AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

IS THIS ANY WAY TO TREAT OUR TROOPS? THE CARE AND CONDITIONS OF WOUNDED SOLDIERS AT WALTER REED

HEARING

BEFORE THE

SUBCOMMITTEE ON NATIONAL SECURITY AND FOREIGN AFFAIRS

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

MARCH 5, 2007

Serial No. 110–40

Printed for the use of the Committee on Oversight and Government Reform

Available via the World Wide Web: http://www.gpoaccess.gov/congress/index.html
http://www.oversight.house.gov

U.S. GOVERNMENT PRINTING OFFICE

40–852 PDF WASHINGTON : 2008

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON OVERSISGHT AND GOVERNMENT REFORM

HENRY A. WAXMAN, California, *Chairman*

TOM LANTOS, California
EDOLPHUS TOWNS, New York
PAUL E. KANJORSKI, Pennsylvania
CAROLYN B. MALONEY, New York
ELIJAH E. CUMMINGS, Maryland
DENNIS J. KUCINICH, Ohio
DANNY K. DAVIS, Illinois
JOHN F. TIERNEY, Massachusetts
WM. LACY CLAY, Missouri
DIANE E. WATSON, California
STEPHEN F. LYNCH, Massachusetts
BRIAN HIGGINS, New York
JOHN A. YARMUTH, Kentucky
BRUCE L. BRALEY, Iowa
ELEANOR HOLMES NORTON, District of Columbia
BETTY McCOLLUM, Minnesota
JIM COOPER, Tennessee
CHRIS VAN HOLLEN, Maryland
PAUL W. HODES, New Hampshire
CHRISTOPHER S. MURPHY, Connecticut
JOHN P. SARBANES, Maryland
PETER WELCH, Vermont

TOM DAVIS, Virginia
DAN BURTON, Indiana
CHRISTOPHER SHAYS, Connecticut
JOHN M. McHUGH, New York
JOHN L. MICA, Florida
MARK E. SOUDER, Indiana
TODD RUSSELL PLATTS, Pennsylvania
CHRIS CANNON, Utah
JOHN J. DUNCAN, Jr., Tennessee
MICHAEL R. TURNER, Ohio
DARRELL E. ISSA, California
KENNY MARCHANT, Texas
LYNN A. WESTMORELAND, Georgia
PATRICK T. McHENRY, North Carolina
VIRGINIA FOXX, North Carolina
BRIAN P. BILBRAY, California
BILL SALI, Idaho

PHIL SCHILIRO, *Chief of Staff*
PHIL BARNETT, *Staff Director*
EARLEY GREEN, *Chief Clerk*
DAVID MARIN, *Minority Staff Director*

SUBCOMMITTEE ON NATIONAL SECURITY AND FOREIGN AFFAIRS

JOHN F. TIERNEY, Massachusetts, *Chairman*

CAROLYN B. MALONEY, New York
STEPHEN F. LYNCH, Massachusetts
BRIAN HIGGINS, New York

CHRISTOPHER SHAYS, Connecticut
DAN BURTON, Indiana
JOHN M. McHUGH, New York
TODD RUSSELL PLATTS, Pennsylvania

DAVE TURK, *Staff Director*

CONTENTS

	Page
Hearing held on March 5, 2007	1
Statement of:	
Geren, Peter, Under Secretary, U.S. Army	1
Kiley, Lieutenant General Kevin C., M.D., U.S. Army Surgeon General; Major General George W. Weightman, Commander, Walter Reed Army Medical Center; and Cynthia A. Bascetta, Director, Health Care, U.S. Government Accountability Office	98
Bascetta, Cynthia A.	113
Kiley, Lieutenant General Kevin C.	98
Weightman, Major General George W.	112
Schoomaker, General Peter, Chief of Staff of the Army; and General Richard A. Cody, Army Vice Chief of Staff	159
Cody, General Richard A.	159
Schoomaker, General Peter	159
Shannon, Staff Sergeant John Daniel; Annette McLeod, wife of Corporal Wendell "Dell" McLeod; and Specialist Jeremy Duncan	37
Duncan, Specialist Jeremy	51
McLeod, Annette	44
Shannon, Staff Sergeant John Daniel	37
Letters, statements, etc., submitted for the record by:	
Bascetta, Cynthia A., Director, Health Care, U.S. Government Accountability Office, prepared statement of	115
Davis, Hon. Tom, a Representative in Congress from the State of Virginia, prepared statement of	35
Kiley, Lieutenant General Kevin C., M.D., U.S. Army Surgeon General, prepared statement of	101
McLeod, Annette, wife of Corporal Wendell "Dell" McLeod, prepared statement of	46
Shannon, Staff Sergeant John Daniel, prepared statement of	40
Shays, Hon. Christopher, a Representative in Congress from the State of Connecticut, prepared statement of	30
Tierney, Hon. John F., a Representative in Congress from the State of Massachusetts, various prepared statements	3
Waxman, Hon. Henry A., a Representative in Congress from the State of California, various prepared statements	57
Yarmuth, Hon. John A., a Representative in Congress from the State of Kentucky, prepared statement of	82

IS THIS ANY WAY TO TREAT OUR TROOPS? THE CARE AND CONDITIONS OF WOUNDED SOLDIERS AT WALTER REED

MONDAY, MARCH 5, 2007

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON NATIONAL SECURITY AND FOREIGN AFFAIRS,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:02 a.m., Joel Auditorium, Walter Reed Medical Center, Washington, DC, Hon. John F. Tierney (chairman of the subcommittee) presiding.

Present: Representatives Tierney, Waxman, Cummings, Lynch, Yarmuth, Braley, Norton, McCollum, Cooper, Van Hollen, Hodes, Welch, Shays, Platts, Duncan, Turner, and Foxx.

Also present: Representatives Davis of Virginia; Cummings, and Norton.

Staff present: Brian Cohen, senior investigator and policy advisor; Margaret Daum, counsel; Molly Gulland, assistant communications director; Earley Green, chief clerk; Leneal Scott, information systems manager; Dave Turk, staff director; Davis Hake, staff assistant; Andy Wright, clerk; David Marin, minority staff director; A. Brooke Bennett, minority counsel; Grace Washbourne, minority senior professional staff member; Nick Palarino, minority senior investigator and policy advisor; and Benjamin Chance, minority clerk.

Mr. TIERNEY. A quorum being present, the Subcommittee on National Security and Foreign Affairs' field hearing entitled, "Is This Any Way to Treat Our Troops? The Care and Condition of Wounded Soldiers At Walter Reed," will come to order. I ask unanimous consent that the chairman and ranking minority member of the committee as well as the ranking minority member of the subcommittee be allotted 5 minutes to make opening statements. Without objection, that is ordered.

I would also like to first introduce Under Secretary Peter Geren who would like to welcome people here in a brief statement.

STATEMENT OF PETER GEREN, UNDER SECRETARY, U.S. ARMY

Mr. GEREN. Thank you, Mr. Chairman, members of the subcommittee. I am the Under Secretary of the Army now. Next Friday I will be the Acting Secretary of the Army. Last Friday night the Secretary asked me to take on the health care issues for the

Army in the meantime, not wait until I become Acting Secretary next Friday.

On behalf of the Army I want to welcome all of you to Walter Reed. As a former Member of Congress, I want you to know I appreciate and value the role that the Congress and this committee plays in the life of our Army. We treasure the partnership we have with the Congress. We understand that the Constitution has forged the partnership, from the beginning of this country until as long as this country lasts, between the Congress and our U.S. Army.

We have let some soldiers down. And working with the Congress and with the leadership of the Army all the way down to the lowest ranking civilian or uniformed military, we're going to fix that problem. In fact we're in the process of fixing it. Your involvement is going to help us do that.

We're glad so many of you are here today showing this kind of interest in Walter Reed. So many of you have been out here many, many times, been a part of the life of Walter Reed. We've worked with Members and staff over the last several years in dealing with related problems, and we appreciate very much the role that the Congress plays.

There is a ballad that is part of the soldier's creed: I will never leave a fallen comrade. That is on the battlefield, it's in the hospital that's in the outpatient clinic. And that is part of the soul of every soldier. And anytime that vow is broken, I can tell you it hurts the heart of the Army.

The men and women at Walter Reed are dedicated professionals. They make considerable sacrifice, both financial and personal, to meet the needs of the patients here at Walter Reed, to meet the needs of the families. They provide excellent health care. And when it comes to wounded warriors they set the standard for the world for health care. And they do this and turn down offers in private industry to make several times more money. They do it because they believe in the soldier's creed. They're dedicated to their fallen comrades and it hurts them deeply when they see any member of this service be slighted and not receive the care they deserve.

So on behalf of the staff here, I also offer this welcome. They look forward to working with you. I want to thank them for their work and, again, Mr. Chairman, thank you and Chairman Waxman and ranking members. I appreciate your being here. Thank you for your time.

Mr. TIERNEY. Thank you, Mr. Geren.

Little bit of house cleaning here first. I ask unanimous consent that the hearing record be kept open for 5 business days so that all members of the subcommittee be allowed to submit a written statement for the record. Without objection, that's ordered.

I also ask that the following written statements be made part of the hearing record: The Iraq and Afghanistan Veterans of America; Joe Wilson, Social Workers Psychiatric Continuity Service; Sergeant David Yancey, Mississippi National Guard; Sergeant Archie and Barbara Benware; and John Allen, former Sergeant First Class, North Carolina National Guard. Without objection, so ordered.

[The information referred to follows:]

From Iraq veteran Paul Rieckhoff, Executive Director of Iraq and Afghanistan Veterans of America:

Mr. Chairman and Members of the House Committee on Government Oversight and Reform, on behalf of the Iraq and Afghanistan Veterans of America (IAVA), thank you for the opportunity to address the ongoing issues at Walter Reed.

IAVA is the nation's first and largest organization for veterans of the wars in Iraq and Afghanistan. It is our mission to educate the public about these wars and to advocate on behalf of the newest generation of American heroes. IAVA believes that the troops and veterans who were on the front lines are uniquely qualified to speak about the realities of war, its implications on the health of our military, and its impact on the strength of our country. We are honored to serve as a resource for you today and as you continue your investigation.

The Walter Reed horror stories are not new; I started hearing them over three years ago. In 2004, one IAVA member told me how he had been critically injured when a grenade was thrown into his Humvee. His medical care at Walter Reed was nothing short of miraculous, allowing him to keep both his legs and, eventually, walk again. But once in recovery, he faced a new battle. With only one arm and two shattered legs, this young Army Specialist was forced to hobble unassisted through the snow from building to building on the sprawling Walter Reed campus, just to complete his paperwork so he could go home.

At your hearing on February 2005, this committee showed itself to be at the forefront of these issues, asking the questions that need to be asked, and demanding action. We ask that you continue to do so.

Senators Barack Obama and Claire McCaskill introduced the "Dignity for Wounded Warriors" Act which, if passed, would work to ensure all wounded service members at Walter Reed will receive the treatment, care, and services they deserve. The bill includes measures to ensure safe, clean housing, reduce paperwork and bureaucracy, improve casework, add care for military family members, increase assistance and access to information, and finally, create an oversight board to ensure accountability. Where swift and decisive action is needed, this is a good first step.

But the most shocking stories of how America has failed the newest generation of veterans may be yet to come. Transition to VA care is far from seamless. Local VA clinics are ill-prepared for the problems of new veterans, such as Traumatic Brain Injury and Post Traumatic Stress Disorder. According to a recent study by Congress, 40% of all clinics are providing inadequate mental health care. With almost 400,000 backlogged benefit claims, the VA faces a burden it is simply not prepared for. And as Iraq and Afghanistan veterans continue to flood to VA system, these problems are likely to worsen.

Since FY 2002, nearly 600,000 OEF/OIF veterans have become eligible for VA health care, but over 900,000 troops are still on active duty. Multiple combat tours increasing the rates of PTSD, TBI, and other serious injuries – and pushing up demand for VA services and benefits.

Today, we're calling on you to ensure that all wounded veterans, not just those at Walter Reed, receive the support they deserve. Our wounded heroes have answered their call of duty; it is time for us to do the same.

Thank you.

"IS THIS ANY WAY TO TREAT OUR TROOPS? THE CARE AND CONDITION OF WOUNDED SOLDIERS AT WALTER REED"

WRITTEN TESTIMONY OF
JOSEPH WILSON, LCSW-C
PSYCHIATRIC CONTINUITY SERVICE
DEPARTMENT OF PSYCHIATRY
WALTER REED ARMY MEDICAL CENTER

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
THE SUBCOMMITTEE ON NATIONAL SECURITY AND FOREIGN AFFAIRS

MARCH 5, 2007

6900 GEORGIA AVE, NW
WASHINGTON DC 20037
202-782-9421

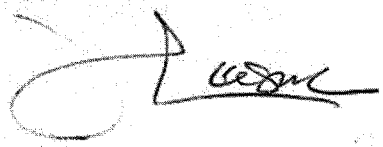


TABLE OF CONTENTS

PURPOSE.....3

BACKGROUND.....3

THE PROBLEM.....2

WHAT'S WORKING.....5

SUMMARY AND RECOMMENDATIONS 6

Written Testimony
Joseph Wilson, LCSW-C

PURPOSE

In response to the recent publicity surrounding conditions at Walter Reed Army Medical Center, this paper is written and compiled to offer an accurate description of the problems and conditions associated with the management of the patient population housed at Walter Reed. Specifically, the issues and needs of those outpatients that are assigned or attached to the Medical Hold (MH) and Medical Holdover (MHO) Companies are outlined; coupled with a discussion of several solution-based initiatives and programs that have attempted to address the issues.

The information contained in this paper is by no means exhaustive, and offers a singular perspective (from a collection of "frontline" workers) regarding the systemic issues that exist as barriers to effective and efficient management of the outpatient population in the Medical Hold and Medical Holdover Companies.

BACKGROUND

Although recent publicity has focused attention on the problems associated with service members getting effective, efficient and appropriate care while at Walter Reed Army Medical Center, it would be inaccurate to state that such problems have gone "unnoticed" by command staff and hospital personnel. It is more accurate to state that the problems described in this paper were not seen as a "priority" in terms of addressing the needs of the wounded. Furthermore, the problems noted in the series of articles by The Washington Post offer only a partial examination of what outpatients in the Medical Hold (MH) and Medical Holdover (MHO) Companies have to confront in their daily living while receiving medical care and treatment at Walter Reed. Although there is consensus that physical plant conditions have contributed to the problems faced by service members in the MH/MHO Companies, it is neither the sole, nor the most significant factor related to the care and activities of daily living of patients assigned or attached to MH/MHO Companies. Other factors such as systemic dysfunction (including problematic, intra-systemic relationships/integration); poor patient interface with the system; and a lack of understanding regarding the needs of this patient population (and their family members) by military command have also contributed significantly to the problems experienced by this population.

Historical Context

Since the beginning of the Global War on Terrorism (GWOT), there has been an increasingly diverse and complex outpatient population housed at Walter Reed. Although current numbers put

the outpatient population at just under 700, this is less than the numbers reported in previous years (at one point in 2004, the number in the MH/MHO Companies numbered closer to 1,000). Not only was this patient population larger than could be housed on post (maximum 200-250 soldiers), but the needs and injuries were complicated and included both bodily and psychological injuries.

In response to a system overwhelmed by the numbers of patients, as well as the complexity of their needs, the staff within the Department of Psychiatry (specifically the Psychiatric Continuity Service (PCS)) engaged in discussions with both hospital and brigade commands to address issues associated with managing the needs of those soldiers assigned or attached to the MH/MHO Companies. These discussions were prompted by critical incidents which had taken place; one of which had resulted in the death of a patient in MH Company (January, 2005). While not all critical incidents have involved patients who were primarily receiving psychiatric treatment, the Psychiatric Continuity Service assumed a primary role for engaging and maintaining these discussions with command.

These discussions were focused on the need for, and the development of, better "risk management" practices to ensure that patients did not engage in problematic, dangerous behaviors. Although initial efforts focused on effectively managing patients who were primarily receiving psychiatric treatment, it soon became clear that ALL patients in the MH/MHO population were at risk of potentially experiencing some mild to moderate emotional/behavioral difficulties as the result of stressors associated with being stationed at Walter Reed. As a result, PCS attempted to offer a clear definition of the scope and severity of the problem. This led to a more comprehensive, well-developed understanding of the needs of the entire MH/MHO Companies, a discussion of which appears in the slide show presentation in Appendix A.

THE PROBLEM

As previously stated, the problems associated with outpatient care for service members in MH/MHO go well beyond physical plant issues. A survey of over 200 soldiers in MH/MHO Companies was undertaken in March, 2006. The results (included in Appendix A) indicated that not only were services needed for the purpose of risk management, but to support patient wellness and provide for more information regarding how patients could effectively interface with "the system". Overall there are three categories of problems/stressors faced by the MH/MHO population: (1) Physical space and conditions of the accommodations in which soldiers are housed; (2) A complicated, overwhelming and disjointed "social service" delivery system; and (3) A slow, confusing, and repetitive medical board and physical evaluation board process.

Physical Space and Accommodation Conditions

As previously stated, it would be inaccurate to suggest that the problems associated with Building 18 went unnoticed by staff and command. Indeed, there were ongoing efforts to improve the living conditions, although these by no means addressed all the issues effectively. It would be more appropriate to state that the living conditions were not seen as a "priority" in terms of designating resources. The situation is a clear example of something patients in MH/MHO

Companies have complained about frequently: the attitude of the Army that as a soldier you should "Suck it up, soldier and drive on!" There is a pervasive attitude shared by many in the command structure that the service members in MH/MHO Companies are soldiers "first". There is a strong resistance to treat them as patients, and as such, afford them the care and comfort associated with that role (including improving accommodations and providing "social services" to better manage the patient population). Soldiers and staff have experienced many encounters with command staff in which this attitude was directly stated, if not tacitly implied. It is the belief of several staff that this attitude led to the existence of the conditions in Building 18, as well as an overall mood of dissatisfaction, disenfranchisement, and resentment among the patients in the MH/MHO companies.

A Complicated, Overwhelming and Disjointed "Social Service" Delivery System

The influx of such a large patient population quickly overwhelmed the Army's ability to effectively manage the needs of the patient population. In fact, the Army's approach has been to adopt a typical company command structure to address the issues of soldier accountability and "asset management". Initially, there was no way in which to appropriately orient soldiers and their families to "life" at Walter Reed. Upon arriving at Walter Reed, many soldiers are routinely admitted as inpatients. While they are in the hospital, they are treated as patients. Once transferred to outpatient status, they are assigned or attached to MH/MHO. Systemically, these patients now have to be accountable to a command structure, in addition to managing their medical care and recovery, while dealing with the implications of their injuries. These competing roles often lead to role overload, resulting in the soldier not being able to meet the requirements of either role effectively.

A good example of this role overload is the "in processing" that is required of all soldiers when they transfer to a duty post. Each time a soldier transfers to a new unit or duty station, they are required to go through an "in processing". For soldiers attached or assigned to the MH/MHO Companies, that requires the signature of up to 23 individuals located all over the post. Managing such a complicated and confusing process, in addition to getting medical care and treatment (which usually involves serious pain medication) is often overwhelming and results in resentment and anger on the part of the patient and their family. Having patients complete these tasks (sometimes in wheelchairs, with missing limbs) seems pointless and irrelevant. In addition, requiring patients to report to formation (in full uniform) on a daily basis adds more challenges for the recovering patient: adjusting medication times to be "awake" and "alert" for formation; getting less sleep in order to get up at 4:30 AM to prepare to report to formation on time; and interacting effectively with platoon sergeants and their "military" expectations.

These noncommissioned officers, who are neither medics, nor have any psychiatric training in dealing with needs associated with this population, often focus on the patient as "soldier first". There have been reports that patients are at times threatened with administrative separations if they do not comply with expectations, which are near impossible to meet given their medical conditions and treatment. This then leads to intense resentment, anger, and certainly withdrawal from important services that are meant to engage patients and help them manage their medical care and recovery in positive and pro-active ways.

Although there is a myriad of professionals and command staff (case managers, doctors, and platoon sergeants) there is no comprehensive "net" of support services for soldiers to access

consistently reliable, relevant and helpful assistance/information. Each professional and NCO has distinct areas of responsibility and information; for the soldier, there is no guarantee that information given from any of these sources is reliable, and in fact the information from one source is usually contradictory to that of another. The inability of the military and medical communities to net resources and put in place a comprehensive system of patient management (information and resources) contributes significantly to a resentful, disenfranchised, angry patient population that is less invested in managing their health and medical care to a positive outcome.

A Slow, Confusing, and Repetitive Medical Board and Physical Evaluation Board Process

Upon arriving as an outpatient at Walter Reed, soldiers have to contend not only with the issues mentioned above, but also the anxiety regarding their status within the military. Often patients are not aware of the medical board process, how it works, how long it takes, and what determines if they will get a medical discharge. This lack of information leads to frustration, anxiety, and unrealistic expectations regarding the outcome of the process. Once it is determined that a patient is receiving a medical board, the process itself can be considered quite simple. The patient is evaluated for a number of factors, with doctors writing a narrative summary regarding their assessment of the patient's condition. If more than one condition exists, there is a primary condition for which the patient is evaluated, with addendums written by other doctors addressing the co-occurring conditions. The problem associated with the process is in the execution.

There are many doctors, interns, residents with whom a patient has contact. This is in part due to the fact that Walter Reed is also a teaching hospital. Narrative summaries can get lost, take longer to complete for a number of reasons, and if the intern or resident has "rotated" to another clinic or department, "tracking" them down can be an arduous task that adds unnecessary time to the process. There are times when locating doctors results in the discovery that they have been deployed to Iraq or Afghanistan, or are no longer at Walter Reed. Furthermore, if another doctor has been designated to complete the board, it takes additional time (and more appointments) for the doctor to adequately assess the patient to competently write the narrative summary. In the meantime, if it's discovered that an addendum is more than six months old, it has to be reviewed/re-written and the entire process begins all over again. It's not unusual for a patient to followed/treated by more than one service (i.e. orthopedics, surgery, internal medicine) and each one must complete a timely addendum. Unfortunately, it can become the patient's responsibility to take on this process. In addition to making appointments, keeping appointments, and complying with requirements of the process (sometimes inaccurately or unclearly represented by professionals), patients become confused, overwhelmed, and can become ineffective in completing the necessary tasks within the appropriate time frame. If this happens, the patient must "renew" evaluations that have become outdated.

In part, this process is complicated by the "accountability gap" created by the way in which the system manages the information. Case managers in MH/MHO Companies do not take responsibility for tracking the progression of a patient's medical board. Indeed, each case manager has a caseload of up to 45 -55 soldiers. Individual doctors only write "their piece" of the report, leaving the patient to be responsible for tracking all the necessary paperwork. In many cases, the patient can be unaware of which professional hasn't completed a portion of the report, resulting in necessary steps having to be repeated. Although there are units and clinics at Walter Reed that have set up their own tracking system for patients on their service getting a medical board, there remains

the issue of accountability and who oversees the entire process. Dealing with this process is not only stress inducing, but it also has the effect of patients wishing to avoid the process altogether, or to accept a lesser percentage than perhaps they are entitled to in order to put an end to the stress.

WHAT'S WORKING

In order to effectively address the issue of change within the system, it's necessary to identify what has been working to address the concerns outlined above. There is a good foundation within the system upon which to build and implement systemic interventions that can more effectively manage the outpatient population currently assigned or attached to MH/MHO Companies. The point has been made previously, and it bears repeating here: there are good people, hardworking professionals (civilian and military) who strive to carry out the mission of providing the best medical care they can to the wounded at Walter Reed. When the question is asked "how this could be allowed to happen?" the answer must include a serious discussion about the lack of systemic flexibility in allowing individuals to create and implement solutions. The culture of the military and of the Army in particular, has never experienced a patient population (in size or complexity) such as this one. Solutions to the problems outlined above come in colors other than "Army Green", and need to be evaluated on their own merits in terms of how well they meet the needs of the patients, rather than in terms of how well they conform to the culture of the Army.

Having taken on a primary role for connecting patients in MH/MHO Companies to services, the staff within the Dept. of Psychiatry, specifically Psychiatric Continuity Service and Psychiatric Continuity Liaison Service (PCLS) undertook some ambitious initiatives, including:

1. Creating a Medical Board Oversight Committee that meets twice a month to track the status of every patient's medical board. Representatives include case managers in MH/MHO Companies; case managers from the Physical Evaluation Board Liaison Office; doctors and service providers from within the Department of Psychiatry; and social workers and staff from the unit discuss and problem solve issues associated with getting medical boards complete and filed in a timely fashion. Since its inception, the committee has reduced the number of patients waiting for medical boards by 65%.

2. Developing and maintaining collaborative relationships with other services/clinics, including the Army Substance Abuse Program, as well as with command staff in MH/MHO Companies to track patients' progress and compliance with treatment.

3. Designing and implementing an innovative and creative program (Warrior Outreach and Wellness) to address issues of risk management, patient wellness, and overall patient management by stressing prevention and early intervention strategies to address unnecessary stressors that have negatively impacted patient wellness. The program was successful in establishing collaborative partnerships with Army Community Services (ACS) and the Occupational Therapy Clinic (OT).

4. Seeking funding through the Commander's Initiative Account to continue to expand and broaden the function of the program. Although funding was approved, materials and

supplies requested have not been ordered, as funds became "unavailable" in the current fiscal year. (See Appendix B).

5. Staff within the Department of Psychiatric Continuity Liaison Services/Preventive Medical Psychiatry (PCLS) has implemented support groups for family members of soldiers to provide them with supportive connections to others, as well as to potentially helpful services. A Reunion and Reunification group conducted by Army Community Services (ACS) and PCLS has just begun meeting for the purpose of assisting patients and family members adjust to the patient's return from Iraq and their injuries.

While these initiatives and programs have been helpful to providing services to the MH/MHO patient population, they are but discreet efforts, individually implemented, with no connection to each other, nor with the larger system. Indeed, these services are typical of the manner in which care is administered to this patient population: individuals (usually civilian) recognize and identify a need within the patient population and advocate for resources to implement services within their own department or service. There is no "centralized" mechanism to funnel these services to the larger population, and patient access to these services becomes "hit or miss". Further, such a collection of discreet services can become overwhelming to illustrate and describe to incoming patients, and does not provide for a friendly, easy, or relevant patient interface. There is a need for these services to achieve a more integrated and connected status with the larger medical and military service systems.

Attaining such status, however, can be difficult, and has only been the case with one such program: the Warrior Outreach and Wellness Program. With concerted and consistent effort, staff members were able to convince command that the initial briefing provided by the program should be placed on the in-processing checklist, so that all patients in-processing to MH/MHO companies are required to attend. While this was a significant step towards "institutionalization" of the program, it further burdens patients with yet another stop in their long trek to complete administrative tasks associated with being a soldier. Feedback from patients and family members who have attended the program is generally positive, although they have often expressed a desire to have attended the briefing FIRST, as the information given would have been useful in helping them navigate the system.

SUMMARY AND RECOMMENDATIONS

The current issues and problems associated with the MH/MHO patient population are best defined and discussed within the context of patient care and management. It's clear from speaking to many "frontline" social workers, as well as with patients and their family members, that the needs of this population require more than an improvement in living conditions. To think otherwise, is to waste valuable time, energy and resources in effectively developing ways to meet the needs of this increasingly diverse and complex population.

Effective and efficient outpatient services must address not only the medical needs of the patients, but their emotional, psychological, and functional needs as well. In doing so, a system must be created to manage and track patients (providing for necessary accountability) and their needs, while at the same time, giving them the tools necessary to manage their own care and recovery to positive outcomes. Such a system of care must be integrated, collaborative, and include: (1) recognition of service members as patients first; (2) sufficient and comprehensive resources devoted to ensuring patients "have what they need" to address all the administrative tasks associated with receiving medical care; (3) services to support family members and bedside caregivers in their often necessary role as liaison between the patient and the medical and military systems; (4) accessible points of entry into the system of care that provide for seamless transitions from inpatient to outpatient status; and (5) a clearly defined mission, role, and "place" within the military patient care system with appropriate scope of authority to direct resources as needed to various initiatives and programs in response to ongoing assessments of patients' needs.

Specifically at Walter Reed, the system of care outlined above would require the following:

1. A comprehensive review of all programs, services, and initiatives currently operating in support of patients and their families in MH/MHO companies, with the goal of creating a system of care to address the previously identified needs of the patients.

2. The establishment and maintenance of collaborative partnerships and relationships between hospital staff and military command to create a system of care that addresses the need for patient accountability, as well as supporting the tracking of patients, and their progress and compliance with treatment.

3. Identifying and making improvements to the current operation of the Medical Board and Physical Evaluation Board processes such that doctors and staff more efficiently and quickly complete necessary "paperwork" to move the process to a speedy and just conclusion.

4. Completely funding the current Warrior Outreach and Wellness program to carry out its mission.

5. Establishing a "one stop" in-processing experience for soldiers and their families to ease the transition from inpatient to outpatient status.

The design and implementation of these recommendations, both qualitatively and quantitatively will require systemic change of an order greater than the renovation of buildings. Such change will require a strong commitment to viewing wounded soldiers as patients first; and to recognize the necessity for collaborative, cooperative relationships that can effectively pool resources to carry out a patient-centered mission. That mission must include more than providing the best medical care to the wounded: it must also include caring for patients while they receive that medical care.

Statement of SGT David Yancey, Mississippi National Guard

As a wounded soldier here at Walter Reed Army Medical Center. I am a about to summarize my stay here as briefly as I can. Including strugles that I have faced, but not leaving out the positive things and great help I have received from people who are concerned.

I am SGT. David Yancey of the Mississippi National Guard, HHC 155 BCT. I joined the national guard in July,2003. I left for bootcamp at Fort Leonard Wood,Ms in January,2004. I completed basic training and advanced individual training at the end of May,2004. Upon arriving back home in May,2004, I was faced with a divorce and a deployment to deal with in a two month time frame. Our brigade was scheduled to deploy to our mobilization site in August,2004. These personal references I am describing will be useful to the reader as I continue with my story desribing my stay here at Walter Reed.

Our Brigade moved ahead as scheduled to our mobilization site in Camp Shelby, Ms. This took place in Aug,2004. Training went as planned with no mishaps, except some personal struggles of my own. My father was diagnosed with Lugared's disease. At this time my only brother was deployed in Afganistan. This was a personal struglle for me. I understand all soldiers and their families deal with these struggles. Many of them alot more severe than mine. We soldier up and drive on. Again I believe personal struggles are worth mentioning to best illustrate the the intense and stressful circumstances soldiers drive on through to serve there country. These that I have mentioned have been more complicated and highlighted even more due to being injured in Iraq and processing through the process here.

Our brigade then moved in to Iraq in January,2005. Everything went as planned. March 29,2005. Plans changed. The explosion of an IED under our humvee sent me and the driver out on a medivac to Germany and then here to Walter Reed. Upon gaining conciousness here at Walter Reed. I began to be informed of the future.

The future? The present? Alot in between. Not to be misleading in any way. I will best describe my stay here. Not knowing any of the medical process, I began to try to comprehend things as little as acronyms up to who all would be involved in this process. Names of doctors, staff members,nurses,organizations,etc. My stay in the hospital brought many visitors promising that they would do there best to make this a seemless transition. My family visited for a few days, but were forced to return home due to my fathers health. Not to return again, except for a weekend visit months later. My conditon was somewhat stabilized in the next couple of weeks. I was visited by my social worker who began to tell me about being discharged to the Malogne House. I learned more about Malogne House and procedures to come as I asked questions. My main concern was mobility. I could not walk due to a fractured femur which had a rod placed in it from my hip to my knee. I could hardly move my right arm due to an injury from shrapnel. I graciously asked for a motorized wheelchair to assist me with this transition. No, I was answered with no consideration. Ok, I sucked it up. At this point I had not been contacted by medical holdover. I was discharged to the Malogne House. Less than twenty four hours brought problems with my arm.I was attempting to enter my room there with no assistance. Catching my arm in the door. Re-injuring it. I was helped to the emergency room by the va represntative to undergo emergency surgery. Abandoned by the military and medical holdover at this point. My arm was at stake and also my life due to fact I had

just finished a full meal (no eating prior to surgery for twenty four hours is allowed) and been discharged to early from the hopital. . The surgery landed me back in the hopistal recovering. During this stay. The medical staff was very respectful and I had complete trust in their abilities. No question in my mind. Doctors seemed very knowledable,etc. At the same time I was being questioned by other departments when I was leaving as if they were pushing me out. At this point, I learned to speak out for myself. I demanded a powered whellchair. My family was making phone calls to my general and my senator to try and get me one. Finally, I was given one.

To the malogne house I went again. Only to return the next day with an infected leg. Hospitalized again. Another discharge had taken place to early. These discharges were made with the hopital knowing I had no family here to assisist me and knowing that medical holdover was not there to assist me. My aunt had been to visit me prior to me being released the second time. She is a registered nurse. She pointed out to the nurses on the ward that my leg was infected. No reaction was taken, but released to the Malogne House. This left me hospitalized until early June,2005. Back to the malogne house, but in a powered wheelchair.

I had still not been contacted by medical hold at anytime at this point. I was released from the hospital not remembering the names of my doctors and no clear instruction or reminders on what I was to be doing. I talked with other soldiers and struggled to make contact with leadership who would give me direction. I began to learn the process and making appointments to start my rehab. Again , this time frame was in June,2005. Everyting started progressing and rehab was underway. Learning the acronyms,names of people who be involved in my care. Still, no contact from medical holdover. No help moving from the hopital to the malogne house earlier in June. In August,2005. I was contacted by medical holdover. They instructed me about formations and the processing into medical holdover. My Platoon Sgt, who was SFC Gines was very disrestpectful and demanding of what they needed. Not being concerned with what I needed at all. I was told to get a job. I had been visited many times by Congressman Gene Taylor. Congressman Talylor had offered me and the driver who was also in my cituation,but missing two legs, and internship at his office. We took him up on it. Excited was an understatement of what we felt. Only to be harrassed by medical holdover to no end. Major Middleton, commander of medical holdover called us in and questioned us on how we was offered the internship and let us know they didn't approve of it. They wanted us to have a job, just not this one. Anyway, the internship was underway. Questioned by my 1SG, who was 1SG Zelch and my Platoon Sgt, SFC Gines everyday what we were talking about at captial hill and what we were doing, not knowing we made an effort to not mention Walter Reed. Restricting the internship to eight weeks was their reaction. 1SG Zelch turned out to be a respectful guy. He advised me that Col. Cardereli, our brigade commander was restricting the internship. Anyway, we completed the internship, though it left me with a question about our leadership. I was called in by command and given a counseling statement ending the intership. I was informed not to go back down to capital hill. They wanted soldiers to work. But did not want any light shed on Walter Reed to goverment. I had found a good leader in 1SG Zelch. He had took the heat for us during this and became friends with us. He was a positive influence from medical holdover only to be followed by some who were good and bad. Med holdover is the soldiers main base here. A better screening process on selecting command would help. I

put all this behind me at this point. Not really concerned with what was going on at Walter Reed, besides figuring out the process and rehab.

