 90 percent of chem-bio detectors didn't work. They said soldiers at 18 of 25 units they reviewed weren't proficient and couldn't operate basic equipment.

GAO has also testified before this committee about shortages of critical items. One military wing, for example, had only 25 percent of the protective masks required. In addition, the GAO discovered—the General Accounting Office discovered, amazingly, that some military units were selling their protective suits on the Inter-

net for $3, while other units were desperately clamoring for these critical items. In fact, the Pentagon's own inspector general raised these concerns, stating that, "420,000 suits were not on hand as recorded in the inventory balance."

For these reasons, Congresswoman Jan Schakowsky, a former member of this subcommittee, wrote to Defense Secretary Rumsfeld to ask him do the troops going to Iraq have the minimum required levels of chem-bio protective equipment. She asked him to certify this to Congress. On February 27, just 3 weeks before the war in Iraq began, she got her answer, and that answer was no. The Defense Department refused to certify to Congress that it had provided to troops in Iraq the minimum levels of chem-bio equipment as those levels were established by the Pentagon itself. And I would like to ask that this letter also be included into the record.

[The information referred to follows:]

JANICE D. SCHAKOWSKY
9TH DISTRICT, ILLINOIS

COMMITTEES:
FINANCIAL SERVICES
GOVERNMENT REFORM

FLOOR WHIP

515 CANNON HOUSE OFFICE BUILDING
Telephone: 202-225-2111
Fax: 202-225-6890
TTY: 202-225-1904

Congress of the United States
House of Representatives
Washington, DC 20515-1309

CHICAGO, IL 60640
Telephone: 773-506-7100
Fax: 773-506-9202

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EVANSTON, ILLINOIS 60201
Telephone: 847-328-3399
Fax: 847-328-3425

6767 N. MILWAUKEE AVENUE
NILES, IL 60714
Telephone: 847-647-6355
Fax: 847-647-6954

November 27, 2002

The Honorable Donald H. Rumsfeld
Secretary
U.S. Department of Defense
The Pentagon
Washington, DC 20301--1155

Dear Secretary Rumsfeld:

I am writing to express my concern that if President Bush decides to deploy U.S. military forces against Iraq, the service men and women who are sent into battle may not be adequately protected against chemical and biological attacks.

During a press briefing on October 17, 2002, you discussed several issues that you believe should be considered before U.S. military force is deployed. In the context of sending U.S. Armed Forces to Iraq, you said: "If an engagement is worth doing, then we need to recognize that ultimately lives could be put at risk." You also made this comment:

> When there's a risk of casualties, that risk should be acknowledged at the outset, rather than allowing the American people or others to think that an engagement can be executed antiseptically.

I agree. I believe the American people have a right to know the true risks of any military engagement the President decides to undertake. I am concerned, however, that Pentagon officials may be downplaying the actual risks to our service men and women, particularly with respect to the preparedness of our forces for chemical and biological attacks. On September 18, 2002, for example, General Myers, the Chairman of the Joint Chiefs of Staff, testified before the Armed Services Committee. He was asked whether forces that would be deployed against Iraq are prepared to handle potential chemical and biological attacks by Iraqi forces. In response, he made this assertion: "Obviously our forces prepare for that, they train for that, and they would be ready to deal with that type of environment."

On October 8, 2002, however, the House Democratic Caucus received a briefing by the U.S. General Accounting Office (GAO) and was provided with testimony from the Defense Department Inspector General (IG) regarding this issue. The caucus was presented with information about various pieces of equipment, including 250,000 protective suits that are known to be defective and that were delivered to commanders in the field, but that can no longer be located or recalled by the Department because of flawed inventory controls. The caucus also

received information regarding existing shortages in other equipment, as well as questionable levels of training to prepare units for possible chemical and biological attacks. Although this unclassified information was extremely troubling, the classified information provided by GAO and the IG was even more disturbing, especially in light of the Defense Department's previous expressions of confidence on this issue.

As you know, during the Gulf War, we gained a great deal of intelligence about Saddam Hussein's chemical and biological capabilities. His resources, combined with his demonstrated penchant for using them, formed the basis for Security Council resolutions that have governed Iraq ever since. Indeed, the threat of Saddam Hussein's chemical and biological arsenals has been cited as one of the primary and most urgent reasons for taking military action against Iraq.

Our experience during the Gulf War, however, also exposed our own military's limitations in facing this type of threat. Our service members did not have enough protective gear, such as suits and masks. They had inadequate equipment to detect the release of deadly agents. And as thousands of veterans who continue to experience the full range of Gulf War Illnesses can attest, our service members were ill-prepared for the medical regimens they were rushed to implement. During the Gulf War, we were fortunate that Iraq did not use its chemical or biological arsenals because our forces were not ready.

According to GAO and the IG, the military's progress since the Gulf War in preparing our troops for these threats has not occurred as rapidly as necessary. For this reason, and because this issue is critical to hundreds of thousands of service members, their families, and the American public, I ask that prior to the deployment of U.S. forces, you personally make the following certification to Congress:

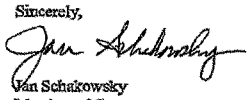
> I, Donald Rumsfeld, Secretary of Defense, certify that all United States Armed Forces that could be deployed, or are intended to be deployed, against Iraq pursuant to the exercise of authority specified in H.J. Res. 114 have been provided with equipment to protect against chemical and biological attacks in quantities sufficient to meet minimum required levels previously established by the Department of Defense.

As you can see, this certification addresses only equipment. It does not deal with training deficiencies or medical concerns that conceivably are equally important. In addition, I recognize the obvious concern with revealing to our adversaries potential vulnerabilities with specific units or commands, so this certification does not require you to reveal any classified information with respect to specific vulnerabilities of specific units. If our forces are in fact "ready to deal with that type of environment," as Chairman Myers asserted, you should have no difficulty certifying that our troops possess minimum established levels of protective equipment.

If you cannot in good conscience make this certification, however, I believe the American people are entitled to know this information, as you explained during the press briefing in October.

I respectfully request that you provide a response to this request by December 15, 2002, and I appreciate your assistance in this matter.

Sincerely,



Jan Schakowsky
Member of Congress

THE UNDER SECRETARY OF DEFENSE
3010 DEFENSE PENTAGON
WASHINGTON, DC 20301-3010

ACQUISITION, TECHNOLOGY AND LOGISTICS

27 FEB 2003

The Honorable Jan Schakowsky
U.S. House of Representatives
Washington, D.C. 20515-1309

Dear Representative Schakowsky:

I appreciate your interest and concern for military personnel serving in the Armed Forces and the policies regarding their chemical and biological (CB) protection. U.S. forces are trained, ready, and will deploy with the best available equipment. The safety of our Armed Forces remains a top priority for the Department of Defense.

We have made tremendous strides in recent years in training our Armed Forces and providing them with modern equipment, modern infrastructure, and adequate spare parts. Our deploying military units will be trained and equipped to meet the operational challenges of today and the future.

Since Operation DESERT STORM, the Department of Defense has fielded new and improved CB defense detection equipment and individual protective equipment. Every Service member to support near-term operations in Southwest Asia will carry at least two of the newer Joint Service Lightweight Integrated Suit Technology (JSLIST) suits and will have an additional two suits in contingency stocks. The contingency suits will be the Battle Dress Overgarments (BDOs) until replaced by JSLIST suits.

The Department of Defense increased its procurement of JSLIST suits from 79,000 per month to over 90,000 suits per month in December and is taking steps to surge the production even higher over the upcoming months.

Your concern for the safety of the Nation's military members is deeply appreciated.

Sincerely,

E. C. Aldridge, Jr.

Mr. KUCINICH. If the Secretary of Defense won't certify that the troops are prepared, I'm at a loss as to how anyone in the administration can do so. Perhaps it depends on what their definition of "prepared" is. In this case, it does not appear to mean meeting the minimum required levels of critical equipment or training. This certainly does not bode well for the larger question of medical surveillance.

We must also examine how we are treating veterans of the first Gulf war. We must honor those who have fought for this Nation by taking care of their health needs. However, as our Armed Forces are ordered to implement this new war, the administration is proposing sweeping new cuts to veterans' health. The administration's 2004 budget for VA would restrict access to care and increase cost. It would halt the enrollment of all new priority 8 veterans, denying them any access to VA care. According to data from the VA, this proposal will deny care to 173,000 veterans nationwide.

This administration would also charge all priority 7 and 8 veterans a new $250 annual enrollment fee as a new policy for VA, which has never charged an enrollment fee.

The administration would also increase copayments. VA estimates that 55 percent of all enrolled priority 7 and 8 veterans, over half will drop out of the VA system altogether. Overall the administration's proposals would force 1.25 million enrolled veterans, including 425 active patients, out of the VA health care system.

The administration's budget also fails to provide any additional service-connected disability benefits resulting from the present war with Iraq. As we know from the last conflict in the Gulf, war results in adverse health effects and claims for service-connected disability compensation. What message do we send to our troops in Iraq, knowing that many won't receive health benefits when they come home? Congress is to receive a $75 billion war supplemental request from the President. Why is there not a single dime for veterans' health benefits in that $75 billion? It's hard to believe that this war will not increase the cost to the veterans' health system, yet the administration is solely focused on war to the exclusion of its effect on our troops, our veterans or our economy.

Mr. Chairman, our men and women in uniform, both Active Duty and Retired, deserve more than empty assurances. They deserve the best protection we can provide, and frankly, we're not living up to that promise. Thank you, Mr. Chairman.

Mr. SHAYS. Thank the gentleman.

At this time the Chair would recognize Mr. Murphy, if he has a comment to make.

Mr. MURPHY. Nothing yet. Thank you.

Mr. SHAYS. Thank you. I'll just go down.

Mr. Janklow.

Mr. Lewis.

Thank you.

Mrs. Maloney, we're kind of getting to you as you're walking in.

I have a feeling, knowing you, you have a statement you want to make.

Mrs. MALONEY. I'm looking forward to the testimony. I'll put my statement in the record in the interest of time.

Mr. SHAYS. Thank you very much.

[The prepared statement of Hon. Carolyn B. Maloney follows:]

Statement of Congresswoman Carolyn B. Maloney
House Government Reform Committee
Subcommittee on National Security, Emerging Threats, and International Relations

Protecting the Health of Deployed Forces: Lessons Learned from the Persian Gulf War
March 25, 2003

I thank the Chairman and Ranking Member for their leadership on this issue.

I also would like to thank Dr. William Winkenwerder, Assistant Secretary of Defense for Health Affairs, for his willingness to provide the Subcommittee a more comprehensive detailing of the sites at which our troops may have been exposed to chemical and other toxic agents. Additionally, I greatly appreciate his commitment to include in his report to the Subcommittee an analysis of the locations listed in Saddam's Bombmaker, by Khidhir Hamza.

The witnesses provided to the Subcommittee a welcomed update on the extensive neurodegenerative research being conducted by both the Departments of Defense and Veteran Affairs. These agencies are investigating the causes, mechanisms and treatments of neurodegenerative diseases. With this research, the hope for our troops is that we may be able to better prevent, detect and treat environmental toxicity that may result from exposure to military threat agents and operational hazards. As a co-chair of the Congressional Parkinson's Disease Working Group, I know that this research has the great promise of leading to accelerated development of better treatments or even cures for devastating illnesses like Parkinson's, Huntington's, Alzheimer's and other neurodegenerative diseases. I applaud the Departments of Defense and Veteran Affairs work on this vital research.

I must add that I am still deeply troubled that information about the 1991 Gulf War continues to be hard to unearth. It has long been unclear to what degree our fighting men and women were exposed to toxins in the Gulf War.

Today's testimony did add some level of clarity. According to the senior Defense Department officials testifying today, in addition to the facility at Khamisiyah, based on testimony today, we were told that there were two other locations where chemical exposure could have taken place – Muhammadiyat and Al Muthanna. Full disclosure is so important for our troops and veterans.

Yet, there continues to be confusion about exposures.

For the sake of our troops and our veterans, I call on the Defense Department to stop focusing on the unknowable (about exposures) and notify ALL troops that were on the ground, either during or after the Gulf facilities were bombed, so that our servicemen and women can be screened for health effects.

Most importantly, I implore the Pentagon to do an extraordinarily better job on behalf of troops in the field today.

Mr. SHAYS. I would like to first take care of some business and ask unanimous consent that all members of the subcommittee be permitted to place an opening statement in the record and that the record remain open for 3 days for that purpose. And 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.

We have two panels. Our first panel is Dr. William Winkenwerder, Assistant Secretary of Defense for Health Affairs, Department of Defense; accompanied by Dr. Michael Kilpatrick, Deputy Director of the Deployment Health Support Directorate, Department of Defense; accompanied by Dr. Robert H. Roswell, Under Secretary for Health, Department of Veterans Affairs. Excuse me. I'm sorry. Dr. Robert H. Roswell will be making a statement, accompanied by Dr. K. Craig Hyams, Chief Consultant, Occupational and Environmental Health, Department of Veterans Affairs. And Dr. Roswell is Department of Veterans Affairs as well for Under Secretary for Health.

At this time, gentlemen, I will swear you in. Now, if there is anyone who might be behind you that might need to respond to questions, I'd like them to respond as well so we can swear them in, if you have anyone you want to direct to stand. So if you'd rise, I'll swear you in. Raise your right hands.

[Witnesses sworn.]

Mr. SHAYS. Note for the record that our witnesses have responded in the affirmative.

Am I pronouncing your name Roswell—is that—I'm sorry. I'm a tennis fan. I think we'll start with you, Dr. Winkenwerder.

STATEMENTS OF WILLIAM WINKENWERDER, JR., M.D., M.B.A., ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, DEPARTMENT OF DEFENSE, ACCOMPANIED BY MICHAEL E. KILPATRICK, DEPUTY DIRECTOR FOR THE DEPLOYMENT HEALTH SUPPORT DIRECTORATE, DEPARTMENT OF DEFENSE; ROBERT H. ROSWELL, M.D., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY K. CRAIG HYAMS, CHIEF CONSULTANT, OCCUPATIONAL AND ENVIRONMENTAL HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Dr. WINKENWERDER. Thank you, Mr. Chairman. Mr. Chairman, members of the subcommittee, thank you for the opportunity to appear here today. With your permission, I will summarize my written statement. And also with me today to answer questions, if that is acceptable to you——

Mr. SHAYS. That is fine.

Dr. WINKENWERDER [continuing]. Is Dr. Michael Kilpatrick, whom you've already introduced.

I want to begin——

Mr. SHAYS. Let me just ask, can you all hear in the back of the room? No. I need you to speak up a little louder. Thank you very much. It is the silver mic that projects your voice.

Dr. WINKENWERDER. All right. Thank you.

I want to begin by adding my condolences to those of President Bush and the Secretary of Defense for the families' of the U.S. casualties since operations began last week. Each of you is in our prayers. Our country's ultimate weapon against any enemy is the valor of the men and women in our armed services who serve the cause of freedom. They comprise the most powerful force on Earth, and, in this particular case today, a force for peace and liberation of the Iraqi people.

On behalf of all the men and women in medical service to our Armed Forces, I want to recognize the cause for which many have now given their lives and the efforts to ensure the safety of everyone engaged in this conflict. The courage, skill and discipline of our military medical personnel is matched only by the high-quality, swift and effective medical care that they provide.

You have already seen reports by embedded media of heroic acts by U.S. Armed Forces medics to save lives; for example, the MediVac crews and surgical teams that have gone into very dangerous situations. We can be assured that today such acts will continue, and they will continue until our final mission is accomplished. In Operation Iraqi Freedom we have more than sufficient capability to move casualties from their point of wound to any level of care their injuries might require. We have more than sufficient medical supplies, including blood supplies, for all of our troops operating in the field, and all of this is regulated by an integrated logistics system in the theatre.

Our medical medics and soldiers are trained, equipped and prepared to operate in the contaminated environment, if necessary, with equipment decontamination and antidotes. We are prepared for what Saddam Hussein might attempt to deliver to U.S. forces.

As the Assistant Secretary of Defense for Health Affairs, safeguarding the health and safety of our military members is my highest priority. Our force health protection program has made great strides based on the lessons learned from the Gulf war and subsequent deployments. I believe our efforts are in line with your own objectives, as these have been expressed in public law.

The Department is committed to providing an ongoing continuum of medical service to service members from entrance into the military through their separation and as many transition to the Department of Veterans Affairs after their service.

The vigorous requirements of entrants' physical exams, periodic physical examinations, periodic HIV screening, annual dental examinations, routine physical training and periodic testing and then regular medical record reviews are all part of this continuum.

We've established a comprehensive program to sustain and document our service members' health and fitness for duty. All deploying personnel are required to complete individual predeployment health assessments. These health assessments are coupled with a review of medical and immunization records. We look at whether there is a DNA sample on record, and if a blood serum sample has been drawn within the prior 12 months. This information is considered, along with the availability of personal protective and medical equipment. Predeployment briefings on deployment-specific health threats and countermeasures are also provided. All personnel complete postdeployment health assessments when they return.

Any indication of health concerns results in an individual health review and, if appropriate, referral for further medical evaluation or testing. These health assessments are to be maintained in the individual's medical records and centrally in electronic format in the defense medical surveillance system.

Additionally, all immunizations are tracked by service-specific systems, and the data are fed into a central data base. We're currently transitioning from paper-based medical records to automated medical records for patient encounters and reporting of nonbattle and disease events.

Health care focused on postdeployment health concerns is available through both military and VA providers who are using jointly the postdeployment health clinical practice guidelines. These guidelines were designed to ensure that the medical providers render effective and appropriate responses to the medical concerns of our deployed service members and their families upon return.

We've established three deployment health centers. One focuses on deployment-related health care, one on related health surveillance, and the third on health research. All are working toward prevention, treatment and understanding of deployment-related health issues.

Desert Shield, Desert Storm taught us knowledge of the environment is vital if we're to protect the health of our service members. Today the Army's Center for Health Promotion and Preventive Medicine conducts environmental health assessments that enable intelligence preparation of the battlefield before and during deployments. This unit employs equipment to monitor the combat environment, and it samples soil, air and water. They also perform extensive environmental assessments of staging areas and base sites. This information is used to make determinations of where we can safely put our military people. We also archive that information so that we can go back amend, look at it later to evaluate for correlation between an area of known or suspected exposure and illness that may appear in the future.

In the past few months, we've been working to develop and have implemented a joint medical workstation. This is an important development. We're using a Web-based force health protection portal to our classified system, and DOD now has the electronic capability to capture and disseminate real-time and near real-time information to commanders about in-theatre medical data, patient status, environmental hazards, detected exposures and critical logistics information like blood, beds and equipment availability.

The transition from paper-based processes to automated systems offers us a much greater opportunity for collecting and analyzing medical information that is useful in real time. We proceed with that work with an awareness of operational security and personal security for our service members who expect their medical records to remain confidential.

When we deploy, we bring a formidable medical capability. This includes far-forward surgical care, and we've seen this on the battlefield just in the past few days; medical evacuation assets, with the ability to provide intensive care, ICU care, inside an airplane; and ship-based medical capabilities.

In the event of a biological or chemical attack, we also maintain significant decontamination equipment and the ability to treat both chemical and biological casualties. All services have made training improvements, and they've been significant to do that, to assure that their medical personnel can work successfully in a contaminated environment and decontaminate and rapidly evacuate their patients to safer environments.

Much has been accomplished in the past decade. Our level of effort and our capability to protect our forces is unprecedented in military history. However, today we face new and deadly threats and the possibility that a brutal regime would use chemical or biological weapons.

As military professionals and as health professionals, we're well aware that war, and particularly this war, involves real risks, but our message to you, to our service members, to their families, to the American people is that we're prepared, and we have extraordinary capability to protect and care for our people.

Mr. Chairman, I thank you again for inviting me here today. I'm pleased to answer your questions, and I know there will be many. Thank you.

Mr. SHAYS. I thank you.

[The prepared statement of Dr. Winkenwerder follows:]

Prepared Statement

of

The Honorable William Winkenwerder, Jr., M.D., M.B.A.

Assistant Secretary of Defense for Health Affairs

on

Protecting the Health of Deployed Forces

Before the Subcommittee on National Security, Emerging Threats, and International Relations

House of Representatives Committee on Government Reform

March 25, 2003

Mr. Chairman and members of this distinguished committee, thank you for the opportunity to be here today and thank you for your continuing support of the men and women who have served in our Armed Forces.

As the Assistant Secretary of Defense for Health Affairs, safeguarding the health and safety of our military members is my highest priority. Our Force Health Protection program has made great strides, based on the lessons learned from Operation Desert Storm. I believe our efforts are in line with your own objectives, as expressed in Public Law 105-85. Force Health Protection is a strategy that applies to the continuum of medical care experienced by each Service member from entrance into the military to separation from the military and transition in many cases to the VA healthcare system. The vigorous requirements of the medical entrance physical examination, the periodic physical examinations, periodic HIV screening, annual dental examination, physical training and periodic testing, and the regular medical record reviews are parts of this continuum.

In order to clarify our program, I will address the requirements of Public Law 105-85 individually, and then explain our actions that go beyond what that law requires.

Public Law 105-85 - Section 765 (a) - Improved tracking system

Our actions are based on two primary medical tracking policy documents. DoD Instruction 6490.3, August 7, 1997, *Implementation and Application of Joint Medical Surveillance for Deployments*, implements policy and procedures, and assigns responsibilities for joint military medical surveillance in support of all applicable military objectives. It describes routine military medical surveillance activities during major deployment, or deployments in which there is a significant risk of health problems. *Updated Procedures for Deployment Health Surveillance and Readiness* provides standardized procedures for assessing health readiness and conducting health surveillance in support of all military deployments.

Based on those policies, the DoD has taken steps to improve deployment-related medical record keeping by developing the Composite Health Care System II (CHCS II) and the Theater Medical Information Program (TMIP), and by expanding the electronic tracking and centralized collection of immunization data. Electronic tracking of immunizations was initially implemented for the Anthrax Vaccine Immunization Program (AVIP) in 1998, using Service-specific automated systems. Efforts are underway by the Services to electronically track all immunizations and to centralize collection of immunization data for surveillance and research purposes.

The Defense Medical Surveillance System (DMSS) has been established under the Army Center for Health Promotion and Preventive Medicine (CHPPM) to provide improved DoD joint health surveillance capabilities. Operated by the Army Medical Surveillance Activity (AMSA), the DMSS database contains historical and up-to-date data on diseases and medical events such as hospitalizations, and ambulatory visits, as well as longitudinal data on personnel and deployments.

The Services have begun implementation of health surveillance and computerized medical record keeping during deployments, allowing for surveillance of health events as well as documentation of health care and countermeasures utilized during deployment. The TMIP, which is currently undergoing testing, will gather individual medical information throughout operational deployments. This information will help to document deployment-related health problems and can be shared with the VA to facilitate continuity of care for veterans.

In the past few months, DoD has developed and implemented the Joint Medical Work Station. This is the most recent addition to our capability to monitor the health status of our deployed forces. Using the Force Health Protection portal to our classified system, DoD now has the electronic capability to capture and disseminate near real-time information to commanders about in-theater medical data, patient status, environmental hazards, detected exposures and critical logistics data such as blood supply, beds and equipment availability.

For longitudinal study, one important health surveillance initiative prompted by post-Gulf War health issues is the monitoring of birth defects among DoD beneficiaries through establishment of a birth defects registry. This registry has been established and is a valuable resource. Another is the use of the DoD Serum Repository for routine and pre-deployment collection and storage of serum specimens, which are subsequently available for analysis regarding military- and deployment-related health concerns.

In addition, the Millennium Cohort Study is an ongoing comprehensive DoD health research initiative that responds to concerns about whether deployment-related exposures are associated with post-deployment health outcomes. A cross-sectional sample of 100,000 military personnel and veterans will be studied prospectively over a 21-year period.

Section 765 (b) - Predeployment medical examinations and postdeployment medical examinations

The DoD has instituted a deployment health surveillance program that includes pre-deployment and post-deployment health assessments which documents individuals' medical readiness to deploy and address health concerns upon their return, along with improved occupational and environmental health surveillance programs for protecting Service members' health during deployment.

Deploying personnel receive individual health assessments that are documented on DD Form 2795, Pre-Deployment Health Assessment. Individual pre-deployment health assessments include eight questions and further include reviews of required immunizations and other protective medications/measures, personnel protective and medical equipment, DNA and serum (HIV) samples (preserved in the DoD Serum repository), dental classification, and briefings on deployment-specific health threats and countermeasures.

Redeploying personnel receive individual health assessments that are documented on DD Form 2796, Post-Deployment Health Assessments. These assessment forms include questions on health and exposure concerns. Medical personnel review the forms and positive responses result in a review of deployment health records and appropriate referral for follow-up care.

Follow-up health care is also available through military and VA providers using the jointly-developed Post-Deployment Health Clinical Practice Guideline, which has been designed specifically for addressing deployment-related health concerns. The guideline provides a structure for the evaluation and management of Service members and veterans with deployment-related concerns. It also provides access to expert clinical support to physicians and other health care professionals for patients with challenging symptoms and illnesses, and may provide a useful platform for research into post-deployment health concerns. The post-deployment health care process is managed by the DoD Deployment Health Clinical Center (DHCC) located at Walter Reed Army Medical Center.

Section 765 (c) - Improved medical record keeping

The original deployment health assessment forms are placed in the Service member's permanent medical record. Copies of the forms are sent to the Army Medical Surveillance Activity, where the forms are scanned and the data entered into the Defense Medical Surveillance System for archiving and analysis.

Immunizations are tracked by specific systems within the Services and the data is fed into the Defense Eligibility Enrollment Reporting System (DEERS). The Army's Medical Protection System (MEDPROS), and the Navy's Shipboard Automated Medical System (SAMS) are partially implemented. The Air Force Comprehensive Immunization Tracking System (AFCITA) is fully implemented. We have developed DD Form 2766 as the standard form in the medical record for recording essential readiness indicators. This form accompanies the deploying Service member.

We are currently transitioning from paper based medical records to automated medical records for patient encounters and disease non-battle injury (DNBI) reporting.

Section 765 (d) - Quality assurance

Currently, quality assurance is being executed by the individual Services. The Air Force has included deployment health quality assurance in their medical Inspector General inspection checklist. The Army Surgeon General has recently sent out a memo requiring audits of medical surveillance records.

Our Deployment Health Support Directorate is in the process of developing DoD-wide systems for quality assurance of medical record keeping and medical surveillance data.

Section 767 - Tracking Service member location

As previously reported, TMIP has been partially implemented and DoD has implemented an interim deployment medical surveillance system, the force health protection portal. In the future, TMIP developments will tie into the Defense Manpower Data Center that will capture data on unit and individual locations. TMIP will also tie into operational, personnel and medical data systems that will capture information on possible harmful exposures or health related events. The Defense Integrated Military Human Resource System (DIMHRS) will ultimately receive and archive both medical and personnel information. DIMHRS is several years away from implementation, but an interim solution is in progress. DoD is also in the process of developing individual medical readiness standards and looking at developing a comprehensive DoD health surveillance system.

Section 768 - Specialized units for monitoring chemical/biological hazards

The DoD now routinely deploys preventive medicine, environmental surveillance, and forward laboratory teams in support of worldwide operations. For example, the Army's Center for Health Promotion and Preventive Medicine (CHPPM) conducts pre- and during-deployment environmental health intelligence studies for the battlefield, and performs extensive environmental assessments of operationally selected staging areas and base sites. CHPPM also supplies environmental sampling materials for deployed forces, conducts operational risk management estimates for field commanders, and develops pocket-sized "staying healthy" guide books for deployed Service members.

Additional efforts

Beyond the actions required by Congress, DoD has taken several steps that we believe to be vital for the protection of the health of deployed service members. For example, the DoD has established three deployment health centers. One is focused on deployment health surveillance, another on deployment health care, and the third on deployment health research. These centers are concentrating their efforts on the prevention, treatment, and understanding of deployment-related health concerns.

The DoD has improved health risk communication through the provision of regionally specific medical intelligence, environmental risk assessments, medical threat briefings, pocket-sized health guides, and deployment-focused web sites.

We are developing improved health protection measures to counter an increasingly broad range of threats. Such measures include the fielding of new biological and chemical warfare agent detection and alarm systems; the operational testing of integrated electronic medical surveillance and emergency response networks; current vaccines and anti-malarial drugs; and research on the next generation vaccines and pharmaceuticals.

In addition to pre- and post-deployment health assessments, the military medical departments incorporate routine health and medical readiness appraisals to ensure service members meet and maintain health standards. A complementary effort is underway to develop standardized DoD-wide individual medical readiness indicators.

Mr. Chairman, this concludes my statement. I thank you and the members of this committee for your outstanding and continuing support for the men and women of the Department of Defense.

Mr. SHAYS. Dr. Roswell. I'm going to ask you to bring the mic a little closer. I know it's got a bulky platform to it.

Dr. ROSWELL. Mr. Chairman, I'm pleased to be here to testify before the subcommittee today. With me, as you indicated, is Dr. Craig Hyams, who is the VA Chief Consultant for Occupational and Environmental Health.

The VA today is better prepared to provide high-quality health care and disability assistance than at any other time in history. And let me begin by dispelling two concerns raised in his opening remarks by Mr. Kucinich. First of all, let me point out that Public Law 105–368 authorizes 2 full years of medical care for any veteran serving in a combat zone for any possible condition related to the military service. So despite the constraints of our current budget, despite an unprecedented demand for VA health care, I want to assure this committee that no veteran serving in the current conflict with Iraq will go untreated by the VA upon their return, should they need such care.

Let me also point out that disability compensation was authorized following the Desert Storm/Desert Shield war for even undiagnosed illnesses when those became problematic for many of the men and women who served in the Persian Gulf war. Special legislation authorized VA to provide disability compensation for undiagnosed claims, and because the Persian Gulf war has never officially ended, that same authorization exists today and will exist and be available for anyone currently serving in the conflict in Iraq.

Since the operation of Desert Shield and Desert Storm in 1991, a number of improvements have been put in place to better allow us to meet the health care needs of our veterans. VA has implemented an innovative new approach to health care known as the Veterans Health Initiative. This is a comprehensive program designed to increase recognition of the connection between military service and certain health effects, better document veterans' military and exposure histories, improve patient care and establish a data base for further study.

In 2002, VA established two war-related illness and injury centers to provide specialized health care for veterans for all combat and peacekeeping missions who suffer difficult to diagnose, but disabling illnesses. These centers provide research into better treatment and diagnoses and develop education programs for health care providers.

The Gulf war made clear the value of timely and reliable information about wartime health risks. VA has already developed a brochure that addresses the main health concern for military service in Afghanistan and is currently preparing another brochure for the current conflict in the Gulf.

VA has recently developed new clinical practice guidelines based on the best scientifically supported practice that will give health care providers the needed structure, clinical tools and educational resources that will allow them to diagnosis and manage patients with deployment-related health concerns. It's our goal that all veterans who come to VA will find their doctors to be well informed about specific deployment and related health hazards.

We're also working very closely with the Department of Defense to improve care and interagency coordination of health information. As you know, governmental coordination plays a critical role in addressing health problems of veterans.

In fiscal year 2002, a special deployment health working group of the VA, DOD Health Executive Council, was established to ensure interagency coordination for all veteran and military deployment health issues. This group continues the efforts begun by the Persian Gulf Veterans Coordinating Board and the Military and Veterans Health Coordinating Board.

DOD with VA support is developing the Recruit Assessment Program to collect comprehensive baseline health data from all U.S. military recruits. As the first module of a lifelong military veteran and health record, this program will help DOD and VA evaluate health problems among service members and veterans and address post-deployment health questions and document changes in health status.

VA and DOD are collaborating on several important health applications that will permit the departments to offer a seamless electronic medical record system, a lifelong medical record system. Key initiatives are the Federal Health Information Exchange and the Healthy People Federal Project.

Mr. Chairman, a veteran separating from military service and seeking health care today will have the benefit of VA's decade-long experience with Gulf war health issues, but the real key to addressing long-term needs of veterans is improved medical recordkeeping and environmental surveillance.

For VA to provide optimal health care and disability assistance after the current conflict with Iraq, we will need a complete roster of veterans who served in designated combat zones; and second, we will need any data from predeployment, deployment and postdeployment health evaluation and screening.

Furthermore, in the event Iraq uses any weapon of mass destruction, it's vital that VA have as much health and environmental information as possible on potential exposure and their health effects. This information will allow us to provide appropriate health care and disability compensation for veterans of this conflict.

Mr. Chairman, this concludes my statement. Dr. Hyams and myself would be happy to answer any questions you may have.

Mr. SHAYS. Thank you very much.

[The prepared statement of Dr. Roswell follows:]

Statement of
The Honorable Robert H. Roswell, M.D.
Under Secretary for Health
Department of Veterans Affairs
Before the
Committee on Government Reform, Subcommittee on National Security, Emerging Threats, and International Relations on
"Protecting the Health of Deployed Forces: Lessons Learned from the Persian Gulf War"

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March 25, 2003

Mr. Chairman, I am pleased to be here to testify before the Subcommittee on "Protecting the Health of Deployed Forces: Lessons Learned from the Persian Gulf War." With me today is Dr. Craig Hyams, VA's Chief Consultant for Occupational and Environmental Health.

Since nearly 250,000 U.S. troops are engaged in renewed conflict in the Gulf region, I am grateful for the opportunity to emphasize that VA today is better prepared to provide high quality health care and disability assistance than at any other time in our history. Since Operations Desert Shield/Desert Storm in 1991, VA has developed and implemented the following policies and programs in response to the lessons learned from that conflict.

Health Care, Surveillance, Education, and Outreach

Health Care following Combat

It is critical to provide informed, knowledge-based health care after every war. Congress has shown an appreciation for the importance of providing health care for combat veterans. Under 38 U.S.C. § 1710(e)(1)(D), added by Public Law 105-368, VA is authorized to provide health care for a two-year period to veterans who serve on active duty in a theater of combat operations during a

period of war after the Gulf War, or in combat against a hostile force during a period of hostilities after November 1, 1998. Under this provision, all veterans of conflicts now have a two-year period of access to VA health care for any illness, regardless of whether there is sufficient medical evidence to conclude that the illness is attributable to that service. An exception to this general rule occurs when VA has found that a particular condition is not due to the period of service in question. Veterans of the current conflict with Iraq will be eligible for health care under this provision of law. Although they may be deemed to be serving in the Southwest Asia Theater of Operations during the Gulf War era, our special authority to provide treatment to such veterans expired December 31, 2002 (38 U.S.C. 1710(e)(1)(C)).

In addition to providing needed health care, VA has the capability to collect and analyze information on the health status and health care utilization patterns of veterans. The capability to collect this basic health information helps us evaluate specific health questions, such as determining the causes of difficult-to-explain symptoms experienced by some veterans returning from certain combat theaters or areas of hostilities. VA's medical record system now permits patient health information to be tracked for special groups of veterans. Moreover, standard health care databases allow VA to evaluate the health care utilization of veterans every time they obtain care from VA, not just on the one occasion that they elect to have a registry examination, as was the practice in the past. This will provide a much broader and longer-term assessment of the health status of these veterans because many veterans return frequently for VA health care and are often seen in different clinics or even different parts of the country for specialized health care.

Ensuring High Quality Post-Deployment Health Care

Specialized health care during the post-deployment period can help prevent long-term health problems. Therefore, VA has developed evidence-based clinical approaches for treating veterans following deployment. Newly developed Clinical Practice Guidelines (CPG's), which are based on the best

scientifically supported practices, give health care providers the needed structure, clinical tools, and educational resources that allow them to diagnose and manage patients with deployment-related health concerns. Two post-deployment CPG's have been developed in collaboration with DoD, a general purpose Post-Deployment CPG and a CPG for unexplained fatigue and pain. Our goal is that all veterans who come to VA will find their doctors to be well informed about specific deployments and related health hazards. Information on Clinical Practice Guidelines are available online at www.va.gov/environagents. This web site also contains information about unique deployment health risks and new treatments.

Assessment of Difficult-to-Diagnose Illnesses

We have learned that sustained clinical care and research is needed to understand post-deployment health problems. Congress also understood this need and in legislation enacted as Public Law 105-368 required establishment of a plan to develop national centers for the study of war-related illness and post-deployment health issues. Subsequently, in 2002, VA established two such centers, known as "War-Related Illness and Injury Study Centers" (WRIISC's), in East Orange, NJ, and Washington, DC, to provide specialized health care for veterans from all combat and peace-keeping missions who suffer difficult-to-diagnose but disabling illnesses. These centers are available through referral to veterans from all eras, including veterans of a future war with Iraq. These centers also provide research into better treatments and diagnoses, develop education programs for health care providers, and develop specialized health care programs to meet veterans' unique needs, such as the National Center for PTSD.

The majority of veterans returning from combat and peacekeeping missions are able to make the transition to civilian life with few problems. Most who come to VA for health care receive conventional diagnoses and treatments, and leave satisfied with their health care. Nevertheless, VA has learned that some veterans have greater problems on their return to civilian life, and a small

percentage of them develop difficult-to-diagnose symptoms. The two WRIISC's focus on determining the causes and most effective treatments for difficult-to-diagnose symptoms, problems seen in veterans of all wars. More information on the WRIISC's can be found at the VA website, www.va.gov/environagents.

Veterans Health Initiative

VA has built upon the lessons learned from our experiences with Gulf War and Vietnam veterans' programs to implement an innovative new approach to health care for veterans. The Veterans Health Initiative (VHI) is a comprehensive program designed to increase recognition of the connection between military service and certain health effects, to better document veterans' military and exposure histories, to improve patient care, and to establish a database for further study.

The education component of VHI prepares VA healthcare providers to better serve their patients. We have completed modules on spinal cord injury, cold injury, traumatic amputation, Agent Orange, the Gulf War, PTSD, blindness/visual impairment and hearing loss, and radiation. We are currently developing modules on infectious disease health risks in Southwest Asia, sexual trauma, traumatic brain injury, and military occupational lung disease. These important tools are integrated with other VA educational efforts to enable VA practitioners to more quickly and accurately arrive at a diagnosis and to provide more effective treatment.

Enhanced Outreach

Outreach is critical, and the Gulf War made clear the value of timely and reliable information about wartime health risks for veterans and their families, elected representatives, the media, and the nation at large. VA has already developed a brochure that addresses the main health concerns for military service in Afghanistan and is preparing another brochure for the current conflict in the Gulf region. These brochures answer health-related questions that veterans, their families, and health care providers have about these hazardous

military deployments. They also describe relevant medical care programs that VA has developed in anticipation of the health needs of veterans returning from combat and peacekeeping missions abroad.

Another challenge for outreach is to address the specific concerns of veterans and their families over the potential health impact of environmental exposures during deployment. Veterans also have questions about their symptoms and illnesses following deployment. These concerns are addressed through newsletters and fact-sheets to veterans covering health and compensation issues, including environmental health issues; regular briefings of veterans service organizations; organization of national meetings on health and research issues; media interviews; other educational material and websites with information, like www.va.gov/environagents.

Recruit Assessment Program (RAP)

Based on the Department's experience providing health care and benefits to Gulf War veterans, VA recognizes the critical importance of health documentation and life-long medical records that cover pre-, during-, and post-deployment period. Previously, new health problems among Gulf War veterans were not readily verifiable due to a lack of detailed computerized records documenting enlistment and pre-deployment health status. Research efforts to understand Gulf War veterans' illnesses were also hampered by inadequate base-line health information, and inadequate documentation of health status during active duty.

DoD and VA have recognized these shortcomings and are attempting, through development and implementation of the Recruit Assessment Program (RAP), to collect comprehensive baseline health data from all U.S. military recruits. The RAP is a DoD program, which is under development with the support of VA. The goal is for the RAP to be the first module of a life-long health record for military personnel and veterans. The RAP will help DoD and VA to evaluate health problems among service-members and veterans after they leave

military service, to address post-deployment health questions, and to document changes in health status for disability determination.

It is important to note that during the last two years all U.S. Marine Corps recruits initially trained on the West Coast have completed a RAP questionnaire as part of a pilot RAP development program. Therefore, baseline health data is available for over 31,000 Marines, many of whom are currently serving in the Gulf region.

VA Vet Center Program

VA's Vet Centers, originally conceived to provide a wide variety of readjustment services to Vietnam veterans, have been invaluable in providing similar services to veterans from more recent combat and peacekeeping missions. More than 115,000 veterans of Operations Desert Shield/Desert Storm have made use of their services. We fully expect that the VA Vet Centers will be available to help both veterans of the current hostilities in Afghanistan and Iraq and veterans of future conflicts elsewhere in the world.

Disability Compensation

To assist in disability determinations, VA has actively worked with DoD to develop separation physical examinations that thoroughly document a veteran's health status at the time of separation from military service and that also meet the requirements of the physical examination needed by VA in connection with a veteran's claim for compensation benefits. VA has also worked to provide fair compensation for Gulf War veterans with difficult-to-diagnose illnesses. Under 38 U.S.C. § 1117 (as amended by Public Law 107-103), VA has authority to compensate Gulf War veterans for chronic disabilities resulting from an undiagnosed illness or certain medically unexplained chronic multisymptom illnesses. It is our belief that servicemembers serving in the Southwest Asia Theater of Operations during the current conflict with Iraq would, as veterans, also be eligible for compensation for disabilities resulting from undiagnosed illnesses.

Coordination with the Department of Defense

Enhanced Interagency Collaboration

One of the important lessons learned from addressing Gulf War health issues was the need to significantly increase intergovernmental coordination among VA, DoD, and Department of Health and Human Services (HHS). The initial Government response to Gulf War veterans' concerns about their illnesses was not effectively coordinated among these Departments. As a consequence, the Persian Gulf Veterans Coordinating Board (PGVCB) was established in January 1994. This board, consisting of representatives from VA, DoD, and HHS, was created to coordinate Federal efforts in the areas of research, clinical care, and benefits. The initiation in 2000 of the tri-agency Military and Veterans Health Coordinating Board (MVHCB), replacing the PGVCB, served to institutionalize future interagency cooperation. In 2002, the MVHCB was disbanded and a special deployment-health working group of the VA-DoD Health Executive Council was established to further its work and ensure continued interagency coordination for all veteran and military deployment health issues. Governmental coordination will continue to play a critical role in addressing health problems among veterans in future conflicts and peacekeeping missions.

Increased collaboration has also extended beyond America's borders and strengthened coordination with Military and Veterans Affairs agencies in other countries. On post-war health issues, such as those arising after Operations Desert Shield/Desert Storm, VA scientists and policy makers collaborate and share lessons learned with their counterparts in Canada, the United Kingdom, and Australia. Because of the similarity of health problems among war veterans of different countries, these collaborations have focused on difficult-to explain-symptoms that consistently arise among military personnel returning from hazardous deployments.

Transmission of Health Data between DoD and VA

VA and DoD are closely collaborating to develop the ability to share medical information electronically. Recently, the VA/DoD Joint Executive Council and Health Executive Council approved the adoption of the Joint VA/DoD Electronic Health Records Plan. This Plan provides for the exchange of health data and development of a common health information infrastructure and architecture supported by common data, communications, security and software standards, and high performance health information systems. Since June 2002, the Departments have successfully been sharing electronic medical information. Key initiatives in the Electronic Health Records Plan are the Federal Health Information Exchange (FHIE) and HealthePeople (Federal).

FHIE (formerly known as the Government Computerized Patient Record) provides historical data on separated and retired military personnel from the DoD's Composite Health Care System (CHCS) to the FHIE Data Repository for use in VA clinical encounters, and potential future use for aggregate analysis. Patient data on laboratory results, radiology reports, outpatient pharmacy information, and patient demographics are now being sent from DoD to VA via secure messaging. This first phase of FHIE is fully deployed and operational at VA medical centers nationwide. The next phase is currently being deployed and includes admission discharge transfer data, discharge summaries, allergies, and consult tracking.

HealthePeople (Federal) is a strategy to achieve full interoperability among Federal health information systems, starting with the ability to provide a two-way exchange of health-related information between VA and DoD by 2005. VA and DoD are collaborating on several important health information applications in moving toward HealthePeople (Federal). Taken together, they will permit the Departments to offer a seamless electronic medical record.

- Clinical Data Repository/Health Data Repository (CHDR): This project seeks to ensure the interoperability of the DoD Clinical Data Repository with the VA Health Data Repository by FY 2005.

- Consolidated Mail-Out Pharmacy: The Departments are testing a system that allows VA to refill outpatient prescription medications from DoD's Military Treatment Facilities.
- Lab Data Sharing and Interoperability: VA and DoD are testing an application that will allow both Departments to combine resources and provide laboratory services to one another.
- Credentialing: A project team has identified common credentialing data to be exchanged between the DoD and VA. Software is being jointly developed and there are plans to begin testing at three sites by 4th Quarter FY 2003. This will decrease the time and resources needed to credential providers who need to practice in both health care systems.
- Scheduling: VA and DoD are sharing technical requirements to ensure interoperability between scheduling applications of each Department. This will allow providers to see all appointments a patient might have scheduled at both VA and DoD facilities and, where authorized, to schedule appointments in each other's clinics.
- E-portal Systems: The Departments are collaborating on a joint acquisition of health content for their electronic web portal systems. This will provide uniform patient health information to VA and DoD beneficiaries.

Deployment Health

VA applauds the efforts of DoD to prevent health problems among deployed troops and to provide immediate care for combat casualties. However, just as DoD has made substantial progress preventing morbidity and mortality on the battlefield, we also need to focus greater attention on the long-term health problems of veterans after the war. The trauma of warfare has lasting effects. The physical and psychological wounds of war can heal slowly, and toxic exposures on the battlefield may have enduring health consequences long after the actual war has ended.

The key to addressing the long-term needs of veterans is to improve medical record-keeping and environmental surveillance. To provide optimal

health care and disability assistance after the current conflict with Iraq, VA needs the following:

- a complete roster of veterans who served in designated combat zones; and
- data from any pre-deployment, deployment, or post-deployment health evaluation and screening of deployed troops.

Furthermore, in the event Iraq uses weapons of mass destruction against U.S. troops, it will be vital for VA to have as much health and environmental information as possible on potential exposures and their health effects in order to provide appropriate health care and disability compensation for veterans of this conflict. Ideally, information would be available from representative environmental samples, biological samples obtained from exposed troops, clinical data from exposed troops who seek medical care, and data from an epidemiological survey of symptoms and illnesses among potentially exposed troops.

Summary

A veteran separating from military service and seeking health care today will have the benefit of VA's decade-long experience with Gulf War health issues. VA has successfully adapted many existing programs, improved outreach and education, and readjustment counseling services for Gulf War veterans. VA now has significance experience with the special provisions in law authorizing disability compensation for Gulf War veterans. In collaboration with other federal agencies, VA has additionally initiated new programs for developing and coordinating federal research on veterans' health questions. The Department of Veterans Affairs has learned many lessons since Operations Desert Shield/Desert Storm. The Federal government is committed to caring for deployed service members both during deployment and after they leave military service.

Mr. Chairman, this concludes my statement. Dr. Hyams and I will be happy to respond to any questions that you or other members of the subcommittee might have.

Mr. SHAYS. We've been joined by Mr. Bell and Mr. Tierney, and we have a full group of Members here. We're going to do the 5-minute rule. Usually we do 10 minutes, because it allows us to get a little deeper, but we'll have a second round. And I am going to start off this time.

I want to ask why the Department of Defense is not taking actual physicals of every member who goes into conflict overseas. When we passed Public Law 105–85, the medical tracking system for members deployed overseas—that is section 1074, subsection (a), the system required, the Secretary of Defense shall establish a system to assess the medical conditions of members of the Armed Forces, including members of the Reserve components who are deployed outside the United States or its territories or possessions as part of a contingency operation, including a humanitarian operation, peacekeeping operation or similar operations, or combat operations.

And subsection (b), elements of system, a system described in subsection (a) shall include the use of predeployment medical examinations and postdeployment medical examinations, including an assessment of mental health and the drawing of blood samples to accurately record the medical condition of members before their deployment and any changes in their medical condition during the course of their deployment.

I'm pretty clear, when we voted on this law, what that meant to me. I'm just curious to know why we're not seeing it implemented. And, Dr. Winkenwerder, would you kind of tell me why not?

Dr. WINKENWERDER. We believe that we are following the law, and that we're doing it in a way that makes sense. As you read—and I think it is very helpful to read the actual language of the law here—you note the fact that we're required to develop a system to assess the medical condition. I think that's the operative point. It is to understand what is the baseline health, and when one is looking at a young generally healthy population, the most useful information to ask—or to determine the health status of that individual is a set of questions. I think, from my experience as a physician, that history-taking is really the most useful information to get a picture of the health status of the individual, not so much a hands-on physical examination. Usually those types of examinations are of very limited value.

We do perform periodic full physical examinations, along with the drawing of blood, but it is our view that we are meeting the letter and the spirit of the law——

Mr. SHAYS. Let me just tell you, from my standpoint, you're not meeting the letter of the law clearly, and I don't even think you're meeting the spirit of the law.

So I'd like to know where it says that this examination should be a self-assessment. Where in the law do you read self-assessment?

Dr. WINKENWERDER. Well, it is not only a self-assessment. There is a review by a medical provider with questioning by the medical provider that gets at the history of the individual, the medical history of that individual.

Mr. SHAYS. The challenge that I have is that we've had countless numbers of hearings since Gulf war, because our folks came home

sick; 125,000 are registered with the VA out of 700,000. And it started out when we had our hearings that the government officials would respond and say, no one came home sick, and our second panel were people who were sick, and you knew they were sick just looking at them. Then when you heard their history—so we then reversed it. So we had them go first and then had the VA and DOD come second and be the second panel.

What I'm struggling with right now is we didn't accept self-assessment when our VA folks—when our military folks came back. We gave them a physical. We didn't ask them to fill out a questionnaire. We gave them a physical. I can understand you'd have them fill out a questionnaire, but doesn't the law say that there's supposed to be a medical examination?

Dr. WINKENWERDER. Well, again, medical examination and physical examination are not synonymous. Some may have read that to be the same, but as a physician, I would say that they're not the same.

Mr. SHAYS. You know——

Dr. WINKENWERDER. What we're attempting to do to really—to answer your question, which I think is a very fair question, is to ensure that we have a good baseline of information for every individual that gives us what we need to know about the health status of that individual.

Now, I'll stop at that. I was going to go into the issue of the postdeployment.

Mr. SHAYS. Well, I'm sure you'll have an opportunity.

Let me just say before I recognize Mr. Kucinich that one of the challenges with the concept of medical examination versus physical examination is that it reminds me of what was alluded to by Mr. Kucinich when we went to DOD and questioned whether our troops had been exposed to chemical weapons, and we found them using the word, they weren't exposed to offensive use of chemicals.

Then we had a hearing in which we had a video of the blowing up of Khamisiyah, and DOD has a press conference on Friday at 4 o'clock before our Tuesday hearing to disclose that our troops were exposed to defensive chemical exposure. I just hope we're not getting a play on words here.

So at any rate, Mr. Kucinich, you have the floor.

Mr. KUCINICH. Thank you very much, Mr. Chairman. Again, I want to thank you for demonstrating your concern for the men and women who serve by calling this hearing.

Dr. Winkenwerder, I would like to ask you about the press release that you issued in January. In it you made a broad statement. You said the U.S. military is prepared to protect its personnel against the use of biological weapons. That's a direct quote. You stated that, "America's troops are well trained and protected with a robust multilayered set of defenses against bioweapons."

Now, you say the troops are prepared. Does your definition of prepared include training in a realistic environment?

Dr. WINKENWERDER. Yes.

Mr. KUCINICH. But, Dr. Winkenwerder, the GAO testified before this subcommittee last fall, "no realistic field exercises for medical personnel of chemical and biological defense have been conducted."

None. How can you say that you're prepared with no chem-bio field exercises for your medical personnel?

Dr. WINKENWERDER. That study, if it is the same one that I believe you're referring to, was in 2001. That is the time when that information was collected was approximately 2 years ago. And I can just tell you that since that time there has been an intensive effort to train a large number of people, both nonmedical and medical.

When I took my position about 18 months ago and then was before this committee about 14 months ago or 13 months ago, I think, now, I committed to you that this matter of training people would be one of my highest priorities.

Mr. KUCINICH. Thank you.

Dr. WINKENWERDER. And let me just say, we issued——

Mr. KUCINICH. Doctor, I've got a question here that is a followup, and I appreciate you taking this time to answer the question, but I have another question.

Dr. WINKENWERDER. OK.

Mr. KUCINICH. And that is that are you familiar with the war game called Millennium Challenge 2002?

Dr. WINKENWERDER. Generally. So yes, I——

Mr. KUCINICH. You say we're talking about 2001. Now let's go to 2002. That was the largest war game in American history, and it was also the most expensive at $250 million. It involved over 13,000 soldiers, sailors, airmen. But when the commander claimed the enemy wanted to simulate the use of chemical weapons, he was told to disclose his troop locations and be destroyed. He told the Army Times that instead of testing against the most urgent threats, the game was rigged. Now, how can you say, 2002, that you're prepared, when from this report realistic field testing had not been done?

Dr. WINKENWERDER. I'm not going to try to speak for our commanders in the field, Army officers that planned and conducted those exercises.

Mr. KUCINICH. But how do you answer the question, though? Do you have an answer to that question?

Dr. WINKENWERDER. Well, I can't answer your question, because I'm not in a position——

Mr. KUCINICH. Let me move on to the next question if you can't give me an answer.

Dr. WINKENWERDER. Well, let me just stay this. I stand by what I've said in terms of the preparation of our medical personnel to operate in those environments, the preparation and training to care for people, whether there's been exercises——

Mr. KUCINICH. Doctor, Doctor, with all due respect, you said you stand by what you said, but I gave you an example that contradicted what you said, but you still stood by what you said. Now, I just want that on the record.

Does your definition of "prepared" include providing troops with the minimum level of necessary chem-bio equipment as said by you and the Defense Department?

Dr. WINKENWERDER. The minimum level of equipment to protect people would be part of being prepared, absolutely.

Mr. KUCINICH. And in light of all the equipment shortages identified by the GAO, the critical deficiencies identified by the Army audit agency and the false inventories identified by the inspect general, tell me, Doctor, how can you assert that you're prepared?

Dr. WINKENWERDER. The first thing I would say to you is you're bringing up issues that are not directly within my area of responsibility, but I will tell you, based on my conversations with other people in the Department of Defense who do have some responsibility in that area, that the concerns about suits and equipment have been addressed, and that there is confidence, a high level of confidence, that the issues that you refer to have been addressed and that people believe that we are prepared.

Mr. KUCINICH. Mr. Chairman, thank you. I just want to conclude with this. Now, the doctor has said that the problem has been fixed, and we were told this as well, and that's why Congresswoman Schakowsky, who was part of our last committee, wrote to Secretary Rumsfeld and asked him to certify to Congress that these minimum required levels of chem-bio equipment have been met. She got her answer 3 weeks before the war, and her answer was no.

Dr. WINKENWERDER. I'm not sure—I might respond, because I think this is an important issue.

Mr. SHAYS. Sure. I do want you to respond. And I would like the gentleman to put on the record the letter. I think the letter didn't say no. I think it said they had two JSLIST suits, which then you could interpret as not meeting the minimum requirement. The JSLIST suits have 30 days each to them.

Dr. WINKENWERDER. Right.

Mr. KUCINICH. Mr. Chairman, here is the letter.

Mr. SHAYS. We'll put that in the record.

[The information referred to follows:]

THE UNDER SECRETARY OF DEFENSE
3010 DEFENSE PENTAGON
WASHINGTON, DC 20301-3010

ACQUISITION, TECHNOLOGY AND LOGISTICS

27 FEB 2003

The Honorable Jan Schakowsky
U.S. House of Representatives
Washington, D.C. 20515-1309

Dear Representative Schakowsky:

I appreciate your interest and concern for military personnel serving in the Armed Forces and the policies regarding their chemical and biological (CB) protection. U.S. forces are trained, ready, and will deploy with the best available equipment. The safety of our Armed Forces remains a top priority for the Department of Defense.

We have made tremendous strides in recent years in training our Armed Forces and providing them with modern equipment, modern infrastructure, and adequate spare parts. Our deploying military units will be trained and equipped to meet the operational challenges of today and the future.

Since Operation DESERT STORM, the Department of Defense has fielded new and improved CB defense detection equipment and individual protective equipment. Every Service member to support near-term operations in Southwest Asia will carry at least two of the newer Joint Service Lightweight Integrated Suit Technology (JSLIST) suits and will have an additional two suits in contingency stocks. The contingency suits will be the Battle Dress Overgarments (BDOs) until replaced by JSLIST suits.

The Department of Defense increased its procurement of JSLIST suits from 79,000 per month to over 90,000 suits per month in December and is taking steps to surge the production even higher over the upcoming months.

Your concern for the safety of the Nation's military members is deeply appreciated.

Sincerely,

E. C. Aldridge, Jr.

Mr. KUCINICH. Here's the letter, here's the response, and it's very clear the answer was no.

Mr. SHAYS. For the record, since this is so technical, find where the no is on that letter.

Mr. KUCINICH. The text of this does not answer the question as far as certification.

Mr. SHAYS. OK.

Mr. KUCINICH. She asked for certification. If the Secretary of Defense will not certify that these suits are OK, the American people have a right to know that. The answer was no.

Mr. SHAYS. I got the same letter, and my interpretation of it was that he was certifying that they would have—well, I first have to make sure I have the same letter. I'll look at it and then——

Dr. WINKENWERDER. I want to attempt to answer your question, even though I want to be clear that the issues you're talking about are not within my area of responsibility, but I don't want to avoid trying to answer the issue that is in front of us.

Mr. SHAYS. I realize we have a 5-minute rule, but I will extend a little more time if a Member, you know, is nervous that the answer is a little long. But I don't want to have the answer not be thorough enough to respond.

Dr. WINKENWERDER. The issue with respect to chemical protective suits, I believe you're referring to, is the number of them, and each service member has been issued at least two, and I'm told—the information I have is that each will have three within a matter of less than a week.

Now, obviously that's to reach 100 percent. So they've been moving toward that target obviously for the last several weeks. And then I think there was another issue with some defective suits, and, again, I'm going to relate to you my best understanding of that, but my understanding is that those have been removed from the inventory, and there was a very deliberate, scrupulous effort to remove all of those suits, and they are not being used in this situation today.

Mr. SHAYS. Well, we'll be here for a bit, so we can nail this one down.

Mr. Turner.

Mr. TURNER. Dr. Winkenwerder, I just recently met with representatives from the Ohio National Guard, and they were talking to me about the issue of National Guard Reservists that do not have continuous health care coverage. They have indicated numbers between 20 and 40 percent of the Reservists do not have continuous health care coverage for insurance.

To what extent do you have a concern that might have an impact on the medical condition of those deployed?

Dr. WINKENWERDER. If I might just ask you, the 20 to 40 percent, is this without health insurance coverage, and they're sort of private——

Mr. TURNER. Correct. Correct.

Dr. WINKENWERDER. My hope is that it would not impact upon their health status. We do have a check on that, however, and that is that we require a certain level of medical readiness before people come on to Active Duty, and so we would hope to screen for and identify individuals who are not medically ready to serve.

Obviously the issue of health insurance or the lack thereof among certain members of the population is an ongoing problem.

I will say that with respect to caring for National Guard and Reservists and their families, when they come on Active Duty, they are eligible for the military health system benefit program, TRICARE. We've made—in a change that we had just 2 weeks ago, made it easier for them to gain coverage for their families. There had been a glitch in the system where if a person was living, for example, in one part of the country and got deployed from another, that because they weren't residing with their family—or their family wasn't residing with them, they would not be eligible. We changed that. They're now eligible right then and there. There was also a hurdle that one had to be activated for 180 days. We changed that and said they only need to be active for 30 days. So all those benefits are commensurate between reservists and Guard and our ongoing Active Duty.

And we gladly did that. Our Reservists and Guard are playing a very important role in this conflict, and particularly so in the medical area. So it's important that we take care of them.

Mr. TURNER. Thank you.

Mr. SHAYS. Thank you. I think we will go to Mrs. Maloney.

Mrs. MALONEY. A few, Mr. Chairman, and I want to be associated with your comments and those of the panel in appreciation of our men and women who are serving in the armed services.

I would like to ask some questions that were raised in this book, Saddam's Bomb Maker. It was written by Khidir Hamza, who says that he was in charge of Saddam's efforts to secure materials from foreign governments to build nuclear bombs, and he also talks about their chemical and biological weapon program. And I would like permission to place in the record page 244 and page 263.

[The information referred to follows:]

The helter-skelter looting was rank evidence that Iraq expected to be evicted. What Saddam still worried about, however, was the capture of Baghdad and his personal vulnerability. For him, there was no escape. Where could he go?