The journey continued through the medical process. Rehab was going great with great rehab specialists who worked hard in the clinics and were very repectful and willing to help, whatever it took. This was a continious learning process and I had no doubt other soldiers were experiencing the same. Some better, some worse case senarios. Learning the process as I asked questions, I began to learn about the medical boards. I made an evaluation of what I had heard about the boards in January,2006. I decided to attain a civilian attorney. David P. Sheldon would represent me through the board. As this process got underway in March,2006 when my doctor completed the narrative summary, I had negative feelings about the boards from talking with others in process. I was dealing with medical holdover on duties they expected and juggling career decisions, learning the process as I went. I lost my father in March,2006 while at the same time, staying focussed on the tasks at hand to complete this process. Throughout the summer of 2006, I began to try and assisit my medical board counselor, SFC Craig. I asked her what she needed to gather my case for submission. I then ran into road blocks. Going to doctors asking them for the paperwork for SFC Craig was exhausting. SFC Craig told me throughout the summer that we were waiting in paperwork from Psychiatry. I would ask one of my Psychiatry doctors for the adendum. They would refer me to another doctor. I would ask that doctor. They would refer me to another doctor. All of them putting it off on the other. My case manager in medical holdover was aware of this on going problem. Her answer was, maybe you will get out of here one day. No help from anyone. Sit and wait seemed to be the routine of my case and alot of soldiers who I talked with about their cases. My attorney faxed them a couple of times in the summer, upon my request, asking them to expedite the process. Still, no action. Sucking it up, seemed to be the answer. Trying to be respectful with all parties involved. My rehab had been complete since the early part of the year. Med holdover seemed to have no say in this timeless issue and never attempted to get down to the bottom of the problem.. It was completely up to the medical evaluation board. The only one I was introduced in the medical evaluation board office was Sgt. Craig. I would learn later that she was not properly provided with the information she needed to pass on to me, the soldier. Leaving me in limbo for weeks on end not knowing anything. I did learn one thing. When I was given a time frame on something to be turned in to them. I was held to it to the day. Which was sometime very frustrating due to the fact I had representation and other reps I would have to meet with. When the ball was in their court. The medical board was not held accountable to any time frames established by the military. Never offering any appoligies or sympathy or alot of times, even an explanation.

This was beginning to frustrate me. Needing to get back home to take care of personal family issues that I mentioned earlier in this story. Around october of 2006, I started getting a few phone calls form the medical board. They were showing signs of progression. I was contacted and told they had the paperwork from Psychiatry. Only to find out that my TBI testing was out of date. I then completed the testing again and everything seemed to be up to date. I feel it is relevant to mention that during this process, that SFC Craig was on leave or training for approxiamtely six weeks. No one was appointed to take her place. Leaving the soldiers sitting. My case was submitted around the end of october. I also believe it is worth mentioning that during this process, I

attended town hall meetings expressing my problems with the roadblocks. My name was taken and no further contact was made. I quetioned command on what to do. I also questioned frequent friends I met through my stay here on how to navigate the system. Around early december of 2006, I was called in and given a informal rating of 10%. I talked with my attorney the disabled american verterans rep. and others. They all told me this was unexceptable,looking at my medical records. I looked back at my stay here. Thinking about all the soldiers who had given up the system. Took what the military offered them on their informal because they were ready to leave. Fight. Stay and fight was what I would do. I started pulling in resources for this. One of my resources was Congressman Gene Taylor. He submitted an inquiry on my behalf in december. I was then given a foraml hearing date. January 17th would be my hearing. We proceeded to the formal. Everyone expects a rating to decision at the formal hearing. January 17th, I received a no decision. No rating. I was told by Col. Gerdling of the baord that they needed more x-rays of my leg.I had been here for twenty-two months at this point. I had x-rays that were three months current. Respectfully, I asked her what would happen after the x-rays were performed again. She said it might be another hearing or maybe a new rating would be issued for me to decide upon. No time frame was given on how long this would take. I waited until around the middle of Febuary, approaching the year mark form when I started the medical board process, the two year mark from when plans changed and I arrived at Walter Reed. I ran into a friend who asked me if I was still having difficulties. I told him yes. He urged me to call Mrs. Grace Washbourne. I had been given Mrs. Washbourne's number by other friends back in the summer of 2006. I had hesitated about calling anyone for outside help. Trying to navigate the system through town hall meetings,etc.

I went ahead and called Mrs. Washbourne for help around the the 14th of Febuary. She proceded with an inquiry. On Febuary 16th. I was called in by Sgt. Domingo. A medical board counselor. He gave me a new DA Form 199. This is a form which includes a soldiers rating from the medical board. I had been rated at 20%. Looking at the rating, there were clear discrepancies. The rating of my miagrain headaches said that the doctors reports of May,01, 2006 stated that they did not effect the soldiers ability to function. I looked at the doctor's note on May,01. It stated exactly the opposite of what the rating form said. It also stated that I had no medicated for them since June,2006. Pharmacy records indicate clearly that I have medicated for them continiously. Sgt. Domingo advised me I had fought a good fight. This was my rating. Take it to the VA. Not advising me of my choices whether to agree or disagree with the 20% rating. Sunday, Febuary 18th, articles started appearing in the Washington Post about conditions here at Walter Reed. I continued to work with Mrs Wasbourne on my medical board case. Thursday, Febuary 22nd. I was retalliated on by command. Staying out of the contraversy had been my approach. 1SG Gordon advised me at formation that I was to be escourted over to Sgt. Craig's office by another soldier. There was something there for me to sign. I had never been escourted anywhere on base before. I was in Sgt. Craig's office the day before. She had my cell number. I had hers. We were up to date on everything.

I was escourted by Sgt. Ward to her office only for her to tell me she didn't know what they were talking about. I took this as a retalliation move by command. After the articles, istead of doing the right thing. They did the wrong thing. Retalliating on a soldier who had complained of his medical board case and been forced to ask for help from a

congressional staffer after he had exhausted all other measures. I called my Platoon Sgt. and asked respectfully about this action and received no answer. I called Mrs. Washbourne and others and expalined what was going on here immediately. If you can't trust command at that point, who can you trust?

Since I was retalliated upon, trying to stay out of the contraversy. I decided to speak to media.Then, Monday, Febuary 26,2007. I was called in by Sgt. Craig. I was given a rating of 30%. The discrepencies that were obvious had been looked at and corrected.This was still not a fair rating. But at this point, I had given up on being rated on other things. She advised me I had a hearing on March 13,2007. I asked what the hearing was about. I knew there was not suppose to be a hearing if I agreed with the 30%. Sgt. Craig said she didn't know what the hearing was about. She assumed it was concerning the Congressional inquiry that had been submitted on my behalf by Mrs. Wahsbourne. It has been a struggle since trying to get clear answers here at Walter Reed. I have finally been informed that if I agree with my 30%, that there will be no hearing. Mrs. Washborne has worked with me to get these answers from the medical board. Looking for a ending.

Hindsight of my stay here? At this point, it is still hard to descirbe. There is definitely the "Other Walter Reed" as we have all read about. Walter Reed consists of great doctors and medical attention that in my opinion is the best in the world. The other Walter Reed consists of both positive and negative things and people who are involved. There is a tremendous outgoing of support from volunteers and organizations. They offer plane tickets, meals, events, etc with alot of dedication. It consisits of goverment officails who care and Congressmen and Senators who care for the wounded and take it as a personal challenge to assist the soldiers. It consist of dedicated staff members and great military leaders who try very hard. Unfortunately, it consist of red tape and bureaucracy that never ends throughout a soldiers stay here.. A soldier is faced with trying to represent himself against a
a complex system. It seems to me that the complex system is designed to give soldiers a battle at every step. Every corner we turn. We are ready to fight as though we are expecting it. Sometimes, we are prepared. As I mentioned earlier in my story. We constantly question each other and others on how to approach each battle. From trying to get copies of your medical records, which is a fight in itself,to dealing with a handful of leaders who seem to work against you, and those who go the mile to help you, to trying to get the a fair shake at the end of the medical process. Along the way, I and other soldiers try to coperate with command, staff members, and develope close relationships with volunteers. While at the same time, we make career decisions, deal with personal conflict.

I understand there is differnt senarios here. Every soldier and his case is different. Amputies have there own battle with more serious wounds, while not having to worry so much about the medical boards and getting a fair shake. Other soldiers are being returned to duty. Other soldiers navigate the process on CBHCO (at home). Which I have no idea about. I am sure it is difficult. Telephonic? Has to be a headache.

Solutions? As I have described in my story. The struggle between soldiers and the complex system. "The battle". I have taken a look back many times. Soldiers departing from the military for medical reasons are entered into the VA system which somewhat has a better reputation. Wounded soldiers here are only battling for Tricare and military

benefits. Most will recieve their monthly checks from the VA. Congressman Gene Taylor and others struggled to pass Tricare for reservists and guardsmen even when they are nor activated. This was well deserved. Soldiers who are rated over 30% on there medical boards/physical evaluation boards receive these benefits. This leaves a door open. Soldiers who are rated 30% or less on these boards are left with no benefits from the military. If a soldier is injured in combat overseas, receives a purple heart. Offer them the benefits from the military, including the option to buy into Tricare. This would take away all the stress on soldiers going through the "Other Walter Reed" and take away the military's need for bureachratic red tape and road blocks which are placed in front of the soldiers. Take the fight out of the battle. This would move soldiers through here quicker leaving more room. Maybe even doing away with Bldg. 18, which we here so much contraversy over. At the same time, eliminating the rivalry between soldiers and the complex system. Allowing both the soldiers and command to focus only on rehabilitation. Apply more staff to medical /physical boards. Do away with the "Other Walter Reed". I have mentioned this to Congress in the past months as I looked back at my stay here and was concerned with what I have witnessed .

This is only my opinion on the "Other Walter Reed". I have seen alot of soldiers in my shoes here though. I feel assured and I have great faith that the leaders involved in this decision making will make sound decisions.

March 11, 07

My grandfather once told me that a person should always start a critical statement by saying something positive about the subject.

Here are the positives, Angela Mc Cann- social worker

Sergeant Dwayne Frost - platoon SGT, Lieutenant Colonel Stephan Blake -

Case manager, Doctor Oakes and Doctor Smith - Oral / maxial facial and Colonel Hamilton.

My grandfather also said don't white wash problems. Soldiers records are mixed up with other records. For example according to medical staff here at Walter Reed my husband has three more children and another wife in Arkansas. How can soldiers Be treated right when records in the computers are wrong. Updates punched in and promptly kicked out. Excuse me for the pun; It takes an act of congress and an act of God to correct these problems.

If you're National Guard that doesn't even work.

Families arrive at Walter Reed with no place to stay and little to no resources to help themselves or their families. I arrived at Walter Reed helping other families in this regard . Those who have successfully found other bases like Andrews Air force Base, with commissaries and Post exchanges have donated out of their own pockets . Items such as food cooking implements, cleaning supplies, personal hygiene items, baby supplies , entertainment and transportation. Simply because transportation to other bases are not so common knowledge and the location of said bases are as good of secrets the CIA would be proud of .

Getting anything accomplished requires navigating the Walter Reed Labyrinth. Offices and personnel close down switch around without notice and locations are not updated . Most of the time you end up navigating through the Walter Reed Labyrinth as blind as ships of old on a storm tossed sea.

Living at the Mologne House is a trip on the wild side in and of itself. If you actually get a real bed the box springs are busted up and the mattresses are all covered in mold, outlet boxes with no covers, case moldings falling off walls and only two or three people working there that actually speak clear English. In the out buildings there's mice, rats, mold , loose stair threads and unraveling

carpets all prepared to snag the unwary. One soldier fell down in the middle of the night as a result of the neglectful maintenance of this facility.

Exam rooms are accidents waiting to happen.While I am waiting for a doctor who might or might not arrive , I start cleaning his exam room.. Even though I could ask for a spare sponge and some 409 cleaning solution, because if nothing else cleaning helps pass the time.

The reason you do not hear from more soldiers is that they need to be if not healthy, at least not sick in order to be strong enough for the strenuous task of fighting a treacherous and dangerous course of action. Making themselves heard. Simple things like the use of soap and water and of gloves would keep infections down.

The wards however are the worst. The wards are infamously known for non-English speaking nurses. If you are on meds do not tell the nurses.

They screw up your schedule, giving you the meds that react poorly with the other meds at the same time. They do not know how to draw blood. They do not know how to do the simple things like draw blood. It takes them several attempts to get it correct. Missing the veins completely and inflation of your hands to get the medications into your stream are just a few of the mistakes that are recurring at Walter Reed. Or they just keep sticking you until you get upset with them. Then they put recommendations against you in the system. Like visits to building six.

For them to be a professional staff here, there are a lot of mistakes.

There solution for simple maintenance is just ridiculous. Trash overflowing no problem just kick it even further into the corner. Dirty laundry being full, no problem just pile it on top. Ward seventy-five seems to be among the worst. One woman I became friendly with Linda Foster die there. We, like the several other witnesses there, witnessed the neglectful and compromising situations the staff can put you in. Like the premature death of Linda Foster. Several of the staff members who knew Miss Foster verified what we saw and witnessed. Premature death. This woman who looking forward to going home in two to four weeks after several complications with this system of things, is now dead, at forty-eight .

Neglectful situation, "wrongful death" . I mean this is something serious, you are supposed to come here to get treated not suffer neglect but; Several of the situations my family, I and others have witnessed stated something otherwise.

This woman spent several hours in her own feces, because the nurses didn't know which nurse was assigned to her. When I reassess the situation , the situation becomes more clear that the common mentality is it's not me or my loved ones I much rather not deal with it. Until it cannot be avoided and it becomes evidently clear that the situation must be handled, and people start asking questions and necks are on the line. Mrs. Linda Foster died of a massive stroke that nurses may have been able to treat, had they been given the proper training to recognize the symptoms that were reported to them the night before. Responses to complaints about nurses are, well you know this is a nursing hospital are you refusing treatment.

Well contrary to popular belief, I disagree. You aught not give treatment, if you are not trained properly enough to give treatment.

Now, waiting in the surgical waiting rooms is no fun. Especially at night. It is a long way to food or drink, definitely when you are disabled. Everything in the hospital closes early except the snack machines that almost never work. So that doesn't do any good either. Then you have to fight the cockroaches for a seat on the couch or chairs for a place to sleep for the night. I reported this to nurses before, and in response, was told that roaches were common in old buildings. Keep in mind most of the people being treated here are here for long periods of time. Family members are here just as long. So a place to sleep for the night or several nights is a necessity.

Also certain clinics are infamous, in that they are power hungry, arrogant, rude and insulting. The TBI Clinic, The clinic for (Traumatic Brain Injury) is especially known for this. The staff in this clinic treat the patients as if they are brain dead idiots. Belittling them and insulting them. The staff of this clinic is guilty of making the soldiers wait for their test results. Forcing them to go back to the clinic, time after time, after, time, after time.

Months later they are degraded and insulted once more. With phrases like and I quote," Test results are inconclusive, and he didn't try hard enough. This is in writing in the reports. In trying to get the results of the reports and the tests, "You are to use the chain of command." Still with no results.

Recently I was called a liar by the manager of their clinic when I told him, we still didn't have the reports on the November testing this happened 28 of February 07. Now we are being told that we have to go through the TBI battery again; because oops it wasn't done right (Per case manager).

By the way; There is no therapy given for TBIs at Walter Reed . As for observing him, no one even asks how he's doing. Much less check on him.

MEB/PEB Process

Here's a few of the problems (I have numbered this section as we have not yet experienced the total humiliation of this process, seeing as we are still at the beginning of the process).

1)you need permission from the pueblo counselor to have surgery

2) pueblo counselors go on power trip

3) you are given short notice (1 hour) when ordered to appear for meetings

(so far, twice)

4) 72 hour period to read, understand, and sign your MEB (By the way;

They don't need your signature).

5) They don't need to have all the facts to do an MEB/PEB. For example:

No records from Iraq or Germany. (No doctor's reports or medical trans-

criptions; no surgical procedure notes or summaries or evac orders.)

My husband was injured in Ramadi, Iraq on 12 December 2005. Our family has lived here since that time; caught in a purgatory of not knowing what is going to come next. Archie was injured while loading jersey barricades for the election, when a u bolt broke loose and the barricade swung, basically crushing his head between it and another barricade. This resulted in a Traumatic Brain Injury- all the bones in his face were broken. We have tried going north to Vermont(home) on leave. The cold gives him such severe migraines that it scares me. It is the only time I've ever seen him cry. If Archie is discharged tomorrow we would be homeless. In June of 2006, our landlady asked us to give up the house we were renting as she didn't want the place setting empty. We found homes for the dog, and the cats; and put our possessions in storage. Even if we had our place in Vermont; I don't think Archie will be able to survive the winters there anymore. This situation preys on Archie's mind a s well as my own. We do have an old 1969 camper the four of us could live in. Though our 17 year old autistic son Michael may not like it. Tre'Maine helps

with him as much as he can, but Michael can be quite the handful (seeing as Michael's not receiving treatment or meds through the Echo program yet. He's still on the waiting list because regular service dependents have priority over national guard. Since we've been here; we've seen no museums or monuments because I can't figure out how to get around the crowds (since the war Archie has a hard time dealing with a lot of people) or the distances (I'm a disabled Vet in my own right; due to chrohn's disease, no large intestines and nerve damage in my legs and back it's hard to walk far distances). Archie is constantly aggravated, and upset with the system; different authority figures telling contradictory things; sending us on wild goose chases, and outright lying to us. In my husband's words he states our situation very clea r ly "We are dumpster-bound and hitting rock-bottom with no way out and nowhere to go."

Thank you

Barbara A. Benware

Good Morning,

I apologize for not being here in person today to give this testimony, but I was not able to make it back to the U.S. in time. As I sat down to write this and was deciding what to write I came up with the conclusion that there was really and truly nothing more for me say. I have been saying the same thing over and over again for years now to anyone that would listen except the media as I never felt it appropriate to go down that road but rather try to resolve the issues for the next generation of disabled veterans. . I am contacted frequently by former patients, and current patients looking for advice, guidance and assistance with their tragic situations that are the same situations my comrades and I faced while we were there. As I am contacted I always ask the appropriate questions such as have you notified you chain of command? Has your chain of command had adequate time to react? What other avenues have you pursued in trying to address the issues? After hearing their responses most cases are so ridiculous and have had so much effort put into them that almost every avenue has been pursued at this point I put them in contact with the GAO and Congress. The reason that I started out saying that I really had nothing to say is that I have said it all over and over again but either no one listens or cares at the level that is required to fix the problem. As from mine and others testimonies in the past it was clearly shown to the chain of command and the military machine what was wrong. The Committee on Government reform certainly gave them the opportunity and all the support they needed to fix it but once again years later here we are as a nation still discussing it and trying to fix it. I still go to Walter Reed at least every three months for follow on treatment and procedures and the one thing that is clear and evident is that the attitude of administration and I would make to like that very clear again as I did in my last testimony by the administration I do not mean the medical personnel as in my opinion the majority of Medical staff at Walter Reed are very competent and care, but are also facing the same battle as the patients of battling with the administration. What is clear and evident is that the general attitude of the administration is that we are a nuisance. The doctors will not tell you how understaffed they are or you won't hear the doctors say they are not going to perform extra surgeries, but the administration will surely tell you every excuses while this has not been fixed and have a hole brief, report and slides to show you if you ask. They will tell you the hours are too long, they have too many patients and that may be the case but no one forced them to work there. The examples are abundant but here are two to give you an understanding of the mindset of the command philosophy. 1. Go to the pharmacy and take a look for your self. As a disabled veteran you walk up to the pharmacy to receive your medication but first show your ID and get your number to wait. The hospital has a policy which is if you are in uniform you are seen first. Well considering the majority of people in uniform are administrators and the majority of disabled veterans being treated are not in uniform, the disabled handicapped veteran has to not only wait longer but healthy fit individuals get to go in front of the disabled veteran. Most times the disabled veteran is not in uniform not by choice but due to their wounds and disabilities received in defense of his country and those wounds or disabilities do not allow them to be in Uniform. Has anyone in the Command ever thought about having a disabled veteran handicapped system so the disabled veteran doesn't have to spend as much time waiting around and can go home and rest and recover and maybe feel a little special and appreciated for being seen first? After having to wait longer than the uniformed soldiers with which you once served but are now regarded as a nuisance your number is finally called and go up to the window to pick up your medication, if you were in a

normal hospital or pharmacy Walter Reed is meeting the standard. The difference is Walter Reed is not a normal hospital or pharmacy it is not treating normal people, Walter Reed is treating our nation's heroes. Just go look at the 25 year old patient on crutches standing at the window for 15 minutes shifting his weight from leg to leg or arm to arm to ease the pain and discomfort from their injuries or amputations, but look across the counter and the 25 year old healthy support person getting the medication and they are sitting comfortably in their chair joking and having fun while the disabled veteran is waiting on his crutches. Has the Command ever thought maybe have chairs for the patients to sit in while they are waiting for their prescriptions. When I go to my civilian pharmacy I go up to the counter and my order is ready in a bag, so why at Walter Reed do they call wounded disabled soldiers up to stand there while they get the medication. 2. The other example is go to Dunkin Doughnuts or Subway in the hospital and see how many administrative people let the same individuals go in front of them to ease their suffering? The way I was raised and brought up if you are somewhere and you see someone that needs assistance or handicapped it is normally the proper and courteous thing to do, to assist them and it is understood to allow them to go in front of you to make their difficult life a little less difficult. You mean that Walter Reed where the majority of the Army's severely wounded go to be treated cannot figure out that it might be a good idea to have a handicapped line? The command could easily make it a hospital policy to show the disabled they care. Are these trivial things, to normal people they are but not to wounded disabled veterans that have served their country honorably. What these two little examples show is the same problem not the specific problems but the problem with the command philosophy and mentality of the hospital to not have the patients comfort at the forefront. As I started writing this I said I really don't have much more to say as I have said it all over and over again so I will close with this. Please read all the former testimonies and read what they say. I do not know how much truth there is to the open source media reporting but what I have seen on the news and heard from the soldiers at Walter Reed now is that the same problems exist today as when I was there the huge difference is **the same excuses do not.** The old excuse was that the administration and command stated they did not know about all the problems. Well myself and several others did tell them so what is the excuse now for not taking care of my newest Hero's?

Thank you God bless my comrades in Arms, Congress and The President of the United States.

John Allen

Mr. TIERNEY. I also ask unanimous consent that the gentleman from Maryland, Representative Elijah Cummings, and the delegate from the District of Columbia, Representative Eleanor Holmes Norton, members on the full committee on Oversight and Government Reform, be allowed to participate in the hearing. In accordance with our committee practices, they'll be recognized after all members of the subcommittee. Without objection, so ordered.

So, getting down to business, let me first and foremost welcome everybody here and thank the brave soldiers at Walter Reed for allowing us to have this hearing at this facility. Thank you all for your service and your patriotism and your courage. Everybody here is mindful of what you've done and how you've answered the call for this country, without distinction from party or any other factor. You are an inspiration to all of us. And from the bottom of our hearts, we appreciate all you have done for our country and for each of us.

I also want to welcome the members of the National Security and Foreign Affairs Subcommittee. It was vital we convene a hearing at Walter Reed so we would be able to see and hear for ourselves whether or not what we've seen reported is actually accurate and true. While I intend that this subcommittee will conduct hearings and investigations into many areas of defense, homeland security, and foreign policy, I can think of no more important topic for our very first hearing than the proper care of our Nation's wounded soldiers.

I would like to start by playing a short video clip from the WashingtonPost.com Web site that I think indicates for us the seriousness of this matter.

[Video clip.]

Mr. TIERNEY. Walter Reed has long been perceived as the model of taking care of our Nation's soldiers when they return from battle. The Under Secretary is absolutely correct that the people respect and honor the service of the medical personnel and other staff that are here at the hospital. But when we look at the unsanitary conditions and some of the other situations in the living quarters, we find it appalling.

We also realize that not only is it flat wrong, but that it is the tip of the iceberg. Far too often, the soldiers at Walter Reed wait months, if not years, in sort of a limbo; and they must navigate through broken administrative processes and layers upon layers of bureaucracy to get basic tasks accomplished.

Today we're going to hear firsthand of the conditions and lack of respect for our soldiers and their families. I want to thank Staff Sergeant Dan Shannon, Corporal Dell McLeod and his wife Annette, and Specialist Jeremy Duncan for your bravery, for your service, for your sacrifice, and for sharing your experiences with us here on this panel today.

I understand that you are frustrated. I think we all understand that, and we respect that fact and we all understand why you are. Let me be clear: This is absolutely the wrong way to treat our troops, and serious reforms need to happen immediately.

Over the past month, the perception of Walter Reed has gone from the flagship of our military health system to a glaring problem. This subcommittee wants some answers.

I want to thank Major General Weightman, the former commander of Walter Reed; Lieutenant General Kiley, the Army's current Surgeon General and also a former commander at Walter Reed; General Cody, the Vice Chief of Staff of the Army and the Army's point person on this issue; and General Peter Schoomaker, the Chief of Staff of the Army, for being with us today. .

I look forward to hearing from all of you why our wounded soldiers have not been getting the care and the living conditions that they deserve. I also want to hear what we're going to do about it in the future.

I want to stress that this is an investigative hearing and not an inquisition. Our purpose is to get to the bottom of things and to get honest answers, and it will take our cooperative efforts, all of us working together to make sure that a broken system is fixed and fixed quickly.

That all being said, I do have serious concerns and many, many questions. First, is this just another horrific consequence of the terrible planning that went into our invasion of Iraq?

Did the fact that our top civilian leaders predicted a short war, where we'd be greeted as liberators, lead to a lack of planning in terms of adequate resources and facilities devoted to the care of our wounded soldiers?

Are we headed down the same path again with the President's surge? Or are we prepared this time for the increase of injuries, patients and wounded veterans? What concrete steps have been taken and are being taken, as a reaction to the surge, to make sure that every soldier gets cared for properly?

Did an ideological push for privatization put the care of our wounded heroes at risk? A September 2006 memorandum that this committee has obtained describes how the Army's decision to privatize was causing an exodus of "highly skilled and experienced personnel" from Walter Reed and that there was a fear that "patient care services are at risk of mission failure."

Did the fact that Walter Reed is scheduled to close in 2011 because of BRAC, the Base Realignment and Closure process, contribute to unacceptable conditions at Building 18 and elsewhere?

And with a Defense Department budget of $450 billion and more, this is not a case of there not being enough money to take care of our wounded soldiers; this is a case of the lack of the proper prioritization and focus.

More and more evidence is appearing to indicate that senior officials were aware for several years of the types of problems that were recently exposed in the excellent reporting by the Washington Post reporters.

These are not new or sudden problems. Rats and cockroaches don't burrow and infest overnight. Mold and holes in ceilings don't occur in a week. And complaints of bureaucratic indifference have been reported for years.

Moreover, this committee, under former Chairman Davis and Chairman Shays, have been investigating over the past several years problems faced by our wounded soldiers, including those at Walter Reed. And I want to thank those members for their leadership so far.

I also want to thank Congressman Peter Welch from Vermont and others who insisted that this committee have its first hearing out here at Walter Reed so we could see firsthand the conditions in question.

Where does the buck stop? There appears to be a pattern developing here that we've seen before: first deny, then cover up, and then designate a fall guy. In this case, I have concerns that the Army is literally trying to whitewash over the problems.

I appreciate the first steps that have been taken to rectify the problems at Walter Reed and to hold those responsible accountable. We need a sustained focus here, and much more needs to be done.

I also, unfortunately, fear that these problems go well beyond the walls of Walter Reed, and that there are problems systemic throughout the military health care system. As we send more and more troops into Iraq and Afghanistan, these problems are only going to get worse, not better, and we should be prepared to deal with them.

Let me conclude by thanking all the soldiers who all able to be with us here today for their sacrifice on all of our behalf. We all agree that our soldiers deserve the best possible care. So let's give them the respect and gratitude that they rightly deserve. They've earned it with their dedication, with their patriotism, and with their sacrifice.

With that, I yield to Mr. Shays or Mr. Davis for an opening statement.

Mr. SHAYS. Thank you, Mr. Chairman. I am going to defer my statement. I know we have a short agenda. We will just have one on each side, so I welcome Mr. Davis to make our statement.

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

HENRY A. WAXMAN, CALIFORNIA
CHAIRMAN

TOM DAVIS, VIRGINIA
RANKING MINORITY MEMBER

ONE HUNDRED TENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

2157 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6143

Majority (202) 225–5051
Minority (202) 225–5074

OPENING STATEMENT OF RANKING MEMBER CHRISTOPHER SHAYS

**"Is This Any Way to Treat Our Troops?
The Care and Condition of Wounded Soldiers at Walter Reed"**

Monday, March 5, 2007

Thank you, Mr. Chairman.

Over the past ten years, this Committee has investigated the care and treatment of our soldiers returning from battle. After each hearing, promises were made that things would get better.

Today we again discuss the care of our wounded soldiers. I thank each of the witnesses for being here to help us understand this process and where it's failing our soldiers. And, I especially thank you, Mr. Chairman, for holding this hearing and continuing the efforts of this Committee.

Nearly 150 years ago, Abraham Lincoln closed his second inaugural address with the following words: "[L]et us strive on to finish the work we are in, to bind up the nations' wounds, to care for him who shall have borne the battle and for his widow and his orphan…."

"To care for him who shall have borne the battle." Such was our duty 150 years ago and remains our duty today.

A number of investigations including our Congressional hearings have challenged whether that duty is being fulfilled. Reports of substandard conditions at Walter Reed Hospital have shocked the Nation.

According to *Washington Post* articles, "[in] Army Specialist Jeremy Duncan's room, part of the wall … hangs in the air, weighted down with black mold," and Building 18 is littered with "mouse droppings, belly-up cockroaches, stained carpets [and] cheap mattresses."

On top of that, records are regularly lost, per diems delayed, and uniforms the injured left on the battlefield have yet to be replaced. For Sergeant David Thomas, that meant "[spending] his first three months at Walter Reed [Hospital] with no decent clothes."

When we read these articles, we are appalled and ashamed because we know we have not fulfilled Lincoln's admonition to properly care for our soldiers.

Regretfully, this is not new news. But, what we must discuss today is just how outrageously bad some of these living conditions are and why some patients are locked in a system that is failing to respond because of an incredible amount of red tape.

Besides poor living conditions, our soldiers are being smothered by a bureaucracy that is not helping them. And, so, we want an answer from the Administration, what are we going to do to make things right for our injured heroes?

Every day, our men and women in uniform—and it's not lost on any one of us that many of these soldiers are just kids out of high school—put their Country before their families, their mission before their jobs at home, and their bodies before their futures. Every day, we ask our men and women in uniform to face death. And, they do this without question or hesitation because of their duty to their Country and their duty to each other.

In war, tragically, some are lost, and some are wounded quite seriously. And, how are some of our wounded repaid? Well, the photos of cockroaches and mold and mice droppings and crowded quarters got our attention, but this is only part of the story. The rest of the story is that our men and women are incarcerated in outpatient clinics indefinitely because the bureaucracy is not responding to their needs.

It is understood but it needs to be stated by each of us time and again: our mandate to our war-wounded has not changed from the first days of our Nation. We—whether legislators or the Administration or the Military's top brass—we as Americans owe an immeasurable debt to our men and women wounded and felled on the battlefield because they fought to preserve the rights and freedoms we enjoy.

When they return to the United States, their navigation through "the system" should be caring, straightforward, and timely, but it's not. It's time to fix this problem once and for all and to put Walter Reed and our soldiers back on the right track.

We have a tough and emotional hearing ahead of us today. And, I want to thank our witnesses from the Administration for their honesty and candor.

I want to state for the record that I recognize and value the incredible medical treatment our military personnel receive on the battlefield in Iraq and Afghanistan, in Germany, and here at Walter Reed. To put it simply, you perform medical miracles, and you give our wounded soldiers and their families hope and courage, and that is something each of us here on this dais applauds you for.

I also want to thank the wounded soldiers and their families for their patience, dedication, and sincerity. Each of you has demonstrated immense courage, and now we're asking you to show another kind of courage by speaking out about your experiences. You are heroes of the highest order for your service to your country on the battlefield and for your service to your fellow men and women in uniform who hopefully will never have to experience what you have had to endure.

Soldiers and families alike, you have borne the battle, and, now, as Lincoln proclaimed, let us strive to finish the work we are in, to bind up the nations' wounds and to care for you who have borne the battle.

Mr. DAVIS OF VIRGINIA. Thank you, Mr. Shays. And let me thank Chairman Waxman and Chairman Tierney for agreeing to convene this hearing at the Walter Reed Army Medical Center.

For too long, complaints about substandard and disjointed care for wounded soldiers have been treated as distant abstractions. Here, no one should be distracted by numbing statistics, soulless technical jargon, impersonal flow charts or rosy "good news" action plans. Here we get an unfiltered look at a torturous system that has proved so far stubbornly incapable of reaching the standard of care this Nation is honor-bound to provide returning warriors.

We meet on the grounds of a world-class, world-renowned medical institution. Walter Reed has a venerable tradition of scientific advancement and clinical success. No one cared for here yesterday, today, or tomorrow should doubt the skill and dedication of the doctors, nurses and administrative staff who labor every day to save lives and repair broken bodies and minds. The problems that bring us here today are the product of institutional indifference, not a lack of individual commitment.

Recent reports of decrepit facilities and dysfunctional outpatient procedures at Walter Reed amplified oversight work this committee started in 2004. Pay and personnel systems—it got that wrong far more often than right—were inflicting financial friendly fire on those returning from war. Some of those erroneous dunning notices found their way here. Men and women already struggling to regain their physical health were also being forced to fight their own government to protect their financial well-being.

Members of the National Guard and Reserve units have a particularly difficult time navigating this Byzantine, stovepiped, paper-choked process that was never intended to deal with so many for so long. The charts that we have lay out only part of the MedHold system. Apparently, among other prewar planning errors, the Pentagon somehow failed to anticipate that deploying unprecedented numbers of Reserve component troops into combat would produce an unprecedented flow of casualties.

As a result, the Defense Department has been scrambling ever since to lash together last-century procedures and systems to care for returning citizen-soldiers. But institutional habits and biases have proven remarkably impervious to demands for change. It took well over a year to stand up an ombudsman program to help guide soldiers and their families through a complex, confusing, and frustrating medical and administrative labyrinth involving mountains of forms and multiple Army commands.

Last October a systems analysis review team inspection of Walter Reed found no process to track submitted work orders, particularly for Building 18. They pronounced the facility otherwise safe and secure. That must have been remarkably fast-growing mold that we found in the Washington Post, in Building 18.

Two years ago, the Government Reform Committee heard testimony that concluded Army guidance for processing patients in medical hold units does not clearly define organizational responsibilities or performance standards. The Army has not adequately educated soldiers about medical and personnel processing or adequately trained Army personnel responsible for helping soldiers. The Army lacks an integrated medical and personnel system to

provide visibility over injured soldiers, and, as a result, sometimes actually loses track of soldiers and where they are in the process. And the Army lacks compassionate customer-friendly service.

The last one says it all and, sadly, appears to be as true today as in 2005.

And these problems are not unique to Walter Reed. Here, uncertainty over the use of contractors or decisions by the Base Closure and Realignment Commission may have contributed to staff turnover and attrition, but the crushing complexity and glacial pace of outpatient procedures and medical evaluation boards are Army-wide problems. Building 18 is one visible symptom of a far more insidious and pervasive malady. All the plaster and paint in the world won't cure a system that seems institutionally predisposed to treat wounded soldiers like inconveniences rather than heroes.

On the long road home from war, this is a place wounded soldiers and their families should be embraced, not abandoned. They should be healed and nurtured, not left to languish or fend for themselves against a faceless bureaucratic Hydra.