Accordingly, he ordered General al-Saadi to organize a two-pronged defense. The first was to load chemical and biological warheads onto Iraqi missiles, in the event Allied troops stormed through the gates of Baghdad. But the second, and ultimately more relevant prong was to bury thousands of chemical and biological weapons in southern Iraq, at Basra, Nasiriyah, Simawa, Diwaniyah, and Hilla, the likely routes of the Allied invasion. His thinking was that the Allies, following U.S. tactical doctrine, would blow up the bunkers as they advanced, releasing plumes of invisible gas into the prevailing winds and ultimately onto themselves. Any depots the Allies missed could be blown up by retreating Republican Guard units. The invaders literally wouldn't know what hit them, until it was too late—maybe weeks or months after the conflict ended. The pattern of contamination would be so disparate, the symptoms so amorphous, the sources of illness couldn't be easily confirmed.

Iraq would be hell to the invaders, win or lose, Saddam gambled. A corollary benefit was that the chemical shower would decimate the despised Shia in the south, whom he concluded were of little concern to the Allies, given their potential role as troops for Iran. In any event, if chemical residues were eventually detected, the Americans would have only themselves to blame. And the West would tie itself in knots over an appropriate retaliation. Washington, Saddam reasoned, had no stomach for carrying out retaliation in kind.

On the night of January 16, 1991, Iraq's top nuclear officials met for a candle-lit dinner at Le Soufotel, a French restaurant in downtown Baghdad. The dinner was to celebrate my new good fortune at being assigned away from AE.

The gathering was official self-delusion at its worst. The Allied air campaign was scheduled to kick off in four hours, yet many Iraqi officials were still in denial, despite weeks of repeated warnings from Washington.

"It's all a bluff," a colleague uttered, drawing agreeable guffaws around the table. "These guys have no stomach for a land war.

03/25/03
Submitted for the record by Mrs. Maloney
Nat'l Security - 2:00pm. - 2247 RHOB

in other cancer rates. The pediatric wards, meanwhile, were becoming a nightmare, as a growing number of mothers just walked out after giving birth to deformed babies. Most of them were Shiites from the contaminated zones.

Gulf War Syndrome was well known to everybody in Iraq, but Saddam remained silent. In this he had a secret ally—the U.S. Pentagon, which continued to deny that there was proof of a war-based disease despite growing evidence to the contrary. But evidence soon leaked of Allied forces blowing up chemical dumps during the war, and of the U.S. government's efforts to suppress repeated reports of contamination by units during the conflict.

The conspiracy of silence has remained to this day. Saddam has no interest in confessing his use of chemical and biological weapons, nor does Washington, which would be confronted by an outraged people to do something about it—and Saddam—if the deliberate contamination became known. Both sides have suppressed the real causes of Gulf War Syndrome because it has been convenient for both. Saddam blames the sickness on malnutrition and drug shortages caused by the embargo, and Washington blames it on . . . nothing.

After the war, officials like me were prohibited from visiting Baghdad hotels or other public places frequented by UNSCOM inspectors. The regime figured, rightly, that we'd be tempted to contact a foreigner and run.

My friend Ahmed Numan had a chilling experience with one of the inspectors. U.S.-educated and fluent in English, Ahmed was assigned to the Iraqi team that dealt with UNSCOM. His attitude was friendly but careful, especially with the Americans, who often quizzed him on why he didn't return to the United States. One day one of them pressed a scrap of paper into his hand with his name and telephone number on it. Numan tucked it discreetly into his pocket and went home. At midnight, a security officer knocked on his door.

"Where is the paper?" he asked. Numan didn't even consider bluffing. He turned around, walked back into his house, retrieved the scrap of paper, and handed it over to the security man. It was a warning, he knew. A lot of questions and trouble would follow.

Many others had run. Jaffar's cook had disappeared with his

Mrs. MALONEY. And he raises really an alarming statement, and I would like to just quote from his statement here. He says, "the Gulf war syndrome was well known to everyone in Iraq, but Saddam remained silent. In this he had a secret ally, the U.S. Pentagon, which continued to deny that there was proof of a war-based disaster—war-based disease despite growing evidence to the contrary. But evidence soon leaked of allied forces blowing up chemical dumps during the war and of the U.S. Government efforts to suppress repeated efforts of reports of the contamination of our troops."

He also on page 244 talks about Saddam's effort to put biological—or that he did put, according to him, biological and chemical weapons into missiles that he was going to fire on the U.S. military if they went into Baghdad, but that he had a more sinister plan in that he buried chemical and biological weapons in southern Iraq, knowing that the tactics of the U.S. military would be to blow up the bunkers; therefore, they would release the contaminated material, they would not even know that they were affected, and that they would then be laden with chemical and biological disease from these terrible weapons.

I'd like to ask you if you, No. 1, have read the book; No. 2, your comments on what Saddam's bomb maker, Mr. Hamza, who has defected to the West and I understand is working with our military and has been very outspoken against Saddam in hearings, publicly and so forth.

Dr. WINKENWERDER. I have not read the book, Congressman. I have heard of the book. And by all accounts, it is a—from what I understand, is a reliable piece of information.

Mrs. MALONEY. Are you aware that our troops were exposed to these biological weapons? The allegation that he makes that our Pentagon knows, that Saddam knows, that people in Iraq know that our troops were exposed to these terrible chemicals in the Gulf war?

Dr. WINKENWERDER. Well, from all the information that I've been presented during my tenure, no one has ever indicated to me that there is any knowledge of an acute exposure or the exhibiting of symptoms that would suggest an acute exposure to chemical or nerve agents during that conflict.

Mr. SHAYS. Would the gentlelady yield? I'll make sure she gets additional time.

Mrs. MALONEY. Sure.

Dr. WINKENWERDER. That is a separate question, an acute exposure, someone who is acutely ill, than the issue of whether there were low levels of exposure——

Mrs. MALONEY. Were there low levels of exposure?

Dr. WINKENWERDER. Well, that is what the whole Khamisiyah incident is about.

Mr. SHAYS. This is very important, and I don't want—since this is testimony under oath, I do want to make sure. There are really two issues, but one issue is sites. The only one that the Department of Defense has acknowledged is Khamisiyah. So I would love it if you would ask the question of whether there were other sites, and then get into this other shoe. But I want to make——

Mrs. MALONEY. Were there other sites besides Khamisiyah where they were exposed to chemical weapons?

Dr. WINKENWERDER. Not to my knowledge.

Dr. Kilpatrick.

Dr. KILPATRICK. I can answer that. In looking at——

Mr. SHAYS. A little closer to the mic, Doctor.

Dr. KILPATRICK. In looking at the air war campaign, it's very clear that at his storage sites at Al Muthanna and Mahamadia there were releases of chemical agents. In one location we have no indication there were American troops in the area where that plume would have gone, and the other area there were possibly up to 70 Special Forces people in that area, but there were no coalition forces or American forces in that area.

Then Khamisiyah is the third area, and that's been widely publicized and put out, and certainly we've identified the 101,000 American forces who were in that hazard area that was determined.

Mrs. MALONEY. Well, Mr. Hamza alleges that Iraqis were likewise exposed, and women gave birth to deformed children. People died of cancer early. People had Parkinson's-like neurological problems. And he blamed it all on malnutrition, according to this professor, and he likewise said that the same symptoms—or he alleges are now in the troops who regrettably were exposed to these terrible chemicals in the war.

If you have any other information, if you could get back to the chairman on it, on how many troops we think were exposed, where they were exposed and what chemicals—what chemicals do we think they were exposed to? Do you have an idea of what the chemicals were or biological weapon they were exposed to? Do you have an idea what it was?

Dr. WINKENWERDER. Yes.

And Dr. Kilpatrick.

Dr. KILPATRICK. In all three areas, sarin—cyclosarin were the agents that we were concerned about. As far as biological agents, we don't have any indication that American troops were exposed to biological agents. We do know that bombs and rockets filled with biological agents were found by the United Nations Special Commission, but we have no indication that they were ever launched against Americans.

Mrs. MALONEY. Excuse me. Go ahead, Mr. Chairman. My time is up. I'd like to continue with this questioning.

Mr. SHAYS. Why don't you ask the next question, and then we'll——

Mrs. MALONEY. If you have another question.

Mr. SHAYS. I just want to say to you that it's a little unsettling to me, because we've had so many instances—DOD has insisted that the only place that our troops were exposed was at Khamisiyah, and now we're hearing that we had other troops that were nearby. So I'm not sure whether I should consider this new information or old information, but it is a little unsettling to me, because either way it's new to me. And so I want to be clear that you have said that—there were two other sites. I want you to say what those sites were, and I want you to be very clear as to what

level of the amount of chemicals we think were onsite and compare them to Khamisiyah.

Dr. KILPATRICK. Those reports we released in the last 2 years, and I can get you specific details. Al Muthanna is one site, and Mahamadia is the other site. These were large production storage sites in Iraq near Baghdad, and they were damaged during the air war. We don't know exactly which day, because the bombing runs in each of those sites were over some 17 days. We don't know whether the release was at one time or over multiple periods of time. The determination of the hazard area assumed a release of all agent at one time, and the amount of agent is information that we receive from CIA, and they have recently released a report to give that amount. We can provide that to you.

Mr. SHAYS. Well, I understand we have the GAO looking at this, but—the plume modeling—but one thing I want to ask you would be then how many American troops do you think—first off, it's unsettling no matter what humanity was there, but how many Americans do you think were at——

Dr. KILPATRICK. At Al Muthanna, we don't believe there were any Americans in the area. At Mahamadia, we believe that there were up to 70 Special Forces, and we have identified them and notified them.

Mr. SHAYS. And have you notified the VA?

Dr. KILPATRICK. And that's been done also, yes.

Mr. SHAYS. OK. I thank the gentlelady for asking those questions.

Mrs. MALONEY. Mr. Chairman, could I followup with other sites that——

Mr. SHAYS. Yes. Why don't we do that real quick.

Mrs. MALONEY. They mentioned that they had it really as a war strategy, burying these chemicals knowing we might bomb them. The symptoms would not arise until weeks, months later. They would not know where it came from.

But he mentions that they were buried, thousands of chemical weapons in southern Iraq at Basra, Nasiriyah, Simawa, Diwaniyah, and Hilla, the likely routes of the allied invasion. And he says that that's what they did, and that we walked into that trap.

Dr. WINKENWERDER. I think you can conclude that this provides a good window into the twisted mind of Saddam Hussein.

Mr. SHAYS. But is that an answer that is a yes?

Dr. WINKENWERDER. We will take that information for the record, and certainly——

Dr. KILPATRICK. And I have no information at this time to be able to comment positively or negatively. I have no knowledge that in fact is true.

Mrs. MALONEY. Just very briefly, for years, literally, the Pentagon denied that they were exposed to chemical weapons, and he says that in the book. Why did we do that when we knew that they were exposed? And when did we acknowledge in the timeframe that they were exposed to chemical weapons?

Dr. WINKENWERDER. Let me just say this. I cannot speak for those who had my responsibility or were associated with those re-

sponsibilities 5, 6, 7 years ago, at the time the information began to come to light.

Mrs. MALONEY. But can you get us that information?

Dr. WINKENWERDER. Well, what I can tell you is that I am committed to getting that kind of information out and making it available, and that we know what happened. I think it is in everyone's interest, our service members, their families.

Mrs. MALONEY. And you will get that information to the chairman, so we can——

Dr. WINKENWERDER. We will take your request. But I just want you to know that I am committed to making that kind of information—and we have sought to establish a track record with this for the release of the information regarding the SHAD.

Mr. SHAYS. Let me just say. You are not just taking the request. You are going to get us the information, correct?

Dr. WINKENWERDER. We will.

Mr. SHAYS. Thank you.

[The information referred to follows:]

Hearing Date: March 25, 2003
Committee: House Government Reform
Subcommittee on National Security
Member: Rep. Maloney
Witness: Dr. Winkenwerder
IFR: Pages 48-49, lines 1014-1025

Question: For years, literally, the Pentagon denied that Service members were exposed to chemical weapons. Why was that done when we knew that they were exposed? When did we acknowledge the time frame that they were exposed to chemical weapons?

Answer: It is true that in the early years following the 1991 Gulf War, despite suspicions, no one in the Department of Defense, Congress, or other government agencies had evidence that U.S. Service members were exposed to chemical warfare agents. However, that changed on June 21, 1996 when, with the assistance of the CIA and with information provided by the United Nations Special Commission on Iraq (UNSCOM), the Department was able to confirm that U.S. Service members destroyed munitions at Khamisiyah that, unknown to the Service members and Pentagon leadership at the time, contained chemical warfare agents.

Following this announcement, the Department established the Office of the Special Assistant to the Deputy Secretary of Defense for Gulf War Illnesses (OSAGWI) to investigate this incident and determine the extent of the possible exposure of Service members to the chemical warfare agents released in the demolition. In February 1997, the OSAGWI published its first report on the events at Khamisiyah, and followed it in July 1997 with the results of predictive modeling requested by the Presidential Advisory Committee on Gulf War Illnesses. Those results showed that release of chemical warfare agents from the demolition at Khamisiyah probably created a hazard area of low level chemical warfare agents that lasted from March 10 – 13, 1991. In 1997, the Department identified units that may have been present in the hazard areas and notified Service members in those units of their possible exposure to low levels of chemical warfare agents.

Mr. SHAYS. Mr. Murphy, thank you for being so patient.

Mr. MURPHY. Thank you, Mr. Chairman. Are there differences between British troops and American troops in the Gulf war syndrome incidents?

Dr. WINKENWERDER. I am going to turn to Dr. Kilpatrick for that.

Dr. KILPATRICK. I think the research that has been done to date shows that there is tremendous similarity, not really difference. As far as numbers of British troops, the numbers of course are smaller. They had deployed some 50,000 and they've had some 3,000 people go through their health assessment program, which is very similar to our clinical—comprehensive clinical evaluation program, the VA's Persian Gulf registry program.

Mr. MURPHY. Is anybody still pursuing the line—I found the article from Pain and Central Nervous System Week from a year ago, a year ago last week, saying that research teams identified clusters of postcombat syndrome, some debilitating syndrome from the Boer war and the First World War, somatic disorder focused on the heart from the First and Second World Wars, and neuropsychiatric syndromes, in essence saying that every war seems to have those.

Are people still following that or has that been seen as not scientifically valid to say that perhaps Gulf war syndrome is similar to what is seen after every war?

Dr. WINKENWERDER. My answer to that is that even though different kinds of issues and maybe even some similar kinds of issues do occur in all wars, we saw something and later better understood something coming out of the Gulf war that was a constellation of symptoms and complaints that were quite real, that were occurring in higher proportion among those people who were deployed than among those who didn't deploy.

So I would distinguish what we saw there from what maybe had occurred in other, prior wars.

Mr. MURPHY. I have also read some studies that have looked at animal studies of some chemicals used for example for insect control and other things, particularly DEET, permethrin, and an antinerve gas agent, pyridostigmine bromide—I hope I am pronouncing that right—PB, which was administered to both British and U.S. troops; and have found a number of problems—cell degeneration, cell death, animal behavior differences—and have found that those things were exacerbated more when the animals were under stress, etc.

Given that these were—there also seems to be an additive effect, a multiplier effect, that any individual chemical, when used alone, doesn't have that, even when the dosage of those chemicals is low. But when you add them together, you end up with some pretty severe outcomes.

With those, that kind of data, have there been changes in how the military is using such things as immunizations, insect control agents, and other things in dealing with the Gulf war now?

Dr. WINKENWERDER. First of all, let me just say that the area that you are talking about is an area of research that we continue to support and believe is very important to better understand whether a variety of simultaneous or near-simultaneous insults

from low-level agents produces these effects. And that is very important work. It is ongoing. We are supporting that.

I would distinguish that from immunizations. From my perspective, particularly with respect to the use of the anthrax vaccine, we have had millions of doses given. We have followed all of that very closely for the last several years, and from my perspective, don't believe that there is any—and I think others would corroborate this, experts, outside experts, Institute of Medicine—that there is any association between the use of that vaccine and any of the symptoms that we saw.

Mr. MURPHY. Not even an interactive effect with these agents?

Dr. WINKENWERDER. Not with respect to the vaccine.

But I think your other point is very well taken in terms of low-level chemical exposure, nerve agents and pesticides. The way they work in the body is similar, and so you could hypothesize or theorize that there might be this additive effect. And I think that is important work that is ongoing, and we are supporting that.

Mr. MURPHY. Is that changing, though, how—a lot of what is being done that we are talking about here is the epidemiology of exploring pre and post-data. But I am just wondering if there has been a difference in handling things like insecticides and knowing that there may be nerve agent exposure.

Dr. WINKENWERDER. There have been some changes in the use of pesticides and pesticide management policy, and I think the long and short of that is that they are used more sparingly and more carefully, and with a lot better documentation and control. So that is something that we had already begun to respond to and change practice.

Mr. MURPHY. One other factor I want to ask, perhaps because of my background as a psychologist. But what I see frequently in these studies is the impact or the interactive effect of stress upon any of these.

Can you comment on how that works?

And it also relates to some of the comments—you talked about soldiers who are in the actual theater of war and those who remain home.

Dr. WINKENWERDER. I think it is certainly plausible that stress could add to any sort of physiologic—yeah, and as Dr. Roswell was saying. But I would distinguish that from saying that stress alone is responsible for the symptoms; I don't happen to believe that.

Mr. MURPHY. I understand. I just think as we discuss these things, as one is looking at pre and post-histories, that getting some understandings of the mental health, which is oftentimes extremely difficult to get from just a self-disclosing questionnaire, is very important.

That is not to say that these folks have mental illness, that is not—although some may have post-traumatic stress syndrome. It is important to understand that stress has an impact on many diseases, cancer being one on which there has been extensive amounts of research. And one that you can't build a cure to protect you from that, but it is one that we need to be aware of, how we help soldiers with that.

Dr. WINKENWERDER. We agree with you.

Mr. MURPHY. Thank you, Mr. Chairman.

Mr. SHAYS. Thank you, Mr. Bell, for your patience. You now have the floor.

Mr. BELL. Thank you very much, Mr. Chairman.

I want to followup on some lines of questioning that were begun by my colleagues, Congresswoman Maloney and Congressman Kucinich. I want to begin with this letter that Congressman Kucinich referred to, since we didn't really—I know it's been offered for the record, Mr. Chairman, but we didn't really get to delve into the text.

And I would disagree with my colleague that it was a no; actually, it was a little more disturbing than that in that it was a nonanswer completely. And Representative Shakowsky had asked a very direct question in her letter to the Department, requesting information on the suits and would they provide protection for our troops. And I am not going to read the entire letter since it has been entered in the record, but where you come to the paragraph where he could easily answered the question yes or no, he says, instead: "since Operation Desert Storm, the Department of Defense has fielded a new and improved CD, defense detection equipment and individual protective equipment. Every service member, to support near-term operations in Southwest Asia, will carry at least two of the newer, joint service lightweight integrated suit technology JS list suits and will have an additional two suits in contingency stocks. The contingency suits will be the battle dress overgarments, BDOs, until replaced by JS list suits."

So we know what they will have in terms of supplies, but we have no idea whatsoever whether they are safe because nowhere in the letter of response does it say that they are safe. And I think the frustration felt by me and some of my colleagues in recent weeks is that it is hard to get a direct answer.

And the purpose of this hearing is to focus on lessons learned from the Persian Gulf. Persian Gulf war syndrome was not something that was immediately announced after the Persian Gulf war, if I recall correctly. I was not—obviously not serving as a Member of Congress at the time, but if memory serves, it took months, perhaps years in some cases, for all the information regarding that syndrome to filter out regarding what people had been exposed to.

And we are highly critical of our enemies in this conflict as to their propaganda machine. And I am not saying that our information system compares to that in any way, shape, or form, but it does seem that we do engage in misinformation sometimes. And I would like for your comments on that and whether you think that we could learn a lesson from the Persian Gulf war and perhaps do a better job of educating both Members of Congress and the American people as to the risk we face. Because I don't think any right-thinking individual in this country believes that we don't face very serious risk by going forward with this conflict.

Dr. WINKENWERDER. Congressman, I can just assure you there is no thought of misinformation or trying to misinform either our service members or the public. That does not serve any of us in the short run or the long run.

I think that, from my review of what transpired in the past, it did take months and years to find out more about what happened. I do believe that has informed a lot of action and activity on the

part of the Congress, as well as DOD and VA, to put into place better recordkeeping, better tracking, better equipment, better monitoring detection across the whole board.

And my conclusion is that we are prepared. However, we face an enemy that is prepared to use some of the most lethal and awful weapons we have ever known, and that is a daunting situation. So I don't think there is any effort to tread lightly over this issue or to not acknowledge the seriousness of the risks that are out there. These are very serious risks that we face.

Mr. BELL. And I think that is a very important statement, because by putting a statement on the record that we are prepared, basically you put yourself in a position that, if we come up against something that we really didn't know we were going to come up against during the course of this conflict, then you are in a box if we come back and face something and you have to say, well, we weren't prepared completely for that.

But aren't we in a situation, Doctor, where it is almost impossible—based on your statement about what he is prepared to do, almost impossible to completely prepare for what we might face?

Dr. WINKENWERDER. That's a judgment. I think we have very good information about what the threats are. We have good information about the detection capabilities. We have good information about the protective capabilities of the equipment and suits. We have good information about the protective capability of medical countermeasures. So I think that we are prepared.

There are certain situations, there are circumstances that one can envision where an enemy can create harm and damage, and we have already seen that in the war thus far. So being prepared does not mean being able to completely prevent any adverse outcome in every single service member serving.

Mr. BELL. Can I ask one more question?

Mr. SHAYS. Sure.

Mr. BELL. As far as the lessons-learned category, are we prepared, after we face whatever we are going to face in this conflict, to come back and say, this is what we are looking at, this is what we are testing our troops for?

Dr. WINKENWERDER. Yes.

Mr. BELL. And to treat that instead of trying to pretend that we didn't face any of those things?

Dr. WINKENWERDER. Absolutely. We will be looking at people very carefully after deployment. And we have a process in place. We are looking at and currently evaluating that system to ensure that it will collect all the information in a timely way that we want and think that we might need.

Mr. BELL. Thank you very much, Doctor.

Thank you, Mr. Chairman.

Mr. SHAYS. Thank you.

Just for the record, the committee's counsel reminds me that all three sites had been discussed. The only thing that we think is a bit new is that maybe we had Special Forces near one of those sites, but that the committee is trying to determine where those plumes went. So I just want the record to state that.

Also say—Dr. Winkenwerder, you are getting all the questions right now.

Dr. Roswell, you are going to get some.

But you have, for the record, turned over some stones and have been very cooperative and very helpful with this committee. So these are big issues. But I do want the record to note that you have been pushing DOD to be more candid, to be more open, and to treat these very serious questions that you are being asked with a lot more attention than has been done in the past. I do want the record to note that at well.

Dr. WINKENWERDER. Thank you.

Mr. SHAYS. Mr. Janklow.

Mr. JANKLOW. Thank you very much, Mr. Chairman.

You know, let me, if I can, ask questions kind of like we used to take our English lessons—what, where, when, how, why, and to what extent—if I can.

Let's talk about the current war that we are in. In order to try and make sure that we don't have some of the problems that—and nobody wants to repeat the problems of Desert Storm. One, is it—will it be difficult at all—and you used the phrase before, production areas, storage areas. Would it be difficult now, if we come across any production areas in the country, to document, using GPS, GIS, whatever, exactly where these locations are; two, exactly what storage facilities we come across within the country; three, exactly where utilization of chemical, biological types of weapons are used; and four, to the best extent possible, identifying, if not the individuals, at least the units that are in the area so that all of these kinds of problems that we have wrestled with from Desert Storm don't have to be revisited?

Is there a plan in place to deal with it that way?

Dr. WINKENWERDER. I will try to give you the best answer I can. But I will note that, again, you are asking very good questions. They are out of my——

Mr. JANKLOW. Are they out of your bailiwick?

Dr. WINKENWERDER. They are really, truly are out of my area of responsibility.

Mr. JANKLOW. OK. If they are, then could you find somebody that could—could you at least take the message back?

And I've got to believe they're doing this. It isn't that they operate in a vacuum over there. They are the best there are.

Dr. WINKENWERDER. Absolutely.

Mr. JANKLOW. This is a way to try and obviate some of these kinds of problems.

Dr. WINKENWERDER. I can just tell you from my exposure to those types of discussions, there is an exquisite level of sensitivity to the issue of how to deal with the issues that you brought up and to avoid any inadvertent or any kind of contamination.

Mr. JANKLOW. Doctor, based on your position, your experience, your background, are you satisfied that we have a good baseline on the troops that are currently in the field or will be going to the field over in Iraq?

Dr. WINKENWERDER. I am.

Mr. JANKLOW. In terms of a medical baseline for them?

Dr. WINKENWERDER. Yes, sir, I am.

Mr. JANKLOW. And Mr. Roswell, are you satisfied that within the President's budget, the existing budget or the supplemental re-

quest, there are sufficient funds to take care of the medical liens, medical needs that are reasonably foreseen—and I realize we could argue about terms—but the medical needs that are reasonably foreseen, that may be necessary for these soldiers, sailors, airmen, Marines when they come home? Or, obviously, in the field, but when they come home?

Dr. ROSWELL. Certainly, based on the current availability of resources we have concerns. But given their high priority, I have no reservation about our ability to——

Mr. JANKLOW. When you say that, is there any anticipation at all that you will be bumping other people that are currently eligible out of the system or aside to take care of these folks when they come home?

Dr. ROSWELL. That is a contingency that the Secretary of Veterans Affairs, in exercising his statutory authority as mandated by this Congress, would have to consider. So it is possible that if there was an unpredicted demand for care from the Department of Veterans Affairs, by law, Secretary Principi would have to consider other lower priorities of veterans and their ability to continue to enroll in and receive a full health care benefit.

Mr. JANKLOW. Mr. Chairman, can I see that letter for a second? I guess I have it here, the one that was mailed to you. I am unfamiliar with these letters, until today, that have been talked about. But one of the letters I saw is a letter from Mr. Eldridge—or an E.C. Eldridge, Jr., I am sorry, I assume that is a Mr. Eldridge—to Representative Shays; and in it—I am sorry, one signed by Mr. Eldridge on February 27, 20O3.

And in that one, Mr. Eldridge says to—excuse me—Ms. Schakowsky that every member of Desert Storm will carry at least two—excuse me—every member support near-term operations in Southwest Asia will carry at least two of the new joint service lightweight integrated, the J list suits, and will have an additional two suits in contingency stocks.

Is that the case for the people currently operating in Iraq?

Dr. WINKENWERDER. That is my understanding. Yes.

Mr. JANKLOW. OK.

Thank you, Mr. Chairman. I have no more questions right now.

Mr. SHAYS. Thank you very much. We are going to put both letters in the record. But the bottom line is, that was the response to my request and also Ms. Schakowsky's.

[The information referred to follows:]

THE UNDER SECRETARY OF DEFENSE
3010 DEFENSE PENTAGON
WASHINGTON, DC 20301-3010

ACQUISITION, TECHNOLOGY AND LOGISTICS

10 JAN 2003

The Honorable Christopher Shays
U.S. House of Representatives
Washington, DC 20515

Dear Representative Shays:

Thank you for your recent letter to Secretary Rumsfeld requesting an update on our assessment of supplying chemical and biological protective suits to deploying forces. The Department of Defense (DoD) fully intends to provide our deploying forces with the best available chemical and biological defense equipment.

The Joint Staff has directed that every military Service member deploying for any potential conflict in Southwest Asia have a minimum of two Joint Service Lightweight Integrated Suit Technology (JSLIST) or Saratoga suits. Based on a recent logistics assessment, the DoD currently has an adequate supply of JSLIST suits to support this requirement. The Services will continue to use the Battle Dress Overgarment (BDO) as a backup to the JSLIST until sufficient additional inventory of JSLIST suits are available to provide a final basis of issue of four suits per person. Priority of issue for future JSLIST suit distribution is to deploying forces

The production of JSLIST suits was increased from 79,000 suits per month to 90,000 suits per month beginning in December 2002. In addition, the DoD is taking steps to surge the production higher over the upcoming months and intends to accelerate the planned replacement of BDOs.

The safety of our military members is a top priority of DoD. Your concern for their welfare is deeply appreciated. Thank you for your continued support of U.S. national defense.

Sincerely,

E. C. Aldridge, Jr.

Mr. SHAYS. Mr. Tierney, you have the floor for a generous 5 minutes.

Mr. TIERNEY. Thank you, Mr. Chairman.

Mr. Chairman, thank you for the long series of these hearings that you've had over the years. I think they have served to benefit the men and women that are there now. I don't think that without having had the hearing on the condition of our protective suits, that they would have the two new suits; and so I appreciate that, and I am sure their families do.

Mr. SHAYS. It has been a team effort on both sides of the aisle.

Mr. TIERNEY. Doctor, Dr. Winkenwerder, let me ask you for a second: One of the concerns that we had in doing the homeland security measures was that if there was a contamination, the people responding to that, the medical personnel who oftentimes found themselves unprepared, sometimes exacerbated the situation and completely knocked out an entire medical unit because they hadn't been prepared to separate the contaminated folks out from the others.

My understanding is that, in the Gulf, most of the medical people, the doctors and nurses sent over there, are Reservists, which would raise the specter that their training is 1 weekend a month or 2 weekends a month and 2 weeks in the summer; and I would guess that would probably be barely enough to keep up on their training for medical treatment in the field.

Can you give us some assurance that those Reservists have, in fact, been properly trained to meet what might happen in terms of a chemical or biological attack?

Dr. WINKENWERDER. We expect every service to be trained equally to the Active Duty to take care of those situations.

Mr. TIERNEY. How is that happening if they are getting 1 weekend a month and 2 weeks in the summer, and in that period of time have to keep up with their own medical treatment? How are they getting this additional training? Where are they getting that in a fashion that would give us the comfort that they are really prepared and ready?

Dr. WINKENWERDER. Well, there are a variety of training courses that we offer. And it is part of this overall requirement that I set into place last year that for every medical person in the military health system, professional, that depending upon his or her level, there should be training to deal with chemical and biological events.

And so we expect that. That is a responsibility of each of the services, to provide that training and to ensure that we meet the standards.

Mr. TIERNEY. Have you been monitoring that?

Dr. WINKENWERDER. Yes, we have been.

Mr. TIERNEY. And how much additional training other than that 1 weekend a month and 2 weeks a summer are these personnel getting?

Dr. WINKENWERDER. Well, I had some figures that we recently generated from the three services, and I want to be careful with this, to describe it as accurately as my recollection will allow. But the percentages are in the high double digits now as opposed to the low single digits, what they were a couple of years ago.

So there has been——

Mr. TIERNEY. Double digits? Single digits? What?

Dr. WINKENWERDER. That means like somewhere between 60 and 80-something percent. And again, there has been an effort to make sure that those that are deploying are the ones that get the training. So when I describe those statistics, that is across the whole system.

Obviously, not everybody is going, so the training has been targeted more toward people that are serving. But I will—I understand the gist of your question and we will try to get back with that information.

Mr. TIERNEY. Would you get that information?

Dr. WINKENWERDER. Yes, sir. We would be glad to.

[The information referred to follows:]

Hearing Date: March 25, 2003
Committee: House Government Reform
Subcommittee on National Security
Member: Rep. Tierney
Witness: Dr. Winkenwerder
IFR: Pages 64-66, lines 1411-1442

Question: My understanding is that, in the Gulf, most of the medical people, the doctors and nurses sent over there, are Reservists, which would raise the specter that their training is one weekend a month or two weekends a month and two weeks in the summer; and I would guess that would probably be barely enough to keep up on their training for medical treatment in the field. Can you give us some assurance that those Reservists have, in fact, been properly trained to meet what might happen in terms of a chemical or biological attack? How is that happening if they are getting one weekend a month and two weeks in the summer, and in that period of time have to keep up with their own medical treatment? How are they getting this additional training? Where are they getting that in a fashion that would give us the comfort that they are really prepared and ready?

Answer: All medical personnel (active and reserve) are fully trained in their medical specialties before being designated for medical occupational specialties in the military. In addition, they receive extensive military-specific training, both medical and non-medical. Reserve Component medical personnel receive the same quality and level of training as their active duty counterparts. The Services have made great strides in the training of medical department personnel in chemical and biological casualty care. We have increased the training opportunities for the seven-day Medical Management of Chemical and Biological Casualties (MCBC) course. In addition to this course, we continue to employ distance learning technologies to train our medical forces and have a large number of web-based, computer-based, video, and satellite courses available. For each of the past three years, we have also produced and widely distributed to medical treatment facility personnel a CD with all chemical biological training materials to broaden our overall medical preparedness to respond to a chemical or biological incident. Today, 42% of Army officer clinicians and 18% of Army enlisted clinicians have completed more than 12-hours of specific chemical and biological casualty care training in addition to the chemical and biological training already incorporated in their mandatory professional development training. Also 72% of Navy clinicians assigned to hospitals received specific chemical and biological casualty care training primarily through the 12-hour Medical Management of Chemical and Biological Casualties satellite course or a 10-hour self-paced learning CD-ROM. And 85% of Air Force clinicians received specific chemical and biological casualty care training primarily through the 12-hour Medical Management of Chemical and Biological Casualties satellite course.

Mr. TIERNEY. Thank you.

And again, because I continue to have concerns about those suits, and even though you've now told me how many suits they have, in my reading anyway, it indicates that that may well not be enough depending on how long this conflict goes.

But you put out the impression at least, that Mr. Kucinich mentioned earlier, about the people being ready; and I am wondering, can you give us the assurance that Secretary Rumsfeld, through Under Secretary Aldridge, was not able to give us? Can you give us the assurance here today that the troops have sufficient equipment to protect them against chemical and biological attacks in quantities sufficient to meet the minimum required levels previously established by the Department of Defense?

Dr. WINKENWERDER. Certainly, from a medical standpoint; and by that I mean the medical countermeasures, the antibiotics, the vaccinations and all of that; those are the issues that come directly under my area of responsibility. The others, my understanding from recent conversations with—Dr. Anna Johnson Winegar, who is the chief responsible person within the Office of the Secretary of Defense for those matters and has testified before this committee and others, has indicated that she believes that we are well prepared on the issues that you have just raised.

Mr. TIERNEY. Well, your impression at least was not contained just to the medical end; it also involved the protective suits. Or did it not?

Dr. WINKENWERDER. That is not—and I know from your perspective, as well it should be, you should be concerned about everything, and so I don't want to be bureaucratic here. But——

Mr. TIERNEY. I appreciate that.

Dr. WINKENWERDER. It is not directly within my area of responsibility. It is another area that does work under Mr. Aldridge. We work closely, very closely with those people. The responsibility for executing those policies resides within each of those services.

Mr. TIERNEY. Thank you.

And just to finish up my generous 5 minutes, the reason I raised the initial question was that we had an exchange here in committee with Dr. Kingsbury, Nancy Kingsbury, at some point in time; and her answer indicated, to me at least, that in instances of mass casualties she did not believe that the exercises that have been done so far indicated that we could deal with those appropriately.

So whatever assurances you could give the committee in terms of medical personnel being ready would be greatly appreciated.

Dr. WINKENWERDER. We will do that.

[The information referred to follows:]

Hearing Date: March 25, 2003
Committee: House Government Reform
Subcommittee on National Security
Member: Rep. Tierney
Witness: Dr. Winkenwerder
IFR: Page 68, lines 1503-1513

Question: What assurances can you give the committee that medical personnel can deal appropriately with mass casualty situations.

Answer: Military medical providers (active and reserve) train for mass casualty situations, both in their installation hospitals and during exercise deployments, and have done so for decades. Since the start of the "Cold War" almost all of their "training scenarios" include weapons of mass destruction. Their training includes the wearing of full chemical/biological protective gear. No civilian hospital staff has near the vast training experience under these conditions. Many local civilian hospitals request copies of our military's medical training and mass casualty exercise programs as a template for some of their training, given the current War on Terrorism, and several exercises are conducted jointly with civilian facilities.

Military mass casualty exercises are designed to "overwhelm the available providers and resources." The military trainers want to test all aspects of evaluation, triage, treatment, evacuation and disposition. The training goals are the same for both deployed medical providers, and those stationed at a fixed military treatment facility.

Military mass casualty exercises are only part of the medical preparation for a deployment. Additional specific medical training is provided in order to further hone their trauma skills. Specifically, DoD has sponsored Tri-Service training on advanced surgical trauma care for the surgeons and nurses deploying to our currently deployed field hospitals (five active duty and two reserve hospitals). Additionally, extensive advanced trauma training is provided through multiple means for both active duty and reservists, and educational aids (e.g., "flash cards") are made available to assist primary care providers in mass casualty care (since most mass casualties are expected to occur outside the hospitals).

During the most recent war in Iraq this training has been validated. Changes in personnel, equipment and doctrine were effective in the success of the medical mission in Iraq, but training was the paramount reason. Initial feedback further documents this point. As more after-action reports are reviewed, we will enhance the excellent training of our medical providers to assure that the best capabilities are always utilized.

Mr. TIERNEY. Thank you.

Mr. SHAYS. Thank the gentleman.

We are going to do a second round here, and I just want to ask—so we can close up the issue of the questionnaire, I want to know why our men and women aren't given physicals when they go into battle, so that we know. What is the logic of that?

Mr. JANKLOW. Aren't given what, sir?

Mr. SHAYS. Aren't given physicals. They are given questionnaires, but they aren't given physical examinations.

Dr. WINKENWERDER. I think, Mr. Chairman, that the logic is that a hands-on physical examination yields not a great deal of information in terms of the baseline health status of young, healthy individuals. And far more important and relevant is a series of questions that are asked that can go into greater detail if a flag goes up that indicates that there is some problem with that person's health.

Mr. SHAYS. First off, I am not going to concede that we didn't intend that they weren't going to have physicals. So I understand your doing the questionnaires, and I understand when we talk about a medical examination versus a physical examination, you have decided that you have some flexibility there.

But what about the Reservists and the National Guard folks who simply, you know, might be eating a little differently, might—you get my gist. Why wouldn't they have physicals? They might be older. They might not have been active for a while. Why treat them all the same?

Dr. WINKENWERDER. Why treat them all the same?

Mr. SHAYS. Why treat them all the same? Why not have a little bit more of an interest in giving a physical to someone who may not have been in the Active Service?

Dr. WINKENWERDER. You raise a good point. I think it is something we could certainly take a look at.

Dr. Kilpatrick.

Dr. KILPATRICK. If I could, for the Reservists that are called to Active Duty, there is a more stringent process put in place to look at them, having physical examinations, their periodic physical examinations.

For Reservists under 40, they need to have one every 5 years; over 40, every 2 years. I think there is a recent GAO report that showed that people were not meeting the mark—I mean, the numbers were terrible—on doing that. So when people are called to Active Duty at that mobilization center, if they have not had a physical within the last 5 years for under 40 or the last 2 years over 40, they have to have a physical before they go, so they are caught up.

Mr. SHAYS. Why not at least draw blood?

Dr. KILPATRICK. And I think the drawing of blood is—we do make sure that everyone has an HIV screening sample done within the previous 12 months prior to deployment. That serum sample is banked in a serum bank. It is kept permanently. There is no sort of portfolio of tests to do on a serum sample, but that is kept in the eventuality there is an exposure, either recognized or unrecognized, and then a determination of a set of tests that could be done.

So the serum sample is saved, but there is no testing done, prior to leaving, for levels of any agents.

Mr. SHAYS. Dr. Roswell, how are you involved in the predeployment questionnaire? How much involvement did you have in this questionnaire?

Dr. ROSWELL. Relatively little, Mr. Chairman.

Mr. SHAYS. Does relatively little mean, really, I didn't have much involvement at all?

Dr. ROSWELL. The survey was shared with us. We have effective communication through the Health Executive Council that Dr. Winkenwerder and I cochair. So there is an active sharing of information.

Mr. SHAYS. But this was basically designed by DOD, Dr. Winkenwerder?

Dr. KILPATRICK. Yes.

Dr. WINKENWERDER. Designed in 1997.

Mr. SHAYS. 1997. OK. We have a letter that Principi—Principi; I'm sorry, I went to a college called Principia, so I have a bit of a problem with that name—where the Secretary had written. And he said—and this is a letter he drafted to Mr. Rumsfeld on—Secretary Rumsfeld on February 14 of this year; and the second page says, "In the event of hostilities, VA further requests more extensive postconflict health data. Within the first month after hostilities cease, VA recommends administration of a detailed postwar health questionnaire to accurately document the health status and health risk factors and health in Gulf war troops immediately after the conflict."

Can you explain that a little to me?

And, Dr. Winkenwerder, can you respond?

Dr. ROSWELL. I think what Secretary Principi was asking for was to get risk assessment and self-reporting——

Mr. SHAYS. Excuse me. Let me just say for the record, with just three members, I am going to roll to a 10-minute question. So you'll have 10, and we'll go from there.

Thank you. Go ahead.

Dr. ROSWELL. Our concern is that particularly with Reservists and National Guard, when they are demobilized, the immediate concern—and it's true of Active Duty as well—is to get home to family and loved ones. But unlike the Active component, when the Reservists are demobilized, they may be lost to followup, and it may be difficult to get information.

We learned, painfully so, in the Gulf war that when we surveyed service members who had separated from military service months or years after their service in the Gulf war, that there was a high level of what we would call "recall bias." They don't really remember the specifics, it is hard to recall a specific date. A service member might not remember an actual grid coordinate or an actual physical location.

So I think what Secretary Principi was asking Secretary Rumsfeld was that, in the event of possible exposures, we get as much information as possible at the time military members are demobilized and separated from service. That would help us evaluate possible symptomatic exposures and health consequences that might have——

Mr. SHAYS. So there's logic to doing this.

Let me just ask, Dr. Winkenwerder, do you—we had in 1997, you have this—developed this questionnaire we are using today.

Do you have a postsurvey questionnaire that was done in 1997, or is that still a work in progress?

Dr. WINKENWERDER. That was developed in the same timeframe.

Mr. SHAYS. We are asking that questionnaire be updated and improved.

Dr. Roswell.

Dr. ROSWELL. The postdeployment survey that Dr. Winkenwerder speaks of would certainly be helpful. Obviously, we'd seek more complete information if there was a documented or suspected exposure.

Mr. SHAYS. It's just a two-page document?

Dr. ROSWELL. Correct.

Mr. SHAYS. It doesn't even look as extensive. I guess it's the same as—both are two pages.

I would hope, Dr. Winkenwerder, that you will give tremendous consideration to Principi's letter and request, and absolutely determine that our troops, shortly after—not after they are sent back home, but you know, a month or two after the conflict ends, that they are going to have this kind of questionnaire.

I am seeing the nodding of heads. I would love to know if you could put something in that we could transcribe here.

Dr. WINKENWERDER. Yes. Well, I share the objective of getting accurate information in a timely way.

Mr. SHAYS. And do you believe that maybe a more than just two-page questionnaire would be helpful?

Dr. WINKENWERDER. I have already initiated an effort to reassess this survey tool to see if it collects all the information that we think it ought to collect.

Mr. SHAYS. Do you give some weight to the Secretary of Veterans Affairs, who ultimately has to deal with this, that——

Dr. WINKENWERDER. Oh, absolutely.

Mr. SHAYS. OK.

Dr. WINKENWERDER. Yeah, absolutely. So I've, No. 1, done that.

And second, ideally, if we could collect that information even before people come back to the United States, it would be great. Logistically, we are still looking at that. Obviously, we have to have a lot of cooperation and assistance from many, many people to——

Mr. SHAYS. You may have to do some physicals. You may have to add more than physicals to the questionnaire, and you may have to have more of these folks actually take a physical when they leave.

Dr. WINKENWERDER. Well, I would expect, with a good detailed questionnaire that whenever people gave any reason for concern, they would then be very carefully evaluated.

Mr. SHAYS. OK.

Mrs. Maloney.

Mrs. MALONEY. Thank you, Mr. Chairman. I would like permission to place in the record an article written by Judith Coburn entitled Suited for war, and it is very thought provoking. In it, she alleges——

Mr. SHAYS. Without objection, that will be put in.

Mrs. MALONEY. Thank you. In it, she alleges that it took a 4-year struggle of Gulf war veterans from Georgia before they got the Pentagon to declassify documents which revealed that Iraq's stocks of sarin gas stored in Khamisiyah had been blown up, and that roughly 140,000 American troops were exposed.

I realize, Dr. Winkenwerder, this did not happen on your watch, but I fail to understand the mentality or the mind frame of a department that would withhold valuable information on the exposure to chemicals that could hurt people.

And I understand this was not on your watch, but if you can find any documentation on what they were thinking about or what, in their minds, they thought they couldn't reveal to our men and women, that they may have been exposed, I would love to get that back in writing.

But my question—and Ms. Coburn further goes on.

Mr. SHAYS. Let me be clear. What do you want back in writing?

Mrs. MALONEY. Why the Pentagon fought the release of information on men and women being exposed to sarin gas when they knew they were exposed in that particular area.

Mr. SHAYS. The record will note that they acknowledged that our troops were exposed, before our hearing, at a press conference. Then there was a question as to how many troops were ultimately exposed, and the numbers kept going up.

And so what would be helpful is if, in fact, additional information was held and for how long and why. And that will be—it is just not a wish, it is a request that—Dr. Kilpatrick, you are nodding your head—you will get back to us on.

Dr. WINKENWERDER. Yes. There is a great deal of information. We will pull out all together and provide it.

[The information referred to follows:]

Hearing Date: March 25, 2003
Committee: House Government Reform
Subcommittee on National Security
Member: Rep. Maloney
Witness: Dr. Winkenwerder
IFR: Pages 77-78, lines 1691-1721

Question: During the Gulf War, how many troops were ultimately exposed to sarin gas? Why have the numbers kept going up? If, in fact, additional information was held – for how long and why?

Answer: The Department of Defense always has provided information it had on our Service members' possible exposures to low levels of chemical warfare agents as soon as the information was available. Our estimates of the number of possibly exposed Service members changed as we developed more accurate information on the amounts of chemical warfare agents present, better information on the locations of Service members during a specific time frame and as our modeling improved.

At the time of the June 1996 announcement that Service members probably destroyed chemical weapons at Khamisiyah, we did not know the extent of possible exposures to low levels of chemical warfare agents. We knew that there had been no known injuries and no reports of acute symptoms of chemical warfare agent exposure at the time. In an effort to collect more information about the effects of the demolition, the Deputy Secretary of Defense mailed a memorandum to the approximately 20,000 soldiers believed to be within 50 kilometers of Khamisiyah during demolition activities informing them of the possible presence of chemical weapons and requesting that they provide any information they might have about the event.

In a parallel effort, the Presidential Advisory Committee on Gulf War Veterans' Illnesses (PAC) requested predictive modeling of the demolitions at Khamisiyah and the bombings at Muhammadiyat and Al Muthanna. In November 1996 and February 1997, the Institute for Defense Analyses (IDA) reviewed the results of that modeling and recommended using an ensemble of multiple atmospheric models to account for the fact that different models will produce different but equally plausible results. The IDA also recommended demolition testing to improve information about the source characteristics in the weapons that had been demolished. The Office of the Special Assistant to the Deputy Secretary of Defense for Gulf War Illnesses (OSAGWI) initiated investigations focused on determining the number of rockets present, the amount and purity of chemical warfare agent in the rockets, how soldiers placed the demolition charges on the stacks of rockets, and where units were during and immediately after the demolition. In May 1997, the Department of Defense tested at Dugway Proving Ground how rockets like those at Khamisiyah were damaged by demolition. At Aberdeen, the evaporation characteristics of agents spilled as a result of the demolition were determined.

In July 1997, the Department of Defense and CIA announced the results of modeling with the best information available at the time, which indicated that 98,910 Service members were

possibly exposed. DoD sent letters to these Service members notifying them of their possible exposure to low levels of chemical warfare agents.

After publishing the results of our modeling, the Department requested a review by an independent panel of scientists renown for their expertise in this area. The panel recommended some improvements for future modeling efforts. The results were also reviewed by the U.S. Senate Committee on Veterans Affairs' Special Investigative Unit, which commented that the results of the modeling grossly overstated the number of Service members possibly exposed because the summation of all models was used to define the hazard area rather than the intersection of all the models.

In addition, the Department recognized several weaknesses of the initial effort to identify Service members possibly exposed. First, we knew that the chemical warfare agents released had been a mixture of sarin and cyclosarin, but because we lacked toxicity data on cyclosarin, the modeling only considered the release of sarin.

Second, chemical warfare agents are highly reactive chemical compounds. The very chemical and physical properties that make them dangerous also make them susceptible to reacting with substances in the environment. These reactions, in turn, can result in significant reductions in an agent's effectiveness. The overall effect of this interaction is an estimated reduction (or removal) of the agent available over time (sometimes called degradation) to create a potential exposure hazard. The 1997 modeling did not consider this degradation.

Third, the UNSCOM investigations continued with more findings reported each month. Using newly released UNSCOM data, the CIA was able to refine and improve its assessments of the amount of chemical warfare agent that had been released in the Khamisiyah demolition.

Finally, and most importantly, we knew that the database of information about the location of military units during the war was seriously deficient. That, in turn, affected our ability to identify what individuals may have been exposed. To identify additional unit locations and to verify existing locations, the Department assembled former Gulf War brigade, divisional, and non-divisional operations officers (G3s/S3s) whose area of responsibility included Khamisiyah during March 10 – 13, 1991 to review, refine, and enhance their units' location information. These conferences continued from September 1997 through June 1998. This effort significantly enhanced the contents of the database, improved our knowledge of unit locations from 55 percent to 85 percent, and reduced the uncertainties associated with locating U.S. units around Khamisiyah during the demolitions.

With all of the new information and following suggestions of the independent scientific peer review, the Department modeled again the demolition at Khamisiyah. Using the same ensemble modeling methodology, but using improved versions of the models, the Department was able to include more accurate amounts of nerve agent released, and deposition and degradation of the chemical warfare agent. Driven largely by the better accounting for units' locations, the Department was able, in December 2000, to more accurately estimate the number of Service members possibly exposed at 100,923, and we took action to appropriately notify these Service members. At that time, we notified approximately 35,000 additional Service members of their

possible exposure to low levels of nerve agent and notified approximately 32,000 Service members that the most recent modeling and analysis indicated that they had not been exposed.

Although we were (and are) confident about the units possibly exposed, we know that some individual may not have been with their units, and some parts of units may have been located in places not with the main unit. Consequently, we continue to uncover and receive information about units and Service members who were probably in the hazard areas. As we collect this new information, we update the numbers that we believe may have been exposed (and notify Service members accordingly). At the present time, the Department believes that 101,754 were potentially exposed to low levels of nerve agent.

Mrs. MALONEY. She further states that 148 Americans died in the war, but that roughly 160,000 have fallen ill; and that 11,000 have died since the Gulf war—much higher than other men and women in the military—and that they have collected a series of 57 symptoms for which there is no known cause, which is the Gulf war syndrome.

I would want to ask what we are doing to protect the health of the men and women that were exposed and the possibility, God forbid, that they may be exposed yet again. And I am the cochair of the Parkinson's Disease Task Force, along with Fred Upton; it is a bipartisan effort. And my father suffered from Parkinson's.

But it has been reported that some of the Gulf war veterans have suffered symptoms similar to Parkinson's. And each year we have been working with the Defense Department, and we have received funding for Parkinson's research on neurotoxin exposure, seeing if that is a reason for the brain damage that causes Parkinson's. But I would argue that, likewise, it may be a study for what we can do to help the men and women that may have been exposed to chemicals.

So my question right now is more of a proactive one of, what are we doing in research?

As I understand it, we have no cure for Gulf war syndrome. And what are we doing to find—are we spending some of our research dollars in trying to find a cure for neurotoxin disease that may be caused by the sarin gas or other things? What are we doing? I am very thankful to the Department of Defense for funding the Parkinson's research.

My question is, is this likewise connected to the Gulf war syndrome?

Dr. WINKENWERDER. To your general question of what are we doing? We are continuing to fund with millions of dollars ongoing research into many of these questions that you have raised. As I alluded to earlier, it's difficult to determine with the levels of certainty that one would like in this case, if one is talking about evaluating these individuals that served, when the baseline of information and what was collected and what people may or may not have been exposed to is not good.

The information is not good, so—by definition, to do good research, you need good information. That shouldn't prevent us from funding additional research, as we have done, to look at some of these questions of what would low levels of exposures do to laboratory animals. Certainly we would never do this to any individual on an experimental basis. But studying what happens with animals and looking at some of these things is very important.

Mrs. MALONEY. Specifically, is the Parkinson's research that you are funding—and I thank you for that research. Is that connected to the Gulf war syndrome?

Dr. WINKENWERDER. I am going to turn to Dr. Kilpatrick.

Dr. KILPATRICK. Let me just address it. It is being pursued in two directions.

One is a clinical basis, looking at people; and then that is very tightly tied to a program looking at chemical nerve agents in particular and the effects that they have on brain function. There are projects funded at $5 million a year over the next 3 years; 1.5 mil-

lion is looking at repeated low-level exposures of animals to sarin nerve agent, to look at long-term health consequences. That is very applicable to what Gulf war veterans' concerns are.

The other part of the money each year is spent toward what we call the high end of low-level exposure, below symptomatic response to nerve agents, one exposure, and then seeing what are the physiological responses.

And those data from those research sets are really very closely shared with people looking at Parkinson's disease, because they are really looking at the same pathway potentially as far as disease cause.

Dr. ROSWELL. If I may respond to that from a combined perspective.

Since the Gulf war, over $200 million in federally funded research has been focused on possible causes for Gulf war syndrome. I would like to set the record straight.

One of those studies has looked at death rates in veterans in the Gulf war, and in fact, the overall death rate for veterans who served in the Gulf war is not increased compared to their military counterparts who were deployed outside the theater of operations. If you look at specific-cause mortality in veterans who served in the Gulf war, there is a very slight increase in death due to trauma, such as automobile accidents. But other than that, the mortality rate is not increased in any subcategory, and the overall mortality is not increased.

And I certainly wouldn't want to create a fear for the men and women currently serving in Iraq.

Let me point out that Parkinson's disease is one of several neurodegenerative diseases that DOD and VA are currently studying. VA recently funded the creation of a neuroimaging Center of Excellence for neurodegenerative diseases to look not only at Parkinson's but also other diseases, even when unpublished data suggested that there might be an increase in a degenerative disease known as amyotrophic lateral sclerosis, or Lou Gehrig's disease.

Secretary Principi moved quickly to presumptively service-connect veterans who suffered from that illness and served in the Gulf war, so that they received disability compensation.

I would also point out that 160,000 veterans of the Gulf war have received approved disability claims. But most of those claims are for diseases that we would expect to see in a military age population, and it is a relatively small number for undiagnosed illnesses or the Gulf war syndrome you spoke of.

Mrs. MALONEY. When you mentioned the clinical trials, are you doing them on our veterans? Are we tracking our veterans and seeing if—particularly those that we know were exposed to sarin gas? That would be helpful to see, because some of them apparently—I am talking to doctors that treat Parkinson's. They have told me that they are developing Parkinson's-like symptoms.

Dr. ROSWELL. We have extensively reviewed literature for symptomatic exposures to the organophosphate, which is the class of compounds that sarin nerve gas falls into. The study suggests that there is cognitive impairment in people who suffer symptomatic exposures, but I am not aware of evidence that conclusively links any

kind of organophosphate or nerve agent exposure to Parkinson's disease specifically.

Some investigators have reported a possible neurodegenerative disorder that involves part of the vasoganglia, which are structures that are affected in Parkinson's, but in a way different than in Parkinson's disease, which is why we've funded the neuroimaging center.

Mrs. MALONEY. Where is the neuroimaging center?

Dr. ROSWELL. Actually, there are several within the VA. There is one in San Francisco; there is—a final selection for the designated center has not yet been made, however.

Mrs. MALONEY. Well, thank you for investing in research for coming up with some cures. And thank you for your testimony. My time is up.

Mr. SHAYS. We have just two more members who will ask some questions, and then we are going to get to the next panel.

Mr. Janklow.

Mr. JANKLOW. Thank you very much, Mr. Chairman.

Help me, if you could. With the testimony—the hearing is about lessons learned from the Gulf. My question is, both of you in your capacities, you, Dr. Roswell, and you, Dr. Winkenwerder, have you looked into the history of why was this so secret so long? With everybody clamoring for information, why did it take so long to get the information out? Why did it have to be dragged out of people? What was the reason for the mystery?

I guess—have you ever been able to find out, or have you ever looked as to the reason for the mystery? It couldn't have been national defense secrets.

Dr. WINKENWERDER. I can't give you a good answer. I will give you the best answer I know, and that is that in many cases it took months and even years for symptoms to develop with people. And that, combined with the poor record base, made it very difficult to do research or to even develop good, plausible mechanisms, causal-related mechanisms.

Mr. JANKLOW. Have those problems been solved?

Dr. WINKENWERDER. In my judgment, we have a far superior baseline of information. We have a far improved recordkeeping system. We have a far improved ability to surveil and actually keep records in the theater. We have these pre and postdeployment assessments. So our information base, by all accounts, should be far, far better in our current situation.

Mr. JANKLOW. Doctor, I believe you said you have been in your position about 18 months.

Dr. WINKENWERDER. Yes, sir.

Mr. JANKLOW. And for you, is there anything, at least at this point in time in your tenure in this position, where we have a lesson we haven't learned?

Dr. WINKENWERDER. Well, I hope we don't have one that I am not attending to.

Mr. JANKLOW. Are there any—do you know of any that concern you or that we ought to be concerned about?

Or you Dr. Roswell?

Either one of you, are there any lessons we haven't learned?

Dr. ROSWELL. If I could, I think the Gulf war was an unprecedented conflict. The breadth and nature of military occupational exposures had never been experienced by our men and women in any prior conflict. So part of the delay, if you will, the confusion—I think, in retrospect, it is fair to say there was some confusion about exposures and possible health consequences—was because we didn't recognize that a vast number of unprecedented exposures could be factors: the anthrax vaccine, the pyridostigmine bromide that was used, the dense oil fire smoke, the fine particulate sand in the desert, the use of petroleum products to cut down on the blowing sand, the use of permethrin and DEET to protect people from insects—there were so many exposures—the use of depleted uranium as both an armour-piercing munition and a firearm plate, even chemical agent-resistant coating paint, which was applied to vehicles to make them resistant to chemical agents—were just some of the possible exposures that were investigated methodically, consistently over time to try to ferret out possible causes for the illnesses we saw in Gulf war veterans.

And I think that, to me, if there is a lesson learned, it is that we have learned that all of these exposures, singly or in combination, as has been pointed out in this hearing, could be factors in the development of illness. Certainly, every major conflict that U.S. men and women have served in has yielded unexplained illnesses.

But that doesn't obviate our need to methodically and thoroughly investigate each and every exposure. And that is why we are committed to do that, and I think that is the partnership that VA and DOD, through the Deployment Health Working Group, are vested in right now.

Mr. JANKLOW. Dr. Kilpatrick, are there any unlearned lessons that you know of lingering from the Gulf war?

Dr. KILPATRICK. I think one of the hardest ones is communication. It doesn't matter how good a job you do, you can always do it better.

And I think one of the issues that we are working at very hard now is to make sure that leaders in the field are communicating to their troops that they are concerned about these various exposures and their health. They are concerned about documenting where they are. They are concerned about making sure they have that access to health care when they come home—I think DOD and VA share the same concern for those who are getting off Active Duty; they will be looking perhaps to the VA for health care—that they understand that, in fact, there is the ability for them to have 2 years of health care coming out of a combat zone now. That was not present after the Gulf war in 1991. And I think that is—getting that communicated to people, so they know they have that access to health care, is so important.

So I think that is one of the areas where, as good a job as I think we are doing, we always need to look to say, how can we do it better. And I think doing that, through even this hearing, is very helpful to those men and women who are serving today.

Dr. WINKENWERDER. And if I might add to that to say, you know, you never know when you haven't learned a lesson until—there are many times you don't until you've learned it, which to me speaks

to the need culturally to have an open mind, be open to learning things that you didn't know before.

And so if there is one thing that I would continue to hope to convey to our people it is a continued vigilance about different sources and causes of illness and ways to improve. It is sort of a culture of learning and getting better.

Mr. JANKLOW. Assuming we have the baseline data that we need for the current war that we are in, recognizing that our troops could be exposed to biological or chemical warfare, do we have the systems in place?

I mean, that is the key thing. Do we have the systems in place to be able to get the information about the individuals and about the chemical or the agents or the toxins that are being—that they have been exposed to, so that we will have the data base of information to address it without all the types of—new types of frustration that we will have to go through in order to find out whether or not there are or aren't legitimate reasons for illnesses or problems that people have after the war?

Am I making sense to you?

Dr. WINKENWERDER. Yes.