What will transform this dysfunctional uncaring arrangement into the compassionate effective medical and military operation wounded soldiers deserve? All our witnesses today will help find the answer to that question.

Those on our first panel speak from hard personal experiences. They have every reason to be disillusioned, even bitter about frustrations and indignities they endured or witnessed while captive to a broken process. Their testimony is one more selfless act of bravery, and we are profoundly grateful for their willingness to speak out.

[The prepared statement of Hon. Tom Davis follows:]

HENRY A. WAXMAN, CALIFORNIA
CHAIRMAN

TOM DAVIS, VIRGINIA
RANKING MINORITY MEMBER

ONE HUNDRED TENTH CONGRESS

Congress of the United States
House of Representatives

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
2157 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6143

Majority (202) 225–5051
Minority (202) 225–5074

Statement of Rep. Tom Davis
Ranking Republican
Is This Any Way To Treat Our Troops? The Care and Condition of Wounded Soldiers at Walter Reed
March 5, 2007

Let me thank Chairman Waxman and National Security Subcommittee Chairman Tierney for agreeing to convene this hearing at Walter Reed Army Medical Center. For too long, complaints about substandard and disjointed care for wounded soldiers have been treated as distant abstractions. Here, no one should be distracted by numbing statistics, soulless technical jargon, impersonal flow charts or rosy "good news" action plans. Here, we get an unfiltered look at a torturous system that has proved, so far, stubbornly incapable of reaching the standard of care this nation is honor-bound to provide returning warriors.

We meet on the grounds of a world-class, world-renowned medical institution. Walter Reed has a venerable tradition of scientific advancement and clinical success. No one cared for here – yesterday, today or tomorrow – should doubt the skill and dedication of the doctors, nurses and administrative staff who labor every day to save lives and repair broken bodies and minds. The problems that bring us here today are the product of institutional indifference, not a lack of individual commitment.

Recent reports of decrepit facilities and dysfunctional outpatient procedures at Walter Reed amplified oversight work this Committee started in 2004. Pay and personnel systems, that got it wrong far more often than right, were inflicting financial friendly fire on those returning from war. Some of those erroneous dunning notices found their way here. Men and women already struggling to regain their physical health were also forced to fight their own government to protect their financial wellbeing.

Members of National Guard and Reserve units have a particularly difficult time navigating this Byzantine, stove-piped, paper-choked process that was never intended to deal with so many for so long. Apparently, among other pre-war planning errors, the Pentagon somehow failed to anticipate that deploying unprecedented numbers of reserve component troops into combat would produce an unprecedented flow of casualties.

As a result, the Defense Department has been scrambling ever since to lash together last century procedures and systems to care for returning citizen-soldiers. But institutional habits and biases have proven remarkably impervious to demands for change. It took well over a year to stand up an Ombudsman Program to help guide soldiers and their families through a complex, confusing, and frustrating medical and administrative labyrinth involving mountains of forms and multiple Army commands. Last October, a Systems Analysis Review Team inspection of Walter Reed found no process to track submitted work orders, particularly for Building 18. They pronounced the facility otherwise "safe and secure." That must have been remarkably fast-growing mold found recently in Building 18.

Two years ago, the Government Reform Committee heard testimony that concluded:

- Army guidance for processing patients in Medical Hold Units does not clearly define organizational responsibilities or performance standards.
- The Army has not adequately educated soldiers about medical and personnel processing or adequately trained Army personnel responsible for helping soldiers.
- The Army lacks an integrated medical and personnel system to provide visibility over injured soldiers and as a result, sometimes actually loses track of soldiers and where they are in the process.
- The Army lacks compassionate, customer-friendly service.

That last one says it all, and, sadly, appears to be as true today as in 2005.

And these problems are not unique to Walter Reed. Here, uncertainty over the use of contractors, or decisions by the Base Closure and Realignment Commission, may have contributed to staff turnover and attrition. But the crushing complexity and glacial pace of outpatient procedures and medical evaluation boards are Army-wide problems. Building 18 is one visible symptom of a far more insidious and pervasive malady. All the plaster and paint in the world won't cure a system that seems institutionally predisposed to treat wounded soldiers like inconveniences rather than heroes.

On the long road home from war, this is a place wounded soldiers and their families should be embraced, not abandoned. They should be healed and nurtured, not left to languish or fend for themselves against a faceless bureaucratic Hydra.

What will transform this dysfunctional, uncaring arrangement into the compassionate, efficient medical and military operation wounded soldiers deserve? All our witnesses today will help find the answer to that question. Those on our first panel speak from hard personal experience. They have every reason to be disillusioned, even bitter, about frustrations and indignities they endured or witnessed while captive to a broken process. Their testimony is one more selfless act of bravery, and we are profoundly grateful for their willingness to speak out.

Mr. TIERNEY. Thank you, Mr. Davis.

The subcommittee will now receive some testimony from the witnesses before us today. I would like to start by introducing those witness on the first panel. We have Staff Sergeant John Daniel—or Dan Shannon—a resident of Walter Reed since he was injured near Ramadi, Iraq in November 2004; we have Mrs. Annette McLeod and her husband, Specialist Wendell "Dell" McLeod, Jr. from Chesterfield, SC. Actually, Mrs. McLeod will be testifying. Dell is here with us today; Specialist Jeremy Duncan, currently an outpatient at Walter Reed residence who was housed in Building 18.

Welcome to all of you. Thank you for coming and sharing your experiences here today. It is the policy of this subcommittee to swear you in before you testify. So I will ask you to please stand and raise your right hands.

[Witnesses sworn.]

Mr. TIERNEY. The record will please reflect that all of the witnesses so swore. I am going to ask that each of you now give a brief opening statement. We will start from my left with Staff Sergeant Shannon and Mrs. McLeod and Specialist Duncan. Statements are 5 minutes. If you can, please try to contain your remarks. Davis, of the subcommittee staff, to my left, is going to throw something in the air to get my attention when you get near that point in time. I will give you a signal. We do want to allow you to fully express yourselves.

Staff Sergeant Shannon, if you would please start.

STATEMENTS OF STAFF SERGEANT JOHN DANIEL SHANNON; ANNETTE McLEOD, WIFE OF CORPORAL WENDELL "DELL" McLEOD; AND SPECIALIST JEREMY DUNCAN

STATEMENT OF STAFF SERGEANT JOHN DANIEL SHANNON

Sergeant SHANNON. I hope that I can stay within those time constraints and, of course, more information with the written statement I submitted.

Mr. TIERNEY. All of the written statements have been entered in the record and will be there. Is your microphone on, sir? Thank you. You might want to move it a little bit closer to you if you could and that will be helpful.

Sergeant SHANNON. Better?

Mr. TIERNEY. Yes.

Sergeant SHANNON. All right.

Mr. Chairman and members of the committee, thank you for inviting me to testify today on issues at Walter Reed Medical Center. My name is Staff Sergeant John Daniel Shannon. I do go by my middle name.

What has brought me to speak is my personal ethic as a professional soldier. I will not see young men and women who have had their lives shattered in service to their country receive anything less than dignity and respect.

I was wounded while serving in Iraq with the 1st Battalion 503rd infantry regiment. We were conducting operations out of Habiniyah, Iraq and had moved to "Combat Outpost," a small compound on the southeast side of Ramadi. On November 13, 2004, I

suffered a gunshot wound to the head from an AK–47 during a firefight with insurgent forces near Saddam's mosque. The result of that wound was primarily a traumatic brain injury and the loss of my left eye.

I arrived at the Walter Reed Army Medical Center's ward 58 on or about the November 16, 2004. I was discharged in outpatient status on approximately November 18, 2004. Upon my discharge, hospital staff gave me a photocopied map of the installation and told me to go to the Mologne House where I would live while in outpatient. I was extremely disoriented and wandered around while looking for someone to direct me to the Mologne House. And eventually I found it.

I had been given a couple of weeks' appointments and some other paperwork upon leaving ward 58, and I went to all of my appointments during that time. After these appointments, I sat in my room for another couple of weeks, wondering when someone would contact me about my continuing medical care. Finally I went through the paperwork I was given and started calling all the phone numbers until I reached my case manager who promptly got me the appointments I needed. I soon made contact with the Medical Holding Company. At that time, I was then processed and assigned to the 2nd Platoon MedHold Company.

I was informed that my Medical Evaluation Board/Physical Evaluation Board would not continue until my face was put back together. This process is important to me because the results of the evaluation determines the percentage of my disability. During the time my injuries were being fixed, posttraumatic stress disorder symptoms started surfacing.

I was informed that the medical retirement process would not proceed until the PTSD was medicinally controlled. Months later, I was informed that my medical board paperwork, my medical board had to be restarted because my information had been lost. I began meeting with my new physical evaluation counselor Mr. Giess in late January and early February. He informed that my MEB needed to be stopped again until the plastic surgery and ocular prosthetic procedures were finished. Therefore, 2 years after first being admitted to Walter Reed, I am hearing the same thing about the process that I heard when I first began it 2 years ago.

I want to leave this place. I have seen so many soldiers get so frustrated with the process that they will sign anything presented to them just so they can get on with their lives. We have almost no advocacy that is not working for the government; no one that we can talk to about this process, who is knowledgeable and we can trust, is going to give us fair treatment and informed guidance. My physical evaluation counselor and the MEB/PEB process both here work for the government and have its interests, not our interests, in mind.

In my opinion, Danny Soto, who works in the Mologne House as an independent advocate for those of us going through the process, is priceless in the assistance he gives, but he is only one man. The system can't be trusted. And soldiers get less than they deserve from a system seemingly designed and run to cut the costs associated with fighting this war. The truly sad thing is that surviving veterans from every war we've ever fought can tell the same basic

story, a story about neglect, lack of advocacy, and frustration with the military bureaucracy.

Thank you again for allowing me the opportunity to share my experiences with this committee.

Mr. TIERNEY. Thank you, Staff Sergeant.

[The prepared statement of Staff Sergeant Shannon follows:]

Prepared Remarks of SSG John Daniel Shannon
Government Reform and Oversight Committee
U.S. House of Representatives

March 5, 2007

Mr. Chairman and Members of the Committee, thank you for inviting me to testify today on issues at Walter Reed Army Medical Center. My name is SSG John Daniel Shannon. What has brought me to speak is my personal ethic as a professional soldier. I will not see young men and women who have had their lives shattered in service to their country receive anything less than dignity and respect.

I joined the Army in late 1984 to earn money for college. Over the next few years I discovered something that I loved: service to my country. I got out of the Army on June 3, 1988, to pursue an education. While going to college I was a Reserve Officers Training Corps (ROTC) cadet and received a reserve commission as an officer in the Army. I became dissatisfied with the politics involved in serving as an officer and went into the Inactive Ready Reserve in 1993. After 4 more years chasing the American dream, I realized I needed to continue my service to my country. I reenlisted in August of 1997 with the intention of serving for as long as my health and abilities allowed. I have served at many different posts and countries around the world during the course of my career. I am trained as a unit Equal Opportunity representative, in Airborne operations, Air Assault operations, Jungle Warfare operations, and Sniper operations. I am also trained in the planning, coordination, and implementation of intelligence gathering operations; basic Infantry operations to include Light Infantry up to Mechanized Infantry; and Field Artillery Basic Officer operations.

I was wounded while serving in Iraq with the 1st Battalion 503 infantry regiment. We were conducting operations out of Habiniyah, Iraq, and had been moved to "Combat Outpost," a small compound on the Southeast side of Ramadi. On November 13, 2004, I suffered a gunshot wound to the head from an AK-47 during a firefight with insurgent forces near Saddam's Mosque. The result of that wound was, primarily, a traumatic brain injury and the loss of my left eye.

I arrived at the Walter Reed Army Medical Center's Ward 58 on or about the 16th of November, 2004. I was discharged in outpatient status on approximately the 18th of November, 2004. Upon my discharge hospital staff gave me a photocopied map of the installation and told me to go to the Mologne House, where I would live while an outpatient. I was extremely disoriented and wandered around while looking for someone to direct me to the Mologne House. Eventually, I wandered into a building near the Mologne House where I was given directions.

I had been given a couple of weeks of appointments and some other paperwork upon leaving Ward 58, and I went to all of my appointments during that time. After these appointments, I sat in my room for another couple of weeks wondering when someone

would contact me about continuing my medical care. Finally, I went through the paperwork I was given and started calling all the phone numbers until I reached my case manager, who promptly got me the appointments I needed. She was somewhat distressed because she hadn't been able to locate me since I had been released to outpatient status, even though the record indicated I had been making all of my appointments in the first two weeks since being discharged from Ward 58. I soon made contact with the Medical Holding Company. At that time I was in-processed and assigned to the 2nd Platoon, Medical Holding Company.

I was informed that the process for my medical retirement would not proceed until my face was put back together. This process (Medical Evaluation Board and Physical Evaluation Board [MEB/PEB]) is central to determining what benefits we receive for our injuries, i.e., whether we are classified as Return to Duty, Medical Discharge, or Medical Retirement status. I then went through periodic evaluations to determine what type of plastic surgery was going to be successful in preparing my face for receiving a prosthetic eye. Due to the nature of my injuries I was reevaluated every 3 months. During this evaluation, Post Traumatic Stress Disorder (PTSD) symptoms started surfacing. I was informed that my MEB/PEB would not proceed until the PTSD was medicinally controlled. Months later, I was informed that my MEB had to be restarted because my information had been lost.

I believe I was contacted by my physical evaluation counselor, Mr. Michael Thornton, informing me that we had to restart my retirement process because my paper work had been lost. This was another significant blow to my trust in that process—a process which seems designed specifically to reduce the government's cost of veteran care.

On the morning of January 1, 2005, I was questioned in my room by Army Criminal Investigation Division. They were investigating the death of a soldier a few doors down from me. At the time, it appeared to be a suicide. This lead to my efforts to work on better accountability for service members at Walter Reed.

The Medical Holding Company at that time was responsible for 900 or more patients. Platoons consisted of 100 to 200 or more personnel with one Platoon Sergeant working on accountability of those personnel every day. The company commander, Major Middleton, had an XO and, I believe, less than 15 staff members at that time. As a result of my seeking a squad leader position within my platoon I was moved to work with SFC Jason Alexander in the OIF/OEF platoon.

I had already been going to my old ward in the hospital every day to check on comings and goings in that ward. Because paperwork took so long to get to the Medical Hold Company, with a platoon staff of approximately 10 personnel, SFC Alexander and I implemented and ran a program to check every ward in the hospital on a daily basis to better track accountability. We would receive the patient report from the Aero-Medivac office every morning and use that in conjunction with the "white boards" on the wards to determine where service members had been sent upon discharge. We would meet with incoming evacuees to identify ourselves and offer whatever assistance they might need.

We provided patient escort to the Mologne House and ensured they were properly in-processed to the Medical Holding Company. We also briefed them on their responsibilities to maintain proper, daily accountability with us while being, first and foremost, in recovery for their injuries.

During the time I worked with SFC Alexander I became aware of several programs being run by volunteers to help soldiers and families in need while they are receiving medical care at Walter Reed Army Medical Center and other treatment facilities. Operation First Response (run by Cindy McGrew) and Operation Second Chance (run by Peggy Baker) are two of these programs. The compelling thing about their programs is that they "just help"—no convoluted paperwork and no excuses. Their mission is simply to give assistance. After dealing with the bureaucracy at Walter Reed and trying to get assistance from a system obviously overwhelmed by the number of wounded, these two individuals and their programs are a tremendous blessing to those in need. One of the extremely distressing things for service members wounded in combat is to seek assistance from people who are just going about their daily workplace activities without an apparent inner sense of understanding of what we're going through physically, psychologically, and emotionally.

In December of 2006, I was told there was a push to get anyone having been here more than a year done with their MEB/PEB and returned to duty, discharged, or medically retired. Having been here for over 2 years at that point, this was very encouraging news. I was under the impression that, based on the time needed for the process, I could expect to be medically retired by May of this year.

I began meeting with my new physical evaluation counselor, Mr. Giess, in late January and early February. He informed me that my MEB/PEB needed to be stopped until the plastic surgery and ocular prosthetic procedure was done. Therefore, 2 years after first being admitted to Walter Reed, I am hearing the same thing about the MEB/PEB process that I heard when I first began it two years ago. I find myself wondering why I've been here for all this time.

I feel like I've been lost in the system. I want to leave this place. I've seen so many soldiers get so frustrated with the process that they will sign anything presented them just so they can get on with their lives. By signing the documentation without fighting for the benefits they've earned they are agreeing, in writing, to the Army's determinations of their benefits. We have almost no advocacy that is not working for the government. No one that we can talk to about this process, who is knowledgeable and we can trust, is going to give us fair treatment and informed guidance. The physical evaluation counselors and MEB/PEB both work for the government and have its interests, not our interests, in mind.

I would like to mention Mr. Danny Soto at this point. He works as an advocate for those of us going through the process and is priceless in the assistance he provides. But he is only one man. The system can't be trusted and soldiers get less than they deserve from a system seemingly designed and run to cut costs associated with fighting this war. The truly sad thing is that surviving veterans from every war we've ever fought can tell the

same, basic story.

My wife constantly reminds me that I have benefits I've earned. Left to myself, I don't really care most of the time. My professional ethics as a Sergeant are: "My soldiers will always come before myself"; "confirm, deny, and never lie"; "no excuses, mission first"; and "no one is more professional than I." These ethics have dictated my growth, over the years, into a leader of personnel who truly believes in self-sacrifice. In fact, these very ethics guided my decision-making process on the day I was wounded, while making sure one of my men was not. Finally, these ethics lead me to seek help for a broken system in the only way I believe remains.

The command keeps talking to us about using the "open door policy." The open door policy is a system implemented by military leadership at all levels that allows soldiers to raise their concerns about any given situation. If that soldier's concerns are not satisfactorily met by a leader, that soldier can take those concerns to the next level of authority and continue this process until their concerns are addressed. I understand this policy and agree with its intention. However, during the time I've been here, I've seen the chain-of-concern passing our needs and concerns up the chain frequently. When changes are not made, the open door policy ultimately becomes a tool for leaders to squash problems and keep them in-house. Now, once this situation has been made public, the "powers that be" see fit to relieve some people of duty who are doing the best they can with what they've been given.

This is an obvious example of a broken system trying to survive when what it really needs is to be fixed. I lost the ability to trust the system and sought an open door that would bring public attention to the problems here. Things are now getting done. Some of the lower leaders at Walter Reed have paid a price—possibly with their very careers—as action is taken by higher levels of authority to show they are "fixing" the problem while, at the same time, trying to save themselves from accountability for their dereliction of duty. I believe that is an indicator of how the situation was handled in the past. And I quote, "There's not a problem until the wrong people have a problem with it." And, finally, sometimes the wrong people are made to pay the price for someone else's mistakes.

Thank you again for allowing me to the opportunity to share my experience at Walter Reed with this Committee.

Mr. TIERNEY. Mrs. McLeod.

STATEMENT OF ANNETTE L. McLEOD

Mrs. MCLEOD. Mr. Chairman and members of the committee, thank you for holding this hearing today. My name is Annette McLeod, and I am testifying today because my my husband Wendell has been through the nightmares of the Walter Reed Army medical system. I am glad that you care about what happened to my husband after he was injured in the line of duty, because for a long time it seemed like I was the only one who cared. Certainly the Army did not care. I didn't even find out that he was injured until he called me himself from the hospital in New Jersey. When the Army realized that they had made a mistake and sent him to Fort Dix instead of Walter Reed, they transferred him.

On September 23, 2004, Wendell was deployed on the Iraqi border and the 1/178th Field Artillery out of Greenville, SC. He had been a sergeant with the National Guard for 16 years when he was activated for this deployment. About 10 months into his tour he was hit in the head by a steel cargo door of an 18-wheeler while climbing in for inventory. The injuries were serious enough that he had to be evacuated to Germany under heavy medication. And after the hospital mix-up I just mentioned, he was sent to his apartment complex leased at Walter Reed.

I took a leave from my job and went to see him in the capacity of a nonmedical attendant, with Army approval. This was in August 2005. When I arrived to care for him, I found that he had no appointments scheduled with any Walter Reed staff. He had been assigned a social worker. But aside from the evaluation he received after his injury, the Army had just left him without any evaluation or opportunities and, therefore, no treatment. I complained and had him transferred to the Mologne House where he could get some help. He had back and shoulder injuries and mental problems. After being admitted to the Mologne House, he was tested for brain functioning comprehension. I remember how medicated he was when they gave him the test. Later the Army said the tests were inconclusive because he didn't try hard enough. We waited for 4 months to get those results.

He is a high school graduate. As I said before, he served in the National Guard for 16½ years, but the Army refuses to acknowledge that he suffered a brain injury. He freely told the Army that he was a Title I math and English student in grade school, meaning that he needed extra help with reading and math. But the Army has taken this information and used it against him. Over the months, we have listened in disbelief as the Army interpreted Title I math and English to mean that he has a learning disability. He was considered fit enough to serve in the National Guard for 16 years. He was fit enough for deployment. But now they are saying his mental problems he had before he went to Iraq.

In January 2006, he was sent to a neurological care facility in Virginia for 10 weeks, at my urging. Before he transferred, he received several shots in his back for his back injury. I was assured by the Army that this was the first of many treatments. But for 10 weeks while he was in Virginia, he didn't receive any more shots. Before leaving for Virginia, he was put on cholesterol medi-

cine, which he had no trouble with before, that required blood work every month to monitor his body's response. The required blood work was never performed and he had developed an allergic reaction to the medication, from which he sustained liver damage and gained 25 pound during those 10 weeks.

Back at Walter Reed, a doctor ordered an MRI to check the condition of his shoulder, but the case manager refused to do the MRI. Her reason was that it would cost the Army too much money. And the only followup for Wendell's back injury was the decision of the Army that he suffers from degenerative disk disease, a preexisting condition that they claim was unrelated to injuries overseas.

On October 28th, the Army and the National Guard retired him. He suffers from episodes of anxiety, forgetfulness, and very bad mood swings. He walks with a cane and with a limp.

Mr. Chairman, and members of the committee, American soldiers are injured every day in operations overseas. Every day, family members learn that their loved ones are coming home to them different than when they left. I am here for Wendell, but I am also here because family members should not have to go through this with a loved one that we have already been through. I thank you again for the opportunity to tell my story.

Mr. TIERNEY. Thank you, Mrs. McLeod.

[The prepared statement of Mrs. McLeod follows:]

Prepared Remarks of Annette L. McLeod
Wife of SPC Wendell W. McLeod, Jr
Government Reform and Oversight Committee
U.S. House of Representatives

March 5, 2007

Mr. Chairman and Members of the Committee, it is a distinct honor to be here to discuss the medical care of my husband and other wounded soldiers while at Walter Reed Army Medical Center.

My name is Annette L. McLeod. I am from Chesterfield, South Carolina, where I reside with my husband. His name is Wendell W. McLeod, Jr. Friends call him Dell for short. Until his medical retirement in October of 2006, he was a member of the 1/178th Field Artillery Unit from Manning, South Carolina. He has several Military Occupational Specialties and was deployed as a 92G (food services). He has been a soldier for 19 years and 10 months, with almost 17 of them being in the South Carolina National Guard. He sustained multiple injuries while serving in Kuwait near the Iraqi border. The most extensive injury was a traumatic brain injury, secondary herniated discs in the lower and upper back, and a ganglion cyst in the right shoulder. While his injuries aren't visible, they have caused him great difficulty with everyday life.

Dell may be the injured one, but we have both had a stressful and painful journey through the medical system at Walter Reed. After long conversations, we decided that I should tell our story so that retribution would not be taken against him during future evaluations. It is my hope that, by sharing our pain and our experiences, no more family members will have to suffer at the hands of the bureaucratic fiasco at Walter Reed.

Dell was injured on July 6, 2005, while doing inventory on a food transport truck. After receiving treatment and tests he was kept under observation by doctors in Kuwait and Germany. Many days later he was assigned orders to medivac to Walter Reed for further treatment. I was never notified of his accident nor his medivac until he was back in the United States. He called me himself from Fort Dix, Maryland. I find this very upsetting. Finally, on August 8, 2005, he came to Walter Reed. I took leave from my job and went to stay with him in Washington, D.C.

His appointments were very sporadic, and during this time he became very agitated. He had outbursts of anger and hostility, followed by tears and depression. He would get angry that he couldn't remember simple things, like someone's name or his medication. He would go from one emotion to the next, living next to me as though he were a stranger. I noticed that he would forget simple things like his hat and wallet. He would forget to brush his teeth. He would forget to shave. On several occasions I expressed my concerns to his case manager. I know what Dell is capable of, and I knew that there was truly something wrong with him. It wasn't until late September that the case manager made an appointment to have brain injury evaluations done. At my persistent urging, an

R-Bands test was run.

Dell also had numbness in his leg and could only move one of his arms a short range. He couldn't stand straight and would trip over his feet. Because I was persistent, doctors finally decided to run some tests. They did an MRI of his back and shoulder. They did an EMG on the lower back and he was scheduled for a pain management appointment and an epidural injection in his back. He received physical therapy for his shoulder and back and the epidural injection between September and December 2005.

We finally found out the results of the R-Bands test in December, 2005. According to doctors, something had gone wrong with the brain testing, and as a result Dell had to do a complete Traumatic Brain Injury (TBI) test. The test took 3 days to complete, 7 hours per day. I was not allowed to stay with him so I sat in the waiting room, waiting and watching. According to Dell, doctors asked him if he had always been a slow learner. He said no, but he did admit to being in Title I math and reading while in grammar school. The TBI clinic deemed his brain injury test inconclusive, saying that "he didn't try hard enough and that his lack of effort showed signs of over-exaggeration of his physical injuries." They stated that Dell appeared to be intellectually slow and that this was the cause of his problem. They also said he over-exaggerated his injuries so that he could get attention. The doctor concluded that Dell had a pre-morbid learning disability—in other words, that he had learning problems before his injury and not because of the injury—and within a few months his paperwork noted that, rather than being in Title I reading and math, he had been in Special Education classes. The doctors had labeled him as being retarded. This upset Dell terribly, because he knew that it was a lie. Lots of children have trouble learning math and reading in grammar school, but it doesn't mean they are retarded. I believe Dell received very little support during these tests, and for the 3 days he was taking them he did not receive his pain medication.

In January 2006, Dell's primary care doctor put him on cholesterol medication and told him to have bloodwork every month to make sure his liver wasn't affected. He was sent to Lakeview Virginia Neurocare for treatment, where he would receive compensatory measures to enable him to live independently. His case manager assured me that any treatment for the back or shoulder injuries, and the bloodwork, would be performed in Virginia. If not, the Army would bring him to Walter Reed for treatment. This never happened. By March 2006, Dell had no further injections in his back, no treatment for his orthopedic injuries, and no bloodwork for his cholesterol medicine. He was taken back to Walter Reed after being in Virginia for 10 weeks. After Dell was not able to meet some of the facility's goals for independent living, it was stated that he would need to live a supervised life and would need help with basic daily living tasks.

I also want to note that, while at Lakeview, another soldier befriended Dell and stole his social security number and password for several of our important accounts. It took me 6 months to get everything straightened out. When going to his chain of command, the comment I heard was: "How do I know you are not having marital problems?" It didn't seem to concern his commanders that I had no money to live on and that everything we had was at risk. Only one person in finance would help me stop this intruder from taking

everything we had. I was told I couldn't press charges because the money was transferred electronically and it wasn't put in the intruder's name. We could have lost everything. My husband didn't realize what had happened until I explained everything to him. He understood then that a soldier had stolen his social security number and password during a friendly chat and was able to access our accounts.

By late March, Dell's case manager had started his Medical Evaluation Board process without following up on his orthopedic injuries. Dell's case manager told him, "You have been here almost a year, it is time for you to move on and live the best you can with the injuries." Her favorite thing to say was: "The Veteran's Administration (VA) will take care of you, they are extremely good with long-term treatment."

Finally, in April of 2006, Dell got an appointment with the orthopedic surgeon to prepare him for possible shoulder surgery. The doctor ordered another MRI to compare it with the first. When the case manager was given the job of making his appointment, she denied him the test. She said that the Army doesn't have the money, and that she didn't feel the MRI would change anything. This particular case manager got upset with me for trying to explain to her that, if the doctor didn't think the test was necessary before scheduling surgery, he wouldn't have ordered it. Still, she simply denied him treatment.

By June of 2006 Dell had extremely high liver profile tests. Nobody had followed up with bloodwork after he was put on the cholesterol medication. On June 23, 2006, Dell was finally scheduled for a shoulder MRI. The test showed a ganglion cyst in the ball and socket joint of the right shoulder, and it had caused damage. The doctor said there was no need to do surgery, as the damage was non-repairable.

At this point, I began speaking with staff for this Committee. After a congressional investigation into our situation, the commander of the hospital and the brigade called me into a conference. They were more than eager to try to sort things out. We agreed that Dell needed more cognitive treatment but Walter Reed was not equipped for out-patient occupational therapy to help with the brain injury. He was set up by his case manager to get occupational and speech therapy at the Washington, D.C. branch of the VA. He was then given more brain injury testing to see if there had been a true honest effort put in originally. The head of the TBI clinic told me that, this time, the tests did find memory loss and cognitive deficiency consistent with a mild brain injury.

With the help of this committee, Dell was given a 50% disability rating, leaving his benefits intact. His ratings were as follows: anxiety disorder 30%, cognitive disorder and headaches 10%, chronic low back pain 10%, and chronic shoulder pain 10%. The brain injury itself didn't warrant a percentage at all, because the Army considered it a pre-existing condition and a matter of low intellectual capacity. I don't understand how the Army could consider Dell to be smart enough for deployment, but then claim the cognitive problems he now exhibits have existed from childhood. The Army put a label on him and pushed him to the side, denying him the treatment he needed. He admitted that he was in Title I as a child, but that never hindered him from serving in the military. He did his duty to his country, to the Army, and to his fellow soldiers, and now I want to

know: when will the Army do right by him? The other question I have is this: what happens to the injured soldiers who don't have someone to advocate for them, as I did for my husband? Someone needs to stand up against this broken system.

Before I close, I would like to tell you a little bit more about my husband. Dell is the kindest person I have ever known. Among his friends, he is known as an all-around nice guy. He has a simple life, working hard and trying to live comfortably. He worked while going through high school and still was able to graduate with his class. He loved sports, mainly football, fishing, and playing pool. He was always eager to lend a helping hand, making people feel special to be his friend. He loved to read and has a vast collection of books. He could make you smile with hardly any effort, and his own smile had such a beautiful glow. His father was a Marine. Dell loved the military and it was his dream to follow in his father's footsteps. He considered it an honor to serve his country and managed his paperwork and responsibilities on his own with no help from me. He took pride in his daily hygiene, often telling me: "This is the way the Army taught me to do it." He shined his boots until they sparkled. He held the record of expert shooter with the M-16 in his prior units and often was called "the master of shot." He loved the bragging rights that came with wearing the uniform. He wasn't afraid of anything.

Now I am married to a man I no longer know. Dell has become very timid, very vulnerable. There are few things that truly seem to make him happy. Most of the time he is in a daze, trying to find his way back to normalcy but not knowing how to accomplish the task. He has reminders pasted on the walls telling him to brush his teeth, shave, and take his medication. His "meds" are in a weekly and daily pill planner so that he knows he has taken them, but I have to double check everything behind him to make sure all is done and in order. He can't finish a project without help and he can't remember the things that used to be so important to him. He triple checks the locks to make sure he locked the doors. He is often scared of the dark. He has lost his life as he knew it, his freedom and his independence. He hasn't driven since the injury, and when somebody else is driving he constantly grabs the steering wheel in fear of traffic. He spends his life in his own little world, not knowing what is going on with the real world. His days are uneventful, unless I am able to compel him to get out and about. He spends his time being angry and not knowing how to vent his frustration. He just can't seem to adapt to society. He often overcompensates for his injury and tries to make excuses for being slow, or not remembering the simple tasks he has to do. We both know that the brain injury changed his life, but the bureaucracy of the Army pretends that its tests know better.

I have so much compassion and respect for the families of the injured and wounded soldiers. I realize the tremendous sacrifice that my husband and thousands of other soldiers made during the deployment. Risking their lives and being away from those they love so dearly to protect and serve our wonderful country and defending our freedom, they give so freely of themselves and ask so little of those at home and in our country. It concerns me greatly that the Army and the Medholdover system has let Dell and other National Guardsmen down. Forcing them to live in unsanitary conditions, and delaying and sometimes denying them medical care, jeopardizes their recovery and causes them more stress as they battle the mountains of paperwork, case managers, and doctors.

Thank you for you time. Again, I appreciate the opportunity to speak on my husband's behalf. I respect the work of the Committee and I know you will do what is right. Our time at Walter Reed is over, except for a re-evaluation in 2008. The others that follow in our path will have hopefully an easier path to walk, as we have already paved the way with our tears. I would not want anyone to go through the anguish we have suffered during our stay at Walter Reed. I do hope that the injured and wounded will receive better treatment than Dell received. I will never forget this journey, and I hope I never have to walk it again.

Mr. TIERNEY. Specialist Jeremy Duncan has opted not to give a statement so much as to respond to questions, and since we're moving on into the question and answer period now and we'll be under the 5-minute rule, alternating from one side to the other, I thought, Specialist Duncan, that I might start just by asking you, if you are willing to talk about it, could you tell us and this panel a little bit about what chain of events led you to become a patient at Walter Reed?

STATEMENT OF SPECIALIST JEREMY DUNCAN

Specialist DUNCAN. I myself was deployed in Iraq in Samara with the 101st 3rd Brigade reconnaissance. During patrol, came across an IED. I got blown up, and I came here, and since then I have no problems with medical care getting mixed from the problems I have had.

Mr. TIERNEY. What were the nature of your injuries?

Specialist DUNCAN. I had fractured my neck, almost lost my left arm, I got titanium drawn, lost left ear, and loss of sight in the left eye.

Mr. TIERNEY. Now I think many of us first learned of your situation by reading the Washington Post and the description of the physical conditions of Building 18 and the area where you were staying. Could you tell us on the record here today about those conditions in your room of Building 18?

Specialist DUNCAN. The conditions in the room in my mind were just—it was unforgivable for anybody to live—it wasn't fit for anybody to live in a room like that. I know most soldiers have just come out of recovery, have weaker immune systems. Black mold can do damage to people, and the holes in the walls, I wouldn't live there even if I had to. It wasn't fit for anybody.

Mr. TIERNEY. What did you do to try to get the room fixed?

Specialist DUNCAN. I contacted the building manager and informed them that there was an issue with my room. They told me they would put it in the system for a work order. I did that. A month went by. I asked them to do it again. He said he would put it back in the system. That went on two or three times. Finally, I had my chain of command from Fort Campbell who came and visited me, they seen it, made some phone calls to the person over here at Walter Reed. I don't know where it went and it still never got fixed. That's when I contacted the Washington Post.

Mr. TIERNEY. And after the Washington Post article was published?

Specialist DUNCAN. I was immediately moved from that room and the next day they were renovating the room.

Mr. TIERNEY. Do you have any personal thoughts about other ways that—to be put and implemented to assist soldiers that are new to the facility here?

Specialist DUNCAN. As in what perspectives?

Mr. TIERNEY. How to assist them in the services of information and getting that process working better than it apparently did for you?

Specialist DUNCAN. Keep following on through and keep bugging them about it. Let them know; keep letting them know until finally somebody gets sick of it and it finally gets done.

Mr. TIERNEY. Mrs. McLeod, you had a situation attempting to at least bring attention to Dell's condition and situation. Would you share that with us? Did you make known that you had some issues with his treatment and care? To whom did you go and what were the results with that?

Mrs. MCLEOD. I was very persistent. I went to his case manager. She even got tired of dealing with me. I went as far as the commanders. I went to the generals. Anybody that would listen to me, I would talk.

Mr. TIERNEY. Who was the commander here at that point in time? Was it General Farmer?

Mrs. MCLEOD. General Farmer, yes, sir.

Mr. TIERNEY. Did you go to General Farmer and express to him the difficulties?

Mrs. MCLEOD. Yes, sir, I did. I was at his office door several days, and each time they turned me around.

Mr. TIERNEY. And how do you mean turn you around?

Mrs. MCLEOD. They told me he did not have time to talk to me, there were other situations present at the time also. He knew of the situation, he knew of some of the conditions, and each time I went to him, they told me that he did not have time. He knew the situation, there was nothing he could do to help me.

Mr. TIERNEY. At some point in time, did you have a chance to meet with General Weightman?

Mrs. MCLEOD. I did. We were sitting in Burger King 1 day and we were enjoying the day. He had a day of leave, and so we were sitting there, and General Weightman walked up and my recollection he is a fine, honorable man. He had nothing to do with our situation. He was, in my perspective, being punished because he caught the tail end of it. Mr. Weightman, in my opinion, he was just shoved into a situation that was already there. And because there had to be the fall guy, he was there. He has never done anything to me. He never knew about my situation. When I asked him questions, he was more than willing to give me answers that I needed.

Mr. TIERNEY. I have about a minute left here. We have a rather antiquated system on time watching, because our lights aren't working.

Staff Sergeant, I wanted to ask you, I know that at some point you took matters in your own hands in trying to assist people that were just coming new to the facility. Could you tell us about what you did and what caused you to take that action?

Sergeant SHANNON. Well, after the young service member died two doors down from me New Year's of 2005, I had been looking at the system as it stood, and we were having up to that point over 100 or over 200 personnel at one platoon run by one E–7. Typically that type of level of authority is in charge of 30 to 40 personnel. And they had no E–6s, my job, underneath them to help them keep accountability of those personnel.

At that point I started asking my platoon sergeant at the time to give me 25 percent of the people in the platoon and let me help track them, because they've worked long hours just trying to keep track of everyone.

The primary problem with the system, starting with the hospitals, it takes days for the paperwork to catch up with the Medical Holding Company to let them know just that someone has gone outpatient to the Mologne House. I had already been going to my ward on a daily basis to see who was coming and going. When I asked for a squad leader position, they moved over me, over to work with a Sergeant First Class Alexander, in the OIF OEF platoon at the time; an outstanding NCO, by the way. And we implemented a program and eventually received 10 personnel to work underneath us that we checked every ward in the hospital every day, receiving the patient report from the Aero MedEvac Office here in the hospital to let us know incoming and outgoing personnel. We would meet with incoming personnel, identify ourselves, give them business cards, let them know if they had any questions they can contact us.

We implemented a program to provide escorts from the hospital over to the Mologne House; and the primary thing, some go to other hospitals. We identified those that were staying here and going outpatient to the Mologne House. When we identified them, we were able to contact them in the Mologne House and give them at that time a proper in processing.

Mr. TIERNEY. Thank you very much.

Sergeant SHANNON. You're welcome.

Mr. TIERNEY. Mr. Shays.

Mr. SHAYS. Thank you, Mr. Chairman, for holding these hearings and thank you, our witnesses, for coming and testifying under oath. You met with us before and you told us a number of stories that will be very helpful to this committee. I want you, Staff Sergeant Shannon, to just describe one example of the kind of attitude you encountered more often than you should have when you came and asked for information 5 minutes before an office opened up. Do you remember that story? Yes.

Sergeant SHANNON. I have an anger problem, and I think this is common across the board with the patients at the hospital. It is something these people are going to go through to some degree or a another. Forgive me. I have been told there was a time constraint problem, and I am talking quickly.

Mr. SHAYS. You needn't talk quickly. Take your time.

Sergeant SHANNON. OK. In the course of the work I did at the hospital, I became very familiar with how things worked in the hospital. I became a person that would take a new soldier around and showed them where they needed to go, who they needed talk to. Because if I didn't have the answers, I could send them to where they needed to go.

Mr. SHAYS. I am just going to interrupt you. You described that was quite common, that the soldiers helped other soldiers because they weren't getting the help from a caseworker or whomever.

Sergeant SHANNON. There just wasn't the staff at the time. The staff has increased significantly since that time, but still not enough staff. But at that point I was showing a new soldier who was also a patient in ophthalmology down to the office. It was 5 minutes before they opened. I just needed to ask the lady if a certain neuro-ophthamologist worked there. And she looked me up and down, in my opinion like a piece of dirt and said, come see me

when we open. I won't repeat what I said to her. I cussed a blue streak, and it took everything I had not to jump over the counter and smash the printer she was just using to copy.

Mr. SHAYS. Do you feel that was more typical, or an unusual kind of experience?

Sergeant SHANNON. Human nature indicates that in the course of any given day, in spite of your productivity, you will have the easiest day you could have. What needs to not be forgotten here is that there is a human issue involved with these guys, and the problem—and I apologize, I talk a lot these days. It takes me a while to get to the point. There is a hospital policy, that regardless of hours, this is a written policy at this hospital, regardless of whether they are on the clock or not, they will always provide assistance to patients when they require it. I found that out because my wife worked here.

Mr. SHAYS. That's the policy. You didn't feel it happened?

Sergeant SHANNON. No.

Mr. SHAYS. Let me ask you this: Almost all of you have said the help you received from the doctors when you received help was outstanding.

Sergeant SHANNON. Yes.

Mr. SHAYS. Would you agree, Sergeant? I mean—or Specialist Duncan?

Specialist DUNCAN. Yes, sir.

Mr. SHAYS. Mrs. McLeod, would you agree with that?

Mrs. MCLEOD. Fifty percent, yes.

Mr. SHAYS. Let me ask you this. You got the sense that you were being pushed out of the Active Army, the military facilities, to the VA. Describe to me your attitude about that and what positions you took.

Let me start with you, Specialist Duncan. You don't choose to leave the military.

Specialist DUNCAN. I'm not leaving the military at all, sir.

Mr. SHAYS. OK. This is something that is amazing to me. You told the military you had no intention of retiring. What was their reaction?

Specialist DUNCAN. They were kind of shocked. At first they said, well, we don't think you can stay in because of the conditions I had. But like I said, some of the doctors here helped me find the actual regulations on my conditions, and I meet the requirements to stay in, and therefore I am staying in.

Mr. SHAYS. So you don't have an issue of getting help from the VA. But first, thank you for wanting to stay in, thank you for having to argue to stay in, and thank you for your incredible service, all of you. And Mr. McLeod, thank you, sir.

Let me have both of you, Staff Sergeant, Mrs. McLeod, tell me whether you would prefer to have VA help or—help and why?

Mrs. MCLEOD. In our situation, the VA has absolutely been wonderful to him, but he was only referred to the VA because they refused him treatment here. My goal was to have him to receive his treatment because I felt that he would receive better treatment when he was on Active Duty because they stand first priority.

Mr. SHAYS. Thank you. I only have 30 seconds left. Sergeant Shannon.

Sergeant SHANNON. I will receive care anywhere I can get it.

Mr. SHAYS. What are you waiting for right now? Describe for us what you are waiting for.

Sergeant SHANNON. I'm waiting for the plastic surgery to be done to make my face capable of receiving a prosthetic eye and then they will start the procedure to start a prosthetic eye. They have given me the option to have the VA do it. I have a right to have it done before I am retired. And as a workaholic, I am not taking 30 days off from a job to have the surgery done.

Mr. SHAYS. You told us your biggest concern. What is your biggest concern right now?

Sergeant SHANNON. My biggest concern is having the young men and women who have had their lives shattered in service to their country getting taken care of. Thank you.

Mr. SHAYS. Thank you. Mr. Waxman.

Mr. WAXMAN. Staff Sergeant Shannon, that's your biggest concern and that has to be the biggest concern of all Americans. I think that people were shocked when they heard about the Washington Post story of the deplorable conditions here at Walter Reed. And some of the reactions to those news reports have been, we never knew things were out of hand.

Now, I can't understand that when we get officials that say they just didn't know things were happening, that was so shocking because I have—and I am going to ask the chairman to make it part of the record—I have a long list, a stack of reports and articles that sounded the alarm bells about what was going on here and around the country.

Example: In February 2005, Mark Benjamin wrote an article in Salon Magazine, describing appalling conditions and shocking patterns of neglect in ward 54, Walter Reed's inpatient psychiatric ward. Another report from Salon in 2006 warned that soldiers with traumatic brain injuries were not being screened, identified or treated, and others were being misdiagnosed, forced to wait for treatment, or called liars.

And then we have in June 2006, Military Times ran a story reporting on problems with the Physical Evaluation Board process. In 2005 RAND issued a very comprehensive report for the Secretary of Defense finding that the military disability system is unduly complex and confuses veterans and policymakers alike. And then the GAO, the Government Accountability Office, found inadequate collaboration between the Pentagon and the Veterans Administration to expedite vocational rehabilitation services for seriously injured service members.

The GAO did some other reports as well, because in February 2005, GAO reported on gaps in pay and benefits that create financial hardships for injured Army, National Guard and Reserve soldiers. And in March 2006 GAO warned that a quarter of the Active Duty soldiers and more than half of reservists and guardsmen do not get their cases adjudicated according to Pentagon guidelines.

And in April 2006, GAO reported that military debts posed significant hardships to hundreds of sick and injured soldiers serving in Iraq and Afghanistan.

And in May 2006, GAO issued a report on problems with the transition of care between the Pentagon and the Veterans Adminis-

tration. And in fact, 2 weeks ago, the Army Inspector General revealed an ongoing investigation of problems with the Physical Evaluation Board system and investigation which has also identified 87 problems with the medical evaluation system.

Even Congress acted on this issue. The 2007 Defense Appropriations bill called for Physical Evaluation Board members to document medical evidence justifying disability ratings rather than simply allowing them to deny disabilities by writing preexisting conditions, the kind of problems your husband had, Mrs. McLeod.

Despite all of these press reports, studies and investigations, it took the Washington Post finally to capture people's attention, and they deserve an enormous amount of credit for what they've done. But despite all the work that went on before, top Pentagon officials reacted to the reports at Walter Reed 2 weeks ago by claiming surprise.

Let me just read what the Pentagon's highest civilian official in charge of the military medical program said in a press conference. Dr. William Winkenwerder Jr. the Assistant Secretary of Defense for Health Affairs, said: This news caught me, as it did many other people, completely by surprise.

Well, my question for the three of you or whoever wants to respond, what is your reaction to these kinds of statements? What is your response to top military officials when they claim they had no idea that there were any of these kinds of problems? Sergeant Shannon.

[The information referred to follows:]

Behind the walls of Ward 54

They're overmedicated, forced to talk about their mothers instead of Iraq, and have to fight for disability pay. Traumatized combat vets say the Army is failing them, and after a year following more than a dozen soldiers at Walter Reed Hospital, I believe them.

By Mark Benjamin

February 18, 2005 | Before he hanged himself with his bathrobe sash in the psychiatric ward at Walter Reed Army Medical Center, Spc. Alexis Soto-Ramirez complained to friends about his medical treatment. Soto-Ramirez, 43, had been flown out of Iraq five months before then because of chronic back pain that became excruciating during the war. But doctors were really worried about his mind. They thought he suffered from post-traumatic stress disorder after serving with the 544th Military Police Company, a unit of the Puerto Rico National Guard, the kind of unit that saw dirty, face-to-face combat in Iraq.

A copy of Soto-Ramirez's medical records, reviewed by Salon, show that a doctor who treated him in Puerto Rico upon his return from Iraq believed his mental problems were probably caused by the war and that his future was in the Army's hands. "Clearly, the psychiatric symptoms are combat related," a clinical psychologist at Roosevelt Roads Naval Hospital wrote on Nov. 24, 2003. The entry says, "Outcome will depend on adequacy and appropriateness of treatment." Doctors in Puerto Rico sent Soto-Ramirez to Walter Reed in Washington, D.C., to get the best care the Army had to offer. There, he was put in Ward 54, Walter Reed's "lockdown," or inpatient psychiatric ward, where the most troubled patients are supposed to have constant supervision.

But less than a month after leaving Puerto Rico, on Jan. 12, 2004, Soto-Ramirez was found dead, hanging in Ward 54. Army buddies who visited him in the days before his death said Soto-Ramirez was increasingly angry and despondent. "He was real upset with the treatment he was getting," said René Negron, a former Walter Reed psychiatric patient and a friend of Soto-Ramirez's. "He said: 'These people are giving me the runaround ... These people think I'm crazy, and I'm not crazy, Negron. I'm getting more crazy being up here.'

"Those people in Ward 54 were responsible for him. Their responsibility was to have a 24-hour watch on him," Negron said in a telephone interview from his home in Puerto Rico. While Soto-Ramirez's death was by his own hand, Negron and other soldiers say the hospital shares the blame.

In fact, repeated interviews over the course of one year with 14 soldiers who have been treated in Walter Reed's inpatient and outpatient psychiatric wards, and a review of medical records and Army documents, suggest that the Army's top hospital is failing to properly care for many soldiers traumatized by the Iraq war. As the Soto-Ramirez case suggests, inadequate suicide watch is one concern. But the problems run deeper.

Psychiatric techniques employed at Walter Reed appear outmoded and ineffective compared with state-of-the-art care as described by civilian doctors. For example, Walter Reed favors group therapy over one-on-one counseling; and the group therapy is mostly administered by a rotating cast of medical students and residents, not full-fledged doctors or veterans. The troops also complain that the Army relies too much on pills; few of the soldiers took all the medication given to them by the hospital.

Perhaps most troubling, the Army seems bent on denying that the stress of war has caused the soldiers' mental trauma in the first place. (There is an economic reason for doing so: Mental problems from combat stress can require the Army to pay disability for years.) Soto-Ramirez's medical records reveal the economical mindset of an Army doctor who evaluated him. "Adequate care and treatment may prevent a claim against the government for PTSD," wrote a psychologist in Puerto Rico before sending him to Walter Reed.

"The Army does not want to get into the mental-health game in a real way to really help people," said Col. Travis Beeson, who was flown to Walter Reed for psychiatric help during a second tour with one of the Army's special operations units in Iraq. "They want to Band-Aid it. They want you out of there as fast as possible, and they don't want to pay for it." Indeed, some psychiatric patients at Walter Reed are given the option of signing a form releasing them from the hospital as long as they give up any future disability payments from the Army. One soldier from Pennsylvania, who was shot five times in the chest and saved by body armor, told me he would do anything to get out of Walter Reed, even relinquish disability pay. "I'll sign anything as soon as I can get my hands on it," he told me several days before being released from the hospital. "I loved the Army. I was obsessed with it. The Army was my life. Fuck them now."

The conditions for traumatized vets at the Army's flagship hospital are particularly disturbing because Walter Reed is supposed to be the best. But leading veterans' advocate and retired Army ranger Steve Robinson, executive director of the National Gulf War Resource Center, agrees that when it comes to psychiatric care, Walter Reed doesn't make the grade. "I think that Walter Reed is doing a great job of taking care of those suffering acute battlefield injuries -- the amputees, the burn victims, and those hurt by bullets and bombs," said Robinson, who has spent many hours visiting psychiatric patients at Walter Reed. "But they are failing the psychological needs of the returning veterans."

Walter Reed officials declined requests for interviews, although two spoke to me on the condition of anonymity. In written statements to Salon, Walter Reed said the mental and physical health of patients is the hospital's top priority and described its PTSD treatment regimen as being in line with modern medical standards. The hospital said patients see both "board certified" and "board eligible" psychiatrists, including medical students and residents who "participate in the clinical activities on the ward as part of their training, and as is appropriate for their level of training and needs of the soldiers."

The hospital also cited a recent survey in which 42 out of 45 psychiatric inpatients surveyed, or 94 percent, felt that their care was either outstanding or good. "We are satisfied that there is a very high level of patient satisfaction with their treatment," the statement read. The hospital gave few details about the inpatient survey, such as whether it was anonymous, or whether the patients surveyed were even soldiers who recently fought in Iraq. (Inpatients can include military dependents or soldiers who fought in wars decades ago.)

The high level of satisfaction among inpatients as reported by Walter Reed is completely opposite what I saw and heard while tracking soldiers there over the last year. The soldiers I interviewed invited me to their bedsides in the lockdown ward. They handed over their private medical records. They allowed me to call their buddies, their girlfriends, their mothers. All professed to loving the Army, though some said their trust in the institution had been irrevocably shattered. All said their symptoms either stayed the same or worsened while at Walter Reed; two said they made suicide attempts. While it's true that patients' self-reports about treatment are not always objectively based, the repeated, bitter complaints I heard over the course of more than a year, in combination with conversations with civilian experts, cast serious doubts on Walter Reed's approach to treating PTSD sufferers. It all convinced me that something is seriously amiss at the Army's top hospital.

Politicians and celebrities -- like Dale Earnhardt Jr., ZZ Top and President Bush -- routinely visit the wounded at Walter Reed; but dignitaries don't come to Ward 54. When I first visited the lockdown unit in February 2004, it held around 35 patients, who slept as many as six patients to a room. Most patients stay in lockdown for just a few days, then are moved to rooms in hotel-like facilities to get treatment at the Walter Reed outpatient clinic, known as Ward 53. Within the lockdown unit, doors were kept open so that the patients who padded around the linoleum floors in Army-issued slippers, pajamas and robes could be observed at all times. Patients in various states of consciousness, from alert to near catatonic, sat around a television in a communal room. Some wore bandages from what other soldiers said were self-inflicted wounds. Patients were not allowed near the twin electric doors to Ward 54; these open by a buzzer from the nurses' station, staffed 24 hours a day.

Soldiers who have stayed in the lockdown unit say they were heavily medicated the entire time. Some remember hearing screaming, or patients being subdued on stretchers after shock therapy. "Inpatient can be a traumatic experience for anyone," said Lt. Jullian P. Goodrum, 34, who was in Ward 54 last February after serving in Iraq. Records show Goodrum was held in the ward 13 days longer than needed while the Army decided whether to charge him as absent without leave when, after getting back from Iraq, he was earlier hospitalized by a civilian psychiatrist. He is fighting those charges.

The soldiers told me about their textbook symptoms of PTSD: sudden, ferocious bouts of rage, utter detachment, anxiety attacks accompanied by shortness of breath, and increased perspiration and rapid eye movement. They complained of relentless insomnia, racing thoughts, self-loathing, blackouts, hallucinations and the constant reliving of war through

flashbacks by day and nightmares at night. Some described vivid fantasies of violence toward the Army brass in charge of patients there -- slicing their throats, throwing them out windows or shooting them. One psychiatric outpatient, who watched as his best friend was blown up by a roadside bomb in Iraq, said: "It does not matter how hardcore you are. Once you go to that war and you start to see dead bodies -- you see an arm over here, you see guts over there. There is no way you are ever going to erase that."

When it is done right, PTSD treatment is a delicate task. Trust is crucial, and medications are carefully administered and monitored. Most critical is getting patients to control the powerful and destructive emotions that can follow a traumatic event like fighting a war. What bewildered the soldiers at Walter Reed, though, was that the Army seemed determined to downplay their war trauma and search for other causes for their mental health problems. In group therapy, sessions often focused more on family relationships and childhood experiences than war, the soldiers said. One outpatient soldier was so angered about this avoidance of the topic of war, he threw a chair during group therapy. Doctors promptly sent him to lockdown.

"When you get [to Walter Reed], they analyze you, break you down, and try to find anything wrong with you before you got in" the Army, said Spc. Josh Sanders, in a telephone conversation from his home in Lovington, Ill. "They started asking me questions about my mom and my dad getting divorced. That was the last thing on my mind when I'm thinking about people getting fragged and burned bodies being pulled out of vehicles," said Sanders. "They asked me if I missed my wife. Well, shit yeah, I missed my wife. That is not the fucking problem here. Did you ever put your foot through a 5-year-old's skull?"

Sanders, 25, served in Iraq with the 1st Brigade, 1st Armored Division, from May until December 2003. I met him in the summer of 2004 while he was getting treatment at Walter Reed in the outpatient clinic. Sanders had been evacuated from Baghdad because of the toll the war had taken on his mind. His complaints about Walter Reed were sadly typical. "Nobody hears about this. Nobody hears about what really happens when you are there getting the 'premier' medical treatment," Sanders said.

Dr. Herbert Hendin, medical director of the American Foundation for Suicide Prevention spent many years studying and treating veterans with PTSD after the Vietnam War. In discussing their treatment, Hendin said, "What veterans need is not simply to be able to talk about their combat experiences but to be able to talk about them with someone who understands the context." Hendin said a combat veteran "needs to feel an empathic connection with the treating professional." But to the soldiers, the atmosphere in the Walter Reed psychiatric units wasn't conducive to feeling understood, or getting better.

In Ward 54, recent combat veterans are mixed with other soldiers and even civilians suffering a wide range of mental problems. For them, coming back from Iraq and being treated alongside soldiers with schizophrenia, for example, or maybe even soldiers' dependents with schizophrenia, makes them feel "crazy," as opposed to having a natural reaction to combat stress. "If you are a hard-charging person, or somebody who tries to

do things right, you are already taking a huge hit to your ego by being put in there," Beeson, the Army colonel, told me. One of the two Walter Reed officials who spoke on condition of anonymity agreed that recent combat vets shouldn't be lumped in with other psychiatric patients. Those soldiers "need to have a specialized unit," the official said. "They are labeled goofy and crazy, and they are not crazy."

Beeson served in Iraq with the Army's Civil Affairs Command, part of the Army's special-operations units. He is a 47-year-old reservist with 26 years of service under his belt, a wiry man grizzled by war. Beeson says his PTSD manifested during his second tour in Iraq. He was flown to Walter Reed. When I first met him in August 2004, heavy medication made him speak in slow, halting sentences like a drunk with a stutter. "A lot of the therapy was counterproductive to me," Beeson said in a telephone interview from his home in Arkansas, after getting out of Walter Reed. "It was a very paranoia-inducing place. If I was not paranoid when I got there, I was paranoid when I left ... To me, they need to figure out if they are going to treat people for war or be a regular hospital."

Josh Sanders, like the other soldiers I spent time with, also believes he is worse off because of his treatment at Walter Reed. "I don't trust anybody now ... I wish people could understand," he said. Sanders made two suicide attempts while under outpatient care at Ward 53. Hospital officials would not answer questions about the prevalence of suicide attempts at Walter Reed, but said two incidents that occurred there in January, one apparent fatal overdose and another suicide attempt, are under investigation. Two years ago, the case of Army Master Sgt. James Curtis Coons, also an outpatient, raised serious questions about how Walter Reed handles suicidal patients -- questions that persist today.

Coons was evacuated to Walter Reed from Kuwait on June 29, 2003, after swallowing sleeping pills in an apparent suicide attempt several days earlier. When he arrived at Walter Reed, he wasn't sent to the lockdown unit but to a room in one of the hotel-like facilities on campus. Coons, 36, promptly hanged himself. And although he had a doctor's appointment the next day, Walter Reed officials failed to look for Coons until July 4, so his body hung and decomposed until then. "A soldier coming in from a war zone does not show up for a doctor's appointment and they did not even check on him?" his mother, Carol Coons, said in a telephone interview from her home in Texas. "Until this is taken seriously, this is going to continue on. A psychiatric problem among those coming home from these war zones is just as deadly as a bullet." In a statement, the hospital said it has recently "enacted more stringent policies and procedures to strengthen outpatient soldier accountability"; for example, a Walter Reed staff member is now sent to check on patients who don't show up for appointments, the hospital said.

It's unclear how many combat vets are in need of PTSD treatment. But data from the Department of Veterans Affairs and a published Army study show at least one out of every six soldiers coming back from Iraq may have PTSD. (Many Army bases have psychiatric clinics, but some of the most serious cases go to Walter Reed.) Congress is responding with a flurry of bills that might help keep track of and treat the mental toll Operation Iraqi Freedom is taking on U.S. troops. Illinois Democrat Rep. Lane Evans' bill

calls on the military to use state-of-the-art methods to treat psychological injuries. Sen. Russ Feingold, D-Wis., would require the Pentagon to send reports to Congress on PTSD among troops because there is so little information on psychological injury rates.

Normally, soldiers discharged from the Army seek medical treatment from the Department of Veterans Affairs, which is widely understood to do a superior job at treating soldiers with PTSD. Because of the V.A.'s good track record, Steve Robinson of the National Gulf War Resource Center is asking Congress to put the V.A. in charge of treating soldiers with PTSD even before they leave the Army. Four of the soldiers I interviewed who left Walter Reed and later got treatment at the V.A. all praised the care they received there. They finally got a chance to talk one-on-one with other veterans about war, they said. Their medications were pared down, and their disability pay has been increased.

Indeed, the Army's system for allocating disability pay to traumatized vets is another source of their frustration and anger. An Army panel at Walter Reed, called the Physical Evaluation Board, decides what percentage of income each soldier should get from the military to compensate him if he is too ill to serve any longer. The doctors decide whether wounds are combat related, and then the board decides how much disability the Army will pay. The board's decision is critical for soldiers trying to make a living after leaving the Army with what can be a debilitating mental condition. Fighting with the hospital about disability pay is a source of considerable stress just as these soldiers are trying to heal their minds.

Some of the soldiers are fighting decisions by the board at Walter Reed. Out of the 14 soldiers interviewed, five have left Walter Reed. Three ended up getting zero percent of their income as disability pay, despite what they said was serious mental stress that made it more difficult or impossible to work. Even those who got a third of their pay still had trouble making ends meet. (In every case I followed, the Department of Veterans Affairs made a later determination that the soldiers deserved more. The soldiers can choose to take the higher percentage of pay from the V.A., but in some cases if they do so, they must pay back what they have received so far from the Army.)

After 26 years of service, the Army gave Col. Beeson, from the Army's Civil Affairs Command, zero percent of his income as disability pay for his mental wounds. Luckily, he still gets some retirement pay because of his many years of service, but he says he struggles with his injuries every day. He is appealing Walter Reed's decision.

Josh Sanders, from the 1st Armored Division, got 30 percent from the Army, but the Army also said his problems did not come from the war. "When I was over there [at Walter Reed] the PEB [Physical Evaluation Board] process was degrading. It is like pulling money from an insurance company. All my paperwork says 'non-service connected.' If it is non-service connected, then why am I getting 30 percent?" he asked. The V.A. recently decided to give him 70 percent disability.

One Army reservist I spent time with tried to return to his day job as a policeman after the war, but his mental state prohibited him from carrying a gun. The reservist cannot go back to policing, but since the Army decided his mental problems did not come from the war, the small percentage of disability pay he got is not enough to make ends meet, he said. He's hoping the V.A. will give him more.

René Negron, the former soldier who visited Soto-Ramirez before the suicide, was given 30 percent of his pay until February 2006, when he'll be reevaluated. Negron was a psychiatric patient at Walter Reed after 11 months in Iraq. At one point he checked himself into the emergency room there because he thought he might kill himself. But the Physical Evaluation Board determined that "the soldier's retirement is not based on disability from injury or disease received in the line of duty," according to a copy of Negron's evaluation board proceedings. "This disability did not result from a combat-related injury."

Negron, 48, taught hair care and cosmetology before serving in Iraq as an Army specialist with the Puerto Rico National Guard. Now, he says his debilitated mental state after the war has left him unable to work. He drives two hours each way for mental health treatment at a V.A. medical center. "You think I can live on $700 a month?" Negron asked. "I can't work. My wife is suffering. She can't leave me alone. Sometimes I feel suicidal. Sometimes I hear voices. Sometimes I see lights. I feel like I'm being shot at. They sent me home like that. I've been dealing with this since I got back," Negron said. "I left here in good condition. If I have a mental condition, they have to deal with it ... I did my part. Why can't they do their part?"

4 of 227 DOCUMENTS

Army Times

June 19, 2006 Monday

Who's fit for duty?; GAO finds medical evaluation boards inconsistent

BYLINE: By Kelly Kennedy; Times staff writer

SECTION: NEWSLINES; Pg. 18

LENGTH: 2095 words

Lt. Col. Mike Parker started having back problems eight years ago.

He couldn't carry heavy packs. He had to be near medical facilities. And he needed to keep his medication refrigerated.

He was sent before a medical evaluation board last fall to determine whether, after 18 years in uniform, he could still do his job and stay until retirement.

The board found he was fit for duty as an acquisitions officer. "and that was the end of the story," Parker said.

Almost.

While doing research about his disease, Parker found another service member, Air Force Staff Sgt. Robert Booth, who took the same medication for a similar autoimmune disease that causes back problems: Parker has reactive arthritis; Booth has ankylosing spondylitis.

But Booth's medical board found that because, like Parker, he needed to remain near medical facilities and refrigerated medication, he was unfit for duty.

Booth, an 18-year veteran, was medically discharged last fall with a 10-percent disability rating: no retirement, no medical benefits.

Parker said that made him realize he could have been the one "given the boot without retirement."

"I couldn't believe how low [others] were being rated," he said, emphasizing he spoke only for himself, not his command. Parker continued researching his disease and contacted other service members going through the medical evaluation process. He discovered the system was being swamped by thousands of claims filed by a new generation of soldiers.

From 2001 through 2004, the number of active-duty and reserve claims made with the Army Medical Evaluation and Physical Evaluation boards nearly doubled from 7,218 in 2001 to 13,748 in 2005

A soldier goes before a physical evaluation board if a medical evaluation board determines he is not able to do his job. The physical evaluation board then determines how much the Defense Department will compensate the soldier.

A report by the Government Accountability Office released in March found that no one is checking the consistency of the boards' decisions - whether some soldiers' claims are rejected as others with similar disabilities earn benefits, for example.

in April, the House slipped a section into the 2007 defense authorization bill aimed at helping soldiers make their cases during physical evaluation boards, a change Parker has been pushing for.

The House bill, seeking to expedite claims and bring some consistency to rulings rendered in cases involving similar medical conditions, mandates that physical evaluation board members document each item in their decisions, and that the secretary of defense establish training procedures for counselors who help soldiers through the board process. The bill also mandates changes to make sure decisions are handled in a timely manner and requires the secretary of defense to ensure the new policies are enforced.

An advocate for consistency

After his medical board ruled he could resume his military duties, Parker began spending his spare time digging into the cases of a dozen troops with the same disease.

he noticed the same patterns emerging - patterns that left the soldiers, sailors and airmen he talked with confused and sometimes bitter about the way their cases had been handled. He provided Army Times with documentation for a half-dozen of those cases.

Parker started making phone calls - a lot of phone calls - on the service members' behalf, and set up an in-person meeting with a House Armed Services Committee staffer in early December.

Randy Reese, national service director for Disabled American Veterans, said his organization is monitoring the defense bill and that he has worked with Parker. DAV provides civilian counselors for soldiers who request them during the physical evaluation board process.

"There's been a lot of change because of Lieutenant Colonel Parker," Reese said. "Service members often get low-balled because there are no checks and balances. I think there is room for improvement. It doesn't take a big regulation, just a little language and the impact can be dramatic."

Parker was diagnosed with reactive arthritis, a disease similar to "ankylosing spondylitis" in which the immune system response goes haywire and attacks beneficial protein along with invading bacteria. That causes the joints in the spine to inflame, triggering severe, chronic pain where the spine joins the pelvis.

Parker takes Enbrel, a drug that suppresses his immune system - which causes problems of its own. If bad bacteria attacks while he's taking Enbrel, his body can't fight back, which is why he needs to be near a medical facility.

"If I get shot," Parker said, "it's not good."

Parker said he believes the medical evaluation board members decided to keep him in uniform because, unlike the airman, he had reached retirement eligibility and would be paid whether he stayed active or left the service. Booth's low disability rating meant the Defense Department did not have to pay him retirement or disability pay.

Equal treatment

Parker's not arguing that Booth, who also takes Enbrel, should have kept his job. Rather, he just wants service members to be treated the same.

The proposed legislation in the defense authorization bill would do just that.

As he continued his research, Parker began posting information about the physical evaluation board process on a Web site for the Spondylitis Association of America at http://www.spondylitis.org/ and about a dozen men contacted him asking for help.

But rather than just tell the airmen, soldiers and sailors what to do, he volunteered to go through their paperwork, typed up point-papers to help them support their cases and met with their lawyers and counselors to explain the disease and the regulations that applied to it.

If necessary, he went to the evaluation boards with them. If they had already gone through the process, he wrote letters to doctors, Veterans Affairs Department officials and politicians to help the service members appeal their decisions.

Why do this? "No one else is," Parker explained. "With the war, the lawyers are backlogged and not well-informed about how the law works with all these different diseases."

In its March report, the GAO pinpointed several problems in the medical evaluation process:

. The Defense Department and the services do not have a consistent system in place to monitor the way cases are handled.

. The services do not have a formal training system set up for the people who help troops through the physical evaluation board process.

. The Army does not keep good statistics on how long it takes to process soldiers' physical evaluation boards, so it can't be determined whether they are handled in a timely fashion.

The Defense Department agreed with the recommendations, and William J. Carr, acting deputy undersecretary for military personnel policy, responded in a March 9 letter that the department would implement all of the GAO's recommendations.

Parker said the report hits on a lot of problems, but not all of them.

He points out that to receive retirement pay, a service member has to be rated at 30 percent disability or higher. That qualification is important for the monthly stipend, and more important, the lifelong medical benefits. Enbrel can cost $20,000 a year.

Full disclosure

In February, Army Capt. James Wollman received a severance package of $23,000 - no retirement benefits - because his physical evaluation board determined that his ankylosing spondylitis was a pre-existing condition.

He - and Parker - say it was not. Wollman's symptoms surfaced during physical training as an ROTC cadet in 1992.

At the time the pain was ruled not to be spondylitis, a ruling that was repeated in a 2001 exam when Wollman experienced similar pain.

He suffered similar symptoms again in 2003 while on a combat tour in Iraq, which led to a move from his position as a field artillery officer to a desk job. This time, he was diagnosed with spondylitis.

Meanwhile, he learned that his deployment medical records had been lost.

when Wollman started the medical evaluation board process, he told the doctors that he had received a waiver to get into the military. In fact, he realized later, there was no waiver. His college doctor said a waiver was unnecessary and that he was fit for duty.

The board used the waiver to show Wollman's pain came from a pre-existing condition, which means he can't be medically retired from the military and therefore can't receive medical benefits. Instead, he was found unfit for duty and processed out. He's awaiting his Veterans Affairs board to find out if he qualifies for benefits. When Parker found out, he walked Wollman through the regulations to try to help him with his case.

The proposed legislation could make sure soldiers like Wollman receive full documentation so that it's easier for them to say, "Hey, that's not right."

'A system gone astray'

In Wollman's case, the waiver error might have come out earlier if the board had been required to document it.

Lt. Col. Marie Domninguez, a surgeon with the 1st Armored Division, wrote a letter to the physical evaluation board on Wollman's behalf.

"I believe his findings have been based on an incomplete medical history and factual errors included on the narrative summary that were prejudicial to a fair and unbiased hearing," she wrote. "To me, it is an injustice to thoroughly evaluate someone for a condition, determine that it does not exist, bring them on active duty for seven-and-a-half years, and then determine that the illness existed all along, and that, therefore, he will not receive any VA coverage for the illness, nor qualify for insurance coverage under most policies."