Mr. JANKLOW. Do we have a system in place, is what it comes down to. I realize we had no history before the Gulf war. We now have a history.

Dr. WINKENWERDER. I believe we do have the system in place.

Mr. JANKLOW. Is there anything we can do to make it better?

Dr. WINKENWERDER. Yes.

Mr. JANKLOW. What?

Dr. WINKENWERDER. One of the things that we can do to make it better is to ensure that there is 100 percent compliance with all the policies and all the procedures, the training we have talked about.

Mr. JANKLOW. Have those orders gone out to the military?

Dr. WINKENWERDER. Absolutely.

Mr. JANKLOW. Is there any reason that the military would have for not following orders from above that are lawful?

Dr. WINKENWERDER. No. I have no reason to believe that people have not taken this issue extremely seriously.

Mr. JANKLOW. Do they understand that if they violate direct, lawful orders from a superior, that it sometimes is far more serious in the military than it is in civilian life?

Dr. WINKENWERDER. Yes. I think there is a good understanding of that.

Mr. JANKLOW. Those are all the questions I have, sir.

Mr. SHAYS. Thank you.

Mr. Tierney.

Mr. TIERNEY. Thank you. I have only a followup question.

We know that this 2004 VA budget, Dr. Roswell, has several provisions that are going to restrict the ability of certain classifications of veterans, priority 7 and priority 8, to get treated and to get the cost of care covered—I can't get this thing to stop moving up and down.

Isn't that one of the lessons we've learned, though? If we have incidents that are not really showing signs of symptoms or illnesses for several years after people get out of the service, being covered

for the first 2 years may not be sufficient. And haven't we learned through some of the Gulf war syndrome incidents that it can be any number of years before people start coming down with these symptoms?

So having learned that lesson, we put out a budget that still doesn't seem to address these people's concerns.

What are your concerns about that, and what can we do about the fact that some of these people may not exhibit symptoms in the first couple of years? And how is the VA going to deal with those people without excluding them from coverage?

Dr. ROSWELL. Well, certainly one way to do that is to authorize special access for care for people who have illnesses that occur following a conflict.

We actually had that authority that just expired in 2002 for veterans of the Gulf war. It would be obviously, depending upon the outcome of the current conflict, appropriate for this Congress to consider special authorization for priority care for veterans who have served in this conflict.

The 2 years is a minimum. It would certainly continue beyond that if an identified need were discovered during that period or if an illness, injury, or disability associated with military service were identified that led to a service connection.

Mr. TIERNEY. I think your first recommendation is probably one that we ought to look into, and that is making sure that we provide some sort of flexibility or ability to cover those for people that may be coming out of this conflict, and I appreciate that.

Mr. Chairman, I have no other questions at this time. I want to thank our witnesses for their thoughtful answers and for their assistance here today. Thank you.

Mr. SHAYS. Thank the gentleman. Let me just do a few little minor points for the record.

Dr. Roswell, we are looking at VA data and reports on mortality in the Gulf war. And its recent reports, based on VA data, have been late. There was one report that showed kind of a real spike in deaths, and it was called back and we are curious about that.

So we are going to invite the VA back to have a dialog about this, but I just kind of feel your comment about not showing much difference is something that this committee has a big question with.

And I would also just say, Dr. Winkenwerder, that I have some specific questions about the status of the Armed Forces Radiobiology Research Institute and their work on a drug to counteract the effects of radiation exposure.

And we're going to send these questions in writing to your office and ask that you respond. I don't think we need to take time to do that now, we think.

Dr. WINKENWERDER. We'd be glad to do that.

Mr. SHAYS. Dr. Hyams, you have the biggest challenge here, and I have a theory and it never fails me that the person who says the least has the greatest contribution at the end to make. So I'm going to just ask—no, I'm not going to do it quite that way. But I'm going to say to you that I would like you to put on the record anything that you think needs to be put on the record or any observation that you would like to put on the record, and then we'll get to the last panel.

And Dr. Hyams, I would also invite you as well. I'm not being facetious. I know all four of you have expertise here, and we didn't ask Dr. Roswell as many questions so you didn't need to jump in, but I'm happy to have all four of you make any final comment. I'll start with you, Dr. Kilpatrick.

Dr. KILPATRICK. Well, I think that the Department of Defense is very focused from the lessons learned in the Gulf on how do we better take care of our men and women in harm's way today. I think the Force Health Protection Program is that cascade effect of programs that will protect health. It does depend on good leadership and cohesive units. We believe we have that. We see that in action today, and it is our duty to make sure from a medical standpoint that those men and women have their health concerns addressed, and our medical department stands by waiting to make sure that their health concerns, whether they are related to the deployment or any other concern, get addressed with facts about exposures we know occurred.

Mr. SHAYS. Thank you.

Dr. WINKENWERDER. Mr. Chairman, I'd just say we appreciate the opportunity to be here today. I think this has been a productive exchange of information. I hope you've found it that way and useful.

My first comment is just to say that I deeply appreciate the sacrifice that our men and women in uniform are making, and I also deeply appreciate the outstanding job that our medical people are doing. I think we've seen from the TV reports and all just the incredible job they're doing. They've made us all very proud.

We are absolutely committed to trying to protect our people who are taking on a very challenging situation, a brutal regime that has terrible weapons. We've done everything that we know we can do to protect them. We will continue throughout this conflict and after the conflict is over to ensure that we look after people's health care needs and that we do right by them for the good service that they've done. So I'm committed to that.

Mr. SHAYS. Thank you.

Dr. ROSWELL. Mr. Chairman, let me begin by thanking you for your leadership over the last decade in moving our government closer to a more full and complete understanding of causes of illnesses following military service in combat. I think your leadership has been instrumental in improving our understanding and readiness and preparedness.

Like so many Americans, my thoughts and prayers today are with the men and women in uniform in Iraq and in the theatre of operations supporting that conflict, and I hope that some way they understand and can know that when they return they will face a vastly improved VA health care system that is responsive to their needs, and they will understand that the very best possible care we can provide will be available to them, and we'll do everything we can to provide that for as long as it's needed.

Mr. SHAYS. Thank you. Dr. Hyams.

Dr. HYAMS. I come to this with my own perspective. I deployed to the Persian Gulf in 1990 to help establish a laboratory in the theatre of operation to survey for biological agents. So I've been dealing with these problems for a long time, and I think one of the

points that is often missed is that we have an obligation also to healthy war veterans. I came back healthy. A lot of other veterans did, too. Nevertheless, we had a lot of questions about what happened to us when we were in the Gulf. I think as a Nation we owe it to even healthy veterans to be able to answer those questions.

Mr. SHAYS. Thank you very much. Gentlemen, we appreciate your contribution to the work of this committee, and thank you for your service to your country.

Our second panel is Dr. John H. Moxley III, managing director, North American Health Care Division, Korn/Ferry International; Dr. Manning Feinleib, professor of epidemiology, Bloomberg School of Public Health, John Hopkins University; and Mr. Steven Robinson, executive director, National Gulf War Resource Center, Inc.

You might want to remain standing, and I'll swear you in.

Moxley, Feinleib and Robinson. Thank you, gentlemen. Raise your right hands, please. First off, is there anyone accompanying you or responding? No. OK.

[Witnesses sworn.]

Mr. SHAYS. Note for the record that all three of our witnesses have responded in the affirmative. Thank you, gentlemen, for your patience. You have the opportunity to read a statement or submit a statement and make some comments. You have obviously heard the panel before you. So you might want to respond in what you've heard, which would be helpful.

So we're going to start, just as you are there, and we'll start with you, Dr. Moxley.

STATEMENTS OF DR. JOHN H. MOXLEY III, MANAGING DIRECTOR, NORTH AMERICAN HEALTH CARE DIVISION, KORN/FERRY INTERNATIONAL; DR. MANNING FEINLEIB, PROFESSOR OF EPIDEMIOLOGY, BLOOMBERG SCHOOL OF PUBLIC HEALTH, JOHNS HOPKINS UNIVERSITY; AND STEVEN ROBINSON, EXECUTIVE DIRECTOR, NATIONAL GULF WAR RESOURCE CENTER, INC.

Dr. MOXLEY. Yes, sir. Thank you. Mr. Chairman, members of the committee, as has been noted, I'm managing director of the North American Health Care Division of Korn/Ferry International. I'm here because I served as chair of the Committee on Strategies to Protect the Health of Deployed U.S. Forces of the Institute of Medicine. The Institute of Medicine is part, as you well know, of the National Academies chartered in 1863 to advise the government on matters of science and technology.

We have submitted a written statement for your review and for the record. I shall not repeat that statement. What I intend to do in the next few minutes is to summarize the history of the need for a report, highlight a few of our findings and proposals and then close by attempting to convey to the committee the intensity that our committee felt about the need for progress in the protection of deployed forces.

The immediate history of the committee stems from the concern of then Deputy Secretary of Defense John White that there was a need to learn from lessons of the Gulf war and develop a strategy to better protect the health of U.S. troops in future deployments.

In consultations with the IOM, it was agreed that they would undertake the study. The first step was the development of four technical reports addressing, first, health risks during deployments; second, detection and tracking of exposures; third, physical protection and decontamination; and, fourth, health consequences and treatment and the importance of medical recordkeeping.

All four of those reports were detailed, were released at the time of completion, and were excellent reports.

The committee that I chaired was charged with attempting to synthesize the technical findings of the aforementioned reports and other information to form a final overarching policy report. Our report was completed over 2 years ago.

One of the first and most surprising findings was that we were not alone. Between 1994 and 2000, the Department of Defense sought assistance from seven expert panels who generated 10 reports examining these issues. Although DOD had agreed with the large majority of the findings, we found that very few had been implemented at the field level. Many recommendations remained totally unimplemented. Our committee concluded that despite all the advice and apparent agreement with it, progress had been unacceptable.

We also concluded that it was very difficult to improve upon the recommendations made multiple times since 1994. Hence, many of our recommendations are restatements of recommendations that had been made before but remained unimplemented. We continue to stand behind all of them.

I'd now like to briefly summarize three areas of particular concern to the committee. First, it is vital that the location of units and individuals, together with activity information, be documented during deployments. The information is important for real-time command decisionmaking and essential for reconstructing deployments for epidemiological studies and the provision of post-deployment health care.

Despite many previous painful lessons, adequate systems for recording and archiving the locations of deployed individuals are not in place. The technology exists. Troops can be tracked in real-time, and it is time to do it.

Second, the Department of Defense must be candid and trusted by service members, their families and the American people. To achieve that end, they must be more proficient at understanding and using contemporary principles of risk assessment, risk management and risk communication.

The following vignette from the Somalia deployment vividly makes the point. Problems arose when family members learned of fire fights from news media instead of from official sources of information in the chain of command.

Distraught family members in the United States were calling deployed service members on cell phones, upsetting the service members and causing decreases in force effectiveness. Rather than trying to quash the situation with top-down orders, the commanders worked with the troops and family members and developed a system of phone trees to notify family members in near real-time of the status of their deployed loved ones after a conflict.

The point is that DOD cannot suppress the Information Age. It must find effective means to embrace it.

Finally, medically unexplained symptoms are symptoms that are not clinically explained by a medical etiology, but necessitate the use of the health care system. They are increasingly recognized as prevalent among civilian populations and are associated with high levels of distress and functional impairment. In the military, they have been observed following deployments as far back as the Civil War.

Clinicians and other persons must recognize that medically unexplained symptoms are just that. There are no current explanations for them. Communicating the limits of modern medicine, coupled with the compassionate approach, is essential to management. There's also very good evidence that early intervention leads to better results.

The committee's overriding concern was that everything consistent with mission accomplishment was done to protect the health and lives of U.S. service members who are knowingly placed in harm's way. The committee understood that the changes would be costly and inflict the pain of organizational change. The Department of Defense, however, has in our opinion an obligation to avoid unnecessary disease, injury, disability and death as it pursues the accomplishment of its missions. Not to fulfill that obligation would be simply unconscionable.

Thank you for the opportunity to testify, and I'll be pleased to answer any questions the committee might have.

[The prepared statement of Dr. Moxley follows:]

PROTECTING THOSE WHO SERVE: STRATEGIES TO PROTECT THE HEALTH OF DEPLOYED U.S. FORCES

Statement of

John H. Moxley III, M.D.
Chairman of the Committee on Strategies to Protect the Health of Deployed U.S. Forces
Institute of Medicine
and
Managing Director, North American Health Care Division, Korn/Ferry International

before the

Subcommittee on National Security, Emerging Threats, and International Relations
Committee on Government Reform
U.S. House of Representatives

March 25, 2003

Good morning, Mr. Chairman and members of the Committee. My name is John Moxley. I am Managing Director of the North American Health Care Division of Korn/Ferry International and served as chair of the Committee on Strategies to Protect the Health of Deployed U.S. Forces of the Institute of Medicine (IOM). The Institute of Medicine is part of the National Academies, chartered by Congress in 1863 to advise the government on matters of science and technology.

The report from which I provide testimony today was the end result of a large study initiated in 1997 in response to a request from Deputy Secretary of Defense John White. Secretary White met with the leadership of the National Research Council and Institute of Medicine to explore the idea of a proactive effort to learn from lessons of the Gulf War and other deployments to develop a strategy to better protect the health of U.S. troops in future deployments. A set of four technical reports addressing 1) assessment of health risks during deployments in hostile environments 2) technologies and methods for detection and tracking of exposures to a subset of harmful agents, 3) physical protection and decontamination, and 4) medical protection, health consequences and treatment, and medical record keeping were completed in the fall of 1999. In the study's final year, the Institute of Medicine committee that I chaired was formed and used those reports as well as additional information gathering to inform a final over-arching policy report, entitled, *Protecting Those Who Serve: Strategies to Protect the Health of Deployed U.S. Forces*. This report was completed in the fall of 2000.

The 670,000 service members deployed in 1990–1991 to Southwest Asia for Operations Desert Shield and Desert Storm (the Gulf War) were different from the troops

deployed in previous similar operations: they were more ethnically diverse, there were more women and more parents, and more activated members of the Reserves and National Guard were removed from civilian jobs. The overwhelming victory that they achieved in the Gulf War were shadowed by subsequent concerns about the long-term health status of those who served. Various constituencies, including a significant number of veterans, speculated that unidentified risk factors led to chronic, medically unexplained illnesses, and these constituencies challenged the depth of the military's commitment to protect the health of deployed troops.

Recognizing the seriousness of these concerns, the U.S. Department of Defense (DoD) sought assistance over the past decade from numerous expert panels to examine these issues. Although DoD generally concurred in the findings of these committees, at the time of this IOM study few concrete changes had been made at the field level. The most important recommendations remained unimplemented, despite the compelling rationale for urgent action. A Presidential Review Directive for the National Science and Technology Council to develop an interagency plan to address health preparedness for future deployments led to a 1998 report titled *A National Obligation.* Like earlier reports, it outlined a comprehensive program that could be used to meet that obligation, but there was little progress toward implementation of the program. The Medical Readiness Division, J-4, of the Joint Staff released a capstone document, *Force Health Protection*, which also describes a commendable vision for protecting deploying forces (The Joint Staff, Medical Readiness Division, 2000). The committee feared that the vision outlined in that report would meet the same fate as the other reports. I hope that Dr.

Winkenwerder will have enlightened us on this point in his presentation today.

The Committee on Strategies to Protect the Health of Deployed U.S. Forces concluded that the implementation of both the expert panels' recommendations and government-developed plans was unacceptable. As of the time of the report release, medical encounters in theater were still not necessarily recorded in individuals' medical records, and the locations of service members during deployments were still not documented or archived for future use. In addition, environmental and medical hazards were not yet well integrated in the information provided to commanders. The committee believed that a major reason for this lack of progress was the fact that no single authority within DoD had been assigned responsibility for the implementation of the recommendations and plans. The committee believed, because of the complexity of the tasks involved and the overlapping areas of responsibility involved, that the single authority must rest within the Office of the Secretary of Defense.

The committee was charged with advising DoD on a strategy to protect the health of deployed U.S. forces. The committee concluded that immediate action must be taken to accelerate implementation of these plans to demonstrate the importance that should be placed on protecting the health and well-being of service members. Our report described the challenges and recommended a strategy to better protect the health of deployed forces in the future. Many of the recommendations are restatements of recommendations that had been made before, recommendations that had not been implemented. The committee was very concerned that further delay could result in unnecessary risks to service members and could jeopardize the accomplishment of future missions. The committee

recognized the critical importance of integrated health risk assessment, improved medical surveillance, accurate troop location information, and exposure monitoring to force health protection. They believed that failure to move briskly on these fronts would further erode the traditional trust between the service member and the leadership.

The four reports completed from the work of the first 2 years of this study provided detailed discussions and recommendations about areas in which actions were needed to protect the health of deployed forces. The committee was informed by those reports and endorsed the recommendations within them. In the final report, the committee described six major strategies that addressed the areas identified from the earlier reports that demanded further emphasis and require greater effort by DoD. The committee selected these strategies on the basis of the contents of the four reports, briefings by the principal investigators of those reports, and input from members of the military and other experts in response to the four reports. The committee made recommendations relating to each of those six strategies, as listed below and expanded upon in the report.

Strategy 1

Use a systematic process to prospectively evaluate non-battle-related risks associated with the activities and settings of deployments.

Recommendations

1.1DoD should designate clear responsibility and accountability for a health risk assessment process encompassing non-battle-related risks and risks from chemical and

biological warfare agents as well as traditional battle risks.

•The multidisciplinary process should include inventorying exposures associated with all aspects of the anticipated activities and settings of deployments.

•Commanders should be provided with distillations of integrated health risk assessments that have included consideration of toxic industrial chemicals and long-term effects from low-level exposures.

•Service member perceptions and concerns should be factored into the process of risk assessment. This will require assessing common concerns of the affected populations and evaluating whether the contents of risk assessments address those issues critical to cultivating effective risk management and trust in the process.

1.2Incidents involving toxic industrial chemicals should be among the scenarios used for military training exercises and war games to raise awareness of these threats and refine the responses to them.

1.3DoD should provide additional resources to improve medical and environmental intelligence gathering, analysis, and dissemination to risk assessors and to preventive medicine practitioners. DoD should provide a mechanism for information feedback from the medical community to the medical intelligence system.

1.4DoD should ensure that medical intelligence is incorporated into the intelligence annex to the operations plan and is considered in shaping the operational plan.

1.5DoD should devise mechanisms to ensure that state-of-the-art medical knowledge is brought to bear in developing medical annexes to the operational plans and preventive medicine requirements, drawing on expertise both inside and outside DoD.

1.6DoD should adopt an exposure minimization orientation in which predeployment intelligence about industrial and other environmental hazards is factored into operational plans.

Strategy 2

Collect and manage environmental data and personnel location, biological samples, and activity data to facilitate analysis of deployment exposures and to support clinical care and public health activities.

Recommendations

2.1DoD should assign single responsibility for collecting, managing, and integrating information on non-battle-related hazards.

2.2DoD should integrate expertise in the nuclear, biological, chemical, and environmental sciences for efficient environmental monitoring of chemical warfare agents and toxic industrial chemicals for both short- and long-term risks.

2.3For major deployments and deployments in which there is an anticipated threat of

chemical exposures, during deployments DoD should collect biological samples such as blood and urine from a sample of deployed forces. Samples can be stored until needed to test for validated biomarkers for possible deployment exposures or analyzed in near real time as needed for high-risk groups.

2.4DoD should clearly define the individuals permitted access to and the uses of biological samples and the information derived from them. DoD should communicate these policies to the service members and establish a process to review ethical issues related to operational data collection and use.

2.5DoD should ensure that adequate preventive medicine assets including laboratory capability are available to analyze deployment exposure data in near real time and respond appropriately.

2.6DoD should ensure that the deployed medical contingent from command surgeons to unit medics has mission-essential information on the likely non-battle-related hazards of the deployments and access to timely updates.

2.7DoD should implement a joint system for recording, archiving, and retrieving information on the locations of service member units during operations.

2.8Environmental monitoring, biomarker, and troop location and activity databases

should all be designed to permit linkages with one another and with individual medical records. It is crucial that means be developed to link environmental data to individual records.

Strategy 3

Develop the risk assessment, risk management, and risk communication skills of military leaders at all levels.

Recommendations

3.1DoD should provide training in the contemporary principles of health risk assessment and health risk management to leaders at all levels to convey understanding of the capabilities and uncertainties in these processes.

3.2DoD should institutionalize training in risk communication for commanders and health care providers. Periodic formal evaluation and monitoring of the quality of training programs should be standard procedure. Risk communication should be framed as a dynamic process that is responsive to input from several sources, changing concerns of affected populations, modifications in scientific risk evidence, and newly identified needs for communication.

3.3DoD should jump start training in risk communication by delivering it at appropriate settings for various levels of service, including at the time of initial entry into service and at the service schools. DoD should give particular attention to the training of medical

officers on initial entry into service. Opportunities for supplemental training and support of ongoing education in risk communication should be formally identified.

3.4DoD should include the stakeholders (service members, their families, and community representatives) in the development of a plan for DoD risk communication to include when and how risk communications should take place when new concerns arise.

Strategy 4

Accelerate implementation of a health surveillance system that spans the service life cycle and that continues after separation from service.

Recommendations

4.1DoD should establish clear leadership authority and accountability to coordinate preventive medicine—including environmental and health surveillance, training, and investigation—within and across the individual services and DoD. DoD should ensure that adequate preventive medicine personnel and resources are available early on deployments.

4.2DoD should collect health status and risk factor data on recruits as they enter the military, as planned through the Recruit Assessment Program, now in the pilot stage. DoD should maintain health status data for both active-duty and reserve service members with annual health surveys.

4.3DoD should continue to collect self-reported health information from service members after their deployments to permit comparisons with their predeployment health and with the health of other service members. For a representative sample of those who leave the military health system, DoD should continue to administer the annual health status survey for 2 to 5 years after a major deployment to learn about health changes after deployments.

4.4DoD should mandate central reporting of notifiable conditions including laboratory findings across the services. DoD should strengthen public health laboratory capabilities and integrate laboratory and epidemiological resources to facilitate appropriate analysis and investigation.

Strategy 5

Implement strategies to address medically unexplained symptoms in populations that have been deployed.

Recommendations

5.1DoD should include information about medically unexplained symptoms in the training and risk communication information for service members at all levels.

5.2DoD should complete and implement guidelines for the management of patients with medically unexplained symptoms in the military health system. DoD should provide primary health care and other health care providers with training about medically unexplained symptoms and in the use of the guidelines. DoD should carry out clinical

trials to accompany the implementation of the guidelines and evaluate their impact.

5.3DoD should establish a treatment outcomes and health services research program within DoD to further provide an empirical basis for improvement of treatment programs to address medically unexplained symptoms. This program should be carried out in collaboration and cooperation with the U.S. Department of Veterans Affairs health system and the U.S. Department of Health and Human Services.

5.4DoD should design and implement a research plan to better understand predisposing, precipitating, and perpetuating factors for medically unexplained symptoms in military populations.

Strategy 6

Implement a joint computerized patient record and other automated record keeping that meets the information needs of those involved with individual care and military public health.

Recommendations

6.1DoD should treat the development of a lifetime computer-based patient record for service members as a major acquisition, with commensurate high-level responsibility, accountability, and coordination. Clear goals, strategies, implementation plans, milestones, and costs must be defined and approved with input from the end users.

6.2DoD should accelerate development and implementation of automated systems to gather mission-critical data elements. DoD should deploy a system that fills the basic needs of the military mission first but is consistent with the architecture and data standards planned for the overall system.

6.3DoD should implement the electronic data system to allow the transfer of data between DoD and the U.S. Department of Veterans Affairs.

6.4DoD should establish an external advisory board that reports to the Secretary of Defense to provide ongoing review and advice regarding the military health information system's strategy and implementation.

6.5DoD should include immunization data, ambulatory care data, and data from deployment exposures with immediate medical implications in the individual medical records and should develop a mechanism for linking individual records to other databases with information about deployment exposures.

6.6DoD should develop methods to gather and analyze retrievable, electronically stored health data on reservists. At a minimum, DoD should establish records of military immunizations for all reservists. DoD should work toward a computerized patient record that contains information from the Recruit Assessment Program and periodic health assessments and develop such records first for those most likely to deploy early.

Thank you for the opportunity to testify. I would be pleased to answer any questions the Committee might have.

Mr. SHAYS. Thank you, Dr. Moxley. I understand it's Dr. Feinleib and not Dr. Feinleib. I am noted, unfortunately, for brutalizing names. I apologize, Dr. Feinleib.

Dr. FEINLEIB. No apology needed. Thank you, Mr. Chairman.

Mr. SHAYS. I'm going to have you bring the mic a little closer to you.

Dr. FEINLEIB. I am Manning Feinleib, professor of epidemiology at Johns Hopkins School of Public Health. I was formerly director of the National Center for Health Statistics, and I was a associate director for Epidemiology and Biometry at the National Heart, Lung and Blood Institute.

Today I will discuss some aspects of the design of surveillance systems needed to generate valid epidemiological data on deployed forces. With your permission, I would like to place my full written comments in the record and just give an abridged version right now.

As we have just heard, DOD has established several programs to track the health of veterans in accordance with some of the recommendations which you have just heard. Recently analyses of the data generated from these efforts have begun to appear.

It is my overall impression that implementation of the surveillance programs have been fragmented and little worthwhile data will be forthcoming from the forms currently used for pre and postdeployment health assessment.

Several expert committees have been unanimous in recommending that the type of surveillance most suitable for studying emerging health problems in deployed forces is the prospective cohort study. Congress has already mandated this tracking system in the National Defense Authorization Act of 1998. More detailed descriptions of this tracking system were made by several IOM committees. The committees all recognize the great challenge this presented and that it would require the collaboration and commitment of both the VA and DOD and probably several other agencies.

The committees emphasize that this approach could eliminate major problems encountered in trying to resolve many of the veteran health issues that arose following the Vietnam and Gulf wars. DOD and the VA have recently launched such a study called the Millennium Cohort Study, which will follow 140,000 veterans for 21 years. This is a start in the right direction, and I vigorously endorse this study and urge that adequate direction and resources be provided to implement it effectively.

From an epidemiological perspective, cohort surveillance in a military setting offers formidable challenges but also unique opportunities. I would like to go over some of these in the next few minutes.

First of all, there should be a clear explanation of the purposes of a surveillance system for deployed forces. There are many parties concerned about the health of veterans. So questions to be addressed by the surveillance of these deployed personnel are many and varied. For some of these purposes it may not be necessary to track all of the deployed personnel, and appropriate samples of the population may provide desired information in a more efficient and timely manner.

Two of the basic purposes are to ascertain health status immediately before and after deployment and to provide an opportunity for personnel to address concerns about their health and receive early medical attention.

These, I understand, are the purposes of the currently used pre and post discharge—postdeployment health assessment forms. Three other major purposes have not been as well documented; for example, to document the exposures to known or potential hazards, especially to new substances and technologies that were not seen in previous encounters, to ascertain the health events after discharge, including physical, mental and reproductive effects, and to compare the nature and frequency of health events among groups with different exposures.

A second major point is that of obtaining accurate, timely and complete information at baseline. Although the cohort of deployed personnel is inherently well defined, obtaining accurate, timely and complete information on all of the participants has not been achieved despite strenuous efforts to do so.

Recent reports from the Army medical surveillance activity highlighted some of the deficiencies of the recent experience using the postdeployment health assessment forms. Only about one-third of the completed predeployment forms could be matched with the relevant postdeployment forms. Much of the information that was obtained was incomplete. The question on exposures in particular seemed to be misunderstood by many, if not most of the respondents.

All positive responses about health concerns should have been followed up with more detailed interviews and medical examinations, but apparently were not. Obviously, it would have been desirable if all of the forms could have been linked to records of sites of deployment and to specific exposure information obtained during deployment.

A third point is that of assembling comparison groups, and, except to say that these would be very useful, both in those people who are actually deployed as well as those who are not deployed, would be an advantage.

The issue of active and passive surveillance is paramount after returning from deployment. This is a very difficult task and would require a great deal of effort and resources. Passive surveillance, the ascertainment of health outcomes from routinely collected administrative data, might be possible for veterans using the VA health system. It would be extremely difficult for those using private sector health care providers. A system of active surveillance, periodic contact with the veterans would be more feasible and presents major challenges also.

Contact by telephone or mail requires maintaining an up-to-date roster of addresses and phone numbers. Obtaining the long-term cooperation of the veterans, following up on all positive responses and providing feedback to the participants would be important components of such a tracking system.

A fifth point is that of disease definition. Most epidemiologic studies have a relatively clear concept of the outcomes they are concerned with and go to great lengths to establish standards for defining these outcomes. One of the lessons learned from previous

deployments is that new symptoms and diseases may occur following deployments that do not fit into current classification systems. These may involve physical manifestations, as well as psychological ones.

Concerns have also been voiced about possible effects on the families and progeny of the veterans from possible residual contamination after discharge or from genetic effects of noxious exposures.

Finally, I'd like to discuss the keeping of good medical records. Most of the expert committees stress the importance of upgrading the medical recordkeeping capacity of these surveillance systems. Methods must be created to obtain information in real-time in the field to transfer to a centrally maintained data repository and link the information to individual level records. Quality control measures must be in place to assure that all records are accounted for and that individual items are completed and that editing and coding procedures are adhered to. If systematic deficiencies are uncovered, they should be corrected as soon as feasible.

Structural problems in the design of the instruments may be uncovered that require major overhauls. As mentioned earlier, the AMSA analyses revealed major problems for the question on exposure and recommended major revisions of this question. But even such items as the sex of the deployed person were not completed for about 10 percent of the forms.

An expert group recommended that the pre and postdeployment health assessment forms be dropped altogether. The health enrollment assessment review questionnaire has been suggested as a more useful form. I personally recommend that the potential of computer-assisted interviews be explored as a substitute for pencil and paper forms to obtain more accurate and timely information.

Mr. Chairman, I will close my remarks at this point. I'll be pleased to respond to any questions you may have.

[The prepared statement of Dr. Feinleib follows:]

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"The design and implementation of surveillance systems to generate valid epidemiological data on deployed forces."

Testimony by
Manning Feinleib, MD, DrPH
Professor of Epidemiology
Johns Hopkins Bloomberg School of Public Health
615 N. Wolfe St. Room E6153
Baltimore, MD 21205
Tel: 410-614-0146
Fax: 410-614-9314
mfeinlei@jhsph.edu

Hearings Before the
Committee on Government Reform
Subcommittee on National Security,
Emerging Threats, and International Relations
on

Protecting the Health of Deployed Forces:
Lessons Learned From the Persian Gulf War

March 25, 2003
2:00pm
Rayburn Building Room 2247

Thank you, Mr. Chairman.