But the letter brought about no change.

Disabled American Veterans spokesman Reese said the story isn't unusual.

"It can be a really trying time for people who are hurt to start with," he said. "We've been doing this since Vietnam, so it's nothing new for us. The inequities really come to light when you've got so many people going through the system."

As he waits to see if the changes to the defense authorization bill will make it through the process, Parker continues to post messages seeking out service members who need his help.

"Most of them wanted to stay in and serve their country," Parker said. "But the culture is 'They're sick, lame and lazy: You're not getting a retirement out of us.' This is only a tiny example of a system gone astray, and I think someone needs to call the Army on this."

Navigating the boards

The medical evaluation process can be confusing, but understanding it can mean the difference between staying in the military or being kicked out, as well as getting medical benefits after being discharged - or not.

Here's how the process works:

. A physician evaluates the soldier's injury or disease.

. The doctor's report initiates the medical evaluation board process. At least two doctors informally decide whether that soldier can return to duty. If so, he goes back to work - process over. That's all supposed to happen within 30 days of the first diagnosis, according to Army regulations.

. If not, the medical evaluation board doctors forward their evaluation of the solder deemed not fit to return to duty to the Physical Evaluation Board. The soldier selects a counselor, either from the Army or a civilian provided by the Disabled American Veterans. Without the soldier present, the Physical Evaluation Board conducts an informal assessment. Three voting members - a combat arms colonel, a personnel management officer and a physician - look at the evidence and decide whether the soldier is fit for duty. If so, the soldier is returned. If not, the board assigns that soldier a disability rating, based on injury- or disease-specific factors.

. If the disability rating is at least 30 percent, the soldier gets medical benefits for life as well as the same percentage of base pay.

If it is lower, the soldier receives a one-time severance payment, calculated by multiplying his number of years in service by his monthly pay, and then doubling the total.

. The soldier then talks with his counselor about whether he should accept the recommendations or request a formal hearing.The government does not argue its case against the soldier - the board is there to hear the evidence from the soldier.

If the soldier is still not satisfied, he can appeal to the Physical Disability Agency - the Department of Defense's oversight agency.

LOAD-DATE: June 29, 2006

LANGUAGE: ENGLISH

NOTES: 1 BW PHOTO. 1 COLOR GRAPH. GRAPH HED: DISABILITY EVALUATIONS. SEE AT-Disability Evaluations 06-19. 1 FACT BOX AT BOTTOM OF ARTICLE. FACT BOX HED: NAVIGATING THE BOARDS.

Copyright 2006 Army Times Publishing Co. Publishing Co.
All Rights Reserved

FOCUS - 1 of 3 DOCUMENTS

Salon.com

January 5, 2006 Thursday

Losing their minds

BYLINE: By Mark Benjamin

SECTION: Feature

LENGTH: 2885 words

HIGHLIGHT: More U.S. soldiers than ever are sustaining serious brain injuries in Iraq. But a significant number of them are being misdiagnosed, forced to wait for treatment or even being called liars by the Army.

After fighting in heavy combat during the initial invasion of Iraq, Spc. James Wilson reenlisted for a second tour of duty. Now 24 years old, he loved the life of a soldier.

In the fall of 2004, his 1st Cavalry Division was mostly fighting in Sadr City, a volatile sector of Baghdad. On Sept. 6, Wilson was manning a .50-caliber machine gun atop a Humvee when a bomb or bombs went off directly under the vehicle, rocking his head forward and slamming it into the machine gun. A fellow soldier told Wilson that his Kevlar helmet had been split open by the impact. The heat from one blast felt like "a hair dryer" on his skin, multiplied "times 20," Wilson later wrote in his diary. To the best of his recollection, the force of the blast also knocked the gun from its mount, smashing it into his leg.

Although battered in the attack, Wilson didn't appear badly hurt -- on the outside, at least. But in the days that followed, the young soldier from Albany, Ga., says he often felt "really dizzy, lightheaded and dazed." Two weeks after the battle, Army medics felt Wilson was suffering from post-traumatic stress disorder and evacuated him out of Iraq for medical evaluation. Wilson was first flown to Landstuhl Regional Medical Center in Germany, where wounded troops are stabilized, and then sent to Walter Reed Army Medical Center in Washington, D.C., in October 2004.

After arriving at Walter Reed, Wilson repeatedly told doctors that he had experienced a hard blow to the head during combat in Iraq. He suffered from symptoms strongly associated with a traumatic brain injury, which occurs when the brain is rocked violently inside the skull, tearing nerve fibers: seizures, short-term memory loss, severe headaches with eye pain, and dizzy spells that have made him vomit. During a visit to the Pentagon around Christmas 2004, Wilson got so dizzy he vomited "all over" the carpet while meeting Deputy Secretary of Defense Paul Wolfowitz in his office.

Despite Wilson's description of his injury and his symptoms, Walter Reed officials repeatedly questioned his mental state and the authenticity of his combat story. In a June 2005 memorandum from an Army Physical Evaluation Board, some Walter Reed doctors stated that Wilson exhibited "conversion disorder with symptoms of traumatic brain injury." Conversion disorder holds that symptoms such as seizures arise from a psychological conflict rather than a physical disorder. Col. James F. Babbitt, president of the Physical Evaluation Board, accused Wilson of

being a liar. "I believe that the preponderance of the evidence available to the Board supports an alternative diagnosis ... one of malingering," Babbitt wrote in that memo.

Wilson and his wife, Heidi, who has been staying with him at the hospital, vigorously fought the psychological diagnosis and furiously sought medical treatment. The malingering charge was especially painful. "I want my dignity, pride and respect back," Wilson says. After serving his country, being accused of misleading doctors, he says, "is the worst thing in the world."

Today, Wilson is thin and has a shaved head. He often clenches his eyes shut, as if to squeeze at the pain in his skull, or search out an elusive word or memory. Whenever a dim detail of his combat duty bubbles up in his mind, he types it into his diary. He holds his hands awkwardly, with his thumbs folded over his palms. His speech is at times slow and slurred. "I have been dealing with this all year because no one would help me," he says.

On Dec. 19, 2005, more than a year after he was admitted, Walter Reed finally sent Wilson to a neurological center to be treated for traumatic brain injury. Neuropsychological testing done at Walter Reed on Oct. 11, 2005, led officials to conclude that "there was no indication of malingering." According to a neurosurgeon with extensive experience treating combat head injuries, an October 2004 MRI of Wilson, combined with a description of his symptoms, showed that he should have been treated for a traumatic brain injury right then. Medical experts say the failure to treat a brain-injury victim promptly could hinder recovery.

Spc. Wilson is not alone among Iraq veterans who have been misdiagnosed or waited for treatment for traumatic brain injury. Other soldiers interviewed at Walter Reed with apparent brain injuries say they too have been deeply frustrated by delays in getting adequately diagnosed and treated. The soldiers say doctors have caused them anguish by suggesting that their problems might stem from other causes, including mental illness or hereditary disease. According to interviews with military doctors and medical records obtained by Salon, brain-injury cases are overloading Walter Reed. As a result, a significant number of brain-injury patients are falling through the cracks from a lack of resources, know-how, and even blatant neglect. Exactly how many brain-injured patients are being missed, going without care, or left waiting, as opposed to those who get prompt, top-shelf treatment, is difficult to say. Walter Reed officials and doctors say the Army is getting better at treating brain-injured patients but admit cases like Wilson's are a significant problem.

A November 2003 report from the Army News Service states that because brain injuries aren't always obvious, they "may be neglected, or even pushed aside as merely psychological." Patients with traumatic brain injuries "are suffering as much, but may not get the same support as someone who has an observable injury like a bullet wound or a broken leg," says Dr. Louis French, a neuropsychologist at Walter Reed, in the article.

One thing is certain: Due to today's military technology and insurgent tactics in the Iraq war, more U.S. soldiers than ever before are sustaining and surviving serious head injuries. In fact, traumatic brain injuries are a major problem among soldiers arriving at Walter Reed. According to the hospital's brain injury center, 31 percent of battle-injured soldiers admitted between January 2003 and April 2005 -- 433 patients -- had traumatic brain injuries. Half of those had what the hospital calls a "moderate, severe or penetrating brain injury."

In past wars, brain-trauma rates among combat casualties hovered around 20 percent, according to the Army. The rate of brain injuries among troops wounded in Iraq has shot much higher because the bomb, rather than the bullet, is the weapon

of choice for insurgents. In addition, today's better body armor and helmets save soldiers' lives in explosions that would have otherwise killed them.

Through a spokesperson, Walter Reed and other Army officials, including Col. Babbitt, who accused Wilson of malingering, declined to be interviewed. "We cannot discuss specific cases with anyone except the Soldier due to the Privacy Act and HIPAA [the Health Insurance Portability and Accountability Act], nor could we address the case or responsibilities of the president of the [Physical Evaluation Board] without violating some portion of HIPAA," wrote Lt. Col. Kevin V. Arata, an Army public affairs officer, in an e-mail. "Therefore, I cannot arrange an interview."

But according to a written statement that hospital officials provided to Salon, Walter Reed does have a plan to identify and treat brain-trauma patients. The military has a network of eight brain-injury rehabilitation programs under the rubric of the Defense and Veterans Brain Injury Center.

The program was created in 1992 to prevent brain-injured soldiers from being misdiagnosed as mentally ill, or missing treatment completely. Some brain injury patients get treatment from neurologists or neurosurgeons; others get treatment from physical, occupational and speech-language therapists. The hospital says it screens for brain trauma all patients who arrive at the hospital who were injured in blasts, vehicle wrecks or falls, or who have obvious, penetrating head wounds.

There are many success stories, says John DaVanzo, clinical director at Virginia Neurocare, a rehabilitation center in Charlottesville, Va., where Wilson is receiving treatment. "Yes, there are soldiers being missed," DaVanzo admits, but many others with brain injuries, who would've been overlooked in past wars, are being identified and treated. Still, working in partnership with Walter Reed, DaVanzo has seen the strain on the system during the Iraq war. "There is a massive influx of injured soldiers," he says. "People are overworked."

Walter Reed hospital is renowned for state-of-the-art technology and certain kinds of care. One Walter Reed physician tells Salon that the care for amputees at the hospital is "amazing," and praises the work of colleagues, adding that the nurses "work their butts off." However, the physician is worried that a distressing number of patients at the hospital with brain injuries aren't getting adequate screening and care, and says many doctors at the hospital know little about brain injuries and are prone to making a wrong diagnosis.

"A lot of things are missed because the doctors are swamped," the physician says. Many military doctors are away serving in Iraq or Afghanistan, and some patients are forced to wait too long for surgeries they need. "We're overwhelmed in terms of resources," the physician says. (Salon agreed to withhold the identity of the physician, who was not authorized to speak to the media, and feared retribution from the hospital.)

The delay in proper diagnosis and treatment for Wilson and others with apparent brain injuries is particularly troubling because patients tend to benefit from a prompt response. An April 13, 2005, article about brain trauma from the Department of Defense's own press service says that "if the injury is detected and treated early, most victims can recover full brain function, or at least return to relatively normal lives."

Traumatic brain injury can come from a car wreck, or when the sudden pressure from shock waves from an explosion collide with the fluid-filled cavity around the brain. Diagnosis can be tricky because the memory loss, personality change or depression that can accompany traumatic brain injury can also mimic other combat injuries connected with mental health, including post-traumatic stress disorder.

But Dr. Gene Bolles, a former chief of neurosurgery at Landstuhl Regional Medical Center in Germany, says it is plain wrong to place the burden of proof on wounded soldiers. Soldiers coming out of combat who say they've suffered a head blow and who show symptoms of traumatic brain injury should be treated for it, says Bolles. "You do what you can for them," he says flatly. "You believe them."

Bolles reviewed a summary of Wilson's October 2004 MRI from Walter Reed. He says it showed "evidence of loss of blood supply" to the brain and was "compatible with a head injury." Alongside Wilson's story and symptoms, he says, "This sounds like typical head injury syndrome to me; you can make that diagnosis."

He notes that the "shearing effect" on nerve tissue that comes with a serious head blow can be invisible to MRIs and CAT scans and that "there are no definitive tests that prove this syndrome." But soldiers even remotely suspected of having a brain injury, he says, should be treated aggressively for it, rather than with skepticism.

Bolles, who now practices at Denver Health Medical Center, treated U.S. soldiers evacuated from Iraq and Afghanistan for two years at Landstuhl. While many soldiers get good treatment, in other cases "the system is kind of like you have to prove yourself with an injury before anyone believes you," he says. "I wish we would accept the word of a patient if a patient says, 'This is what I'm feeling,' rather than trying to prove somebody is malingering." It is better to treat soldiers for what they say is wrong with them, he says, even if that means a few cheaters get through the system. Annette McLeod says her husband, Spc. Wendell McLeod Jr., was belatedly diagnosed with a traumatic brain injury. McLeod landed at Walter Reed in August after being hit by a truck in Iraq but was not diagnosed with a brain injury until December. "If you come in and are missing a limb, they know how to handle you," says Annette McLeod. "Anybody with injuries you can't see is shoved to the side."

McLeod says that to her knowledge her husband, Wendell, was not initially screened for brain injury, even though he'd been hit by a truck. But his behavior was so erratic and his memory was so horrible, she says, that she badgered doctors until they ran some tests that identified his problem. "I knew there was something wrong because of the changes in him," she says. "He kept saying, 'I can't remember. I can't remember.' This is a man who used to remember everything."

McLeod, 40, arrived at Walter Reed last August with a fractured vertebra, a chipped vertebra, four herniated discs in his back, and a shoulder injury. He also began suffering from bizarre mood swings. "I can't hardly remember anything," he says. Annette, who is staying with him at Walter Reed, took McLeod to the supermarket recently. "He walked down the aisle three times and could not remember what I asked him to get," she says. She makes her husband sit in the back seat of the car because ever since his accident he wildly grabs at the steering wheel.

McLeod was tested for traumatic brain injury in September but did not hear anything about the results until he was diagnosed in the first week of December. In the meantime, McLeod was told by officials that he might have been born with his brain problem. "They tried to say it was inherited," McLeod says. Annette says they were also told it could be psychological. The misdiagnosis and delays have been excruciating, she says angrily, with a lot of "just waiting around and waiting around and waiting around."

Sgt. Steve Cobb, age 46, tells a similar story. Injured in an armored personnel carrier accident in Iraq in 2004 while serving with the West Virginia National Guard, a head blow left him with short-term memory loss, hearing loss and the loss of peripheral vision in his left eye. He slurs his words and is so dizzy that he

walks with a cane. Medics in Iraq first missed his brain problem completely and gave him aspirin. He served another eight months after the accident.

Cobb arrived at Walter Reed last May. In July, he was diagnosed with traumatic brain injury, but did not start getting therapy until September. He says that he, too, was told by hospital officials that he may have been born with his problem. "They said it was hereditary," Cobb says with disgust.

His memory is so bad that his wife, Natalie, is afraid he can't take care of himself. She has left her 13- and 19-year-old kids at home with family in West Virginia to be with her husband at Walter Reed. "We heard it was brain disease. We heard it was hereditary," she says over dinner one evening at a restaurant near the hospital. "I feel that they are letting the traumatic brain-injury patients slide through the cracks."

The stress of being misdiagnosed can further harm soldiers, says Bolles, the neurosurgeon, especially if patients get stuck in a pattern where doctors are denying that their injuries exist. "That in and of itself becomes a disability to these people if they get angry and frustrated," Bolles says. "That alone makes it worth treating these people early."

Wilson came back from Iraq a totally different man, according to his wife Heidi. In a photo of the couple from before his injury, the two are sitting on the edge of a fountain. Wilson stares squarely at the camera with a deft, slight smile. Heidi, in a white dress, sits in his lap, holding a bouquet.

Wilson's injury has left him so sensitive to light that his room at Malogne House, a residential facility behind the main hospital at Walter Reed, looks cavelike, lighted only by two dim bulbs. Looking at bright light, Wilson says, "is like welding without your mask on." Sometimes even the dim bulbs are too much. "It kills him," Heidi says one evening in the room. "He puts little blankets over them." Heidi says her husband's brow turns a deep red during his worst headaches, which he says feels like his eyes are being sucked back into his skull. "I just want to take a drill and drill into my head," he says.

Sometimes Wilson remembers events from long ago, but not what happened five minutes ago. He still writes bits in his diary, attempting to piece his memory back together. He used to enjoy cooking Cajun food but now that's gone. "Everything tastes like rubber," he says. "I look at stuff I want to taste. I feel like I remember what it tastes like, but I can't." When Heidi is away for a few days, his memory loss and olfactory problems collide, though he tries to keep a sense of humor about it. "If she is away, I may not take a bath for six days, until she gets back," he says. Heidi nods vigorously. "I'll get his bath ready and say, 'Time to get in the tub,'" she says.

But when the conversation returns to Wilson's treatment, their smiles quickly fade. It's hard for them to believe, after two hard tours of duty, that this is the kind of treatment he has received. "I just want to be taken care of," he says. "I just want healthcare."

LOAD-DATE: February 20, 2006

LANGUAGE: ENGLISH

Copyright 2006 Salon.com, Inc.

Sergeant SHANNON. As you will read in my statement, I believe implicitly in an open door policy. The biggest problem they have with me is I have been here long enough to see things constantly go up the chain to be told—and I believe that is General Weightman's primary mistake. I don't think he should have been fired, but he said he did not know. That is not true in my opinion.

Mr. WAXMAN. Let me ask Mrs. McLeod, because I know I will be running out of time, what is your reaction when you have been trying to get people's attention to the situation for your husband, and now when we have it so clearly laid out in the press and there is attention being paid to it, the higher-ups say they are just sort of surprised to hear about all of this.

Mrs. MCLEOD. I have one question. Were they deaf? Because I worked the chain. I worked anybody that would listen. So they didn't—you don't want to hear, you don't hear.

Mr. WAXMAN. Specialist Duncan.

Specialist DUNCAN. There is no way they couldn't have known. Everybody had to have known somewhere. If they wanted to actually look at it or pay attention or believe, it was up to them.

Mr. WAXMAN. There is another statement that I find even more offensive. January 25, 2005, David Chu, the Under Secretary of Defense for Personnel and Readiness, was asked by the Wall Street Journal about the costs of military health insurance and pensions. In response he stated, "The amounts have gotten to the point where they are hurtful. They are taking away from the Nation's ability to defend itself."

What is your view of this statement? Do you believe honoring our service members by ensuring they are properly cared for lessens our Nation's ability to defend itself?

Sergeant SHANNON. Absolutely not. The cost of care for veterans should not come out of moneys that are designated to fight a war. The cost of care for veterans that are wounded in the course of fighting that war should come out of separate funds. If a certain amount of money—I mean, I don't work at that level. But if a certain amount of money is designated to fight a war, it needs to focus on the war, and there needs to be separate funds set aside; because if they're going to indicate they don't have the funds to do it, well, they need to separate—break the issue down. You can't take away from what the soldiers need over there. You can't take away from the soldiers' need over here, and you can't combine the cost because it is too much.

Mr. WAXMAN. Under Secretary Geren welcomed us this morning by saying that there is an Army military tradition that you leave no wounded soldier behind. This sounds to me like this particular man was saying that it is more important to fight, even if it means leaving some of our wounded brave men and women patriots behind in their health care or their disability.

I am very disturbed by what we're hearing and I am glad that Chairman Tierney has convened this hearing right here at Walter Reed. From what we're hearing, what is going on here at Walter Reed may be the tip of the iceberg of what is going on all around the country. People are flooding us with complaints that it is not just Walter Reed. Check out what is going on all around the country. And right now in Los Angeles, the Veterans Administration

wants to privatize the land rather than take care of the returnees and the veterans. Thank you.

Mr. TIERNEY. Thank you, Mr. Waxman. Mr. Davis?

Mr. DAVIS OF VIRGINIA. Well, thank you. And let me thank Mr. Waxman. As you know, a number of those GAO reports this committee requested, some of them coming from complaints from veterans that were stationed right here.

Mrs. McLeod, let me start with you. You went up the chain many times, didn't you?

Mrs. MCLEOD. Yes, sir.

Mr. DAVIS OF VIRGINIA. You finally called this committee, you were so upset.

Mrs. MCLEOD. I would talk to anybody that would listen. And it took the aid of another soldier who actually heard me cry, saw me cry 1 day. He said, this is a number. Make a call. And that is when I called Ms. Washbourne. And you know my story because you have dealt with me. Had I not had any other recourse, I wouldn't be here today.

The thing of the matter is, Mr. Harvey made a statement the other day that really bothers me. He said that he hoped the Washington Post was satisfied because they ruined careers. First, let me come on record by saying I don't care about your career as far as anybody that is in danger. That doesn't bother me. All I am trying to do is have my life, the life that I had, and that I know my life was ripped apart the day that my husband was injured. But then having to live through the mess that we lived through at Walter Reed has been worse than anything I have ever sacrificed in my life.

Mr. DAVIS. Thank you. She is referring to Grace Washbourne of our staff who used to help us by taking the lead in this when people weren't getting paid right, then they sic the bill collectors on them, people are afraid of losing their houses when they come back languishing. If they didn't have any warnings of this, they weren't paying attention, because as Mr. Waxman noted, we had a number of GAO reports that we authorized. GAO calls the balls and strikes for Congress, showing that this was a systematic problem.

Now I understand that Walter Reed holds town hall meetings. Could each of you tell us about these, who runs these meetings, who attends them, how they are advertised, how often they take place, what types of issues are discussed, and do problems get resolved?

Sergeant SHANNON. When I first got here, the wives at the Mologne House started meeting on Thursdays to have a wives' meeting to get issues addressed. That started doing some good. I've been here a long time. The PTSD issues started kicking in. They started having me stay at home. I have never been to a town hall meeting. I had an opportunity, just before the Dana Priest story came out, to go to a sensing session for NCOs and any service members. And I couldn't see the point in it. I have been here too long. It just hasn't done any good. So I didn't go.

Mr. DAVIS OF VIRGINIA. Any of you been to a town hall meeting?

Mrs. MCLEOD. I was the first wife that actually spoke up. I was the one that actually stated my piece because they had denied him treatment. They sent him to Virginia for 10 weeks for the brain in-

jury, and I looked Colonel Hamilton in the face and I told him, y'all must have thought you cured him because you haven't touched him since he's been back.

My thing is, he opened the floor and I blasted him with everything I had, because I was to the point. I really didn't care because it seemed like I had had enough. I was tired of fighting the system. I was tired of trying to help him get well. At the same time, they didn't seem to really care. They wanted him out of here. They wanted to turn him over to the VA.

His case manager at the time was Captain Regina Long. She got tired of dealing with me when he was in Virginia, because I started calling him 3 weeks—calling her 3 weeks before he'd come back from Virginia, letting her know what he needed, what he didn't need, what he needed to followup on. And she got so aggravated with me because there was a span that I had gone home to try to get things together there. She actually sent him home to keep from having to deal with him. She told me, she said, I cannot maintain him the way you want to maintain him. She said, so you—I am going to send him home until we can decide what to do with him, and we will probably turn him over to the VA.

I fought tooth and nail, and that is an old saying for me, because he should have been taken care of.

Mr. TIERNEY. Thank you very much. Thank you, Mr. Davis.

Mr. DAVIS OF VIRGINIA. I will just ask if Mr. Duncan wanted to respond to that.

Specialist DUNCAN. I have never actually been in a town hall meeting, sir.

Mr. TIERNEY. Thank you, sir. Mr. Lynch from Massachusetts.

Mr. LYNCH. Thank you, Mr. Chairman. I want to thank Chairman Tierney and Chairman Waxman and also Ranking Members Shays and Davis for holding this hearing. I want to thank the panelists for their willingness to testify and to help this committee with its work.

You really are speaking this morning not only for yourselves but everyone else in uniform. A lot of the Members up here have been over to Iraq a number of times. I have been over five times, and also Afghanistan. And I know a lot of these Members have gone with me. And one of the things that always struck me, whether we were in—at the Landstuhl medical facility in Ramstein, or whether we were in Balad visiting very severely wounded young men and women in uniform, they always talked about, well, it is is going to be OK once I get to Walter Reed. And there was just this gold standard and this confidence and trust in our military personnel that when they got to Walter Reed, it was going to be OK. They were going to get put back together, and they were going to have a maximum outcome, whatever their injuries were.

And I think these most recent revelations have been—well, it has been a real blow to that reputation. And so the task here for us—and together with your help, and I thank all the members of the military who are here today, and I appreciate their service to our country—our job today is to make this right. It is not just about doing the right thing. It is about doing the thing right and making sure that this process works.

One of the things that was stunning to me in going through all the testimony in previous hearings with the veterans groups is that for disability approval within the Armed Services, I noticed that the Marine Corps—well, it is actually the Navy, but the Marine Corps approves about 30 percent, 35 percent of its injured for temporary or permanent disability. The Air Force approves about 24 percent. But the Army, that had the largest number of Active Duty soldiers and reservists, put less than 4 percent. It is a massive difference, and it can't be, it can't be just random.

And I know each of you went through this process and also witnessed your fellows-in-arms together going through this process, and you saw how this was handled. I know the PTSD issue is out there, and that we saw less willingness on the part of the military to approve disability based on PTSD. Do you see a purposeful effort here to refuse the 30 percent disability that would bring, I think, dignity and the right benefits to those who are injured in uniform? I would like to just get your sense of it, whether this is a purposeful attempt to deny those benefits to men and women in uniform.

Mrs. MCLEOD. We were fortunate because I didn't give up. They had no intention of even compensating him for the cognitive dysfunction. Only when we started the med board, they had already done all of his addendums and sent them in. They tested him for his brain injury after—with the help of Mr. Davis and Ms. Grace Washbourne, they did a congressional investigation, and they called me in the office and they—all the colonels, all the case managers, the nurse case manager, my husband's platoon sergeant, commander of the Med Holdover, what can we do to make this right?

I said exactly what you should have done to start with. Here is a man, his life is messed up, but you not only messed his life up, you messed mine, too. Give us what we need, rightfully, and let me go home.

They tested him the very next day, because when they first tested him they said he didn't try hard enough. He went from being a Title I math and reading to, 6 months down the line, he was in special education, according to the Army. He never was in special education before he was injured. He was as smart as most people are.

Most children have trouble when they are coming up. I had trouble in math. But, believe me, I am far from being mentally retarded.

When the Army was through with him, they had him down to where he was mentally retarded; and that was on black and white. So they retested him, and they come up to me a week later. They told me, Mrs. McLeod, we did find something. We found that he was slow. We found that his cognitive skills don't measure up.

You would have found them to start with if you had paid attention.

Mr. TIERNEY. Thank you, Mrs. McLeod.

Thank you, Mr. Lynch.

Mr. Platts.

Mr. PLATTS. Thank you, Mr. Chairman. I appreciate you and the ranking member for holding this hearing.

I believe that as a Nation we certainly have no greater duty and responsibility than caring for those who defend our freedoms; and it is a privilege to hear the testimony of Staff Sergeant Shannon, Specialist Duncan. Mrs. McLeod, we appreciate your courage and service on the home front, Staff Sergeant, Specialist and Mrs. McLeod, your courage and service on the home front and theirs on the war front.

I want to start, Staff Sergeant Shannon, you talked about your specific case; and I want to make sure I understand the circumstances of when you were first injured. Two days later, here at Walter Reed, from November 13th, and you arrived here—3 days, November 16th.

Sergeant SHANNON. First of all, I don't remember the exact dates. I was wounded November 13th, and I know I spent 2 or 3 days in Landstuhl, but I really don't remember.

Mr. PLATTS. Is it safe to say that within a week you had been transferred here and then discharged to outpatient?

Sergeant SHANNON. I'm pretty sure I was discharged on the 18th, which is about 3 days—or 5 days after I was shot, sir.

Mr. PLATTS. Five days after being wounded in Iraq, severe injuries, traumatic brain injury, you were discharged, outpatient basically, given a map of where to go and left to be on your own, is that correct?

Sergeant SHANNON. Yes, sir. And some of that is my fault. I am a Staff Sergeant. I won't stay in bed. Somebody else can have it. Whether I need to be there or not is something I am not qualified to say. I just won't stay in bed.

Mr. PLATTS. We appreciate that can-do approach in wanting to look out for others. But it just is amazing that—basically cut loose to that outpatient and without some guidance you talked about finally getting in touch with your case manager and then your case manager did assist in setting up some appointments.

Once you made that contact, what was the give and take between you and your case manager? Did he regularly get in touch with you, or is it always you having to pursue them?

Sergeant SHANNON. The problem was directly related to the breakdown in the system. Actually my case manager was a lady named Maggie Hardy, a wonderful case manager. After I had finally made contact with her, she, first of all, was wondering where I had been and yet knowing I hadn't been AWOL, because they were tracking my appointment in the computer system. I was making my appointment in the computer system. But after I met her and that became part of my counseling for incoming personnel—know who your case manager is and work with them because they will keep things happening that need to be happening.

Does that answer the question?

Mr. PLATTS. So the contact, once you established it, then there was a good back and forth between you and her?

Sergeant SHANNON. Yes, sir.

Mr. PLATTS. The gentleman you mentioned, Danny Soto, an independent, how did you come to be in touch with him and what is his official role at the Mologne House?

Sergeant SHANNON. I met Danny Soto a number of different times. I am not sure who he works for. Actually, I think it might

be Wounded Warrior, DAV. But I know that many personnel at the hospital or at the Mologne House and system can speak to the work that he does as an advocate for them in the MEB/PEB process for return to duty, medical discharge or medical retirement.

He is—like I said, he is just one man. There needs to be an entire staff of people that work outside of a Government connection that have knowledge of how the system is supposed to work and can give us guidance in that system. Because a huge problem, regardless of what is done here, is to re-earn the trust of patients here. And I have spoken to some of the officers that are working on it. They can fix the problem. And I know myself, I don't trust it. They have to figure out some way to get me to trust it again.

Mr. PLATTS. So Danny Soto would serve as a good example of the type of ombudsman that you think would be wise for the wounded and the families——

Sergeant SHANNON. Absolutely. He is priceless.

Mr. PLATTS. Question, and, Mrs. McLeod, in the prior two terms I chaired the Subcommittee on Financial Management. We saw significant difficulties with the Army on the financial side of dealing with Guard and Reservist, and I understand your husband was a guardsman and then activated?

Mrs. MCLEOD. Yes, sir.

Mr. PLATTS. Did you feel that it was a different treatment because of having been a guardsman in the family, as opposed to Active Duty, or do you think it was more across the board, regardless of Active Duty, Reserve, guardsman?

Mrs. MCLEOD. As far as the finance, we didn't have any trouble with the finance as far as the issues. We did have a soldier that befriended my husband and stole his identity. That kind of finance I had trouble with. But other than finance issues with the Army, I didn't have trouble.

Mr. PLATTS. But the medical issues, such as you reference a case manager denying the MRI even though the doctor ordered it. Those type of medical issues, did you see a difference?

And, Staff Sergeant Shannon, maybe you can answer this, too, is as how Active Duty soldiers—was there a difference in how they received care and followup versus Guard and Reserve? Did that create a problem because of the challenge of managing a very large deployment of Guard and Reserves?

Sergeant SHANNON. First of all, I apologize, Mr. Platts.

Mr. PLATTS. Take your time.

Sergeant SHANNON. When I was first here, the medical hold company was all services combined, OK? Now they have two companies, medical holdover and medical hold. That was very necessary. But watching them try to go through an additional paperwork process was—there was no question in my mind that the indicators—I say things like that because I am reconnaissance type. But the indicators were such that they were having a lot more trouble figuring out the paper trail that is correct for the services they need and the connections they needed with their States in reference to those services.

Mr. PLATTS. I think my time is up.

Mr. TIERNEY. Time is up. Thank you, sir.

Mr. PLATTS. I want to thank you for your service in taking your personal struggle that each of you had and turning them into public good through your testimony here today. Thank you.

Mr. TIERNEY. Just for the benefit of the Members, to let you know the next speaker will be Mr. Yarmuth, Mr. Duncan, Mr. Braley, Mr. Turner.

Mr. YARMUTH. Thank you, Mr. Chairman, and thanks to all three of you for being here today. I would like to add my voice to what I am sure are millions of American voices who are not only very sorry for the ordeal you have gone through but also are very also angry about it. I am glad we had this hearing, and I know that eventually we are going to correct the problems that resulted in your situations.

I would also like to say one thing as a former journalist, that it is precisely this type of situation for which the first amendment was conceived; and I salute the Washington Post, Newsweek, Bob Woodruff and all those who brought this situation to light.

I am also astounded that it took so long to come to light. These situations apparently are long standing, and I'm curious as to know—and this would be for Staff Sergeant Shannon and Specialist Duncan—what the normal procedure would be for you to raise complaints about the treatment you were getting?

Sergeant SHANNON. Open door policy, sir. Open door policy works well as long as—well, and if people don't understand policy, if you have a concern of a lower-level soldier, he takes it to me. If I don't satisfy that concern for him, he has the right to take it above my head, and he can continue above the chain until his concern is addressed.

And, first of all, the Washington Post didn't come to speak to me. They came to speak with my wife. She is a person that everyone knows, knows the problems that go on here. In the course of that, they met me; and I decided to exercise what, in my opinion, was the necessary open door policy for the problems here. It is called public opinion.

Because when a command uses, in my opinion, the open door policy to keep problems in house—which is the correct method—but not to solve those problems—which is an incorrect method—then there has to be a level you can go to that the problem can be fixed. And my personal understanding of those problems going very high indicated that nobody was going to fix this. And I'm a leader. My wife reminds me I am a patient. Those kids—no offense to the service members—are going to get taken care of, period.

Specialist DUNCAN. I feel the same way. You address it as high as you can until finally you get fed up with it and do what you have to do to get it done.

Mr. YARMUTH. I am curious as to why in this particular case nobody along the chain of command reacted at all, apparently, to do anything about it, since you all had to go outside the system. What is it about the mentality there? Did everyone feel complicit in this? Helpless? I am curious as to why no one in the chain of command would have responded.

Specialist DUNCAN. I guess their idea—they probably, as they already said, is we didn't know this was happening like this, and we didn't have any ideas. Correct me if I'm wrong, Sergeant.

Sergeant SHANNON. Sir, I feel the need to say this. They did respond, as I read my statement, of course. But the response was indicative of a broken system that is trying to survive. They fired a good man. They fired a few of them.

Some of them may have deserved it. But I have to say First Sergeant Walker, the first sergeant of the medical holding company, is someone I have known for a while; and he has gone to bat for us on a daily basis. I would just personally like to apologize to him. He is a good man, and he didn't deserve it, I don't think.

Now I am not privy and I don't have a right to know the ins and outs of his case. But a system that fires people down the chain, once again, in my opinion, is indicative of a system that is trying to protect itself whether it fixes the problem or not and, in my opinion, clearly not focused on fixing the problem.

Mr. YARMUTH. About a year ago, I had a situation which I was on a plane talking to a man who had just come back from Washington and had visited Walter Reed with a friend of his. They were talking to a soldier who was from Lexington, KY, had been a postal worker, was in the Guard, was wounded and so forth. It was near Christmas time. His life had been disrupted, his financial stresses, and all those things that we are well aware of now. And this man to whom I was speaking asked him if there was anything he could do for his family or him for Christmas to make his life easier. He said, yeah, I would like some clean tee shirts, because it is very cold where I am, and they can't afford to give me clean tee shirts. And I kind of forgot about it at the time because you hear about Walter Reed and the extraordinary care that is provided here, and I thought it was kind of an aberration.