I am Manning Feinleib, Professor of Epidemiology at the Johns Hopkins Bloomberg School of Public Health. I was formerly Director of the National Center for Health Statistics at CDC and Associate Director for Epidemiology and Biometry at the National Heart, Lung, and Blood Institute of NIH. I am a member of the Institute of Medicine and have served on a recent IOM Panel on Gulf War and Health.

Today I would like to discuss some aspects of the design and implementation of surveillance systems needed to generate valid epidemiological data on deployed forces.

Following the 1991 Gulf War many groups became concerned about the health of the deployed forces. Several research studies confirmed the impression of the veterans that they were experiencing a variety of symptoms at higher rates than the general population (Joseph 1997, Joellenbeck 1998, Murphy 1999, Kang 2000). However, the studies were hampered by a lack of data on the base-line health of the veterans, lack of objective data on post-deployment health status, and inadequate data on exposures during deployment. Acting on the advice of numerous committees and task forces, and directives from Congress (*PL 105-85 Sec. 765.*) and from the National Science and Technology Council (NSTC 1998), DoD established several programs to improve the health of the military, veterans, and their families. DoD also requested the Institute of Medicine to evaluate

these efforts and several extensive reports were produced providing detailed comments and numerous recommendations. (IOM 1996, 1998, 1999a, 1999b, 2000) Recently, analyses of the data generated from these efforts have begun to appear (MSMR 2002a, 2002b).

It is my overall impression that although some initial steps have been taken to carry out this important mandate, implementation has been fragmented and little worthwhile data will be forthcoming from the forms currently used for pre- and post-deployment health assessment.

As used by epidemiologists and public health workers, surveillance is a process for monitoring the health status of defined populations by collecting, analyzing, interpreting, and disseminating information about the occurrence of diseases in these populations. The various expert committees have been unanimous in recommending that the type of surveillance most suitable for studying emerging health problems in deployed forces is the prospective cohort study. At the time of deployment and immediately upon returning from deployment, a roster of all deployed personnel would be obtained and their baseline health status would be ascertained by means of standardized questionnaires and interviews supplemented with medical examinations and laboratory studies where indicated. During the period of deployment, data would be obtained on potential hazardous exposures and circumstances that may predispose the troops to future health problems. A tracking system would determine ensuing health events among all of the cohort members as early as possible. Procedures would be in place to verify diagnoses

and make referrals to appropriate health care facilities. In order to identify and determine the impact of specific exposures, various comparison groups would be assembled concurrently and followed in a similar manner to the deployed personnel.

Congress has already mandated this tracking system in the National Defense Authorization Act of 1998 (PL 105-85 Sec. 765). More detailed descriptions of the tracking system and strong recommendations to implement such longitudinal cohort surveillance was made by the IOM Committee on Measuring the Health of Persian Gulf Veterans (IOM 1999a) and the IOM Committee on Strategies to Protect the Health of Deployed U.S. Forces (IOM 2000), chaired by Dr. John Moxley. The Committees recognized the great challenge this presented and that it would require the collaboration and commitment of both the VA and DoD, and possibly other agencies. A key requirement for the success of this endeavor would be obtaining the continuing participation of the deployed personnel for many years after their deployment. The Committees emphasized that this approach could eliminate major problems that were encountered in trying to resolve many of the veteran health issues that arose following the Vietnam and Gulf Wars.

I vigorously second this recommendation and urge that adequate direction and resources be provided to implement it effectively.

From an epidemiological perspective, cohort surveillance in the military setting offers some formidable challenges but also unique opportunities. I would like to go over some of these in the next few minutes.

1. **Purposes of a surveillance system for deployed forces**. In designing a surveillance system it is desirable to start with a clear concept of the purposes of the system, what questions it will be used to answer, and what are the population and subgroups of interest. There are many parties concerned about the health of veterans and the purposes for and questions to be addressed by the surveillance of deployed personnel are therefore many and varied. For some of these purposes it may not be necessary to track all of the deployed personnel and appropriate samples of the population may provide desired information in a more efficient and timely manner. Basically the purposes of surveillance include the following elements:

    1. To ascertainment health status immediately before and after deployment.
    2. To document exposures to known or potential hazards.
    3. To provide an opportunity for personnel to express concerns about their health and receive early medical attention.
    4. To ascertain health events after discharge, including physical, mental, and reproductive effects. The experience of Viet Nam and the Gulf War indicate that potential effects may be both subtle and complex, and may take several years to manifest themselves.
    5. To compare the nature and frequency of health events among groups with different exposures.

The Pre- and Post-deployment Health Assessment forms try to address the first and third aims.

2. **Obtaining accurate, timely, and complete information at baseline**. Although the cohort of deployed personnel is inherently well defined, obtaining accurate, timely, and complete information on all of the participants has not been achieved despite strenuous attempts to do so. Recent reports from the Army Medical Surveillance Activity (AMSA) highlighted some of the deficiencies of the recent experience in using the Post-deployment Health Assessment forms (MSMR 2002a, MSMR 2002b). Only about one-third of completed pre-deployment forms could be matched with post-deployment forms. The information was incomplete and the question on exposure concerns, in particular, seemed to be misunderstood by many of the respondents. All positive responses about health concerns should be followed up with more detailed interviews and medical examinations but apparently are not. Obviously, it would be desirable if all of the forms could have been linked to records of sites of deployment and specific exposure information obtained during deployment. This would eliminate biases in recalling putative hazardous exposures if sought after the occurrence of illness.

3. **Assembling comparison groups**. The key analytic comparisons to be made are of subsequent health events among personnel with different histories of exposures. In addition to the exposure information obtained for deployed troops, it would be desirable to assemble comparison groups among military personnel who were not

deployed and among reserve units that were not activated. These would allow, for example, estimates of the health impact of deployment among those without specific exposures.

4. **Active and passive surveillance**. The ascertainment of symptoms and illnesses after discharge is a formidable task and would require a great deal of effort and resources. Passive surveillance, the ascertainment of health outcomes from routinely collected administrative data might be possible for veterans using the VA health systems but would be extremely difficult for those using private sector health care providers. A system of active surveillance, periodic contact with the veterans, would be more feasible but presents major challenges. Contact by telephone or mail requires maintaining an up-to-date roster of addresses and phone numbers. Obtaining the long-term cooperation of the veterans, following up on positive responses, and providing feedback to the participants would be important components of the tracking system. It will be important to clearly explain the purposes of the study and to provide assurances of confidentiality.

5. **Disease definition**. Most epidemiologic studies have a relatively clear concept of the outcomes they are concerned with and go to great lengths to establish standards for defining these outcomes. One of the lessons learned from previous deployments is that new symptoms and diseases may occur following deployment that do not fit into current classification systems. These may involve physical manifestations as well as psychological ones. It is important that methods be in place to capture these emerging

conditions and analyze them properly. Concerns have also been voiced about possible effects on the families and progeny of the veterans from possible residual contamination after discharge or from genetic effects of noxious exposures.

6. **Medical records**. Most of the expert committees stressed the importance of upgrading the medical record keeping capacity of the surveillance system. Methods must be created to obtain information in real time in the field, transfer it to a centrally maintained data repository, and link the information to individual level records. Quality control measures must be in place to assure that all records are accounted for, that individual items are completed, and that editing and coding procedures are adhered to. If systematic deficiencies are uncovered, they should be corrected as soon as feasible. Structural problems in the design of the instruments may be uncovered that require major overhauls. As mentioned earlier, the AMSA analyses revealed a major problem with the question on exposure concerns and recommended major revision of this question. But even such items as sex were not completed for a significant number of forms. An expert group recommended that the pre- and post-deployment health assessment forms be dropped altogether. (IOM 1999b). The Health Enrollment Assessment Review Questionnaire (HEAR) has been suggested as a more useful form. I recommend that the potential of Computer Assisted Personal Interviews (CAPI) be explored as a substitute for paper-and-pencil forms. These may facilitate obtaining more complete and detailed information.

Mr. Chairman, I will close my remarks at this point and will be pleased to respond to any questions you may have. Thank you.

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Mr. SHAYS. Thank you, Dr. Feinleib.

Mr. Robinson.

Mr. ROBINSON. Mr. Chairman, the National Gulf War Resource Center thanks you for this hearing and all the hearings that you've conducted to get to the bottom of what has been very troublesome for people who served in the last Gulf war.

Why is this hearing important? It's important because I and others in this room have family members within striking distance of Saddam's chemical and biological weapons right at this moment. It's important because it's been a personal experience for Gulf war veterans. It's important because it matters, and it's important because a lack of that has prevented meaningful research and prevented scientists from interpreting what really happened on the battlefield.

You don't walk up to your F–16 in the morning and ask it how is it doing. You put your hands on it. You look at the internal mechanisms that control its flight. You make sure it has enough gas. You do what you have to do to ensure that that system will perform.

Public laws that were specifically designed to protect soldiers on the battlefield are currently being ignored, thereby setting a stage for mystery illnesses to again present themselves after a war. Unfortunately, the results of force health protection, as described by the Department of Defense, have been utterly disappointing. These shortfalls demonstrate a lack of willingness to follow the intent of Congress and the public law.

Understanding the lessons from medical mistakes made more than 12 years ago, it's important for us to ensure that these mistakes are not made on a new generation of veterans. Recently the Institute of Medicine completed its review of pesticides and solvents used in the first Gulf war, and one of the conclusions the committee made was that lack of data prevented them from linking exposures of the war to the illnesses that veterans suffer from. And as the IOM began its next round investigations into oil well fires and chemical compounds, they are keenly aware that there's also a lack of data on these types of exposures.

We can safely predict that they may reach the same conclusion, because the baseline data was never considered and the post-exposure data was never collected.

It's important also to note that the reports from the IOM are used by the Department of Veterans Affairs to make conclusions on whether or not illnesses are service-connected to wartime-related exposures.

Briefly I'd like to talk about what we are aware of in terms of what has been implemented and what is not being implemented in terms of the public law. The Department has standardized methods for identifying medical threats and appropriate countermeasures prior to deployment. They've also incorporated planning efforts into the early stages that continue throughout the deployment. They also use surveillance teams to monitor the environment and chemical-biological weapons exposures. These things are lessons learned from the first Gulf war.

What they're not doing and what is the meat of why we are here today is that they are not conducting medical screening and analy-

sis, both pre and postdeployment. Congress passed Public Law 105–85 in 1998 as part of the defense authorization bill at a time when veterans were experiencing various illnesses. The reason Congress passed this law was so that physicians could monitor changes over time, particularly during and after the deployment. This law also called for the drawing of blood samples, significant medical recordkeeping, and an examination of the soldiers's mental health before and after the conflict.

Instead of following the letter of the law in a meaningful way that will produce scientifically valuable evidence, the Department of Defense and the people responsible for force health protection are interpreting the law so that it creates a deceptive compliance. This half-hearted evidence will produce similar results that have prevented the Institute of Medicine from reaching conclusions from the last Gulf war. The Director of the Deployment Health Support Directorate is charged by this law to implement the lessons learned, and DOD is not following the law.

I will now describe what we understand is the current status of affairs for force health protection. In the predeployment phase, the Department is not conducting hands-on physicals to determine the health status of the force before deployment, as required by law. Instead, they give out a questionnaire. A DOD quote from a recent congressional inquiry described its own questionnaire as follows: These forms contain a limited amount of information. They do provide a means to document health status before and after deployment and afford the deployed service member the opportunity to have deployment-related health concerns addressed.

More significantly in the predeployment phase, the Department is not drawing blood samples from the entire force prior to the deployment, as required by law. Instead, the Department relies on serum collection for HIV testing. This serum could be anywhere from 1 to 3 years old and will not be a snapshot of the soldier's current predeployment health condition. Every scientist from the IOM agrees that predeployment and postdeployment surveillance is the key to understanding illnesses on the battlefield after wars.

More data is preferred over less data. The current activities of DOD and health monitoring in the postdeployment phase are that the Department is not conducting mental and physical evaluations after deployment, as required by law. Instead, the DOD hands the soldiers a questionnaire. The survey, as demonstrated by the testimony of the gentleman to my right, is inadequate and does nothing to satisfy the requirements of the law or provide meaningful information.

Additionally, the lack of mental screening has been demonstrated as problematic. Soldiers recently who served in Afghanistan were sent directly home without any medical assessments. Some of these soldiers committed horrible crimes that may have been related to combat stresses. Had the public law been followed, perhaps a terrible tragedy might have been averted.

In the postdeployment phase, the Department is not drawing blood samples from the force after the deployment as required by law. Instead, they rely on the serum collection for HIV. This serum collection can be old and will not be a snapshot of what has recently occurred on the battlefield. Because the Department is again

failing to collect the baseline data, veterans will not be able to meet the burden of proof required by the Department of Veterans Affairs for treatment. This mistake is precisely what created the controversy surrounding Gulf war illnesses. Service members are being set up to face another round of delays, denials and obstructions.

This prospect is unacceptable and must be corrected. The current medical practices of DOD are all half-hearted, and they are a public disaster waiting to happen. Since forces are actively engaged in combat, we have missed the opportunity to conduct baseline predeployment screening. Mr. Chairman, I humbly request that we implore, demand and make the Department collect the postdeployment data so that we will not face another round of unanswered questions.

In the military that I served in, there were consequences for failure to obey orders, and anything less than 100 percent effort was unacceptable. We were not allowed to interpret the intent of orders but rather to obey them implicitly. These core values do not seem to work both ways. Veterans will be the ones who will suffer the consequences of the poor implementation of this law, and veterans will be the ones who face another fight because of the lack of data.

I hope that those responsible for the implementation of this law will understand that their failures are going to impact the lives and well-being of soldiers returning from this conflict.

Mr. Chairman, I would like to know who we may hold accountable, and I humbly request that we find out immediately. Thank you.

[The prepared statement of Mr. Robinson follows:]

National Gulf War Resource Center

Protecting the Health of Deployed Forces

Lessons Learned from the Persian Gulf War

DoD Force Health Protection

Deceptive Compliance

Testimony of Stephen L. Robinson

Executive Director

Before the Subcommittee on National Security, Emerging Threats, and International Relations

March 25, 2003

National Gulf War Resource Center

Mr. Chairman and members of the committee, the National Gulf War Resource Center (NGWRC) is honored to have the opportunity to submit written testimony for today's hearing on Force Health Protection.

Public laws (specifically PL 105-85) designed to protect soldiers on the battlefield are being ignored, thereby setting the stage for mystery illnesses to again present themselves after a war with Iraq.

FHP was supposed to be a catalyst for a fundamental reorientation of military medicine. The intent was to broaden the focus from acute-care services and post-casualty intervention to include proactive, preventive services that maintain healthy and fit forces. Additionally, FHP was designed to correct the mistakes of 1991 by collecting baseline data on the health of our forces before, during, and after war. These efforts were to provide the platform for future research should any chemical or biological event occur.

Unfortunately, FHP results have been utterly disappointing. These shortfalls demonstrate a lack of willingness to follow the public law and a lack of understanding of the lessons from medical mistakes made more than 12 years ago. Ignoring those lessons will create a whole new round of delays and denials should hostilities include the release of CBW on the battlefield.

Recently the Institute of Medicine completed its review of Pesticides and Solvents use in the first Gulf War. One of the conclusions of the committee was that lack of data prevented the committee from linking exposures of the war to illnesses that veterans suffer from. As the IOM begins its next round of investigations into oil well fires and chemical compounds they are keenly aware that there is also a lack of data on these types of exposures. The NGWRC can safely predict that the IOM will reach the same conclusions because baseline data was never considered and post exposure data was never collected.

It is important to note that reports from the IOM are used by the Department of Veterans Affairs to rule in or rule out service-connection for veteran's illnesses. This is why the public law is so important and why ignoring it will harm another generation of veterans.

Looking at the public law it is clear that some initiatives to decrease risks in military operations have been implemented, many others have not:

- Implemented - Standardizing methods identifying medical threats and appropriate countermeasures prior to deployment – these features have been incorporated in early military deployment planning efforts. Also, the use of surveillance teams to monitor the environment and CBW are now an integral part of the war plan and should be conducted throughout the operation.

- Not implemented - Medical screening and analysis, both pre- and post-deployment. Congress passed PL 105-85 in 1998 as part of the defense authorization bill at a time when Gulf War veterans were experiencing various ailments known collectively as Gulf War Syndrome: joint pain, headaches, memory loss, rashes, balance problems, and loss of motor skills. The screenings were meant to provide epidemiologists and doctors a baseline snapshot of every soldier's health. Then, physicians could monitor changes over time, particularly during and after deployment. The law also called for drawing blood samples, significant medical record keeping, and an examination of the soldier's mental health.

The Pentagon has been quoted saying "it cannot verify that soldiers in the anti-terrorism campaign or the war with Iraq are undergoing medical exams before and after deployment as required by law." The NGWRC knows that statement is true based on information from deploying National Guard soldiers.

Instead of following the letter of the law in a meaningful way that will produce scientifically valuable evidence Dr. Michael Kilpatrick and his superiors are interpreting the law in a way, which creates"Deceptive Compliance". This halfhearted effort will produce similar results that have prevented the IOM from reaching conclusions from the last Gulf War.

The director of the Deployment Health Support Directorate is charged by this law to implement lessons learned. DoD is not following the law.

The current activities of DoD and health monitoring in the Pre-Deployment phase are described below.

In the Pre-Deployment phase the Department is **not conducting hands-on physicals** to determine the health status of the force before deployment as required by law. Instead, DoD is **handing out a questionnaire**.

A DoD quote from a recent Congressional inquiry describes its own questionnaire as follows " Although these forms contain a limited amount of information, they do provide a means to document health status before and after deployment, and afford the deployed Service member the opportunity to have deployment-related health concerns documented and addressed."

More significantly the Department is **not drawing blood samples** from the entire force prior to deployment as required by law. Instead, DoD is relying on the serum collection for HIV testing. This serum may be anywhere from one to three years old and will not be a snapshot of the soldier's current pre-deployment health condition. Even a retired Army Ranger knows the best time to collect data is immediately after the event, not months to years later. Every scientist from the IOM also agrees with this assessment. More data is preferred over poor data.

National Gulf War Resource Center

The current activities of DoD and health-monitoring in the Post-Deployment phase are described below.

In the Post-Deployment phase the Department is **not conducting mental and physical evaluations** after deployment as required by law. Instead, DoD **hands soldiers a questionnaire**. The survey is inadequate and does nothing to satisfy the requirements of the law or provide meaningful information. Additionally the lack of mental screening has been demonstrated as problematic. Soldiers who recently served in Afghanistan were sent directly home without any medical assessment. Some of these soldiers committed horrible crimes that may be related to combat stressors. Had the public law been followed perhaps a terrible tragedy might have been averted.

The Department is **not drawing blood samples** from the entire force after the deployment as required by law. Instead, DoD is **relying on the serum collection for HIV testing**. This serum may be anywhere from one to three years old and will not be a snapshot of any changes that may have occurred as a result of exposures during the deployment. Because the Department is again failing to collect the baseline data, veterans will not be able to meet the burden of proof required by the Department of Veterans Affairs for treatment, compensation, and care. This mistake is precisely what created the controversy surrounding Gulf War Illnesses.

Service members are being set up to face another round of delay, denial, and obfuscation regarding possible service-connected medical conditions or disabilities related to their participation in a Middle East conflict. This prospect is unacceptable and must be corrected.

The current medical practices of the DoD and its half-hearted implementation of public law is a disaster waiting to happen. Since forces are actively engaged in combat we have missed the opportunity to conduct base-line Pre-Deployment screening. Will this Nation allow DoD to also ignore the Post-Deployment aspects of this law?

In the military I served in there were consequences for failure to obey orders and anything less than a 100% effort was unacceptable. We were not allowed to interpret the intent of orders but rather to obey them implicitly. These core values do not seem to work both ways.

Veterans will be the ones who suffer the consequences of this poor implementation of the law. Veterans will be the ones who will face another fight because of a lack of data.

I hope that those responsible for the implementation of this law will be haunted by their failures for they have surely shamed the memories of those who have died and lost their livelihood as a result of the exposures of the last Gulf War.

Mr. Chairman, who we hold accountable?

Mr. SHAYS. Thank the gentleman very much. We're going to start with Mr. Janklow.

Mr. JANKLOW. Thank you very much, Mr. Chairman. I'm puzzled as I sit here. I just listened to the previous panel, and now I listen to you three gentlemen, and it's like two trains passing in the night. They're on the same track, but they don't have a chance of hitting each other. I should say they're along the same route, but they are on different tracks.

You listened to the previous panel. This isn't quite fair to the previous panel, but I don't quite know how to do this. Dr. Moxley and Dr. Feinleib and you, Mr. Robinson—let me take you two doctors first. You listened to the testimony of the previous panel. Have you ever expressed to the current leadership of the Department of Defense your concerns about what I would call the unlearned lessons of the Gulf war?

Dr. MOXLEY. Not specifically, sir. I've not been asked to. All I can say is at the time of our report, which is now 2 years ago, all of the criticisms that you have heard—I would have to say—were valid. There was not very much being done.

What has been said—and I have no reason to doubt the Secretary—is that there has been a lot of progress, but it has to have been in the last 2 years because we didn't see it.

If indeed that progress has been made, it is nothing short of miraculous, because there was a long way to go, but I have no way of documenting where, if you will—the correct or—the truth is, I don't mean to imply by that anybody is fabricating it.

Mr. JANKLOW. What I'm puzzled with, sir, one of the things is that your vitae indicates that the organization that you worked for was one that's been around for 100 years.

Dr. MOXLEY. Yes.

Mr. JANKLOW. Amend that, it was mandated by Congress and funded by the public. In the last—from the time you issued your report, did anybody ever go to the Department of Defense to say how you're coming on the list, or is there anything further we can do to contribute, or was it just issuing a report and then stepping back?

Dr. MOXLEY. Well, there is no mandate in any of the reports that we—well, I guess there may be——

Mr. JANKLOW. I know there's no mandate but I'm just wondering——

Dr. MOXLEY. No. We have not—No. 1, we wouldn't have access. I don't think I could get into the Pentagon if I tried at this point in time to talk to anyone, and I'm certain I would have—this—far more difficulty than you would have, for instance, in asking any of the questions. So it is not an automatic part of the report, and we do not have access. I mean, one of the things that could be done is—whether it be the IOM or not, is—there seems to be a great difference in story here as to the status of where things stand.

Mr. JANKLOW. Yes, sir.

Dr. MOXLEY. An outside group taking a quick look at that and trying to determine—what needs to be done. It is fairly clear, and it's printed time and time again in seven different reports. Whether or not it's occurred is hard to determine at this point in time, because there are differing opinions.

Mr. JANKLOW. Do you have a sense from listening to the previous panel that they professionally differ from the—from you gentlemen in the conclusions you have reached?

Dr. MOXLEY. No.

Mr. JANKLOW. Do you, Dr. Feinleib?

Dr. FEINLEIB. Yes, I think I do. One is I think they are acting under very different circumstances than most epidemiologists operate. They have real-time things that have real needs which haven't been explicitly stated.

Mr. JANKLOW. Pardon me?

Dr. FEINLEIB. They have real needs for the data that haven't been explicitly stated. So it's difficult to evaluate it. On the predeployment health assessment they have a question like, do you have a 90-day supply of your prescription medication, yes or no? If it says yes, there doesn't seem to be any followup question, what are you taking, what are you taking it for?

Mr. JANKLOW. And if they say no, same thing?

Dr. FEINLEIB. Then fine, exactly. I don't know the purpose of why they're asking that question. If you say no and you're supposed to be taking medication, you go home or what?

Mr. JANKLOW. And you're probably the wrong gentleman to ask, but what is so tough about all of this? I mean, what we're talking about is looking for elemental data on how healthy someone is. When I went into the Armed Forces a while ago, I had a physical. Some people made it, some didn't. In my State today, if they call up National Guard units, some go, some don't, because some individuals flunk their physical exam.

What is it that's so mysterious about giving people a physical exam before they deploy to war? That's not everybody in the Armed Forces right now. It's those that are going off to war, first of all. And second of all, coming up with the right forms, how can we be 12 years after the war and still trying to figure out what the right form is? That tells me we're never going to get to the right form. I'm not blaming you, but whose fault is all of this, who is doing all of this? Is it the system that's broke or is it the people or both?

Dr. MOXLEY. I don't know what else to say, except it's clear that the responsibility lies with the Department of Defense. Now, you've had two or three changeovers in each of the offices. So in terms of pinning it down below that, I don't know how to help you, but they have the responsibility for implementing the recommendations that have been made. And in part, we're dealing with first and second order of questions here, because 2 years ago—or 3 years ago we did not think there was even an elemental sort of analysis pre and post. At least now there's a document—it may not right document, but there is a document that exists.

Mr. JANKLOW. We talk about the drawing of blood. It can't be that difficult to draw blood on a couple hundred thousand people and store it—several hundred thousand people and store it. Is it?

Dr. FEINLEIB. It can be done.

Dr. MOXLEY. It certainly can be done.

Mr. JANKLOW. Is it an expense problem, as far as you know? And I know you may not be the right people to ask, but I can't believe you've done all this work and just think it's going to get filed on a shelf.

Dr. MOXLEY. Well, is that specifically an expense problem? My guess is the answer is no. Is the implementation of all of the recommendations and of the public law that has been referred to so many times today, is the full implementation of that a significant expense? I would say yes, it is.

Mr. JANKLOW. Let me ask you two doctors again, both of you, if I could. If you were in Congress, Republicans and Democrats, what would you recommend we do?

Dr. MOXLEY. I would recommend——

Mr. JANKLOW. Nobody wants to revisit this Gulf war problem again, and if everything we hear is accurate, we may have to visit it again. So we have learned some lessons, but is there anything we can do legislatively, or is it a matter of implementing the existing law?

Dr. MOXLEY. Well, sir, it strikes me that it's a matter of we don't know what has been implemented and what hasn't been implemented, and there seems to be a lot of debate on that issue.

Mr. JANKLOW. Let me interpret you if I can, please. Could you give us a list of the questions that we ought to send to the Defense Department as a congressional panel that we need the answers to, the questions that you just referred to? Could you do that, sir?

Dr. MOXLEY. I don't know whether I can do it off the top of my head.

Mr. JANKLOW. No. No. Could you prepare them after today and send them to us?

Questions we ought to ask the Department.

Dr. MOXLEY. To do it, I would need the help of some of the staff members of the Institute of Medicine, and I don't know whether that would be made available or not.

Mr. JANKLOW. Could you, Dr. Feinleib, prepare any questions that we ought to ask the Defense Department?

Dr. FEINLEIB. That is a complex question, because I'd like to say there are many epidemiologic studies going on, and all of them spend a considerable amount of time designing their forms, figuring out what the objectives are, making, pretesting them, standardizing them. It is not an overnight operation, and they find from experience for the purposes of their study which types of forms work, which types of questions work, etc.

Mr. SHAYS. This may be a little more simple, because, in other words, it costs money to design a questionnaire and do it properly and so on, and you have your reputations on the line. But would you at least be able to give this committee a document, each of you, that just points out in more specific terms the way the question was asked and the way it should be asked?

For instance, I look at this question. It says during the past year have you sought counseling or care for your mental health? And I'm at a quandary as to know the value of that question. If you said yes, maybe it's a good thing and maybe more of us should be doing it. And if you said no, maybe you should have, and so I don't really know what it tells you.

Dr. FEINLEIB. Yes. That is why I suggested that we ought to be looking to computer-assisted interview. We could allow secondary questions, branching questions, etc. If you answer yes to that, it will say what was the nature of your complaint, what was done,

how do you feel now, whatever would be appropriate, rather than just yes or no not knowing what happened.

Mr. SHAYS. But my point is I don't know whether no or yes is the wrong answer.

Dr. FEINLEIB. Neither do I. But that's where you have to ask more questions if you want a face-to-face interview to find out what it means.

Mr. SHAYS. So without asking you to do this whole questionnaire, but maybe you could just take a few questions and illustrate your concerns. I'm sorry. I didn't even ask the gentleman if——

Mr. JANKLOW. No. That's OK. Go ahead, Mr. Chairman.

Mr. SHAYS. That's what happens when you get to the end of the day. You have the floor and you're asking great questions. I'm done.

Dr. MOXLEY. In our written statement, we——

Mr. SHAYS. Could I just thank—before—I'm interrupting. I'm sorry. I just wanted to thank Dr. Winkenwerder for staying here and having the courtesy of listening to their points. I'd like to do a little connection between you and them and also to point out Dr. Kilpatrick is here and also Dr. Hyams as well, and thank all three of them for showing you the courtesy and also learning from what you might say. That's very helpful of you.

Thank you.

Dr. WINKENWERDER. Thank you. We're glad to have more interaction here.

Mr. SHAYS. We'll make sure that happens. Thank you.

I'm sorry to interrupt.

Dr. MOXLEY. Well, I was trying to come back to some sort of answer to your question. I was going to say in our written statement we recapitulate our recommendations. I mean, it would be a fairly long list of inquiries, but one could ask whoever is responsible has this been implemented. I don't know that going over it I could improve upon it, and they are in the written record.

Mr. JANKLOW. Sir, after this report was submitted to the Defense Department, did you ever hear back anything?

Dr. MOXLEY. I did not personally, no.

Mr. JANKLOW. Do you know of anyone who did?

Dr. MOXLEY. No, I do not.

Mr. JANKLOW. Do you, Dr. Feinleib?

Dr. FEINLEIB. I'm a newcomer to this area, but what I say is I haven't heard directly at all. I see evidence that they've been thinking about these things. The Millennial Cohort Study, for example, follows many of the ideas and recommendations made by the IOM committees, but it's only on a hundred thousand of the troops. There still are several hundred thousand more that aren't covered by this survey.

Mr. JANKLOW. Mr. Robinson, as I read your resume, obviously nobody can question in any way your service to this country or your concern as I listen to you. What do you think is wrong? I mean, understanding that, all right, we weren't prepared in the Gulf war for what we ran into, maybe we didn't really understand and we were destroying these kinds of stockpiles without thinking enough of the safety of our people, I mean, our collective ignorance. But what went wrong after that when the problems started to

arise, people were—Congress is holding hearings, the media is making reports. I mean, you can see, you know, this mushroom cloud of concern going up. What happened? In your opinion, what happened?