I am wondering how trivial and how many of these situations exist? We have heard of, in the Post series and others, some of the more heinous situations with patients being lost and, obviously, the deaths that have occurred and so forth. At what level does this stop?

[The prepared statement of Hon. John A. Yarmuth follows:]

STATEMENT OF CONGRESSMAN JOHN YARMUTH
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
SUBCOMMITTEE ON NATIONAL SECURITY
AND FOREIGN AFFAIRS SUBCOMMITTEE
HEARING AT WRAMC

Mr. Chairman, I want to thank you for holding this hearing, and for doing it expediently. When the American hero is neglected here at home, the urgency to act is paramount. I also want to thank our distinguished witnesses for joining us, especially the soldiers and their families who have suffered through this travesty. That you have chosen to be here shows courage and a faith – which I share –that America is better than this dark episode.

As yet, it remains difficult to fathom the extent to which American troops have been abused and abandoned on their own soil. We have assembled here to determine how such a lapse in our nation's obligations came to pass, and what we can do to fix this broken system and mend the shattered promises. The stakes could not be greater.

When we challenge our young men and women to put on a uniform and risk their lives for our country, our country promises to take care of those who answer the call. Honoring this pact is among the key virtues that make America worth fighting for. Failing to do so undermines our efforts to protect our nation and our fellow citizens. We cannot ask them to fight for our well-being and then disregard theirs.

Our strength as a nation comes not only from military might but from our resolute integrity, and our historical greatness will be judged by our commitment to that principle

We are not here to find a fall-guy; the situation before us cannot be explained away or scapegoated into obscurity. We are here to right the course of a ship that has gone drastically astray, and to do so immediately. The faith of our troops in their country is at stake.

I look forward to hearing the answers, implementing the solutions, and putting this ugly situation behind us as quickly as possible. Thank you Mr. Chairman. I yield back.

Mr. TIERNEY. The gentleman's time has expired, but one brief answer will suffice.

Sergeant SHANNON. I can't speak to levels, but when I have to get my Purple Heart in civilian clothing and show my Purple Heart to supply just so I can get my uniform, it is broken.

Mr. TIERNEY. Thank you.

Mr. Duncan.

Mr. DUNCAN OF TENNESSEE. Well, thank you very much, Mr. Chairman. I join the others in thanking you for calling this hearing, and I want to also thank former Chairman Davis for the great work that he did in this regard trying to at least start doing something about this.

Let me say, first of all, though, that whenever any Government agency seems to screw up in some big way, the two things they always say, they always say that their computers and technology wasn't good enough or wasn't up to date, which they have far better technology throughout the Federal Government than most major private businesses. But, second, and most often, we hear the claim that they are underfunded.

I think we need to point out that both the Defense Department and the VA—but particularly the Defense Department—have received massive increases in funding in the last 5 or 10 years, mega billions; and so this is clearly not a shortage or problem of money. The Congress has given huge increases to the Defense Department in recent years, and we have tried to say many times that we want plenty of money going for this medical care.

I join all the others in saying this should be the highest priority, and I want to also join others in thanking each of you for coming forward.

But, Mrs. McLeod, I notice you said that you thought that General Weightman might be a fall guy; and, Sergeant Shannon, you seem to be less critical of him, also. I believe he just came in August.

But in one of the Washington Post stories it says Congressman Bill Young and his wife stopped visiting the wounded at Walter Reed—which they were doing I think on a weekly basis—out of frustration. Young said he voiced concerns to commanders over troubling incidents he witnessed that were rebuffed or ignored. When Bev and I would bring problems to the attention of authorities of Walter Reed, we were made to feel very uncomfortable.

Beverly Young said she complained to Kiley several times. She once visited a soldier who was lying in urine on his mattress pad in the hospital. When a nurse ignored her, Young said, I went flying down to Kevin Kiley's office again and got nowhere. He has skirted this stuff for 5 years and blamed everyone else.

Did you find that to be true, that everybody was blaming somebody else with the problems that you had? I'll ask each of you.

Mrs. MCLEOD. I feel that everybody is passing the buck. You go to one and they say, it is not my problem. You need to go to so and so. I did everything but camp out. I mean, honestly, if I could get away with that, I probably would have done that, too.

You can't keep looking and not getting answers.

Mr. DUNCAN OF TENNESSEE. Sergeant Shannon.

Sergeant SHANNON. It is difficult for me to speak about people passing the buck. It is something that does surprise me by virtue of the story coming out in the Post, because I didn't want to see anybody fired. I just want to see the problem get fixed. I work at my level. I am good at working at my level. I know that on a constant basis things were passed to higher.

Mr. DUNCAN OF TENNESSEE. Let me ask you this. The sub-headlines in the main Washington Post story said that "bureaucratic bungling," and it says "frustration at every turn." Do you think those are accurate descriptions of what you ran into?

Sergeant SHANNON. Absolutely. The bottom line is like a situation I know of a young man missing his entire right arm that the Army has seen fit to award 10 percent disability because he is going to receive 80 percent of the use of his arm with his prosthetic. Oh, yes, that is the bottom line, sir.

Mr. DUNCAN OF TENNESSEE. One of these stories says, General Kiley lives right across the street from Building 18, which is apparently the worst example of what is going on here. Did any of the three of you—did you see these top generals and the top brass here getting out and going around and observing what was going on? Or do you feel like they stayed isolated in their offices and just meeting with their staff people?

Specialist DUNCAN. After the article came out, there was a lot of people visiting Building 18 and looking into it after the article came out. Before then, it was occasionally a commander come through, check on everybody, make sure things are going right. It wasn't like overwhelmed as it is now. But, before, it was just, you know, a few people going in, check on it, say, hey, how is everybody doing.

Mr. DUNCAN OF TENNESSEE. That is what I was talking about, was before the articles came out.

Let me just—I know my time is about to run out, but let me say this. It is not just Members of Congress up here who are upset about this. I will tell you it is people around the whole country. They are very upset about this, and I think all of us are going to demand that action be taken.

Thank you very much, Mr. Chairman.

Mr. TIERNEY. Thank you, Mr. Duncan.

Mr. Braley.

Mr. BRALEY. Staff Sergeant Shannon, Mrs. McLeod and Specialist Duncan, thank you for your courage in coming here today and sharing your stories with us.

I am here because my brother Brian works as a kinesthiotherapist at the VA Hospital in Knoxville, IA, taking care of patients every day; and I know that every Member who provides medical and psychiatric care to veterans is tainted by the stories we are talking about here today. Every person in the VA system should want these problems solved so that we get back to having pride in the facilities that take care of our veterans.

One of the things that I am not at all shocked about is the fact that case managers may be playing a role in denying access to veterans to the benefits that they are entitled to, because I am familiar with the AMA guides to permanent evaluation. I am familiar with the DSM-IV criteria that are used.

I have represented veterans and their families in life and disability claims, and one of the things that has been known for a long time is that case managers have two functions. One is to return a worker to the work force as quickly as possible and, two, to minimize the cost to the employer of returning them to work. Those don't work at the same level of advocacy that patients need.

What I would like to know, is there anybody who serves the role as an ombudsman or as a patient advocate here at Walter Reed in assisting patients with these claims?

Sergeant SHANNON. My first experience with that—and I apologize, I talk too much. But my first experience was working with my initial PEBLO counselor, and he gave me all the information about, hey, you need to educate yourself about this process. Because once this is done, it is done; and if you miss something you are entitled to, it is gone.

So, based on his knowledge of the system, I said, OK, well, tell me what I need to do or tell me who I need to talk to. He just had to smile at me and said, I don't know who to talk to. They are all retired and gone.

At that point, I was no longer able to trust my PEBLO counselor in the process.

Danny Soto, once again, is a person outside of the system who is knowledgeable of the system. He is someone we can trust. Because, based on what I consider an automatic conflict of interest, the PEBLO and the MEB/PEB process both work for the same organization, the U.S. Government.

Mr. BRALEY. Mrs. McLeod, one of the reasons I am concerned about what we are hearing today from you is that part of the response to the problems here at Walter Reed was to propose adding 39 additional case managers to assist with the processing of these disability claims. And, to me, what we are talking about is a solution to the problems that you and others have shared, is making sure that there are people outside the case managers who are here to assist veterans and their families, negotiate the difficult process of qualifying for and receiving an official determination of whether or not they are entitled to disability benefits. Would you care to comment on that?

Mrs. MCLEOD. My thing is, if the doctor feels it's necessary to run a test, it is not the case manager's job to second guess that. If it were, she would be in the doctor's place.

I went to my husband's case manager. I begged her when, on April 19th, he was supposed to have—set up the MRI, to have it scheduled. He got that MRI June 23rd, when I took him myself. The case managers need to stop playing doctor, and they need to be case managers. They are supposed to get them where they need to go, schedule the appointments and stop questioning it. But, instead, his case manager got so upset at me she sent him home to keep from having to deal with him.

But she got quick enough whenever I put in the resources that I did. She gave him a physical in her office.

Now we are talking sanitary—have you seen those offices? The last thing you want to be doing is examining in the office. I won't tell you how mad I got, and I won't tell you the things that I said.

But the treatment that she gave him, before I had her fired as his case manager, a dog wouldn't deserve it.

Mr. BRALEY. Do the three of you know, does the JAG Corps provide any type of legal assistance to veterans who are processing disability claims?

Sergeant SHANNON. I don't know about processing disability claims, but the JAG has been very helpful here just in the course of my wife's vehicle being repossessed. The vehicle that I owned prior to going to combat and my not knowing—I couldn't remember who to send payments to and stuff after I was wounded, contacting those companies and in getting the message across that we have been wounded and give him some time to catch up.

So I am not sure about processing claims, but they are there, and they have done good work for me.

Mrs. MCLEOD. The only time I dealt with the JAG was during the episode where the guy tapped me—all our accounts when he saw my husband's identity. And they told me that it was not an issue for them, that I had to go through Finance.

Mr. TIERNEY. Thank the gentleman.

Mr. Turner.

Mr. TURNER. Thank you, Mr. Chairman.

Mr. Chairman, I want to thank you and Ranking Member Davis for your efforts in trying to ensure that we have quality medical care and the services that we need for our men and women who serve their country.

Staff Sergeant Shannon, Mrs. McLeod, Specialist Duncan, I want to personally thank you for your service and what you have done not just in trying to ensure that there is appropriate care here but in making certain that the word is known as to what needs to be done. You have a great deal of courage, and you have certainly brought things to light that have saddened many people across the country.

I know that you are aware that in the next panel and the third panel that we have people who are going to come and speak about this issue who have various degrees of accountability or various degrees of answers. We have General Kiley, General Weightman. We have General Schoomaker and General Cody. What would you like to hear from them and what type of questions would you like to hear them answer with the issues that you brought forward?

Sergeant SHANNON. On their level, at this point, this is about accountability.

Like I said, you know, I am a firm believer in the Peter principle. Don't ask me to work in a job I am not qualified to do. This has no reflection on whether they are qualified to do it, but it reflects directly on my ability to speak to what they should do.

I just want them to fix the problem. In fact, I personally got a little angry when Harvey resigned. Now I don't know how things work in Washington, DC, but in combat we don't get to resign when people—bullets are flying and people are dying.

Now the way that reflects on this issue is that this is a political war, to some degree, on a daily basis; and when they are receiving political incoming rounds in the course of helping us or in the course of dereliction of duty in that requirement, they continue to fight for us until they are fired, pull themselves up by their boot-

straps—like any sergeant would do—admit to their mistakes and work to fix them until they are fired.

Mrs. MCLEOD. On my level, as far as the family members are concerned, I would like them to answer to the family, to say, we can guarantee—that is what I want. I want a guarantee that not anybody would have to go through what I went through, that we are going to listen and we are going to take charge.

Specialist DUNCAN. I would like to hear them actually say that they are going to fix the problem and not just cover up—what they are trying to do—cover up, trying to say, yeah, we are fixing Building 18, when all it is is paint and spackle. That doesn't fix. It just covers up. Just fix it like they are trying to do now. Just need to fix it from the ground up, get it fixed so it is fit to live in.

Mr. TURNER. Thank you, Mr. Chairman.

Mr. TIERNEY. Thank you.

Ms. McCollum.

Ms. MCCOLLUM. Thank you, Mr. Chairman. Thank you for holding this meeting.

I would like to thank the people who are testifying. I would like to thank all of those who served our country. We need to show our thanks. We need to show it through respect in the way we welcome our veterans and their families home, and we are not going a very good job, and that is why we are having this hearing today.

I first became aware that the system at the VA level had challenges and was broken by being the daughter of a disabled veteran and watching benefits erode away, talking to veterans in my community about long waits, lack of equipment. They knew when they saw the overworked staff, however, they were going to get the best of care. But it was having the ability to see the staff.

I am very concerned about a lot of issues, but I want to followup on one; and, if you don't mind, Staff Sergeant, I am going to quote from your full testimony.

"I have been lost in the system. I want to leave this place. I have seen so many soldiers get so frustrated with the process they will sign anything presented just so they can get on with their lives." By signing documentation without fighting for the benefits they have earned, they are agreeing in writing to the Army's determination of their benefits. And, as Mr. Lynch pointed out, the Army's only at 4 percent in determining benefits.

We almost have no advocacy that is not working for the Government, no one that we can talk to about this process, no one who is knowledgeable and that we can trust who is going to give us fair treatment and informed guidance. The physical evaluation counselors, the MEB and the PEB, both work for the Government and have its interests at heart, not ours.

Mr. Lynch had been quoting from a document that he had, and I would like to add a little more to what the Staff Sergeant just said in his own words and then ask a question.

Each branch of the military provides for opportunities for injured and service members to challenge their ratings. Most of the injured simply pocket their severance checks and go home. Only 20 percent of the soldiers ask for formal hearings at which an attorney can present evidence and call witnesses. As the Army says, only half of those soldiers proceed with hearings. Perhaps that indicates

most injured soldiers are satisfied with their ratings, but veterans groups say more wounded service members would challenge the ratings if it wasn't so complicated and time consuming.

Most of those hurt in the line of duty are young, weary of fighting and anxious to return home to their civilian lives. In other words—these are my own words—the severance checks can look really quick and a lot less painful at times, not realizing the benefits that they have been signing away.

I would ask you to tell us if you know of any pressures that you have either heard of or witnessed for people who sign away their benefits and what we need to do in order to make sure that veterans know—either by providing an ombudsperson or whatever—that their rights will be protected, we do welcome them home, and we do respect them.

Mrs. MCLEOD. I know a soldier, fairly young, maybe early 20's, was deployed. I took this soldiers under my wing whenever we met; and he was a great guy, very nice. He told his recruiter that he had an episode in high school, and the Army took him anyway. They sent him to Iraq. When he got back to Walter Reed, they diagnosed him with bipolar. But he was pre-existent. The Army gave him 0 percent.

This guy has nothing. He is trying to find his way back into society. They blame him for being what he was. But they gave him 0 percent.

This is how we treat our soldiers. We give them nothing. But they are good enough to go and sacrifice their life, and we give them nothing.

You need to fix the system, compensate where it is needed.

This soldier needs care. Yeah, the VA treated him. But the VA will treat him according to his rating with the Army. Because this is the first thing they ask, what was your rating with the Army? You get a category.

We were fortunate because my fight still continues. They knew me, first-name basis.

Well, what about the ones that don't have me? What about the ones that don't have a wife or a mother or father that can stand up for them?

If you are good enough to go, you are good enough to be taken care of when you leave here. We need to take care of those that took care of us.

Mr. TIERNEY. Thank you, Ms. McCollum.

Ms. Foxx.

Ms. FOXX. Thank you, Mr. Chairman; and I want to thank all of the folks who are here today and all of our military people who are here for being willing to serve to protect our rights to be here.

I am very interested in the issue of accountability; and I realize that, throughout our society, we have people who are unresponsive. We see it every day in the personnel in the Congress. I will tell you that there are people who work throughout Government agencies who don't always react the way they should react, particularly to other staff people.

What I am interested in is, how do we fix the system? Casting blame doesn't do us any good if we aren't fixing the system.

Sergeant Shannon, Mrs. McLeod, Specialist Duncan, do you have some specific recommendations to make? And you don't have to tell them to us today. But do you have any specific recommendations you can make on how the system can be better so that it is fixed? And I particularly am interested in how do we assign responsibility in order to have accountability? It seems to me that the biggest complaint you all have made is this passing-the-buck complaint.

So how can we establish a system that says, you have been to someone, you have asked a question, it is, in your mind, the responsibility of that person to take care of that problem, and they don't do it.

Unless we are willing to fire people who are either incompetent or unresponsive, then what alternatives do we have to try and to solve the problems that we are seeing?

Sergeant SHANNON. I believe I can speak directly to that based on the military system I have grown to know so well myself. Any noncommissioned officer can tell you that you don't just give people instructions to do things. You supervise them.

A person can be getting close to a position where they need to be fired. However, with proper supervision, they can be brought back in line. This directly relates to priorities in my opinion. And the breaking of the story has changed priorities, and now things are getting done.

The priorities of the people above—they need to be supervising what is done below them on a daily basis—can be changed so that they are not supervising at the level they need to be supervising at. If I was doing that at my level, I would be in danger of getting fired in my job.

Like any system, whether it be a civilian or military, at the point where you are seeing somebody that is having a problem doing their job correctly, you counsel them; and if they still can't do it, you counsel them again. I believe it is three times, then they are fired.

But that requires proper supervision, ma'am. If the supervision is not happening—so how can you counsel somebody when you are really not watching what they are doing?

Mrs. MCLEOD. In my situation, for example, my husband went to a doctor. The doctor roughed him up pretty good. Finally, I wound up having to take him to the emergency room because he couldn't move for 3 days. We filed a complaint. When the patient rep called me, first, she wouldn't talk to me; and then my husband said, you need to talk to my wife. She can explain to you more.

I told her what happened; and she asked me, she says, are you sure? I said, yeah, I wouldn't have filed the complaint if I hadn't been sure. She said, well, I am sorry on behalf of the hospital. Well, sometimes things like this happen.

No, it doesn't happen.

When they tell you that is all they can do, that is all they can do. We have doctors—let me specify, he has doctors that were so eager to fight for the system they made him able to move. They put him in the emergency room, but they made him able to move. Because they wanted to fight for the Army.

We need to turn it around. We need to fight for the soldiers. The soldier is the reason you have a job.

When they go to the case manager, there shouldn't be second-guessing. They should say, OK, we will put you where you need to be. We will get the doctor. When you go to the doctor and he says OK, we need to do this, you have to go back to the case manager. She has to set up everything. There shouldn't be, well, I will talk to the doctor. No problem. This needs to be taken care of.

You need to start treating the soldiers like citizens, like the same representative anybody would want. You go to your doctor, you don't want him to second-guess you. You want him to find the problem. You want him to get a result. That is what you go to him for.

That is exactly the same thing they need to do. They need to start at the very bottom first and find out why they can't do their job to the capacity they need to do. You need to work your way up the system. When you find the broken link, you either put some glue on it to fix it or you get rid of it.

Mr. TIERNEY. Thank you, very much.

Mr. Cooper.

Mr. COOPER. Thank you, Mr. Chairman; and thanks to each one of the witnesses for your outstanding testimony.

If there are this many problems in Building 18, how about Buildings 1 through 17 or buildings with higher numbers? We need to make sure that we are getting to all the problems here at Walter Reed. Are there any other facilities or personnel issues that we need to know about?

Specialist DUNCAN. From my understanding—I just got currently moved over to Building 14 myself as of Friday. Our complaint for people living in 18 didn't want to move because over in Building 18 we had free cable and computers downstairs. From my understanding, now they are moving TVs and computers over to Building 14.

How long that is going to take, I am not sure. But they are just trying to make it better now from the issues we have had before.

And everybody was comparing Building 14 with 18. There's no comparison. Building 18—honestly, I hate to say it—was like a ghetto. It was tore up. It had nothing. But it had stuff that we liked to have. Building 14 was a luxury, but it didn't have the same things we had over in 18, which now they are fixing. So, in my opinion, they are starting to make it look better.

Everything is turning back toward the Mologne House. The Mologne House was like—if you had been in the Mologne House and you moved out, you hated it. But if you lived in the Mologne House, you were living the life. It was great. You had a kitchen downstairs. It was great. Had food and everything, ready to go. They are trying to make it better. I will give them that, but it is going to take a while for them to do that.

Mr. COOPER. The U.S. Government under the so-called BRAC round has scheduled the closure of all of Walter Reed in a few years and to move everything over to the Bethesda campus. What opinion, if any, do you have about that shutdown of this entire facility and move over to the Bethesda campus?

Specialist DUNCAN. Like I was telling the press, there is no reason—you can't use that as an excuse: "we're closing down in a few years." There's still soldiers coming in today and tomorrow and the

next day. That stuff needs to get fixed here now before those problems get worse for the new soldiers coming in.

Myself, I have 2 months left here at Walter Reed. I am going back to my unit. I don't know how long Sergeant Shannon has. But I am sure, when he leaves, the guy behind him is not going to live in the same conditions or deal with the same problems that we are having now. Those need to get fixed before Walter Reed closes down. That is not an excuse.

Mr. COOPER. I thank you, Mr. Chairman.

Mr. TIERNEY. Thank you, Mr. Cooper.

Mr. Van Hollen.

Mr. VAN HOLLEN. Thank you, Mr. Chairman.

I want to thank all of the witnesses for testifying as well and add my voice to those who have thanked you and your families for your service to the country and the sacrifices you have made.

As Mrs. McLeod said, you and your loved ones have been fighting a war. You shouldn't have to come back come here and fight a system. I think that is absolutely correct, and we need to make sure the system provides you the respect you need. What we have heard, unfortunately, is a system that has been providing more neglect than respect, at least with respect to outpatients that we are dealing with.

As others have said, I think you have done a terrific service to the country. If you look at the front page of today's Washington Post, you will find that, because of the issues you have raised here at Walter Reed, others around the country who are facing similar circumstances will have their voices heard and will be empowered now. So you have done a great service not just here at Walter Reed but around the country as well.

We all hear from time to time about those insurance companies that tell people, you know, we want to take care of you when you are in trouble and advertise as such. But when the time comes to pay claims for certain insurance companies, they are not there. They try and make their money and make their savings by denying claims. That is clearly not a model that we want the U.S. Government and U.S. military to be following.

But from your testimony about your own personal circumstances as well as other stories as well as reports from the GAO and others, clearly, when it comes to disability claims, it does appear that the system has been stacked against individuals like yourselves and your loved ones. And Mr. Waxman quoted in a statement Mr. Chu made in 2005 suggesting that the health care we have to provide to our veterans is somehow a burden on the system that we somehow shouldn't be having to deal with.

Let me ask you, with respect to the system itself, and GAO essentially has said—and I do want to mention their report—in conclusion, they issued a long report about the disability—military disability evaluation system back in 2006. They concluded that DOD is not adequately monitoring disabililty evaluation outcomes in Reserve and Active Duty disability cases and said that there had been a lack of training, a lack of monitoring and a lack of oversight; and it is clearly an area I think this committee is going to be taking a look at and other Members of Congress, of the committees in Congress.

Do you have any specific recommendations with respect to that disability system, which clearly seems to be designed more to essentially put an overwhelming burden on the individual seeking to show that their disabilities have been related to their service and not providing an ample opportunity for the individual? I don't know if you have any specific recommendations with respect to that process.

Mrs. MCLEOD. Well, that process—like I said, we were fortunate, and we took the compensation because he got 50 percent. The thing about it is, they never acknowledged that he has a brain injury. So they didn't compensate. They compensated for the cognitive disorder.

My thing is, they are so busy trying to make everything acceptable—several things on his med board were acceptable, but yet they still retired him. How can everything be acceptable if you are going to be retired? That is a little contradictory to me.

They gave him—for the anxiety and for the cognitive disorder, they gave him the 30 percent with the attitude in April of next year, when we have to come back, he is going to be better. Well, if he is better—which I really at this point don't see happening—if he is better, he will lose that rating. And guess what? He will get a severance package, and then he will have nothing.

I don't think—if the injury warrants it, I don't think there ought to be a TDRL. The brain injury is permanent. What they have taught him is compensatory measures. If he hadn't had a brain injury, why were they teaching him compensation measures to help him out? That is contradictory again.

My thing is, if you warrant compensation, it ought to be permanent, not something you have to bargain for 18 months down the road. And then we may not have insurance. Then we are going to have to get all his treatment at the VA.

What about the families? What are they supposed to do? I don't have nothing. But all because we still have to bargain up to 5 years with the Army.

He didn't bargain when he signed the line. He didn't bargain when he got injured. Why are you bargaining now?

Mr. TIERNEY. Thank you.

Mr. VAN HOLLEN. Thank you.

Mr. TIERNEY. Thank you.

Mr. Hodes.

Mr. HODES. Thank you, Mr. Chairman. Thank you for holding these hearings and, to the witnesses, thank you so much. You have been very brave, and your courage is being heard around the country now. It is very important. What you have done in shedding light on what is going on here is very important, and I know that feelings that we feel hearing what you are saying are only a very small little piece of the feelings you felt and what you have gone through. So thank you for being here.

Staff Sergeant Shannon, I want to ask you, you have talked about the help you got from Danny Soto. Do you think that there needs to be some independent office or agency that is committed to fighting for the soldiers in this system?

Sergeant SHANNON. Yes, I do. And, to clarify, I haven't received any help from Danny Soto yet. I have guided other people to him,

and I am sure he has helped many others, but I have not been able to start the MEB process—excuse me—to make it easier to understand the medical retirement process because of the holdups I have gone through; and when I get to that point, I will be looking him up.

Mr. HODES. Thank you for that clarification.

Mrs. McLeod, do you think there needs to be some independent office or agency that fights for the soldier in this system whose only duty is to the soldier and not to the system but to the soldier?

Mrs. MCLEOD. I think you ought to stop giving it to committees and give it to the families. That is who you need to be talking to. Give it to the ones that have to deal with it day in and day out.

Mr. HODES. What do you think the best way for us to give that power, if you will, to the families would be, in your opinion?

Mrs. MCLEOD. There needs to be a committee formed with a couple of spouses, a couple of people that have the power to get the things done. And there needs to be the a forum set up to say, OK, we will research the families and the situations. We know, because we have been there, and we need to set action into force. This is what they said they need. Weigh it against exactly where we are today and give them what they need, instead of sitting there waiting on somebody else to do it.

Mr. HODES. Specialist Duncan?

Specialist DUNCAN. I don't have anything to say on that matter. I am not going through the same process as they are.

Mr. HODES. Staff Sergeant Shannon, your picture appeared on the front page of the Washington Post. Before your picture appeared, I understand that you were reporting to formation once a week. Is that correct?

Sergeant SHANNON. That is correct.

Mr. HODES. After your picture appeared, my understanding is you were ordered to report to formation daily, is that correct?

Sergeant SHANNON. That is correct.

Mr. HODES. And who gave you that order after your picture appeared to report daily to formation?

Sergeant SHANNON. Those instructions were passed on to me by my platoon sergeant. He said they came from the sergeant major.

Mr. HODES. And did you inquire about the reason for your being ordered to report to formation daily after your picture appeared in the Washington Post?

Sergeant SHANNON. I just follow orders.

Mr. HODES. Did you consider that retribution against you for going public with your story?

Sergeant SHANNON. I really couldn't say. They tell me to stay home because I tend to break things if I hang around much, and I don't work well in complex environments. So when they told me that, I am like, fine. So the next time I decide to break somebody's arm or smash a piece of furniture they just tell me to go back to my room again.

Mr. HODES. Specialist Duncan, have you experienced anything that you think might be retribution for your going public?

Specialist DUNCAN. I can't say exactly, maybe, for sure, yes. I mean, all of a sudden moving of rooms, moving from building to building, just all of a sudden quickly—all I asked them to do is fix

the walls, not move me a million times. I am tired of moving rooms. I have acquired a lot of bit of things being here for a year, and moving is not fun anymore. I am just tired of moving here and moving there. I just want them to fix it so I can deal with it.

Mr. HODES. Mrs. McLeod, you had to end up going to a Member of Congress to get help for your situation.

Mrs. MCLEOD. Yes, sir. After that, I think they were afraid to retaliate.

Mr. HODES. Thank you. Thank you all very much.

Mr. TIERNEY. Thank you, Mr. Hodes.

Mr. Welch.

Mr. WELCH. Thank you, Mr. Chairman. I just want to thank the witnesses. I am at the end of the line here, and I want to tell you that it has been a very moving experience for me to hear each of you tell your stories.

My concern is that this is the tip of the iceberg. My concern is that there is a culture of disregard that has no place in how we treat wounded veterans. And my concern is that there is a lack of commitment to recognize the obvious, and that is that the cost of the war has to include the cost of caring for the warrior.

I am going to yield the balance of my time because I appreciate that you have been answering lots of questions, and my questions have been asked and very eloquently answered. So I thank you for your service.

Mr. TIERNEY. Thank you, Mr. Welch.

Mr. Cummings.

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

I, too, thank all of you for being here today; and, as I listened to your testimony, I just said to myself, this should not be happening in America. It sounds as if we have a system which should be in intensive care, and it appears we are putting band-aids on it.

As I listen to you, I was just wondering, you know, in another hearing on another committee—I sit on Armed Services also—and we had Sergeant Shannon—and to all of you, in some testimony that there was a lack of psychiatrists and mental health people in the military and they were trying to find more. The mental health piece of the treatment here, how have you found that?

Specialist DUNCAN. I have had no problem with it, sir.

Mr. CUMMINGS. Have you, Sergeant Shannon?

Sergeant SHANNON. Well, I have a big problem with their mental health thing. It is starting with their traumatic brain injury testing.

OK, first of all, they told me I have no loss of cognitive function. Well, how can they do that if they give me a traumatic brain injury test in my opinion that my 6-year old son could pass because it is designed for severely traumatically brain injured people?

I know myself, and I know I have paid a price for the brain injury I received. If they can't even take the time to balance scores from tests I could take that I have taken before and see what the difference is, I have a big problem with that.

Now, the counseling and everything that they give, from the psychiatrists to the psychologists, PTSD counseling, I believe they are running a tremendous program. We have access to a program called polytrauma recovery, and it is a tremendous program run

out of Washington, DC, VA. However, the biggest problem they have is none of the service members will receive benefit from that program until each individual soldier has reached a mental state where they were willing to go seek that treatment.

Mr. CUMMINGS. One of the questions I would ask some members of the Joint Chiefs of Staff in the other hearing went to the Bob Woodruff piece that ran on ABC News a few nights ago with regard to brain trauma and trauma to the head and how people can get treatment here at Walter Reed, for example, but then, when they go back to their rural areas or wherever they may go, small towns or wherever, that they were not able to get followup. So they find themselves going backward. Is that a concern of yours, Staff Sergeant?

Sergeant SHANNON. Absolutely. It is very much a concern of mine, beginning with the start of the process for seeking the treatment where I was told you are not a bad enough brain injury to need the polytrauma recovery. I got angry enough I had to get up and leave. Usually when I have gotten angry and—well, I am a sergeant. Foul language starts coming out of my mouth. And that is a point where I know a trigger is coming and I am going to get violent. They told me I don't have a bad enough brain injury to need treatment.

I have found out since then I am clearly a level two polytrauma recovery person. The point being that proper supervision would be the word that would have to be used in relation to that subject. They have discovered that men suffer post-traumatic stress disorder symptoms from concussive force to their heads. We get mortared every day over there, depending where we were working. Just because a guy has not got a visible injury does not mean he does not have PTSD.

Mr. CUMMINGS. What about you, Mrs. McLeod, with regard to your husband?

Mrs. MCLEOD. When my husband was here, they gave him psychological evaluation and treatment all because they thought it was just a transition problem. I kept fighting and fighting. I knew there was something wrong. When they sent him to Virginia he was treated there as well.

When he come back, he got so out of hand that a friend of ours who is also—her husband is a brain injury patient. She actually took him to her husband's psychiatrist, and that is how he got started with psychiatry. They never offered him any psychiatric treatment.

Mr. CUMMINGS. Let me say this, that—I have about 30 seconds left—what I am hoping for is that we will not—not us but even other Congressmen—in 5 years will not be sitting here going through these same things. Hopefully, with Secretary Gates looking at the system and having the system revamped, we will be able to resolve a lot of these problems.

We thank you very, very much for your service, and we can do better as a country. We must do better.

Mrs. MCLEOD. Thank you.

Mr. WAXMAN. Thank you, Mr. Cummings. Ms. Norton.

Ms. NORTON. Thank you very much, Mr. Chairman. And I thank you and Chairman Tierney and Ranking Members Davis and Shays

for your courtesy. I am a member of the full committee, not of the subcommittee.

I am very proud of this hospital; all my life, have been proud to have it in my district. I just want to say for the record, all the indications are that it is still the crown jewel, it is still the state-of-the-art hospital on the planet for treating soldiers like you.

To say thank you for your service sounds so shallow after what you have gone through, both in battle and here, that I want to just move first to Mrs. McLeod, because thank you for your service must include you who have been, apparently, a volunteer caseworker with considerable family sacrifice, having to give up home and job to come here. I was very concerned when you said, What about those who don't have me? Because that is what I have been thinking as a mother the whole time. What about those who don't have Mrs. McLeod?

May I ask, I mean, when you said you didn't even know, you weren't even informed when your husband was wounded, were you ever officially informed that he was wounded?

Mrs. MCLEOD. No. No one from the Army ever picked up the telephone and called and said there has been an accident. Nobody called me. He called me himself.

Ms. NORTON. This, I think, points to the systemic nature of the problem. It begins on the battlefield and carries through throughout the life of the soldier.

Let me ask you, all three of you roughly—you cannot know, you have not done a census, but you have been around this hospital—roughly what percentage of soldiers are here—without family—are here by themselves?

Specialist DUNCAN. I would say maybe about 25 percent or so, maybe less. I have seen a lot of people here just by themselves.

Ms. NORTON. Twenty-five percent are here with family?

Specialist DUNCAN. Without. Could be less.

Ms. NORTON. Without family. So 75 percent of the soldiers here have some family here; is that your sense as well?

Sergeant SHANNON. I don't know if I would go that high, but in the high range. One of the things that is being discovered right now is having a family member close during this time of recovery is incredibly beneficial to these soldiers as they go through this process. These people understand them. Sometimes they are not coherent, based on medications and things, and it takes someone with intimate knowledge of that individual and how they were on a daily basis before to understand some of what they are trying to get across and some of what they are going through based on their knowledge of them before.

Ms. NORTON. Mrs. McLeod, I appreciate what you said about leaving it to the family because families, obviously, want to take care of their folks. But the fact is, there are very few women like you here in the United States who give up everything to be here.

I don't have much time, so I want to move on beyond accountability. They fired people, they knew they had to do something. I want to move to remedy, and given the systemic nature of the problem that a soldier's life may be on dozens of computers which don't talk to one another and the rest, I am not focused so much on long-term remedies because I think, you know, the Army can

plunge into long-term remedies, and we have the same situation we have now. We learned, for example, that a soldier could come here and not know, not even be given a piece of paper at one point at least saying, OK, this is what you do, A-B-C, these are kind of short-term guidance that you would expect for any wounded soldier.

You might not expect for Eleanor Holmes Norton, she is supposed to be able to know she comes to find a doctor. But let me ask you, given the systemic nature of the problem, whether or not a remedy might involve immediate assignment of people who have no—given what you have said about conflict of interest and the rest—no obligation to anybody but the soldier and how many such—not how many—but if that was to happen, should it be from veterans organizations?