Mr. ROBINSON. I think one of the first things that happened is we didn't listen to our veteran. It's interesting that in this area of force health protection when soldiers get ready to deploy the Department's answer to finding out if they're medically fit to deploy is to ask them if they feel like they're fit to deploy, but yet when soldiers return from the Gulf war and said we think we were exposed to some things that made us ill, they did not listen and said that stress was the reason why they were sick.

Mr. JANKLOW. That's a good point.

Mr. ROBINSON. And I say that I'm troubled, deeply troubled by listening to someone of Dr. Winkenwerder's stature and his responsibility for the Department of Defense and the care of our servicemen and women to say that self-reporting is more important than hands-on evaluation and serum collection. It was the intent of Congress after passing this law from preventing an event like Gulf war illnesses from ever happening again by providing the Department a method for collecting exculpatory evidence to determine whether illnesses were or were not related to their exposures. By handing out a questionnaire and relying on what potentially could be year-old serum, we are setting ourselves up for the exact same event.

So you ask me—to get back to your question—why did it happen? I think it happens because we tend to put more emphasis on systems than we do soldiers, and I think it happened because—it does boggle my mind first off, because I briefed this issue working for the Secretary of Defense, working with Dr. Kilpatrick while assigned to the Department of Defense for 3 years, and the first year that I began to brief it—and this is a copy of the slide that I'll provide to the committee. One of the things that we talked about was that it was important to verify the DNA sample on file. You had to conduct a predeployment serum sample. You had to verify the HIV tests, both in the pre and postdeployment phase.

I briefed this to thousands of soldiers and commanders all across the United States, and they would look at me with a strange look and say, well, that's new. That is important. We should do it. And I would tell them, no, it's more than just important. It's required. And so to now at the 59th minute and the 59th second as people are approaching Baghdad, to tell you why it hasn't happened, I can't begin to imagine, but I can say that since we have missed the opportunity to collect the predeployment baseline data, we must not miss the postdeployment collection of data. We must not just simply hand out a questionnaire. We must do what the public law said.

Mr. JANKLOW. Can I ask one more question, Mr. Chairman?

Mr. SHAYS. The gentleman has as much time as he'd like. I'm learning from his questions.

Mr. JANKLOW. Dr. Moxley, since the time you've written your report, your issue of the report, is there anything new that you've come across that you would have added to the report?

Dr. MOXLEY. No, sir, not——

Mr. JANKLOW. There's no addendums I guess is what I'm asking.

Dr. MOXLEY. No. But realize that this was an intense experience. We were very wrapped up in it for a period of a year. It is not an area that I'm involved in every day in my workaday world. So that the fact that I don't have any addenda does not mean that someone who has spent more time thinking about it in the last 2 years wouldn't. I do not.

Mr. JANKLOW. Dr. Feinleib, have you read the report?

Dr. FEINLEIB. Yes, several of the reports.

Mr. JANKLOW. Is there anything you would add as a postscript or an addendum if we were to seek responses from the Department of Defense?

Dr. FEINLEIB. Yes, in the following sense. I think the military should start——

Mr. JANKLOW. Sir, I wear hearing aids. Could you speak up a little too, please?

Dr. FEINLEIB. I think the military should start changing its time horizon in relation to the veterans. They have the immediate problem of processing probably hundreds of people a day to get them ready for deployment or to get them discharged afterwards. They don't worry what's going to happen to them 10, 15, 20 years later. They have the technologies. They have the resources to call on people and say, how would you plan a system that prevents such and such events 20 years from now rather than just during the next 30 days or 2 years, whatever the current laws are.

I would urge them to use some of the technology which we have seen so much about, smart bombs and things like that. To use pencil and paper forms in this day and age is making short use of available technology. This could really help them. They should be given the resources and the incentive to do this, get the right people to either deal with it directly or contract to. I think they could do a much better job.

Mr. JANKLOW. If I can ask you, Dr. Feinleib, again, what is it—have you ever dealt with a problem of—let me back up, if I can. I'm stumped by—not that it's important, but I'm stumped by the fact that this doesn't seem complicated. I mean, we're 12 years later and we're still deciding whether or not a 2-page form is or is not accurate. You know, somebody once said for God so loved the world he didn't send a committee, but is it that difficult to prepare a form that will give enough information that someone can look at it—and I realize it's not a form to decide whether or not I'm mentally ill now, whether or not I'm sick now as opposed to establishing some kind of baseline to compare me to later to see if something happened to me when I was in a theatre of military operations that for which I needed to be treated or taken care of. That's what I assume is the inference of all of this.

So the three of you are all very bright people. What's——

Dr. FEINLEIB. I share your frustration, because I think that at one level it's a quite doable task. You have to get the agreement of a lot of people. To do a good form might take—I'll take a guess—an hour to fill out. Not for everybody but for the people who answer the questions. They want to followup on it. They might figure we don't have the time to do that during the predeployment procedures. We don't have the time to do it during our postdeployment procedures. So they push it aside, minimize the thing, and are

more concerned with spending no more than 5 minutes on it rather than doing the job properly.

Mr. JANKLOW. And, sir, I realize you're not the one to ask this. I understand if you're deploying very quickly, but they started calling up National Guard units in my State while I was still Governor. Last summer they started calling them to Active Duty, and so there's been—I can't believe that the units of the Active Armed Forces that they're calling, that they've sent overseas, are people they made a decision on somehow in the last 15 or 20 days. There may be some like that that have been suddenly deployed, but my guess is the vast majority of them have been preplanned. So I'm back to my question on the form, and it's not you folks.

Mr. Chairman, I really don't have any more questions, and thank you for the indulgence you gave me. I appreciate that.

Mr. SHAYS. I frankly enjoy the opportunity when there are less Members to allow for a little more delving. So I'm going to follow along some of the lines that my colleague has questions. We passed a law, Public Law 105–85, November 18, 1997. I'm darn proud of this law. The law has improved the medical tracking system for members deployed overseas in contingency or combat operations.

And then under it is another heading, medical tracking system for members deployed overseas, system required, elements of system recordkeeping, quality assurance.

And now we have another report of plans to track location of members in a theatre of operation. All of this was done because lessons learned, and, you know, it's too bad in a way we had to pass the law and it was 1997. It would have been better if we had done it sooner, but now we are in this debate of understanding whether the law—the letter of the law is being implemented in the spirit of the law, and both need to be implemented.

Now, one of the things that I would like to ask you, Dr. Moxley and Dr. Feinleib, and you, Mr. Robinson. You answered one of my questions, but first off, when we use the term, the systems described in subsection (a) shall include the use of predeployment medical examinations and postdeployment medical examinations, did we just blow it if our intent was to have physicals, or what most people have concluded, that it should have been physicals?

Dr. MOXLEY. I think most people would have concluded that when you use the term "medical," you are referring to an examination that includes a physical examination. You could include a history also. If you use the term "health," one could more easily interpret it as being a series of questions without a physical exam.

Mr. SHAYS. I mean, from our standpoint, we didn't want to say physical examination and then exclude the other things that might be involved. So we thought there was something that included a little bit more than just a physical. Dr. Feinleib.

Dr. FEINLEIB. I agree with that, with a slight modification. When you go into your doctor's office nowadays, they give you a sheet to fill out, any allergies, any medications, etc. And then the doctor usually uses that as——

Mr. SHAYS. I call that a questionnaire.

Dr. FEINLEIB. That's right. That's a questionnaire. But he uses that as a starting point to start asking you questions, and that leads to a whole new thing. Then when he gets you up on the table,

he'll know what to look for, what to feel for, etc. That's the way this should be designed.

Mr. SHAYS. And still gives you a physical examination.

Mr. Robinson, you already asked the question, but since we're going in order here, was it your interpretation based on your testimony that this medical examination would include a physical examination?

Mr. ROBINSON. Absolutely. In fact every scientist and doctor that I have spoken with says that the only way to get to the answers about what or whether or not exposures are related to illnesses, you have to have a baseline data.

One of the things that was very interesting that was a theory that came up after the Gulf war was they said perhaps some of the people that deployed were ill before they deployed. A lot of Gulf war veterans found that to be strange.

Let me give you a perspective that——

Mr. SHAYS. I'll tell you—interrupting the gentleman, the benefit of doubt has to go to now the veteran.

Mr. ROBINSON. Absolutely.

Mr. SHAYS. But what it raises is the clear need to either maybe pass a resolution quickly that requires that our veterans be given in their medical examination a physical.

Mr. ROBINSON. Absolutely.

Mr. SHAYS. But you were going to say something.

Mr. ROBINSON. I was going to say that I want to give a soldier's perspective of how this gets implemented. If you're a soldier in the 82nd Airborne about to deploy with your unit to Baghdad or to Kuwait and you're handed this questionnaire and it says, do you have any current illnesses that will prevent you from deployment? Do you got your glasses? Do you got—the chances are the soldier is going to check every answer that is appropriate to allow him to deploy. Soldiers want to go and be with their fellow warriors.

The same is true when they return. When they return, they don't want to sit down and aren't going to sit down—if you hand them a piece of paper and say fill this out and mail it in 30 days later, they are not going to credibly report incidents that are related to their exposures based on this sample questionnaire, and from everyone I've talked to they have said that this would not provide any evidence that could be used in an epidemiological way to find any answers.

Although it may be well intended to have a questionnaire, the intent of the law was to have a medical exam before and after, to include the drawing of blood, and all of those things in combination would be the keys to understanding whether an illness was related to an exposure or whether—you know, we have the capability to look at blood serum to the molecular level, to look at cell changes as a result of exposures. It's important that we get the data when the soldiers—before they deploy and when they return.

I think the public law was written in a way that actually provides a mechanism, if followed properly, to get to the root of this answer, but because it has been interpreted rather than implemented, this particular means by which they use to get answers is not satisfactory.

Mr. SHAYS. I'm not going to dwell too long——

Mr. JANKLOW. Can I ask you a question, Mr. Chairman? I wasn't——

Mr. SHAYS. You're going to ask me a question?

Mr. JANKLOW. If I could. I'm not familiar with that law until you elaborated on it today. How do you conduct—is there a way that you've ever heard of to conduct a medical—not questionnaire but examination without a physical exam? I mean, how would you do it?

Mr. SHAYS. You're asking the wrong guy. I don't know what compelled you to want to ask me that question.

Mr. JANKLOW. Doctor, can you tell us? Can you do a medical examination without physically examining a patient?

Dr. MOXLEY. Yes.

Mr. JANKLOW. You can.

Dr. MOXLEY. There are things called multiphasing screening which a number of HMOs and so forth have set up where one goes through and has a whole raft of laboratory studies and x-rays and so forth but is not physically examined. There are some who would argue that provides a very good index of state of health, assuming the person is feeling well. I mean, if the person is not feeling well, then it's a different story.

Mr. SHAYS. But if the gentleman would just yield a second, are you saying that you actually are taking lab tests?

Dr. MOXLEY. Yes, sir, but it's a——

Mr. SHAYS. That strikes me as a——

Dr. MOXLEY. I haven't looked at it recently, and I am sure it varies from medical group to medical group. My guess is it does involve a questionnaire and then a series of laboratory tests, and so forth and so on. It gives a check for people who are feeling well at the time. It's also true—and I don't want to complicate this any further, but it's also true that repeated physical examinations on people between, say, the age of 20 and 40 who are feeling well yield very little new data, which is why a number of insurance companies——

Mr. JANKLOW. But we're looking for baseline on the——

Dr. MOXLEY. No. I'm saying this is a deployment situation, so it's different. You were asking me a general question, and I'm trying to answer it. So that those sorts of things do exist, where you don't have an actual—but we're talking about a specific predeployment and postdeployment here. That changes it a whole lot.

Mr. JANKLOW. Can I ask one more question?

Mr. SHAYS. Sure.

Mr. JANKLOW. Have you ever in all your medical life, either of you doctors, heard someone say that you could define medical examination as filling out a two-page questionnaire and having drawn blood for HIV purposes from today to 3 years prior to now and heard that defined as a medical examination?

Dr. FEINLEIB. I think at a minimum you'd want to look down his throat——

Mr. JANKLOW. You've got to say yes or no, if you would.

Dr. FEINLEIB. Not a——

Mr. JANKLOW. Would my facts ever have been described to you or would you have ever concluded that's a medical examination, to

fill out a questionnaire and to have drawn blood for HIV purposes and then storage for the rest of it?

Dr. FEINLEIB. No, I do not think that would be a medical exam.

Dr. MOXLEY. No.

Mr. JANKLOW. OK. Thank you.

I have nothing further, sir.

Mr. SHAYS. OK. I am just struck, Dr. Moxley, if you are doing lab work, it sounds pretty physical to me.

Dr. MOXLEY. Well, the physical examination, as it is taught in medical school, is the actual laying on of hands, Mr. Chairman.

Mr. SHAYS. Right.

Dr. MOXLEY. And that's the distinction I was making.

Mr. SHAYS. But the bottom line is, you are still drawing blood, you are still taking pictures. You are doing a lot of things.

Dr. MOXLEY. We are doing everything but the laying on of hands, yes, sir.

Mr. SHAYS. OK. In this, there is the predeployment and the postdeployment. It is two pages long. The first page is, you know, name and today's date and Social Security and gender, service branch component, pay grade, location of operation. That's not unemployment.

Mr. JANKLOW. Does it have your mother's maiden name?

Mr. SHAYS. You know what, it doesn't ask that.

And then down here it has, for administrative use only. And then the second page is eight questions, and then down here is, referral indicated. And I gather this is for the person looking at the form. So, basically in a two-page document, one-third of one page has the questions.

I am going to say this though; I do think at least they are listening. And we have been asking DOD and VA to listen.

So I like the idea of a questionnaire. But to have the questionnaire, in a sense, take the place—and then these eight questions. And I just—you know, I look at some of these questions, but one in particular about the mental health. It's like asking someone, are they crazy. And you know I don't know what they are going to say. I hope they say, no.

But you get my gist. And I look at this and I am not impressed; and you are not impressed.

Dr. FEINLEIB. I agree with you. In fact, one of the things that upsets me most is that on that first page where they ask very simple things like your gender, service branch, etc., so many of them are unknown. They were left blank. They weren't readable. That indicates very poor quality in filling them out, looking at them when they come in; and then I wonder what kind of use you can make of that.

Mr. SHAYS. In other words, really what should happen is when these are filled out, they should be reviewed by someone on the spot to make sure they understand them?

Dr. FEINLEIB. At least. I don't know why some of this couldn't be just passing the dog tag through a card reader essentially.

Mr. SHAYS. Yes. Well—and, you know, and one of the questions is, are you pregnant, which—that leaves out one question for some of us. And it's not an unimportant question.

But my point is that there aren't a lot of questions. And with the postdeployment—there are six questions: Would you say your health in general is excellent, very good? Do you have any unresolved medical or dental problems? Are you currently on a profile or light duty? During this deployment, have you sought or intended to seek counseling or care for mental health? Do you have concerns about possible exposure of events during this deployment that you may feel affect your health? That's not an unimportant question. Then, list your concerns. And the last question is, do you currently have any questions or concerns about your health? And please list your concerns. And they leave you two lines to list your concerns.

So with this panel, at least, this questionnaire doesn't measure up, correct? For the record note that——

Dr. MOXLEY. No.

Dr. FEINLEIB. No.

Mr. ROBINSON. No.

Mr. SHAYS. No. And what this tells me for this committee is that we clearly want to back up Secretary Principi's request that the questionnaire be more intensive, and we also, I think, are going to pursue—I mean, if you had a choice of only giving a physical once, it's too bad it's not done twice and drawing blood once.

Would it be better pre or post? Dr. Moxley.

Dr. MOXLEY. Without the pre, the post would not be nearly as helpful. What you do is, you measure back against what you find pre to see what is new in the post.

Mr. SHAYS. This is a tragedy. It really is, isn't it?

Mr. JANKLOW. Mr. Chairman.

Mr. SHAYS. Just 1 second. If you will keep your thought, just don't ask me the question.

Dr. Feinleib.

Dr. FEINLEIB. I was just going to make one comment. If you impose a full physical examination, you are going to need personnel to do that.

Mr. SHAYS. Right.

Dr. FEINLEIB. If they have to be physicians, you are going to have to have a physician draft to be able to conduct all those examinations. You have to find some other method, trained medics, for example, to check for the specific factors that an expert committee might recommend be checked, and an abbreviated physical exam for what might usually be 95 percent of the time relatively healthy young men and women.

Mr. SHAYS. I am going to come back to you.

Mr. Robinson.

Mr. ROBINSON. Mr. Chairman, when we want to know if our F–16s are capable of flying, we don't ask them questions. We put our hands on them and in them, and then those maintenance records are maintained. And the next time the pilot walks out, before he gets in the plane he himself walks around that aircraft and puts his hands on that aircraft, even though he has read the maintenance logs, to ensure that certain key critical components have been addressed before he gets in the seat and flies away.

We have trained people, medical professionals, that in the process of getting people ready to deploy could conduct a serum draw both pre and postdeployment, and could ensure that if we are going

to use a questionnaire, that it's filled out properly. And we could also, at that same predeployment process and postdeployment process, have medical professionals there to put their hands on soldiers, look them in the eye and talk to them and find out what their current conditions are.

It is not rocket science, and it can be done. And we need to put the same amount of emphasis on looking at the soldier that we do looking at the technology.

Mr. SHAYS. I want to ask both doctors if they agree with that comment, but I would like to yield to my colleague.

Mr. JANKLOW. Mr. Chairman, one, I do believe that everyone who goes into the Armed Forces has a current blood sample drawn—has a blood sample drawn. I don't know if that is saved. Assuming——

Mr. SHAYS. At least within 12 months.

Mr. JANKLOW. Yes. And so, you know, that will at least give you some baseline for some of the people, one.

And, two, with the correct—with a good form, would it—couldn't physicians' assistants and nurses also contribute to doing some of these physicals, if I can call them that?

Dr. FEINLEIB. Absolutely. Yes.

Mr. JANKLOW. And it doesn't have to be a medical doctor. Aren't there certain differential diagnoses that you kind of look at and go from there?

Dr. FEINLEIB. Exactly. Yes.

Dr. MOXLEY. It probably should be under the overall supervision.

Mr. JANKLOW. Sure.

Dr. MOXLEY. But you can have nurse practitioners or physician assistants who are trained to do routine physicals and do them very well.

Mr. ROBINSON. If there is the will to examine, you know, an aircraft, we can find the will to examine people. We can do it.

Mr. JANKLOW. Sir, I am a pilot; I preflight my airplane every flight.

Mr. SHAYS. Well, you know, I just want to make sure, though, that, Dr. Feinleib and Dr. Moxley, you agree with Mr. Robinson's comments or would qualify them. And then I want to—yes, the first one. When he was, his—not his last response, but the response before last.

Dr. MOXLEY. Which was? I'm sorry.

Mr. SHAYS. Which was, well, first the analogy of the airplane to the person. But I guess what—since you didn't hear it, and he spent more than just a sentence describing it, let me ask you these questions.

I am going to share with you that I am concerned that maybe we didn't see the physicals, not because we didn't need them, but because we didn't think we could afford them or we didn't have the people in place. And that makes me very concerned, because we have just put on the record that nobody is going to be denied anything based on cost. Our men and women are going to get whatever they need. And it strikes me that if that is the reason, that's pretty unfortunate.

So let me ask you, first, if you would agree with Dr. Feinleib that we would need a whole host of people to have given a physical to the 250,000 Americans who were sent to the Gulf.

How long does a physical take nowadays?

Dr. MOXLEY. Excluding taking the history or filling out the questionnaire, I would think one could be done every 15 minutes, probably.

Dr. FEINLEIB. I would concur with that. You would need another station in the processing.

Mr. SHAYS. You would have to automate the system a bit, and you'd need different people to do different things. And so I guess we could figure out 15 minutes times 250,000 people does sound like a lot of work, and so that is one issue.

But the other issue that—so, Dr. Feinleib, you made that point. I am happy you made it, but I am unhappy to know it.

Dr. Moxley, you made another point which I'm happy to know—I am happy you made, but unhappy to know—and that's what you are saying, that we can't correct the damage done—if we happen to think it's damage done, in other words, not giving them the physicals before they left. Because what you're telling me is, we need both ends in order to really get the information, unless we assume they were all well before they went. And then we would—it would seem to me then we would have to assume that.

Dr. MOXLEY. Correct.

Mr. SHAYS. And then we would have to—we would then have to, in this instance, when they came home sick, say—we could not allow DOD or VA to say, you know what, they were sick before because we don't know.

So we have to assume they weren't, in order to——

Dr. MOXLEY. Again, I don't know what data DOD has on the troops that were deployed. But unless it's there, you would have to assume that, yes, it was a result of the deployment. I don't know what else you could do.

Mr. SHAYS. But now, assuming that, will we be able to help them? Financially, we will be able to, but are you saying that they may not get the kind of medical attention they need because we didn't check before?

Dr. MOXLEY. I don't know that you can say that, no.

I think that in most of the veterans coming back, the illnesses they develop will undoubtedly be illnesses that people in the general population develop.

The question is, if there is a cohort that develop signs and symptoms that we don't understand, as there apparently were coming back from the Gulf war, then those will have to be just treated with the state-of-the-art which, at the present time, is to understand that we don't know the cause for them, and to be honest with them about that and treat them prospectively and just do the best we can.

Mr. SHAYS. Is there any final point you want to make?

Mr. JANKLOW. I have nothing. Thank you very much, Mr. Chairman. It has really enlightened me.

Dr. MOXLEY. May I add something to an answer I gave to you, Mr. Janklow?

Mr. SHAYS. Just a little louder, Dr. Moxley.

Dr. MOXLEY. You asked me if there was any addendum or anything like that I would add—and I said no, and I meant that.

But let me just say that I would be ecstatic if it could be documented that the recommendations that we made in this report, which were made by, in one form or another, seven other groups in the decade in the 1990's.

Mr. SHAYS. State the report again, please, for the record.

Dr. MOXLEY. Pardon me? The name of the report is Protecting Those Who Serve: Strategies to Protect the Health of Deployed U.S. Forces.

If there was a positive answer from the DOD that these recommendations had been implemented, I would be ecstatic and think that they deserved enormous credit, because there is a lot of work laid out here that had to be done.

Mr. JANKLOW. Can I ask one more question, sir?

Mr. SHAYS. Absolutely.

Mr. JANKLOW. Doctor, can you tell me, do you sense in any way that this is a partisan, political thing? I mean, the report was issued under a previous administration. We are in another one. Do you sense anything like that? Or is that not the issue?

Mr. SHAYS. Now, that's a question you could ask me.

Dr. MOXLEY. No, I really don't. I think that people who are interested in these matters have a deep and abiding interest. My interest in medical readiness goes back 20 years. And they are interested in it as a concept, and they are not interested because of the hat you wear.

Mr. JANKLOW. Good. I'm glad to know that, because we can fix the other.

Mr. SHAYS. You think so?

Mr. JANKLOW. Yes, sir.

Mr. SHAYS. As we look at this, you know, my sense is having—you know, the men and women who serve in DOD and the Department of Veterans Affairs are very good people. They all have restraints. And sometimes I get the view that someone is told, you can't do it, so make the best you can; and so, then, inventive minds are trying to make the best they can.

The problem is—and that's why you sometimes have a Congress that says, are you doing what the law requires? Does this makes sense?

Now, our committee is a committee that looks—we don't write laws and we don't appropriate. We look at how laws are implemented, and we look at waste, we look at abuse, we look at mismanagement, and we look at fraud. What's troubling in this hearing is that we've had 13 years to deal with this problem, and we all know what we need to do and we passed a law that was pretty sensible.

And if DOD didn't think it was sensible or the VA didn't think it was sensible, then they needed to come back to tell us to amend the law because there are restraints like, guess what, it is impossible to give everybody a physical. And then we would have a wonderful debate about that, and then we might amend the law or we might not. Or we might say, well, if you are Active Army you don't, but if you are Reserves and National Guard you are going to. I mean, who knows what we would have concluded? But we would have had an honest dialog back and forth.

What I'm sensing and what the committee will continue to try to look at is that there may have been a concern that we just simply didn't have the capability or resources to do what the Congress wanted and what the President signed into law, and that we didn't pay attention to it back then, and my God, all of a sudden we have 250,000 people sent off to fight a war. And we can't undo that.

And, by the way, we've got the problem with protective gear and that's a higher priority. And the JLA suits are all around the freaking country and we don't know where they are, so let's get that; and the committee's making noise about that, so that's a higher priority.

I mean, I can just begin to imagine in my own mind why this happened. But this I know: It would have been the right thing to have given them physicals, and we could have found a way to deal with it. And we might not have had a doctor at every station, but we could have done that.

And this just makes me more convinced than ever that we had better give them the physicals when they leave, and that we had better have a better questionnaire. And, for that, I thank you all.

I thank you for a lot of things, but I think we have our work cut out for us. Do you agree? OK.

Is there any final word that any of you want to make? Anything on the record that needs to be part of the record? Dr. Moxley.

Dr. MOXLEY. No, sir.

Mr. SHAYS. Dr. Feinleib.

Dr. FEINLEIB. I want to thank you personally for inviting me today and giving me a chance to contribute to your deliberations. And thank you for playing this leadership role again and trying to rectify this problem and preserve the health of the fighting men and women who are helping us.

Mr. SHAYS. Thank you.

Mr. Robinson.

Mr. ROBINSON. I would like to echo the sentiments that we are concerned about our fighting force and pray for them. And I would like to also say that there was no Kosovo syndrome and there was no Bosnia syndrome when soldiers returned. And the reason there wasn't was because there were no mysterious illnesses that came from there.

I look forward to the recommendations of the committee and hope that we can implement them to protect the force. Thank you very much.

Mr. SHAYS. Thank you all very much. And you all have made a wonderful contribution, and I do thank you for that. It's been a very interesting hearing.

I don't want to put anyone in an awkward situation from the first panel. But if there is anything from the first panel that needs to be made part of the record, we would put it on the record publicly if that needs to be done.

If not, we are going to let the record stand as it exists and we will continue this process. And I thank you all very much.

This hearing is adjourned.

[Whereupon, at 5:16 p.m., the subcommittee was adjourned.]

[The prepared statement of Hon. Dan Burton and additional information submitted for the hearing record follows:]

DAN BURTON
6TH DISTRICT, INDIANA

COMMITTEES:
GOVERNMENT REFORM AND OVERSIGHT
CHAIRMAN

INTERNATIONAL RELATIONS

SUBCOMMITTEES:
MIDDLE EAST AND SOUTH ASIA
EUROPE

Congress of the United States
House of Representatives
Washington, DC 20515–1406

WASHINGTON OFFICE:
2185 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-1406
TELEPHONE: (202) 225-2276

DISTRICT OFFICES:
8900 KEYSTONE AT THE CROSSING
SUITE 1050
INDIANAPOLIS, IN 46240
TELEPHONE: (317) 848-0201
TOLL-FREE: (800) 382-8020

435 EAST MAIN STREET
SUITE J-3
GREENWOOD, IN 46142
TELEPHONE: (317) 882-3940
TOLL-FREE: (800) 878-3642

WORLDWIDE WEB PAGE:
http://www.house.gov/burton/

Protecting the Health of Deployed Forces: Lessons Learned From the Persian Gulf

Statement of Dan Burton
Chairman
Subcommittee on Human Rights and Wellness

Member, Subcommittee on National Security, Emerging Threats,
and International Relations

Committee on Government Reform
U.S. House of Representatives

2247 Rayburn House Office Building
March 25, 2002
2:00 pm

Thank you Chairman Shays for calling this important hearing. You have done yeoman's work in conducting oversight activities on behalf of the men and women of the armed services, both past and present. These real world heroes deserve nothing less.

This year, approximately thirty years after our men and women returned from Vietnam, we are still confirming the connection between exposure to Agent Orange and numerous diseases including Non-Hodgkin's Lymphoma, Hodgkin's Disease, Multiple Myeloma, Peripheral Neuropathy, numerous cancers including lung and prostate cancer, and Type 2 Diabetes.

Today, twelve years after the Gulf War, we have over 125,000 veterans who have suffered a myriad of symptoms ranging from chronic flu-like symptoms, rashes, fatigue, joint and muscle pain, headaches, memory loss, loss of concentration, and gastro-intestinal problems. Others have suffered from cancers, heart and lung problems, and Lou Gehrig's Disease. We repeatedly get calls from these veterans who are at a point of total frustration. First, there was a total denial from the Defense Department that there was a Gulf War or Desert Storm Syndrome. Tens of thousands of veterans and active duty military members were told "it was all in their head" or that they were complainers.

Then, once Congress got involved, a program to evaluate those with this new syndrome was created. And yet we still heard from these veterans that they would go to the clinics with a myriad of biomedical symptoms and were subjected to repeated psychological evaluations, but received little or no medical care. Of the 115,000 veterans who have turned to the VA for care, how many have actually received a full complement of medical care? How many have been tested for heavy metal toxicity? How many have received chelation therapy to clear the heavy metals from their bodies? Only by providing complete and rigorous medical care are these veterans going to have any chance of returning to good health.

We have heard from hundreds of Gulf War veterans. One individual we heard from was Captain Frank Schmuck who recovered from Gulf War Syndrome. Frank was forced to look outside the system for solutions to his health problems. He was eventually tested for mercury and other heavy metal toxicities, and then treated with chelating agents. He has now fully recovered, and is giving his time to help other Gulf War Veterans.

Mr. Chairman, as you know, I am concerned about the amount of mercury we use in medicine. I am particularly concerned about the continued use of thimerosal in vaccines. While most children's vaccines are now free of thimerosal, many vaccines that our military members are being given still contain this mercury-containing preservative. Many of the symptoms these veterans display are similar to the known reactions to the vaccines they are routinely given, or to the known symptoms of mercury poisoning. We know from published research that about 16 percent of the military are likely allergic to thimerosal, yet they are routinely exposed to it through their vaccines.

Members of the military may be exposed to 110 to 135 micrograms of mercury in one day. The safe one-day exposure for a 180-pound man is about eight micrograms. Even with a

ten-fold safety margin, these individuals would be expected to suffer adverse reactions with such a high one-day exposure.

When you combine this exposure with exposure to almost three dozen other toxic agents, disease-carrying sand flies, and known endemic diseases in the Middle East, it is no wonder that we have 125,000 ill veterans.

The challenges our veterans have faced from Vietnam and the Gulf War beg the question – What are the Defense Department and Veterans Administration doing differently? Will the changes that have been implemented actually improve the long term health of our veterans? Will the changes gather the needed information to fill gaps in the scientific understanding of health issues connected to military service? If those men and women returning from Operation Iraqi Freedom begin to suffer similar symptoms as those who served in the first Gulf War, will they be treated with more dignity and understanding than their predecessors?