Mr. TIERNEY [presiding]. Who would you like to direct that question to?

Ms. NORTON. I would like to direct that to anyone who can give me—basically it is if you think the soldiers would be better treated if there were people outside of the system. The first people that occur to me are people from veterans organizations. Would those be people who would be most likely in the short term to be responsive to the needs you have discussed in your testimony?

Mr. TIERNEY. Would one of you like to respond to that?

Sergeant SHANNON. No question in my mind. They have been through it. They need to be advocates for it. When it comes down to—well, like my total—being lost completely in the system when I went outpatient, when I complained about it, they informed me that I had spoken to someone within 24 hours of my arriving at the hospital. Anybody want to laugh? I was under a lot of medication. I have no knowledge of anybody speaking to me within that timeframe. In other words, they need to assess the patients and give a time, say, brief them when they go outpatient instead of when they arrive on an aircraft from Germany.

Mr. TIERNEY. Thank you. The gentlewoman's time has expired. All time has expired for questioning. I want to thank you on behalf of all the committee members and everyone else, your willingness to come here, your commitments and sacrifices you have made as well. We all wish you a speedy recovery for those of you that are injured, and Dell as well, Mrs. McLeod, and to you, your situation. Your coming here is a continuation of your service. I think you have really benefited others that will come through here and others that are presently in the system somewhere, and hopefully we will be able to take your testimony and work toward improving situations as well.

So with that, we thank you very, very much. We will allow you to take your leave now and step down. We appreciate all of your time and commitment. Thank you.

Now we will invite our second panel also to take the seat as soon as they can.

Mr. TIERNEY. Thank you and welcome, all of you. I would like to begin by introducing our panel. On this panel we have Lieutenant General Kevin Kiley, M.D., the Surgeon General of the Army and the past commander at Walter Reed. We have Major General George Weightman, former commander of the Walter Reed Army

Medical Center and North Atlantic Regional Medical Command. We have Ms. Cynthia Bascetta, the Director of the Health Care Department at the U.S. Government Accountability Office.

Welcome to you all. Thank you for coming today. As you heard before, it is our policy of the subcommittee to swear you in before you testify. And I would ask you to rise and raise your right hands, please.

[Witnesses sworn.]

Mr. TIERNEY. The record will reflect that all of the witnesses answered in the affirmative. And with that, if we might, I would like to ask each of you to give a brief summary of your testimony. Your full testimony will be entered in the record. You have 5 minutes. Obviously we will try to keep it as close to that time as we possibly can. And we will try to give you some indication that you are nearing the end if we can. So we will start with General Kiley, please.

STATEMENTS OF LIEUTENANT GENERAL KEVIN C. KILEY, M.D., U.S. ARMY SURGEON GENERAL; MAJOR GENERAL GEORGE W. WEIGHTMAN, COMMANDER, WALTER REED ARMY MEDICAL CENTER; AND CYNTHIA A. BASCETTA, DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

STATEMENT OF LIEUTENANT GENERAL KEVIN C. KILEY, M.D.

General KILEY. Mr. Chairman, Mr. Shays, Mr. Waxman, Mr. Davis and distinguished members of this committee, I am here today to address your concerns about the quality of care, the quality of administrative process, and the quality of life for our wounded warriors here at Walter Reed Army Medical Center and across all of our Army.

I am Lieutenant General Kevin Kiley. I am the Surgeon General of the U.S. Army and the Commander of U.S. Army Medical Command. And as a commander, my first responsibility is for the health and welfare of my soldiers. As a physician, my first responsibility is the health and welfare of my patient.

As we have seen over the last several days, the housing condition here in one of the buildings here at Walter Reed clearly has not met our standards. And for that I am personally and professionally sorry. And I offer my apologies to the soldiers, the families, the civilian and military leadership of the Army and the Department of Defense and to the Nation.

It is also clear that the complex and bureaucratic administration systems that support the Medical Evaluation Board and the Physical Evaluation Board are complex and demand urgent simplification.

I am dedicated to doing everything in my power and authority to bring a positive change to this process. Simply put, I am in command. And as I share these failures, I also accept the responsibility and the challenge for rapid corrective action. We are taking immediate actions to improve the living conditions and welfare of our soldier patients, to increase responsiveness of our leaders and the medical system, and to enhance support services for families of our wounded soldiers. We are taking action to put into place long-term

solutions for the complex bureaucratic medical evaluation process that is impacting on our soldiers.

Living conditions in Building 18 at Walter Reed are not acceptable. We are fixing them now. And as of this morning, we have moved out all but six soldiers to other, better accommodations on the campus.

Although Walter Reed base operations staff has corrected some of the things that you have seen in the paper, we are taking immediate action to begin more extensive renovations of the roof, the exterior. We are going to remodel the bathrooms, put new carpets, new air conditioning units into this facility to bring it up to what we consider to be acceptable standards.

Lieutenant General Bob Wilson, the commander of the Installation Command, and I have sent a team out across 11 or so installations to look at similar bureaucratic, administrative, and clinical conditions and infrastructure conditions to ensure that our other installations do not have issues associated with here at Walter Reed. So we know that we have had some mortar problems and we are fixing them.

But we have human problems here, too, and this is about soldiers and their families. America's soldiers go to war and they are confident that if they are injured, they will be returned to a first-class medical facility. It is said that a soldier won't charge an objective out of the sight of a medic. For us it is the 68 whisky, and there is a connection between that 68 whisky on the battlefield, the transportation system, the air-vac system, Landstuhl Regional Medical Center, Walter Reed and the rest of our facilities that is unbroken. And nothing can be allowed to shake the confidence in that system, including the superb performance of Walter Reed and ensuring that our soldiers are cared for.

Secretary Gates has made it very clear that he expects decisive action, and he and our soldiers will get it. You know, the system that we use to decide if a soldier is medically fit for continued service or, if not, determine the appropriate disability system and transferring him to the VA is complex, confusing, and frustrating. What we have realized over these last 4 to 5 years is the nature of the injuries these soldiers receive is also very complex. And I will talk about that in just a minute.

The tactics, techniques and procedures we use in the asymmetric battlefield are required to be changed to adjust to our enemies. The procedures that we use in our medical system need to be changed appropriately as we see the circumstances surrounding our soldiers and their disabilities change. And what we really need to do, in my opinion, is to make this whole process less confrontational, less adversarial.

To meet the human factor changes, we are making some adjustments here at Walter Reed. I think you have heard some of that already. We are bringing on more nurses, case managers, more Physical Evaluation Board liaison officers and more physicians to review medical cases. This will lower the case ratio for case managers, improve communications and speed the processing of paperwork.

We really need to reinvent this process, and we have a team now looking at interanalysis of the MEB process, the PEB process, to

see if we can better improve it. The two most common complaints we hear from soldiers about the MEB/PEB process is that we take too long or we rush soldiers through. So we need to be very careful to simultaneously provide soldiers the very best medical care that modern science and medicine in America can offer, while at the same time ensuring that the rights of those soldiers to a full and equitable analysis is protected, and we will be very careful to protect the quality of the care and the fair assessment of soldier disability. We want all these soldiers to return to their units or to their homes as quickly as they can. But we want them to benefit from the full capability of modern medicine. We want to do it right.

Your Army medical professionals have earned a tremendous reputation during this war. The marvels of modern technology have allowed us to bring more soldiers off the battlefield, increase their survival rates. The training of our combat medics and our frontline surgeons, the equipment we have placed, as I referenced earlier, our Air Force counterparts and their CCATT teams, moving soldiers, sailors, airmen and marines around the world is unprecedented. We can bring soldiers from the battlefield to this great facility in 36 hours or less.

Mr. TIERNEY. General, your comments are going to be put on the record, so if you can help us by just concluding.

General KILEY. I will, sir.

In summary, I would say the staff here at Walter Reed, the technology we have applied, and the unwavering support of Congress and the American people have made all this happen. It is regrettable that it took the Washington Post to bring some of this to light, but in retrospect, it will help us accelerate the process of making change and improving things.

I am committed personally to regaining the trust of the American people, the soldiers and their families everywhere that our Army medical department system can be trusted and that it is the best in the world. I have served in the Army for 30 years as a physician and soldier, taking care of patients and serving our Nation. And I remain honored to command and lead the great men and women of the Army Medical Department. Thank you, Mr. Chairman.

Mr. TIERNEY. Thank you.

[The prepared statement of General Kiley follows:]

UNCLASSIFIED

RECORD VERSION

STATEMENT BY
LIEUTENANT GENERAL KEVIN C. KILEY
THE SURGEON GENERAL

HOUSE COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
NATIONAL SECURITY AND FOREIGN AFFAIRS SUBCOMMITTEE
UNITED STATES HOUSE OF REPRESENTATIVES

FIRST SESSION, 110TH CONGRESS

WALTER REED ARMY MEDICAL CENTER OUTPATIENT CARE

5 MARCH 2007

NOT FOR PUBLICATION
UNTIL RELEASED BY THE
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

UNCLASSIFIED

Statement By
Lieutenant General Kevin C. Kiley

Mr. Chairman, Congressman Shays, and distinguished members of the subcommittee, thank you for the opportunity to discuss recent media reports about the living conditions, accountability procedures, medical care, and administrative processing of Soldier-patients receiving recuperative or rehabilitative care at Walter Reed Army Medical Center (WRAMC) as outpatients. The leadership and staff of WRAMC are committed to providing world class care for our wounded warriors and we are all upset by the problems detailed in the Washington Post series.

Let me begin by informing you that in the past two weeks I have directed three separate investigations into various problems raised by the Washington Post articles. First, prior to the articles being published, I asked the US Army Criminal Investigation Division to open an investigation into allegations of improper conduct by Dr. Michael Wagner, the former Director of WRAMC's Medical and Family Assistance Center (MEDFAC). The Washington Post published these allegations on Tuesday, 21 February 2007. In addition, I directed two more investigations. The second investigation will look specifically at the execution of command responsibility by the WRAMC Medical Center Brigade and the WRAMC Garrison Command to ensure safe, healthy living conditions for our recovering Warriors. The final investigation will look into WRAMC's internal Medical Evaluation Board (MEB)/Physical Evaluation Board (PEB) processing. The intent of these investigations is to uncover systemic breakdowns in our processes and to improve our system of care for wounded warriors. Once these investigations are complete, we will report back to you on our findings and our actions.

Since 2002, WRAMC has provided highly personalized health care by treating more than 6,000 Soldiers from Operation Enduring Freedom and Operation Iraqi Freedom. Nearly 2,000 of these Soldiers suffered battle injuries, more than 1,650 of whom started their care at WRAMC as inpatients – receiving life-saving medical treatments, needed surgeries and physical therapy – then progressed to outpatient status living near the hospital. A team of 4,200 medical professionals treat these

wounded warriors and dedicate their lives and hearts to helping our Soldiers. On average, more than 200 family members also join them to help with recovery, provide emotional support, and offer a strong hand or a warm hug to carry them through difficult days.

The requirement to assign Soldiers to Medical Holding Units (MHU) is dictated by internal Department of Defense regulations. The Army policy for assigning Soldiers to MHUs is intended to support the needs of the individual Soldier and his/her family. Soldiers with long-term debilitating conditions such as spinal cord and brain injuries or terminal cancer fall into this category and require intensive medical and administrative management only available at the MHU. In certain circumstances a Soldier may be assigned to a MHU while undergoing outpatient treatment when the Military Treatment Facility Commander determines that continuous treatment is required and that the Soldier cannot be managed by his or her unit, i.e., is unable to perform even limited duty at the unit.

Army military treatment facilities have two types of MHU. Active component Soldiers whose medical condition prevents them from performing even limited duty within their unit are assigned to a medical hold company. Each Army hospital with inpatient capability is authorized a medical hold company. Generally speaking, a majority of Soldiers assigned to medical hold companies have medical conditions that will eventually lead to separation from service or medical retirement. Since 2003, reserve component Soldiers who cannot deploy, are evacuated back to the US during their units' deployment, or return home with a medical condition are assigned to a medical holdover company. At WRAMC, both companies are organized under the Medical Center Brigade, which also has command responsibility for permanent party and students assigned or attached to WRAMC.

The current conflict is the longest in US history fought by volunteers since the Revolution. Two dozen Soldiers arrive each week and remain on the campus an average of 297 days for active duty, and 317 days for Reserve and National Guard. Often the very first thing they ask when they are able to speak is "When can I get back to my guys?"

The rehabilitation process at Walter Reed is also unique in its focus to restore these wounded Soldiers not just to a functioning level in society, but to return them to the high level of athletic performance they had before they were wounded for continued service in

the US military if possible. This is the stated goal of the WRAMC program, as well as the newer program at the Center for the Intrepid which was modeled after the Walter Reed successes.

The amputee population deserves special note as an example of these initiatives. There have been a total of 552 Soldier members who have suffered major limb amputation in the war. Of these, 432 of the patients were cared for at WRAMC: 394 service members from OIF (68 with multiple amputations) and 38 service members from OEF (6 with multiple amputations). There have been 35 amputee patients with major limb loss who were found fit for duty (17 that are Continuation on Active Duty/Continuation on Active Reserve and 18 remaining to complete the Medical Board process). Five of the 17 Soldiers have returned to serve on the front lines in CENTCOM. All of the Soldiers were monitored and supported by MH or MHO companies during their rehabilitation at Walter Reed.

It is important to note that, with the exception of burn patients, WRAMC cares for most of the critically injured Soldiers. Our Brooke Army Medical Center and its new state-of-the–art rehabilitation center, cares for many critically injured Soldiers with units or home-of record in the South West. The complexity of the injuries and illnesses suffered by these Soldiers often results in a recovery period that is longer and more challenging than those cared for at most other Department of Defense facilities. This places significant stress on the Soldier-patient, their families, and the staff providing care. The media reports about inadequate living conditions brought to light frustrations with billeting and the administrative processes necessary to return these warriors to duty or to expeditiously and compassionately transition them to civilian life. I would like to address three problem areas reported in the Washington Post series: Living conditions in Building 18; accountability management of outpatient-Soldiers; and, administrative processing of medical evaluation boards (MEB) and physical evaluation boards (PEB).

Billeting Issues and Living Conditions in Building 18

As Soldiers are discharged from inpatient status, many need to remain at WRAMC for continued care. Historically, the combination of permanent party Soldier barracks, off-post lodging, and three Fisher Houses have been sufficient to meet the

normal demand for billeting Soldiers assigned to the MHU at WRAMC. Beginning in 2003 the population of active and reserve component Soldiers assigned to WRAMC's MHU increased from 100-120 before the war to a high of 874 in the summer of 2005. To accommodate this increase in outpatient-Soldiers, WRAMC made use of all 199 rooms in the Mologne House – a non-appropriated fund hotel on the installation opened in 1996; 86 rooms in two buildings operated by the Mologne House; 30 rooms in three Fisher Houses; and, 15 contract hotel rooms in the Silver Spring Hilton. With the exception of building 18, all of these facilities have had extensive renovations performed over the last 10 years and have amenities similar to many modern hotels.

In the summer of 2005, WRAMC began housing the healthiest of the outpatient-Soldiers in Building 18 – a former civilian hotel across the street from the main WRAMC campus. Building 18 was constructed in 1969 and leased periodically by WRAMC until the government acquired the building in 1984. Between 2001 and 2005, more than $400,000 in renovations were made to Building 18. In 2005, a $269,000 renovation project made various improvements in all 54 rooms to include replacing carpeting and vinyl flooring. Additional upgrades to the central day room included a donation of a pool table and the command purchase of couches and a large flat screen TV.

The healthiest of our outpatient-Soldiers are assigned rooms in Building 18 after careful screening by the chain of command, case managers, and treating physicians. Patients who have trouble walking distances, have PTSD, or have TBI are not allowed to live in Building 18.

Building 18 has 54 rooms. Whenever a new Soldier was assigned a room, the building manager directed the Soldier and his/her supervisor to identify any deficiencies or damage in the room and initiates work orders to repair identified problems. Additionally, residents and their chain of command may submit work orders through the building manager at any time. This entire process is being reassessed to ensure proper accountability. Since February 2006, more than 200 repairs were completed on rooms in Building 18, repairs continue to be made, and a rapid renovation is planned.

In spite of efforts to maintain Building 18, the building will require extensive repairs if it is going to continue to remain in service. Upon reading the Washington Post articles, I personally inspected Building 18. As noted in the article, the elevator and

security gate to the parking garage are not operational. Twenty-six rooms had one or more deficiencies which require repair. Two of these rooms had mold growth on walls. Thirty outstanding work orders have been prioritized and our Base Operations contractor has already completed a number of repairs. We are also working closely with US Army Installation Management Command, the Army Corps of Engineers, and our Health Facility planners to replace the roof and renovate each room.

There are currently no signs of rodents or cockroaches in any rooms. In October 2006, the hospital started an aggressive campaign to deal with a mice infestation after complaints from Soldiers. Preventive medicine specialists inspected the building and found rooms with exposed food that attracted vermin. Removing the food sources and increased oversight by the chain of command has since brought this problem under control, although such problems require vigilant monitoring, which is on-going.

Accountability and Information Flow to Outpatient-Soldiers

As of 16 February 2007 WRAMC had a total of 652 active and reserve component Soldiers assigned or attached to two MHUs. Currently there are 450 active component Soldiers assigned or attached to WRAMC's Medical Center Brigade. There are 202 reserve component Soldiers assigned or attached. Platoon sergeants and care managers are key to accounting for, tracking, and assisting Soldiers as they rehabilitate, recuperate, and process through the disability evaluation system. Prior to January 2006, WRAMC only had a single medical-hold company to provide command and control, and accountability for all of those Soldiers. Since January 2006, the hospital created new organizational structures to decrease the Soldier-to-platoon sergeant and Soldier-to-case manager ratio from one staff member for every 125 Soldiers to 1 platoon sergeant and 1 case manager for approximately 30 Soldiers.

Platoon sergeants and case managers attend staff training every Thursday. The training consists of various topics ranging from resource availability to Soldier services. Weekly Thursday training is supplemented with a platoon sergeant/case manager orientation program. Departing platoon sergeants work along side their replacement for approximately one week. Reserve component case managers attend a one week training program at Fort Sam Houston Texas for an overview of the Medical Holdover

Program, MEB/PEB process, customer service training and the duties of a case manager. Upon arrival at WRAMC, these case managers undergo a month-long preceptor program. Once hired by WRAMC, these case managers undergo a one-week training program to address organizational structure, MEB/PEB process, case manager roles and responsibilities, use of data systems, administrative documentation, convalescent leave and available resources in the hospital and on the installation, as well as expectations and standards. There is also a weekly clinical meeting held with physician advisory board and case managers for chart reviews and recommendation for the medical evaluation board process. Where ever possible we are working to streamline and merge platoon sergeant and case manager training to make it identical for all new personnel such as incorporating the preceptor concept for both Medical Hold and Medical Holdover units. We will also enhance the weekly training to introduce topics that are not only important to the platoon sergeant and case manager but address recurring issues/concerns raised by Soldiers and family members.

We are conducting a 100% review of the discharge planning and handoff process to ensure the transition from inpatient to outpatient is seamless and patients understand the next step in their recovery. This discharge will now include a battle handoff to a platoon sergeant. We are also in the process of hiring additional case managers and will submit plans to increase other critical positions in the Medical Center Brigade, which will reduce the current staff to outpatient ratio to more manageable levels, allowing more personalized service to the recovering soldier and family member in making appointments, completing necessary paperwork and navigating the complex disability evaluation systems.

The Medical Family Assistance Center (MEDFAC) will co-locate functions performed by Human Resources Command, Finance, and Casualty Assistance into the Medical Family Assistance Center allowing service in one location. In the near term, WRAMC will expand the staff to support the family members and relocate the operations to a more centralized 3,000 SF space in the hospital providing an improved environment for the families to obtain assistance.

The Medical Center Brigade recently established a Soldier and Family Member Liaison Cell to receive feedback from Soldiers and family members. A recent survey of

Soldiers and family members in January 2007 indicated that less than 3% of the outpatient-Soldier population voiced complaints about administrative processes. The command will continue to enhance the structure of the Soldier and Family Member Liaison Cell. We have requested three Family Life Consultants from the Family Support Branch of the Community and Family Support Center, Installation Management Command (IMCOM) to expand the resources available to identify areas of interest as well as provide counseling support to Soldiers and family members. We also will expand the current survey feedback process to include an intake survey for Soldiers and family members, a monthly Town Hall meeting and survey for ongoing issues, and an outtake survey upon the departure of Soldiers and family members. This feedback will be reviewed by the WRAMC Commander and other key leaders.

The Mologne House has approximately 30 personnel on staff that speak Spanish. These personnel work in all departments and a number of them are in management positions. These personnel have been assisting the Spanish speaking Soldiers and their families since the hotel opened. The Mologne House is taking steps to ensure the desk has a Spanish speaking staff member on call 24 hours a day to assist those in need of translation services.

Patients arrive at WRAMC by aero-medical evacuation flights three times a week, (Tuesday, Friday and Sunday). Additionally, some patients arrive at WRAMC on commercial flights for medical care. Family members may arrive with the Soldier or through their own travel itinerary. Soldiers and family members who arrive on MEDEVAC flights are met by an integrated team of clinical staff, MEDFAC, Red Cross, Patient Administration, Unit Liaison NCOs, and Medical Center Brigade representatives. Inpatients are triaged for further evaluation and disposition. Outpatients remain on the ambulance bus and are sent to the Mologne House with a representative from the Medical Center Brigade for billeting. Family members are met by MEDFAC and Red Cross and are escorted to the Mologne House for lodging.

Currently, there are 51 GWOT inpatient casualties. Our census ranges between 30 and 50 depending on the volume of air evacuations (high of 359 in July 2003 to low since OIF began of 64 in November 2005). Roughly half of the patients come as inpatients, and half as outpatients. Outpatients are processed through the Medical

Center Brigade for accountability and billeting when they arrive. Inpatients are accounted for by the hospital's patient administration office. We believe as many as one in five patients may be at risk to miss some of the administrative in processing at the Medical Center Brigade when they are discharged from the hospital, because of the timing of their discharge, their underlying medical condition, or miscommunication. I have directed a complete review of the discharge planning and the development of a new handoff process between the hospital and the Medical Center Brigade. This will include the development of a "GWOT Discharge Validation Inventory" that will be completed by the attending physician, discharging nurse, discharging pharmacist, social worker, brigade staff and hospital patient administration. The checklist will be validated by the Nursing Supervisor, Attending Physician, Deputy Commander for Clinical Services (DCCS) or Deputy Commander for Nursing (DCN).

Each Soldier receives a handbook upon assignment or attachment to Med Hold or Med Holdover. The Med Hold handbook is provided to Soldiers when they are assigned or attached by their respective PLT SGT. Newly arriving family members receive a Hero Handbook as well as a newcomer's orientation binder. Family members attend weekly new arrival meeting and a weekly town hall meeting where information is exchanged to answer questions or discuss ideas. Physical Evaluation Board Liaison Officers conduct monthly training sessions on the MEB/ PEB process for Soldiers and family members. A Case Management booklet with frequently asked questions is also provided to Soldiers.

Administrative processing of MEBs and PEBs

The MEB/PEB process is designed with two goals in mind – (1) to ensure the Army has a medically fit and ready force and (2) to protect the rights of Soldiers who may not be deemed medically fit for continued service. This process was designed to support a volunteer Army with routine health occurrences and it is essentially a paper process. We can and will improve this process in order to ensure that it can support a wartime Army experiencing large numbers of serious casualties.

The average reserve component Soldier assigned to Medical Holdover at WRAMC has been with us for approximately 289 days. We know from past experience

they will be with us, on average, for 317 days from the time they are assigned to the Medical Holdover Company. The primary reason for this lengthy stay is the requirement that each Soldier be allowed to achieve "optimal medical benefit" – in other words, heal to the point that further medical care will not improve the Soldier's condition. All humans heal at different rates and this accounts for the longest part of the process.

Once the treating provider determines the Soldier has reached the point of optimal medical benefit the provider will initiate an MEB. This is a thorough documentation of all medical conditions incurred or aggravated by military service and ultimately concludes with a determination of whether the Soldier meets medical fitness standard for retention. If the treating provider and the hospital's Deputy Commander for Clinical Services agree the Soldier does not meet medical fitness standards, the case is referred to the PEB.

The PEB is managed by US Army Human Resources Command and is comprised of a board of officers, including physicians, who review each MEB. The role of the PEB is to evaluate each medical condition, determine if the Soldier can be retained in service, and, if not retainable, assign a disability percentage to each condition. The total disability percentage assigned determines the amount of military compensation received upon separation. It is important to note that the MEB/PEB process has no bearing on disability ratings assigned by the Department of Veterans Affairs (DVA), but thorough and complete documentation of medical conditions is essential for expeditious review by the PEB and will also aid the Soldier in completing DVA documentation requirements.

The Washington Post articles provide anecdotal experiences of Soldiers and families who have had medical records and other paperwork lost during the MEB/PEB process. All medical records at WRAMC are generated electronically. However, paper copies must be printed since the PEB cannot access the electronic medical record used by Department of Defense hospitals.

There are currently 376 active MEB/PEB cases being processed by the WRAMC PEBLOs. The average time from initiation of a permanent profile to the PEB is 156 days. The MEB is processed through the PEB and Physical Disability Agency for an average of 52 days (including the ~15% of cases returned to the hospital for further

information). Thus, the total time from permanent profile to final disability rating is currently 208 days. At present, WRAMC has 12 trained PEBLO counselors. We are hiring an additional 10 counselors and 4 MEB review physicians to expedite the medical board process. It takes at least 3 months to train a PEBLO counselor and these employees are the main interface between the Soldier and the MEB/PEB system. As you might imagine, PEBLO counselors need to have excellent interpersonal and communication skills to perform well in a system that can be very stressful for the Soldier, family, and counselor.

In closing, let me again emphasize my appreciation for your continued support of WRAMC and Army Medicine. The failures highlighted in the Washington Post articles are not due to a lack of funding or support from Congress, the Administration, or the Department of Defense. Nor are they indicative of the standards I have set for my command. Walter Reed represents a legacy of excellence in patient care, medical research and medical education. I can assure you that the quality of medical care and the compassion of our staff continue to uphold Walter Reed's legacy. But it is also evident that we must improve our facilities, accountability, and administrative processes to ensure these systems meet the high standards of excellence that our men and women in uniform so richly deserve. Thank you again for your concern regarding this series of articles.

Mr. TIERNEY. General Weightman.

STATEMENT OF MAJOR GENERAL GEORGE H. WEIGHTMAN

General WEIGHTMAN. Thank you, Mr. Chairman, Congressman Waxman, Congressman Davis, Congressman Shays, distinguished members of the committee, I appreciate the opportunity to appear today to discuss the problems about which we are all concerned, brought to light at the Walter Reed Army Medical Center.

I am Major General George Weightman and I commanded the North Atlantic Regional Medical Command and Walter Reed Army Medical Center from August 25, 2006 until last week. Secretary of Defense Gates, all of our Army leaders, and you have called this a failure of leadership. I agree. I was Walter Reed Commander, and from what we see with some soldiers' living conditions and the administrative challenges we faced and the complex Medical Board/Physical Evaluation Board processes, it is clear mistakes were made, and I was in charge. We can't fail one of these soldiers or their families, not one, and we did.

There is another point on which I believe we should agree, because it is important that the American people and our soldiers in harm's way believe that both inpatient and outpatient medical care delivered by the professional health care team at Walter Reed are superb. There are not two separate medical systems of care at Walter Reed. Outpatients are seen by the same doctors and nurses as the inpatients. Outpatient medical care is not second class. It is on a par with our inpatient care. You have seen this on your visits, and our soldiers and families deserve it.

Having said that, I acknowledge there are problems and frustrations with a process of accessibility and following up on that outpatient care, and we are aggressively seeking ways and implementing solutions to make that system more responsive, more efficient, more effective and more compassionate.

We do not see where some of these soldier-patients were living, and we should have. There are 371 rooms on Walter Reed where we house our outpatients at Walter Reed; 26 rooms in Building 18 were in need of repairs. We should not have allowed that to happen, because our soldiers deserve better, and it is important to their overall rehabilitation and well-being which is entrusted to us.

Also, we do not fully recognize the frustrating bureaucratic and administrative processes some of these soldiers go through. We should have. And in this I failed.

Over the last 2 weeks, we have heard of problems from months and years ago, many of them individually fixed immediately, but we obviously missed the big picture because not one of those soldiers deserves to be satisfied. I am disappointed that I will not be able to continue and lead the changes we must make to care for these soldiers and their families but I respect the Army's decision. I retain and I hope that you would share the confidence in the abilities of the Army leaders' commitment and the Army Medical Department, wonderful health care professionals who care for soldiers and create the innovative and long overdue process changes that we all agree are needed.

Thank you, Mr. Chairman, for holding this hearing. I hope my testimony today will allow us to address these problems and start

to reaffirm America's confidence in Walter Reed Army Medical Center.

Mr. TIERNEY. Thank you sir.

Ms. Bascetta.

STATEMENT OF CYNTHIA A. BASCETTA

Ms. BASCETTA. Mr. Chairman and members of the committee, thank you for inviting me here today to discuss GAO's work on the challenges encountered by soldiers who sustained serious injuries in service to our Nation. Our work has shown the array of significant medical and administrative challenges these soldiers face throughout their recovery process as they navigate the DOD and VA health care and disability systems.

As you know, blasts and fragments from IEDs, landmines, and other explosive devices cause about 65 percent of their injuries and many more of the wounded are surviving serious injuries that would have been fatal in prior wars. But the miracle of battlefield medicine is also the enduring hardship of the war borne by the soldiers and their families. Following acute hospital care, their recovery often requires comprehensive inpatient rehabilitation to address complex cognitive, physical, and psychological impairments. This exacts a huge toll on the patients and their families.

My testimony today is based on conditions we found during the time of our audit work regarding problems with the sharing of medical records, provision of vocational rehabilitation, screening for post-traumatic stress disorder and military pay.

In 2006 we reported that DOD and VA had problems sharing medical records for service members transferred from DOD to VA polytrauma centers. These VA facilities were mandated in statute to help treat seriously injured Active Duty service members returning from Iraq and Afghanistan. Yet two VA facilities lack realtime access to electronic medical records at DOD facilities. VA physicians reported a time-consuming process involving multiple faxes and phone calls to get information they needed to treat their patients. I emphasize that these are patients still on Active Duty, not veterans.

About 3 weeks ago, it was reported that DOD cutoff VA physicians' access to DOD medical records because the two bureaucracies had not finalized data-use agreements. It is hard to fathom such action and the potentially adverse effects that it could have had on patient care.

In 2005 we reported that seriously injured soldiers may not be able to benefit from early intervention services provided by VA. GAO put Federal disability programs on its high-risk list in part because they lack focus on returning people with disabilities to work. The importance of early intervention for restoring injured persons to their full potential is well documented in the literature. But DOD expressed concerns that VA's efforts to intervene early could have conflicted with the military's retention goals.

Meanwhile, soldiers treated as outpatients in military or VA hospitals were waiting months for DOD to assess whether they would be able to return to Active Duty. We recommended that VA and DOD collaborate to reach an agreement for VA to have access to

information that both agencies agree is needed to promote recovery and return to work, either in the military or in the civilian sector.

Also in 2006 we reported that DOD screen service members for PTSD as part of its postdeployment health assessment, but could not reasonably assure that those who needed referrals received them. We found that only 22 percent of those who may have been at risk of developing PTSD had been referred for further mental health evaluation. DOD had not identified the factors its clinical providers used in making referrals but concurred with our recommendations to do so.

As early as 2004 we also reported that officials at six out of seven VA facilities were concerned about meeting an increasing demand for PTSD services from new veterans returning from the war. They estimated that giving priority to these veterans, as they had been directed to do, could delay appointments for veterans already receiving PTSD services by up to 90 days.

Compounding their health and rehabilitation struggles, we reported to this committee in 2005 and 2006 that problems related to military pay had resulted in overpayments and debt for hundreds of sick and injured soldiers on Active Duty and in the National Guard and Reserves. Hundreds of combat-injured soldiers were pursued for repayment of debt incurred through no fault of their own, including at least 74 who were reported to credit bureaus and collection agencies.

As a result of our audit, we understand that manual overrides are in place to help prevent this problem but that the underlying payment systems have not been fixed. We also found that administrator problems had caused some injured Reserve component soldiers to be dropped from Active Duty. And for some, this led to significant gaps in both pay and health insurance.

In summary, I would not want to overlook the dedication and compassion of the many providers we have met at DOD and VA facilities throughout the course of our work. But the cumulative message from our body of work is that too often our wounded soldiers have been poorly served or are at risk of falling through the cracks of the two bureaucracies responsible for their health and well-being. I would be happy to answer any questions you might have.

Mr. TIERNEY. Thank you Ms. Bascetta.

[The prepared statement of Ms. Bascetta follows:]

United States Government Accountability Office

GAO

Testimony

Before the Subcommittee on National Security and Foreign Affairs, Committee on Oversight and Government Reform, House of Representatives

For Release on Delivery
Expected at 10:00 a.m. EST
Monday, March 5, 2007

DOD AND VA HEALTH CARE

Challenges Encountered by Injured Servicemembers during Their Recovery Process

Statement of Cynthia A. Bascetta
Director, Health Care

GAO-07-589T

March 5, 2007

GAO
Accountability·Integrity·Reliability
Highlights

Highlights of GAO-07-589T, a testimony before the Subcommittee on National Security and Foreign Affairs, Committee on Oversight and Government Reform, House of Representatives

DOD AND VA HEALTH CARE

Challenges Encountered by Injured Servicemembers during Their Recovery Process

Why GAO Did This Study

As of March 1, 2007, over 24,000 servicemembers have been wounded in action since the onset of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), according to the Department of Defense (DOD). GAO work has shown that servicemembers injured in combat face an array of significant medical and financial challenges as they begin their recovery process in the health care systems of DOD and the Department of Veterans Affairs (VA).

GAO was asked to discuss concerns regarding DOD and VA efforts to provide medical care and rehabilitative services for servicemembers who have been injured during OEF and OIF. This testimony addresses (1) the transition of care for seriously injured servicemembers who are transferred between DOD and VA medical facilities, (2) DOD's and VA's efforts to provide early intervention for rehabilitation for seriously injured servicemembers, (3) DOD's efforts to screen servicemembers at risk for post-traumatic stress disorder (PTSD) and whether VA can meet the demand for PTSD services, and (4) the impact of problems related to military pay on injured servicemembers and their families.

This testimony is based on GAO work issued from 2004 through 2006 on the conditions facing OEF/OIF servicemembers at the time the audit work was completed.

www.gao.gov/cgi-bin/getrpt?GAO-07-589T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Cynthia A. Bascetta at (202) 512-7101 or bascettac@gao.gov.

What GAO Found

Despite coordinated efforts, DOD and VA have had problems sharing medical records for servicemembers transferred from DOD to VA medical facilities. GAO reported in 2006 that two VA facilities lacked real-time access to electronic medical records at DOD facilities. To obtain additional medical information, facilities exchanged information by means of a time-consuming process resulting in multiple faxes and phone calls.