When Congress passed the National Defense Authorization Act of 1998, we required that the Defense Department establish a system to evaluate the medical condition of deployed service members. This legislation further required that each deployed service member receive a pre- and post deployment medical examination, an assessment of mental health, and the drawing of blood samples. The law mandates that medical records, including immunizations, be maintained in a centralized location. I am disturbed to learn that it appears that these requirements are not being fully complied with. The Defense Department is substituting a questionnaire filled out by service members for the required medical examination. They are not gathering the required blood samples. Are they tracking the immunizations? These and other important questions need to be answered.

I hope that the concerns that I and other members of Congress have will be addressed in today's hearing. Thank you again Chairman Shays for calling this hearing today.

12 March, 2003

Submission for Congressional Testimony

My name is **Juliana M. Mock**, 8917 NE 151st Place, Bothell, Washington 98011

I served in the Persian Gulf with the US Army and the 87th Medical Detachment (Dental Services) from December of 1990 until May of 1991.

Our group of 62 was dispatched into northern Saudi Arabia in mid-December 1990 and was literally assigned an empty grid area to the right of a dead camel. It is at this location that we spent our Christmas holiday; wringing laundry with blistered hands just before the onset of a large sandstorm. It is also at this location that I would hear the first of a succession of chemical alarms go off.

As the alarms went off, we simply looked at each other with a cynical snarl; we were cold and isolated in our little camp. Making contact with other camps to relate information was impossible. We thought for certain that the ridiculous alarms must have been faulty; the alarms were reset as we watched in our shirtsleeves.

At the end of December my group of 12 dispersed to the 12th Evacuation Hospital along Tapline Road to provide dental support. Located roughly 30 miles from both the Kuwaiti and Iraqi boarders we would be the first hospital open and taking patients. By this time we were instructed to begin taking our expired bromide tablets. As January wore on, we enlisted people carried on with guard duties. Although I am unable to name the dates, there were several occasions when small explosions had taken place certainly within a mile radius of our compound. When I reported these events, I was told that there had been no explosives occurrence despite what I had clearly seen.

Several times the chemical alarms went off at the 12th Evac location during the month of March. However, I recall only being ordered to MOP2 when the initial bombing began in January.

We returned to Germany in May of 1991. Although I was a bit moody and needed to gain weight, I was otherwise healthy. However, over time I began systematically experiencing odd symptoms: significant sun sensitivity, red skin rashes, itching, hives, night sweats, joint pain, loss of muscle function, hair loss, fatigue, joint nodules.

During the last several years I have seen a noted rheumatologist who is quite involved in research in this area. I have submitted to countless blood tests. Nothing in my blood seems to indicate that I should be experiencing any of the symptoms that I present with. I recent months I have had to resort to steroid injections and oral steroid therapy to gain improvement.

I received letters in both 1997 and in 2001 from the Secretary of Gulf War Illnesses informing me that I had been exposed to low doses of both sarin and cyclosarin nerve agents. My husband, also an exposed Gulf War veteran, began to piece events together. In 2001, not only was I experiencing significant health problems, but our children had also been diagnosed with a variety of unexplainable neurological challenges. We were devastated. Our challenges remain great. And so do the challenges of our children.

Juliana Mock Testimony, Continued

I firmly believe that

1. If better communication technology had been in place to allow for timely exchanges in theater

2. If detailed log information had been kept and shared between units in a broader area allowing exchanges of crucial information between units

3. If no experimental vaccinations or drugs had been administered

I would have a much greater chance of being a much healthier person and our children would have been much more likely to be neurologically sound individuals.

It is my greatest hope that with the application of the above coupled with more effective chemical detection devices and MOP gear and fresh medical supplies that the troops now deployed into the Gulf region will come home and remain healthier.

STATEMENT TO THE
SUBCOMMITTEE ON NATIONAL SECURITY, EMERGING THREATS, AND INTERNATIONAL RELATIONS

Hearing on
Protecting the Health of Deployed Forces:
Lessons Learned from the Persian Gulf War

March 25, 2003

REDMOND H. HANDY
President, Government and Business Consulting

Mr. Chairman and members of the Subcommittee, thank you for the opportunity and the honor to present concerns about specific force health protection measures today. I respectfully request that my statement be entered in the Congressional record.

Introduction

Four years and one day ago, I appeared before this committee in the first of several Congressional hearings on the Pentagon's Anthrax Vaccine Immunization Program under former Secretary of Defense William Cohen. The work of the committee that day was overshadowed in the media by the beginning of bombing operations in Kosovo. Yet the persistent investigation by this committee, the GAO, the Government Reform Committee, and other key members and professional staff in Congress, in response to outcries of service members and their families, shed a bright light on a severely inadequate force health protection program. The FDA's quarantine and eventual removal from the market of 5 million doses of older, poorly-manufactured anthrax vaccine were in no small measure a result of the committee's invaluable efforts. Given that an Army Times Publishing Company survey showed 77% of service members opposed being forced to take the anthrax shot, this committee has the abiding gratitude of service members and their loved ones for your stand in support of their health. Many will not have to face some of the severe and life-threatening health risks of the vaccine victims who also appeared before this and other Congressional committees.

Today this modicum of success is, unfortunately, in jeopardy, incomplete, and complicated by new and problematic Pentagon policies. The need to continue oversight of a Defense Department that has exposed its employees to live biological agents, radiation, and LSD without their informed consent is more important than ever. This committee is well aware that the trend of DoD experimentation became more open in the early 1990s as the Pentagon mandated experimental drugs and vaccines for Persian Gulf service members. Unfortunately, the Pentagon has effectively undermined laws and policies (such as Title 10, Chapter 55, section 1107; Executive Order 13139; and DoD Directive 6200.2) that were intended to prevent the Force Health Protection abuses we saw in the Persian Gulf War. Until the mindset that encourages forced and uninformed experimentation is removed from our military's value structure, a

coercive research and force health protection climate will continue to unnecessarily risk service member health. I say this as I, and numerous others across the country, continue to hear almost on a daily basis of continuing anthrax vaccine concerns, injuries, and refusals.

Congress should find the military's allowance for uninformed experimentation completely unacceptable. My father, who fought for freedom in the Pacific in WWII, did not know (as I sometimes wish I did not know) that US officials granted prosecution immunity to Japanese medical criminals in exchange for their biowarfare experimentation data. This complicity set the stage for decades of mixed medical ethics, even as the Department of Defense accepted Nuremberg Code principles (in a *classified* 1953 document). Clearly, the Department's record of forced experimentation is to cover-up the actions for decades, reluctantly declassify documents, and pay out compensation to the few remaining survivors. Never has there been an official commitment to discontinue such experimentation.

It is in this context that I address current DoD policies that, with Congressional intervention, may allow for further improvements in force health protection. My specific concerns are about monitoring service member health for vaccine and drug reactions and for adequate and accessible medical records of such events.

Public Law 105-85, Section 765, Requires Health Monitoring and Adequate Record Keeping for Deploying Service Members

This law requires the Secretary of Defense to "establish a system to assess the medical condition of members of the armed forces. . . who are deployed." This system is to include pre- and post-deployment medical examinations, blood draws, and mental health assessments. The act also requires that:

> The results of all medical examinations conducted under the system, records of all health care services (including immunizations) received by members. . . in anticipation of their deployment or during the course of their deployment, and records of events occurring in the deployment area that may affect the health of such members shall be retained and maintained in a centralized location to improve future access to the records.

To ensure the system is working, the legislation further required the SECDEF to establish a quality assurance program and submit a report to Congress analyzing administrative implications and operational costs. Both the public and service members have a right to know what that report said if it was produced at all, and the Pentagon should post it on the Internet where soldiers can easily find it. After spending $2 million taxpayer dollars on a website touting the benefits of an anthrax vaccine, the Pentagon would certainly also benefit by demonstrating to its employees how well it intends to monitor and care for any health consequences from deployment vaccines, drugs, or exposures.

Lack of Pentagon Compliance Will Worsen Previous Deployment Health Problems

Lack Of Deployment Health Monitoring Obscures New Anthrax Vaccine Safety Performance: As controversial and divisive as the anthrax shot has been, it would be valuable to ascertain if Bioport's new production lots are conforming to the much higher reaction levels acknowledged on its revised package insert. Complying with health monitoring requirements would help establish just how well or poorly the new production lots are performing.

Prior to implementing the Anthrax Vaccine Immunization Program in 1998, Secretary Cohen established four conditions, one being a shot tracking system. If the Pentagon does not comply with health monitoring legislation, such shot tracking provides inadequate information because DoD does not track adverse reactions. In a few cases blood drawn for physical exams has validated that previously healthy servicemembers developed autoimmune problems after taking the shot. Their experience fortifies the argument for pre-deployment exams required by law. As in Gulf War I, there will be those who get vaccines and do not deploy. Since some of those individuals also got sick, exams and blood draws can contribute to early awareness of problems, unclouded by toxic battlefield exposures.

Although the approximately 2000 reported reactions in the FDA's Vaccine Adverse Event Reporting System (VAERS) makes the anthrax vaccine the most reactogenic shot on the market, VAERS alone is inadequate to assess the safety performance of the new lots. The data now shows both old and new lot reactions. Also, a Harvard study of the mid-1970's swine flu reaction reporting indicates military members report at only one-seventh the rate of civilians, perhaps a reflection of both a healthier population and more reticent culture.

Finally, former FDA Director David Kessler has stated that VAERS data may represent as little as one percent of the real reaction picture. Again, because of such limitations, pre- and post-deployment health exams and blood draws may yield a more accurate picture of anthrax vaccine safety. Pre- and post-deployment exams and blood draws become more important as risks increase with new force health protection polices that may interact with other problematic prescriptions such as lariam and GO pills.

Smallpox Inoculation Complications Are Currently Invisible To Congress: Service members are receiving smallpox inoculations from an expired and thus technically adulterated stockpile the FDA re-licensed in October 2002. The Pentagon initiated this program in the midst of significant public resistance by civilian health professionals against the smallpox policy to protect first responders. Many servicemembers have not had both anthrax and smallpox vaccines simultaneously. The Senate Veterans Affairs Committee wrote DoD on February 14, 2003 requesting information on the percentage of deploying troops receiving these two vaccines, the incidence of adverse events, and the number of exemptions.

Pyridostigmine Bromide Problems Could Easily Be Repeated: There are many unanswered questions about the FDA's recent approval of the Anti-Nerve Gas Pill Pyridostigmine Bromide (PB) as a prêtreatment for exposure to the nerve agent Soman. Had PB remained an experimental or investigational drug for nerve gas pretreatment, the military would have had to give soldiers informed consent and the option of whether to take it, or invoke a direct order from the President. By fully licensing PB, FDA saved the President and Congress political liability, not lives, by allowing the military to avoid giving troops a choice.

Documents and scientific studies conducted over the last 12 years (such as the 1999 RAND report and the 2000 Institute of Medicine analysis) have clearly shown PB is both experimental and harmful. The Department of Defense and the Department of Veterans Affairs have both concluded through previous studies that PB could not be ruled out as a factor in Gulf War veteran illnesses. In fact, Congress banned DoD's use of the substance in an amendment to the FY '99 Defense Authorization Bill unless it was approved for use by a Presidential waiver.

While the drug may be approved for civilians who have the neuromuscular disease myasthenia gravis, it has never been shown to be effective or safe for the military application against Soman. This drug is especially problematic for the following reasons:

1. PB's dosing for effectiveness should be variable in each individual and would require individual evaluation due to the genetics and the size of the person receiving the dose.
2. PB is known to cause muscle damage in animal studies with even one dose.
3. PB can increase the adverse effects of Sarin nerve gas.
4. Researchers have shown that PB, with simultaneous exposures to combinations of DEET, permethrin, sarin, or jet fuel, causes brain and testicular injury in animal experiments.

Thus, in allowing this use, the FDA, DOD, Congress, and the President are permitting a questionable protection against Soman and increasing the likelihood that troops will be more susceptible to Sarin. It is possible that those who made the decision think they have chosen the lesser of two evils with the troops' protection in mind. But a decision that ignores the facts about the risks of PB is irresponsible policy-making.

It is unfortunate that the FDA has approved PB when it is known to have harmed veterans of the last Gulf War. Once again our government is putting soldiers in another type of "Harms Way," which could have been prevented. FDA's ruling is most likely the impetus for soldiers saving their sperm prior to deployment. The very least the Pentagon should have done is to give pre- and post-deployment exams and blood draws that may allow for analysis of PB effects on health.

New Pentagon "Limited Access" Medical Record Policy Creates a Climate for Hiding Malpractice And Exacerbates Servicemember Mistrust of Military Medicine: One of the intents of Public Law 105-85, Section 765, is to improve future access to medical records. But the Department of Defense is turning this provision on its ear by instituting its January 2003 Health Information Privacy Regulation. Particularly counterproductive is language that enables medical malpractice by denying servicemembers the information necessary to hold military physicians or clinicians accountable for substandard care. This language reads:

> C11.1.2. Unreviewable Grounds for Denial. Subject to paragraph C11.1.4., a covered entity may deny an individual access (*to protected health information, i.e., medical records – parentheses added*) without providing the individual an opportunity for review, under the following circumstances. . . C11.1.2.2. Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.

Lack of accountability has been the hallmark of DoD's Anthrax Vaccine Immunization Program. In May 1999 the Army's top immunologist exhorted colleagues against continuing anthrax shots in cases of a clear contraindication. Unfortunately, there are still current examples of service members who developed significant and unresolved health complications after receiving anthrax shots and who now are being told they must risk worsening their conditions by taking the shot again. The AVIP was touted as a "Commander's Program" that forced line officers to play doctor. However, five years later most commanders and many military health professionals are still unaware of Army medical guidance on identifying and screening out individuals at risk for reactions. Thus, commanders are forcing some service members to jeopardize their health, and the Pentagon's Health Privacy regulation could allow such actions to go uninvestigated and unpunished.

The Feres Doctrine Shields DoD from Liability for Medical Malpractice and Related Cover-Ups. Pentagon memos obtained by Congressional investigation of the anthrax vaccine program revealed statements that the Feres Doctrine did not apply when care standards were not met. This reality was best exemplified by the 2001 conviction of the Army anesthesiologist who caused the death of a Marine colonel's daughter. For this malpractice and related Army cover up, the doctor was court-martialed only due to the intervention of the Commandant of the Marine Corps. The doctor was sentenced to dismissal from the service, and is still licensed to practice medicine. The Marine colonel whose daughter died expressed hopes through his attorney that "no military family will have to strain, struggle and suffer as they did in order to learn what medical care was actually provided to a family member at a military medical facility."

DoD must revisit its Health Privacy Regulation and ensure that the restriction on medical record access is adjusted to comply fully with PL 105-85 intentions to improve future access to medical records for service members and those who need to know.

Recommendations

1. Congress should send a letter from the subcommittee to the Secretary of Defense insisting on immediate full compliance with health monitoring requirements of Public Law 105-85 and identifying accountability consequences.

2. Service members should be given a copy of the manufacturer package insert for each immunization and pharmaceutical they receive so they can know what reactions to look for.

3. Military doctors, nurses and corpsmen should all be given continuing education on the 26-page guidance written by Engler, Pittman and Grabenstein on when to waive vaccines for those at risk of severe reactions.

4. The Subcommittee should communicate to DoD and introduce legislation, if appropriate, that assures the right of military patients and their family members to obtain complete and unhindered access to their medical records.

Further Considerations Regarding Inadequate Force Health Protection Impacts on the Department of Veterans Affairs

The need for the DoD to adhere to Public Law 105-85 is even more important given that the Veterans Administration (VA) increasing patient workloads, under-funding, and continuing disconnects between DoD and VA health information systems. As with Gulf War I, the VA will shoulder the burden of learning about mystery illnesses from toxic battlefield exposures and/or from force health protection drugs and vaccines. To illustrate the challenges already faced by the VA, I have attached charts presented last week by the Vietnam Veterans of America to the House and Senate Veterans' Affairs Committees.

Given these VA challenges, Congress must force DoD to make it easier for service members to trace potential ailments to deployment events rather than stand in the way of accurate diagnosis and effective treatments as has been done with veterans from the first Gulf War. Complying with the requirements of Public Law 105-85 is simply the right Pentagon policy to maintain the trust of service members and their families.

Conclusion

Effective Force Health Protection measures should be characterized by the following:

A) They should not be "FORCED"

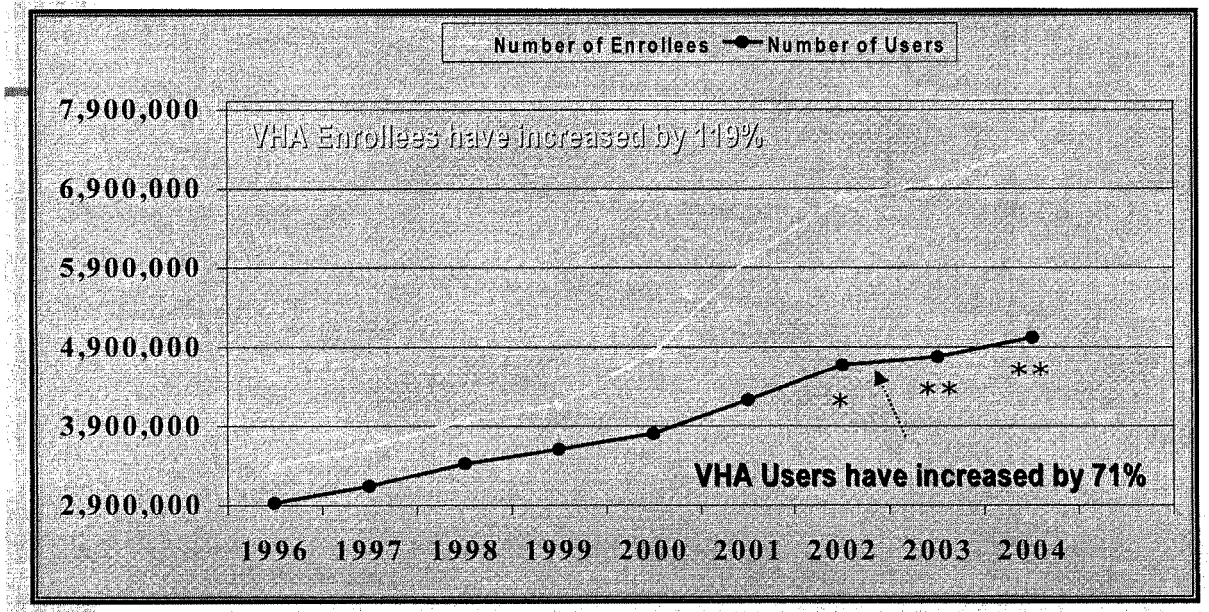
B) They should enhance service member HEALTH before and after deployment, and not unnecessarily risk their health

C) They should be designed to offer PROTECTION for service members, not protection for military medical clinicians responsible for questionable health policies and practices

Public Law 105-85 meets these criteria except for experimentation allowances, and it is my hope that service members will benefit from DoD's full implementation of the provisions of this law.

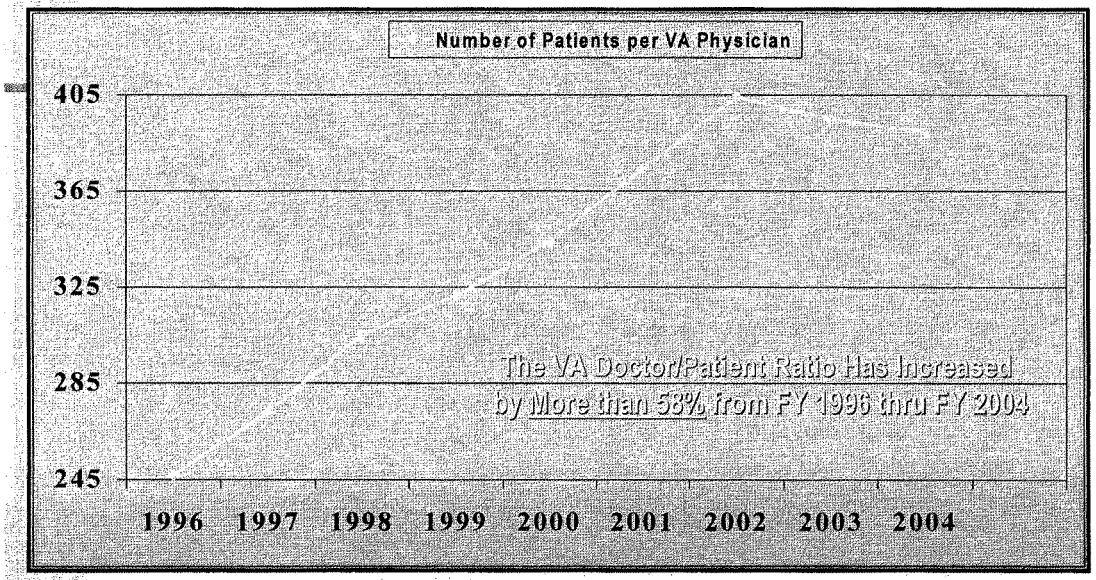
Mr. Chairman, I again thank you for the privilege of submitting this statement. I hope the committee finds the analysis useful, and I stand ready to assist in further efforts to improve health care management for fellow citizens in the armed forces.

VHA Enrollee & User Increases



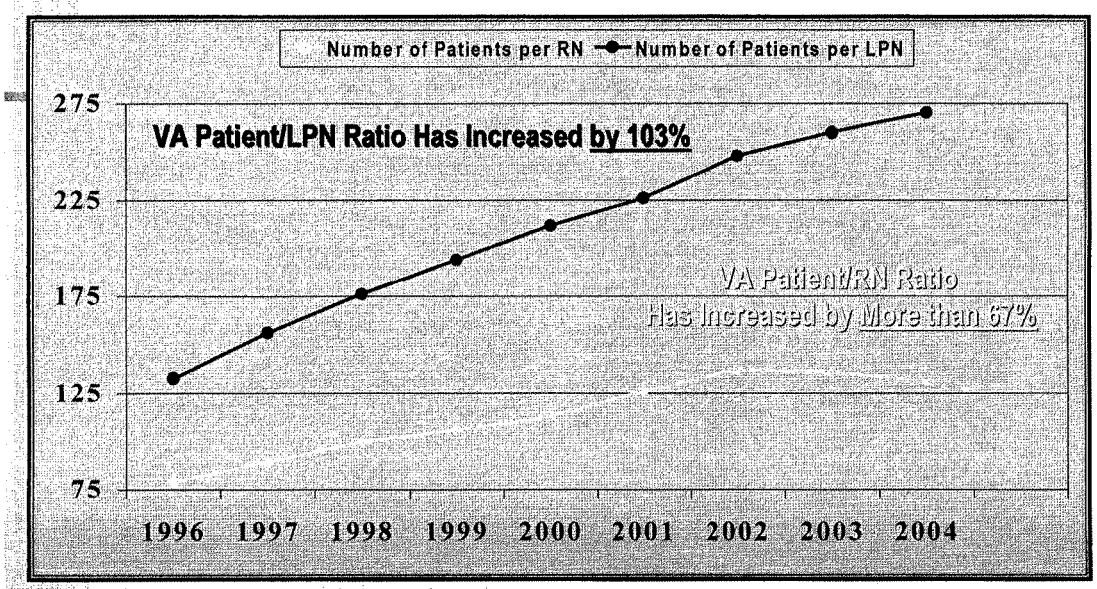
Sources: ***(Enrollees)*** - VHA did not track enrollees prior to '99, so a % difference between FY 99 enrollees and users (16%) was applied to estimate FY 96-98 enrollees. % enrollee/user differences for FY 00 & 01 were not utilized because those % differences were (1) substantially higher, (2) reflect VA policy changes allowing many more enrollees, and (3) could skew the FY 96-98 estimates significantly upward. FY 99-02 data are from an Excel file emailed to VVA from the VHA Policy and Forecasting office titled "enrollees and pts fy99-04 by priority.xls." FY 03 & 04 estimates are from the same office. ***(Users)*** - Defined as VHA "Unique Patients" from Table 6 - VA Health Care, Systemwide WORKLOAD, FY 1996-2001 (www.va.gov/vetdata/ProgramStatics/index.htm). *FY 02 number is listed in the VA 2004 Congressional Submission, p. 2-15; **FY 03 & 04 User estimates are the VA's Full Demand figures. These figures are used because OMB has historically underestimated future FY VHA users in its Budget Submissions.

VA Doctor/Patient Ratio



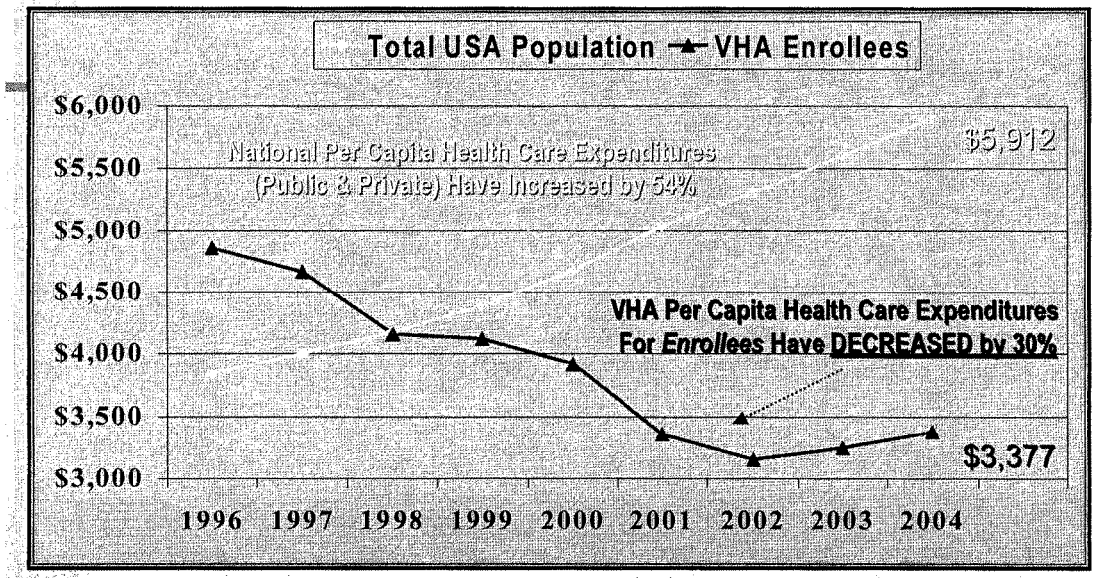
Source: Department of Veteran Affairs Forecasting and Policy Office Fax on 3-13-03.

VA Nurse/Patient Ratio



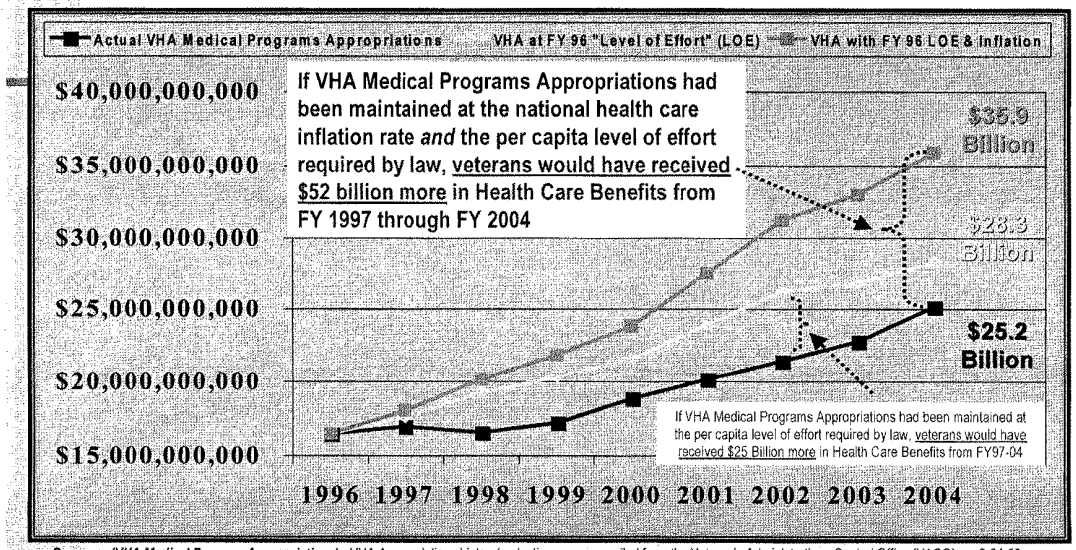
Source: Department of Veteran Affairs Forecasting and Policy Office Fax on 3-13-03.

Annual Per Capita Health Care Expenditures



Sources: ***(National Health Care)*** - Per Capita Expenditures are derived from the Centers for Medicare and Medicaid Services data found at http://www.cms.gov/statistics/nhe/, the "nhegdp01.zip" file (2nd table at bottom of web page). Projections for FY 02-04 are based on the average 5.5% per capita growth rate from FY 96-01.
(VHA) - Enrollee Per Capita Expenditures are derived by dividing FY 96-04 VHA Appropriations by the number of VHA enrollees. FY 96-98 are estimates based on the 16% enrollee/user difference in FY 99. FY 99-04 actual and projected enrollees are from the VHA Policy and Forecasting Office and utilize the "full demand" figures for FY 03 and 04. VHA Appropriations history and projections were e-mailed to VVA from the Veterans Administration Central Office (VACO) on 2-04-03.

VHA Medical Programs "Should Spend" Budget



Sources: ***(VHA Medical Program Appropriations)*** - VHA Appropriations history/projections were e-mailed from the Veteran's Administrations Central Office (VACO) on 2-04-03.
(VHA at FY 96 "Level of Effort" Budget Line) - Data derived by multiplying the FY 96 Per Capita "Level of Effort" ($5,633) by the number of VHA Users. FY 96-98 VHA Users are a VVA estimate. FY 99-04 VHA Users came from the VHA Policy and Forecasting Office and utilize the "full demand" figures for FY 03 and 04.
(VHA at FY 96 LOE & Inflation Budget Line) -- Health care inflation figures for each FY were faxed to VVA from the Centers for Medicare and Medicaid Services (CMS) Actuarial Offices, and can be viewed for 1998-2004 at www.cms.gov/statistics/nhe/projections-2002/t1.asp. The CMS data are conservative because they do not reflect price inelasticity accounted for in the slightly higher health care inflation figures of the Consumer Price Index (patients cannot as easily substitute lower cost drugs/treatments as in other sectors).