In 2005, GAO also reported that VA and DOD collaboration is important for providing early intervention for rehabilitation. VA has taken steps to initiate early intervention efforts, which could facilitate servicemembers' return to duty or to a civilian occupation if the servicemembers were unable to remain in the military. However, according to DOD, VA's outreach process may overlap with DOD's process for evaluating servicemembers for a possible return to duty. DOD was also concerned that VA's efforts may conflict with the military's retention goals. In this regard, DOD and VA face both a challenge and an opportunity to collaborate to provide better outcomes for seriously injured servicemembers.

DOD screens servicemembers for PTSD but, as GAO reported in 2006, it cannot ensure that further mental health evaluations occur. DOD health care providers review questionnaires, interview servicemembers, and use clinical judgment in determining the need for further mental health evaluations. However, GAO found that 22 percent of the OEF/OIF servicemembers in GAO's review who may have been at risk for developing PTSD were referred by DOD health care providers for further evaluations. According to DOD officials, not all of the servicemembers at risk will need referrals. However, at the time of GAO's review DOD had not identified the factors its health care providers used to determine which OEF/OIF servicemembers needed referrals. Although OEF/OIF servicemembers may obtain mental health evaluations or treatment for PTSD through VA, VA may face a challenge in meeting the demand for PTSD services. VA officials estimated that follow-up appointments for veterans receiving care for PTSD may be delayed up to 90 days.

GAO's 2006 testimony pointed out problems related to military pay have resulted in debt and other hardships for hundreds of sick and injured servicemembers. Some servicemembers were pursued for repayment of military debts through no fault of their own. As a result, servicemembers have been reported to credit bureaus and private collections agencies, been prevented from getting loans, gone months without paychecks, and sent into financial crisis. In a 2005 testimony GAO reported that poorly defined requirements and processes for extending the active duty of injured and ill reserve component servicemembers have caused them to be inappropriately dropped from active duty, leading to significant gaps in pay and health insurance for some servicemembers and their families.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss health care and other services for U.S. military servicemembers wounded during Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF).[1] On March 1, 2007, the Department of Defense (DOD) reported that over 24,000 servicemembers have been wounded in action since the onset of the two conflicts. In 2005, DOD reported that about 65 percent of the OEF and OIF servicemembers wounded in action were injured by blasts and fragments from improvised explosive devices, land mines, and other explosive devices. More recently, DOD estimated in 2006 that as many as 28 percent of those injured by blasts and fragments have some degree of trauma to the brain. These injuries often require comprehensive inpatient rehabilitation services to address complex cognitive and physical impairments. In addition to their physical injuries, OEF/OIF servicemembers who have been injured in combat may also be at risk for developing mental health impairments, such as post-traumatic stress disorder (PTSD), which research has shown to be strongly associated with experiencing intense and prolonged combat.[2]

While servicemembers are on active duty, DOD decides where they receive their care—at a military treatment facility (MTF), from a TRICARE civilian provider,[3] or at a Department of Veterans Affairs (VA) medical facility. From the OEF and OIF conflict areas, seriously injured servicemembers are usually brought to Landstuhl Regional Medical Center in Germany for treatment. From there, they are usually transported to MTFs located in the United States, with most of the seriously injured admitted to Walter Reed Army Medical Center or the National Naval

[1]OEF, which began in October 2001, supports combat operations in Afghanistan and other locations, and OIF, which began in March 2003, supports combat operations in Iraq and other locations.

[2]Charles W. Hoge et al., "Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care," *The New England Journal of Medicine*, 351 (2004): 13-22.

[3]DOD provides health care through TRICARE—a regionally structured program that uses civilian contractors to maintain provider networks to complement health care services provided at MTFs.

Medical Center, both of which are in the Washington, D.C., area.[4] Once the servicemembers are medically stabilized, DOD can elect to send those with traumatic brain injuries and other complex trauma, such as missing limbs, to one of the four polytrauma rehabilitation centers (PRC)[5] operated by VA for medical and rehabilitative care. The PRCs are located at VA medical centers in Palo Alto, California; Tampa, Florida; Minneapolis, Minnesota; and Richmond, Virginia. While many servicemembers who receive such rehabilitative services return to active duty after they are treated, others who are more seriously injured are likely to be discharged from their military obligations and return to civilian life with disabilities.

Our work has shown that servicemembers injured in combat face an array of significant medical and financial challenges as they begin their recovery process in the DOD and VA health care systems. In light of these challenges and recent media reports that have highlighted unsanitary and decrepit living conditions at the Walter Reed Army Medical Center,[6] you asked us to discuss concerns we have identified regarding DOD and VA efforts to provide medical care and rehabilitative services for servicemembers who have been injured during OEF and OIF. Specifically, my remarks today will focus on (1) the transition of care for seriously injured OEF/OIF servicemembers—those with traumatic brain injuries or other complex trauma, such as missing limbs—who are transferred between DOD and VA medical facilities; (2) DOD's and VA's efforts to provide early intervention for rehabilitation services as soon as possible after the onset of a disability for seriously injured servicemembers; (3) DOD's efforts to screen OEF/OIF servicemembers at risk for PTSD and

[4] Other MTFs that received OEF/OIF servicemembers include Brooke Army Medical Center (San Antonio, Texas), Dwight David Eisenhower Army Medical Center (Augusta, Georgia), Madigan Army Medical Center (Tacoma, Washington), Darnall Army Community Hospital (Fort Hood, Texas), Evans Army Community Hospital (Fort Carson, Colorado), and the Naval Hospital Camp Pendleton (Camp Pendleton, California).

[5] The Veterans Health Programs Improvement Act of 2004, Pub. L. No. 108-422, § 302, 118 Stat. 2379, 2383-86, mandated that VA establish centers for research, education, and clinical activities related to complex multiple trauma associated with combat injuries. In response to that mandate, VA established PRCs at four VA medical facilities with expertise in traumatic amputation, spinal cord injury, traumatic brain injury, and blind rehabilitation. A PRC addresses the rehabilitation needs of the combat injured in one setting and in a coordinated manner.

[6] See, for instance, Dana Priest and Anne Hull, "Soldiers Face Neglect, Frustration at Army's Top Medical Facility," *The Washington Post* (Feb. 18, 2007).

whether VA can meet the demand for PTSD services; and (4) the impact of problems related to military pay on injured servicemembers and their families.

My testimony is based on issued GAO work.[7] The information I am reporting today reflects the conditions facing OEF/OIF servicemembers at the time the audit work was completed and illustrates the types of problems injured servicemembers encountered during their healing and rehabilitation process. To complete the work for these products, we visited DOD and VA facilities, reviewed relevant documents, analyzed DOD data, and interviewed DOD and VA officials. Our work was performed in accordance with generally accepted government auditing standards.

In summary, DOD and VA have made various efforts to provide medical care and rehabilitative services for OEF/OIF servicemembers. The departments established joint programs to facilitate the transfer of injured servicemembers from DOD facilities to VA medical facilities, assess whether servicemembers will be able to remain in the military, and assign VA social workers to selected MTFs to coordinate the transfers. DOD has also established a program to screen servicemembers after their deployment outside of the United States has ended to assess whether they are at risk for PTSD. However, we found several problems in the efforts to provide health care and rehabilitative services for OEF/OIF servicemembers. For example, VA and DOD had problems sharing medical records and questions arose about the timing of VA's outreach to servicemembers whose discharge from military service was not certain. Furthermore, we found that DOD cannot provide reasonable assurance that OEF/OIF servicemembers who need referrals for mental health evaluations receive them. Finally, problems related to military pay have resulted in overpayments and debt for hundreds of sick and injured servicemembers.

[7]See Related GAO Products at the end of this statement.

DOD and VA Have Taken Actions to Facilitate the Transfer of Servicemembers but Experienced Problems in Exchanging Health Care Information

In our June 2006 report, we found that DOD and VA had taken actions to facilitate the transition of medical and rehabilitative care for seriously injured servicemembers who were being transferred from MTFs to PRCs.[8] For example, in April 2004, VA and DOD signed a memorandum of agreement that established referral procedures for transferring injured servicemembers from DOD to VA medical facilities. VA and DOD also established joint programs to facilitate the transfer to VA medical facilities, including a program that assigned VA social workers to selected MTFs to coordinate transfers.

Despite these coordination efforts, we found that VA and DOD were having problems sharing the medical records VA needed to determine whether servicemembers' medical conditions allowed participation in VA's vigorous rehabilitation activities. VA and DOD reported that as of December 2005 two of the four PRCs had real-time access to the electronic medical records maintained at Walter Reed Army Medical Center and only one of the two also had access to the records at the National Naval Medical Center. In cases where medical records could not be accessed electronically, the MTF faxed copies of some medical information, such as the patient's medical history and progress notes, to the PRC. Because this information did not always provide enough data for the PRC provider to determine if the servicemember was medically stable enough to be admitted to the PRC, VA developed a standardized list of the minimum types of health care information needed about each servicemember transferring to a PRC. Even with this information, PRC providers frequently needed additional information and had to ask for it specifically. For example, if the PRC provider notices that the servicemember is on a particular antibiotic therapy, the provider may request the results of the most recent blood and urine cultures to determine if the servicemember is medically stable enough to participate in strenuous rehabilitation activities. According to PRC officials, obtaining additional medical information in this way, rather than electronically, is very time consuming and often requires multiple phone calls and faxes. VA officials told us that the transfer could be more efficient if PRC medical personnel had real-time access to the servicemembers' complete DOD electronic medical records from the referring MTFs. However, problems existed even for the two PRCs that had been granted electronic access. During a visit to those

[8]GAO, *VA and DOD Health Care: Efforts to Provide Seamless Transition of Care for OEF and OIF Servicemembers and Veterans*, GAO-06-794R (Washington, D.C.: June 30, 2006).

PRCs in April 2006, we found that neither facility could access the records at Walter Reed Army Medical Center because of technical difficulties.

DOD and VA Collaboration Is Important for Early Intervention for Rehabilitation

As discussed in our January 2005 report, the importance of early intervention for returning individuals with disabilities to the workforce is well documented in vocational rehabilitation literature.[9] We reported that early intervention significantly facilitates the return to work but that challenges exist in providing services early.[10] For example, determining the best time to approach recently injured servicemembers and gauge their personal receptivity to considering employment in the civilian sector is inherently difficult. The nature of the recovery process is highly individualized and requires professional judgment to determine the appropriate time to begin vocational rehabilitation. Our 2007 *High-Risk Series: An Update* designates federal disability programs as "high risk" because they lack emphasis on the potential for vocational rehabilitation to return people to work.[11]

In our January 2005 report, we found that servicemembers whose disabilities are definitely or likely to result in military separation may not be able to benefit from early intervention because DOD and VA could work at cross purposes. In particular, DOD was concerned about the timing of VA's outreach to servicemembers whose discharge from military service is not yet certain. DOD was concerned that VA's efforts may conflict with the military's retention goals. When servicemembers are treated as outpatients at a VA or military hospital, DOD generally begins to assess whether the servicemember will be able to remain in the military. This process can take months. For its part, VA took steps to make seriously injured servicemembers a high priority for all VA assistance. Noting the importance of early intervention, VA instructed its regional offices in 2003 to assign a case manager to each seriously injured servicemember who applies for disability compensation. VA had detailed

[9]GAO, *Vocational Rehabilitation: More VA and DOD Collaboration Needed to Expedite Services for Seriously Injured Servicemembers*, GAO-05-167 (Washington, D.C.: Jan. 14, 2005).

[10]We also reported on early intervention in GAO, *SSA Disability: Return-to-Work Strategies from Other Systems May Improve Federal Programs*, GAO/HEHS-96-133 (Washington, D.C.: July 11, 1996).

[11]GAO, *High-Risk Series: An Update*, GAO-07-310 (Washington, D.C.: January 2007).

staff to MTFs to provide information on all veterans' benefits, including vocational rehabilitation, and reminded staff that they can initiate evaluation and counseling, and, in some cases, authorize training before a servicemember is discharged. While VA tries to prepare servicemembers for a transition to civilian life, VA's outreach process may overlap with DOD's process for evaluating servicemembers for a possible return to duty.

In our report, we concluded that instead of working at cross purposes to DOD goals, VA's early intervention efforts could facilitate servicemembers' return to the same or a different military occupation, or to a civilian occupation if the servicemembers were not able to remain in the military. In this regard, the prospect for early intervention with vocational rehabilitation presents both a challenge and an opportunity for VA and DOD to collaborate to provide better outcomes for seriously injured servicemembers.

DOD Screens Servicemembers for PTSD after Deployment, but DOD and VA Face Challenges Ensuring Further PTSD Services

In our May 2006 report, we described DOD's efforts to identify and facilitate care for OEF/OIF servicemembers who may be at risk for PTSD.[12] To identify such servicemembers, DOD uses a questionnaire, the DD 2796, to screen OEF/OIF servicemembers after their deployment outside of the United States has ended. The DD 2796 is used to assess servicemembers' physical and mental health and includes four questions to identify those who may be at risk for developing PTSD. We reported that according to a clinical practice guideline jointly developed by VA and DOD, servicemembers who responded positively to at least three of the four PTSD screening questions may be at risk for developing PTSD. DOD health care providers review completed questionnaires, conduct face-to-face interviews with servicemembers, and use their clinical judgment in determining which servicemembers need referrals for further mental health evaluations.[13,14] OEF/OIF servicemembers can obtain the mental

[12]GAO, *Post-Traumatic Stress Disorder: DOD Needs to Identify the Factors Its Providers Use to Make Mental Health Evaluation Referrals for Servicemembers*, GAO-06-397 (Washington, D.C.: May 11, 2006).

[13]Health care providers that review the DD 2796 may include physicians, physician assistants, nurse practitioners, or independent duty medical technicians—enlisted personnel who receive advanced training to provide treatment and administer medications.

[14]DOD's referrals are used to document DOD's assessment that servicemembers are in need of further mental health evaluations.

health evaluations, as well as any necessary treatment for PTSD, while they are servicemembers—that is, on active duty—or when they transition to veteran status if they are discharged or released from active duty.

Despite DOD's efforts to identify OEF/OIF servicemembers who may need referrals for further mental health evaluations, we reported that DOD cannot provide reasonable assurance that OEF/OIF servicemembers who need the referrals receive them. Using data provided by DOD,[15] we found that 22 percent, or 2,029, of the 9,145 OEF/OIF servicemembers in our review who may have been at risk for developing PTSD were referred by DOD health care providers for further mental health evaluations. Across the military service branches, DOD health care providers varied in the frequency with which they issued referrals to OEF/OIF servicemembers with three or more positive responses to the PTSD screening questions—the Army referred 23 percent, the Air Force about 23 percent, the Navy 18 percent, and the Marines about 15 percent. According to DOD officials, not all of the OEF/OIF servicemembers with three or four positive responses on the screening questionnaire need referrals. As directed by DOD's guidance for using the DD 2796, DOD health care providers are to rely on their clinical judgment to decide which of these servicemembers need further mental health evaluations. However, at the time of our review DOD had not identified the factors its health care providers used to determine which OEF/OIF servicemembers needed referrals. Knowing these factors could explain the variation in referral rates and allow DOD to provide reasonable assurance that such judgments are being exercised appropriately.[16] We recommended that DOD identify the factors that DOD health care providers used in issuing referrals for further mental health evaluations to explain provider variation in issuing referrals. DOD concurred with the recommendation.

[15]In our review we analyzed computerized data provided by DOD to identify 178,664 OEF/OIF servicemembers who were deployed in support of OEF/OIF from October 1, 2001, through September 30, 2004, and who have since been discharged or released from active duty. These servicemembers had answered the four PTSD screening questions on the DD 2796 and had a record of their completed questionnaire available in a DOD computerized database. We found that DOD data indicated 9,145 of the 178,664 servicemembers in our review may have been at risk for developing PTSD.

[16]The John Warner National Defense Authorization Act for Fiscal Year 2007 required DOD to develop guidelines for mental health referrals, as well as mechanisms to ensure proper training and oversight, by April 2007. Pub. L. No. 109-364, § 738, 120 Stat. 2083, 2303-4.

Although OEF/OIF servicemembers may obtain mental health evaluations or treatment for PTSD through VA when they transition to veteran status, VA may face a challenge in meeting the demand for PTSD services. In September 2004 we reported that VA had intensified its efforts to inform new veterans from the Iraq and Afghanistan conflicts about the health care services—including treatment for PTSD—VA offers to eligible veterans.[17] We observed that these efforts, along with expanded availability of VA health care services for Reserve and National Guard members, could result in an increased percentage of veterans from Iraq and Afghanistan seeking PTSD services through VA. However, at the time of our review officials at six of seven VA medical facilities we visited explained that while they were able to keep up with the current number of veterans seeking PTSD services, they may not be able to meet an increase in demand for these services. In addition, some of the officials expressed concern because facilities had been directed by VA to give veterans from the Iraq and Afghanistan conflicts priority appointments for health care services, including PTSD services. As a result, VA medical facility officials estimated that follow-up appointments for veterans receiving care for PTSD could be delayed. VA officials estimated the delays to be up to 90 days.

Problems Related to Military Pay Have Resulted in Debt and Other Hardships for Hundreds of Sick and Injured Servicemembers

As discussed in our April 2006 testimony, problems related to military pay have resulted in overpayments and debt for hundreds of sick and injured servicemembers.[18] These pay problems resulted in significant frustration for the servicemembers and their families. We found that hundreds of battle-injured servicemembers were pursued for repayment of military debts through no fault of their own, including at least 74 servicemembers whose debts had been reported to credit bureaus and private collections agencies. In response to our audit, DOD officials said collection actions on these servicemembers' debts had been suspended until a determination could be made as to whether these servicemembers' debts were eligible for relief.

[17]GAO, *VA and Defense Health Care: More Information Needed to Determine If VA Can Meet an Increase in Demand for Post-Traumatic Stress Disorder Services*, GAO-04-1069 (Washington, D.C.: Sept. 20, 2004).

[18]GAO, *Military Pay: Military Debts Present Significant Hardships to Hundreds of Sick and Injured GWOT Soldiers*, GAO-06-657T (Washington, D.C.: April 27, 2006).

Debt collection actions created additional hardships on servicemembers by preventing them from getting loans to buy houses or automobiles or pay off other debt, and sending several servicemembers into financial crisis. Some battle-injured servicemembers forfeited their final separation pay to cover part of their military debt, and they left the service with no funds to cover immediate expenses while facing collection actions on their remaining debt.

We also found that sick and injured servicemembers sometimes went months without paychecks because debts caused by overpayments of combat pay and other errors were offset against their military pay.[19] Furthermore, the longer it took DOD to stop the overpayments, the greater the amount of debt that accumulated for the servicemember and the greater the financial impact, since more money would eventually be withheld from the servicemember's pay or sought through debt collection action after the servicemember had separated from the service.

In our 2005 testimony about Army National Guard and Reserve servicemembers, we found that poorly defined requirements and processes for extending injured and ill reserve component servicemembers on active duty have caused servicemembers to be inappropriately dropped from active duty.[20] For some, this has led to significant gaps in pay and health insurance, which has created financial hardships for these servicemembers and their families.

Mr. Chairman, this completes my prepared remarks. I would be happy to respond to any questions you or other members of the subcommittee may have at this time.

[19]We found that after voluntary allotments and other required deductions, many times there was no net pay due the servicemember.

[20]GAO, *Military Pay: Gaps in Pay and Benefits Create Financial Hardships for Injured Army National Guard and Reserve Soldiers*, GAO-05-322T (Washington, D.C.: Feb. 17, 2005).

Contacts and Acknowledgments

For further information about this testimony, please contact Cynthia A. Bascetta at (202) 512-7101 or bascettac@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Michael T. Blair, Jr., Assistant Director; Cynthia Forbes; Krister Friday; Roseanne Price; Cherie' Starck; and Timothy Walker made key contributions to this statement.

Related GAO Products

High-Risk Series: An Update. GAO-07-310. Washington, D.C.: January 2007.

VA and DOD Health Care: Efforts to Provide Seamless Transition of Care for OEF and OIF Servicemembers and Veterans. GAO-06-794R. Washington, D.C.: June 30, 2006.

Post-Traumatic Stress Disorder: DOD Needs to Identify the Factors Its Providers Use to Make Mental Health Evaluation Referrals for Servicemembers. GAO-06-397. Washington, D.C.: May 11, 2006.

Military Pay: Military Debts Present Significant Hardships to Hundreds of Sick and Injured GWOT Soldiers. GAO-06-657T. Washington, D.C.: April 27, 2006.

Military Disability System: Improved Oversight Needed to Ensure Consistent and Timely Outcomes for Reserve and Active Duty Service Members. GAO-06-362. Washington, D.C.: March 31, 2006.

Military Pay: Gaps in Pay and Benefits Create Financial Hardships for Injured Army National Guard and Reserve Soldiers. GAO-05-322T. Washington, D.C.: February 17, 2005.

Vocational Rehabilitation: More VA and DOD Collaboration Needed to Expedite Services for Seriously Injured Servicemembers. GAO-05-167. Washington, D.C.: January 14, 2005.

VA and Defense Health Care: More Information Needed to Determine If VA Can Meet an Increase in Demand for Post-Traumatic Stress Disorder Services. GAO-04-1069. Washington, D.C.: September 20, 2004.

SSA Disability: Return-to-Work Strategies from Other Systems May Improve Federal Programs. GAO/HEHS-96-133. Washington, D.C.: July 11, 1996.

GAO's Mission

The Government Accountability Office, the audit, evaluation and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's Web site (www.gao.gov). Each weekday, GAO posts newly released reports, testimony, and correspondence on its Web site. To have GAO e-mail you a list of newly posted products every afternoon, go to www.gao.gov and select "Subscribe to Updates."

Order by Mail or Phone

The first copy of each printed report is free. Additional copies are $2 each. A check or money order should be made out to the Superintendent of Documents. GAO also accepts VISA and Mastercard. Orders for 100 or more copies mailed to a single address are discounted 25 percent. Orders should be sent to:

U.S. Government Accountability Office
441 G Street NW, Room LM
Washington, D.C. 20548

To order by Phone: Voice: (202) 512-6000
TDD: (202) 512-2537
Fax: (202) 512-6061

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Web site: www.gao.gov/fraudnet/fraudnet.htm
E-mail: fraudnet@gao.gov
Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Gloria Jarmon, Managing Director, JarmonG@gao.gov (202) 512-4400
U.S. Government Accountability Office, 441 G Street NW, Room 7125
Washington, D.C. 20548

Public Affairs

Paul Anderson, Managing Director, AndersonP1@gao.gov (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, D.C. 20548

PRINTED ON RECYCLED PAPER

Mr. TIERNEY. General Kiley, I understand that you might have some time constraints. We can either address questions to you and go through a round and then go back to the other two panelists or, if you can, can you stay and we will deal with it as a panel?

General KILEY. Sir, I am at your discretion, however you would like to do that.

Mr. TIERNEY. Thank you.

General Kiley, you were in charge of this facility at Walter Reed from 2002 to 2004.

General KILEY. That is correct; yes, sir.

Mr. TIERNEY. How many months were you here altogether?

General KILEY. I believe I assumed command in June, so it was just about 24 months.

Mr. TIERNEY. Two full years.

General KILEY. Yes, sir.

Mr. TIERNEY. Following you, was it General Farmer?

General KILEY. Yes, sir.

Mr. TIERNEY. He was here from 2004 to July 2006.

General KILEY. Yes, sir. Early August, I think.

Mr. TIERNEY. Then, General Weightman, you came in July 2006 to March 2007, a relatively short period of time compared to your predecessors.

General WEIGHTMAN. Yes, sir.

Mr. TIERNEY. General Weightman, when you came in—platoon sergeants, case managers, there was a significant gap in the ratio; there were a lot of soldiers, 125, 130 to each platoon sergeant. Is that correct?

General WEIGHTMAN. No, sir. That is not correct.

Mr. TIERNEY. What was the number that was there?

General WEIGHTMAN. The ratios that you cite were present when we peaked out of our MedHold—MedHold population in the summer of 2005.

Mr. TIERNEY. Before you even came?

General WEIGHTMAN. Yes, sir. And at that point we realized we only had one company to take care of all those soldiers. In January 2006, just a little over a year ago, a second company was created and that is when we split out the Active Duty wounded warriors into the Medical Hold Company, and that is when the ratio dropped down from 1-to–125 to 1-to–50-to–55 for the Active Duty soldiers and for the Med Holdover soldiers. Reserve component soldiers, that ratio is 1-to–25.

Mr. TIERNEY. Thank you, sir. You were quoted in one of the articles that appeared, saying that you had also ordered your staff to focus on the high-risk priorities such as PTSD. Was that not the case before you made the order, the focus wasn't at a level you wanted it to be?

General WEIGHTMAN. Sir, it became apparent to me that we need to focus on two different groups. We need to focus on the groups that had been here the longest to see why they had been here so long and if it was bureaucratic or clinical hurdles that they were still facing. And there was another group that we found that had either history of substance abuse, behavioral health issues, domestic violence, or alcohol abuse that we wanted to keep a very close

eye on to make sure that they got the care in an expeditious manner that they could.

Mr. TIERNEY. None of these things were new to your watch, though. These situations had been as predominant on General Farmer's watch and, presumably, before that as well. Correct?

General WEIGHTMAN. Yes, Mr. Chairman.

Mr. TIERNEY. At some point in time, General Weightman, the Garrison Commander Peter Garibaldi, I believe, sent an internal Army memo to you talking about a situation here with competitive sourcing initiative, the President's initiative allowing the Office of Management and Budget under what they call the Circular 76 to—I am sorry?

Mr. DAVIS OF VIRGINIA. A–76.

Mr. TIERNEY. A–76. Allow you to bid out the private contractors, let them submit a bid in competition with the Federal employees in that process. And I think some of us were looking at that memo and we are a bit disturbed because it seemed to call to your attention the issue of reduction in force, reduction in those employees that was a pretty substantial falloff. And the commander's comments to you were basically that there was a great risk to the whole operation here as a result of that sharp decline. He warned that the workload had grown exponentially since September 11, obviously, because of the wars in Iraq and Afghanistan; that without favorable consideration of the request for increased staff, that the entire base operations of patient care services are at risk of mission failure.

Can you tell us what led up to his writing that memo to you; and then what action you took with respect to that memo and what response as you put that up the chain occurred?

General WEIGHTMAN. Yes, Mr. Chairman. The A–76 process has been going on for, I think, about 3 or 4 years here at Walter Reed and it has been bounced back and forth who wins that contract; whether the government does or the independent contractor. As a result, I think that not knowing what was going to be in the future has affected the work force and particularly the one on garrison operations.

When Colonel Garibaldi floated that memo to me, it was outlined where and what areas that we were at greatest risk. We passed that memo up to our headquarters, and got support from them. However, I will add at that point that about that same time, or within a month or two after passing that memo up, we got support for that, but we were not able to hire the additional workers that we requested because the contract had been awarded to the contractor as opposed to government services. And previously the government had performed all those services itself. So we had trouble attracting all the necessary people that we needed to those positions.

Mr. TIERNEY. It is reported, General Weightman, that in September 2004 the Army actually determined that the in-house Federal work force at Walter Reed could perform the support services at a lower cost than the bid that was received from the outside contractor, which is IAP Worldwide Services. Despite that, there was an appeal taken, and we have seen no record of why this happened, but apparently when certification of the Federal employees was

withdrawn, unilaterally the employee bid was raised about $7 million dollars and the determination was reversed in favor of the private company, IAP.

Can you tell us about that process and what happened there?

General WEIGHTMAN. No, sir I cannot. That happened before I came.

Mr. TIERNEY. As a result of that, a number of people, at least according to this memo, went from about 300 people down to about 60 on February 3, 2007. Did you see your personnel decline to that degree?

General WEIGHTMAN. Sir, not to that degree. They did decline from a work force normally of about 190, it declined to close to 100. It did not get down to 60 but it did get down to 100.

Mr. TIERNEY. General Kiley, did this process of the competitive sourcing initiative happen on your watch?

General KILEY. Yes, sir. It began on my watch and then the issues of awarding the contract first to the MEO and then the appeals was after I left Walter Reed, took command of MEDCOM.

Mr. TIERNEY. So you were not there when the reversal of determination came over from the Federal employees to the private contractors?

General KILEY. I think that was in the fall of 2004, sir, and I was not the commander then.

Mr. TIERNEY. So where is General Farmer these days?

General KILEY. Sir, he is retired.

Mr. TIERNEY. Would it have been on his watch then that whole process would have played out, and at some point the private contractor would have been given the award of $125 million over 5 years?

General KILEY. Yes, sir. Under the direction of the Army and contracting services that managed those, and I don't know specifically the name of that, General Farmer would not specifically make the decision as to who to award the contract to. Those decisions are made, I believe, by the Army, not by us. If I am correct.

Mr. TIERNEY. Mr. Shays.

Mr. SHAYS. I would like Mr. Davis to go.

Mr. DAVIS OF VIRGINIA. I think these problems are far more systematic than going back to an A–76 or anything else, or even some of the things happening just right here on the post. What you have is a number of stovepipes. You have the Army not talking to the VA. You have the National Guard and the Army not speaking to each other and people are falling through the cracks.

Ms. Bascetta, would you agree with that?

Ms. BASCETTA. Yes, sir, I would.

Mr. DAVIS OF VIRGINIA. These are systemic problems and really we have known about these problems for years, haven't we?

Ms. BASCETTA. That is correct.

Mr. DAVIS OF VIRGINIA. This recent manifestation really shouldn't surprise anybody. In fact, when I look back at a memorandum of October 12, 2006—this is after Walter Reed officials were asked to attend our committee's quarterly briefing on medical holdovers—I requested a copy of the Assistant Secretary's analysis and review, their SAR report. This review was conducted by individuals from all of the medical commands involved in all of the

processes, including installation management. It clearly indicates the review teams had concerns with Building 18's ability, staffing, the soldiers handbook, training, outprocessing, separation transition, patient transportation and the Medical Evaluation Boards. Attached to the review is a memo that was signed by Colonel Ronald Hamilton, the commander, that indicates that you, General Weightman, and General Kiley, received a copy of this review in October. Do you remember receiving a copy or being briefed on it?

General WEIGHTMAN. Yes, sir, I do.

General KILEY. I believe I did, yes, sir.

Mr. DAVIS OF VIRGINIA. It really wasn't the Washington Post. You knew these were problems. You may not have known specifically what it looked like, and you may not have been able to put faces and stories behind it, but this was an ongoing concern, wasn't it?

General KILEY. Well, yes, sir. And it was not just at Walter Reed. We were concerned about, you know, Medical Holdover operations and Medical Hold operations at all of our installations.

Mr. DAVIS OF VIRGINIA. What did you do when you saw this report in October? We know what you are doing now, after you saw the Post articles. What did you do in October to try to stay ahead of it?

General KILEY. My staff informed me that the Walter Reed staff was working it, that they recognized that there were issues and that they were taking action.

General WEIGHTMAN. Sir, may I address some of the specifics on that? We realized that some of the problems with how long it took our patients to get through the medical board process, that we needed more physicians trained in the MEB process and to help move those records. So we added three different physicians, part time, to work on those records, and we also designated an 06, a colonel, to be in charge of that whole process.

We also recognized we didn't have enough of the PEBLO counselors available—and I think you have already heard from previous testimony their role in counseling and being the patients' advocate in this whole process—realized that they needed more training and they were inadequate in number. So we have increased those and that started after this report. We also realized that we didn't have enough of the case managers as well to work with the patients within the Medical Hold and Medical Holdover Companies. And we began active recruiting efforts for those as well.

Mr. DAVIS OF VIRGINIA. General Kiley, you are no stranger to this committee. You came before us in 2005. During your testimony at that point you assured us that improvements were being made to the Medical Holdover process. This was at the point where we had numerous soldiers come up and talk about how they had fallen through the process, how they languished; their orders would be they would leave from the Army and go back to the Guard and they were in kind of a limbo. And you reported that point, you stated, under oath, MHO soldiers can expect their treatment and recovery experience to meet or exceed that of the Active component, because the Army's Surgeon General has made their care at the medical treatment facilities top priority.

That was your position at that point.

General KILEY. Yes, sir.

Mr. DAVIS OF VIRGINIA. But it didn't happen, did it?

General KILEY. Sir, in my role as the MEDCOM commander, Walter Reed was not my only command—Southeast Regional Medical Command, Brooke, and Tripler. In my discussions routinely with my senior commanders, we discussed the issues of Medical Holdover processing because we had often heard—I had heard, as the Walter Reed commander, that our Reserve and National Guard soldiers felt like they were not getting the same priorities as Active Duty. So I made it clear that, at a minimum, there would be no difference. And in many cases these soldiers, because they were staying at our camps, posts, and stations instead of going home, there was a sense of urgency to get them to the head of the line, to get the evaluations done.

And my comments about a good news story was the numbers of soldiers that we were able to heal and return to the force on the order of magnitude of about 80 percent of those soldiers in Med Holdover.

So my take on this and my comments to your committee were that, while we have problems, and we continue to have those problems, we were still caring for and healing and returning to the force a large number.

Mr. DAVIS OF VIRGINIA. General, our problem I think is a systemic problem that we have more people coming back than was anticipated. We have antiquated systems integrating the Reserves and the Guard and the Army back and forth. It is a paperwork nightmare. It is a labyrinth that you would need a Ph.D. and law degree and you still can't navigate yourself through, and the frustration of these poor injured veterans coming back. This is systemic. I am afraid this is just the tip of the iceberg, that when we go out into the field, we may find more. Ms. Bascetta.

Ms. BASCETTA. I think that is—certainly from our work, it would warrant a top-to-bottom review of the situation across the country.

Mr. DAVIS OF VIRGINIA. Keep putting a Band-Aid on something. It needs a complete overhaul it seems to me.

Mr. TIERNEY. I thank the gentleman. Mr. Waxman.

Mr. WAXMAN. Thank you, Mr. Chairman. General Kiley, according to a Washington Post article on Saturday, former Army Secretary Francis Harvey described a telephone conversation that he had with you, and he said that after the Walter Reed story broke in the Washington Post, you called him and lambasted the Washington Post reports of squalid conditions, and you said the Post story was yellow journalism at its worst.

Did you tell the Army Secretary that you felt The Post story was yellow journalism at its worst?

General KILEY. Sir, I had as I remember a couple conversations from the start of the publication of the Post with the Secretary. I believe one was in person. I had a discussion with him over an article in the Army Times where he asked me to call him back. And I called him back, told him I would go through that. And then I had a discussion with him when he called me——

Mr. WAXMAN. Whatever discussions you had with him, did you say to him that report was yellow journalism at its worst?

General KILEY. I don't believe my comment—my comment to the Secretary about yellow journalism was directed at the larger report, but a follow-on article that took a series of facts that included me and began to say that, you know, what did I know and when did I know it, and I didn't think that was necessarily a fair article.

Mr. WAXMAN. You are talking about the Washington Post articles?

General KILEY. All of them. Yes, sir.

Mr. WAXMAN. OK. Are you denying the accounts of the soldiers in the Post article or what happened to these soldiers?

General KILEY. No, sir. No, sir.

Mr. WAXMAN. And then what were you outraged about?

General KILEY. I was disappointed that the articles characterized the fact that I had been in command from 2002 and that I was aware of some of the circumstances that the Post was revealing in its stories in 2005 and 2006, and that somehow I had known about them. And other parts of that article that I didn't think were accurate.

Mr. WAXMAN. So after you left—when did you leave?

General KILEY. I left in 2004.

Mr. WAXMAN. After you left, you didn't know what happened here?

General KILEY. No, sir, that is not correct. But I was the next higher commander. I had a two-star commander in command, managing Walter Reed as well as the North Atlantic Region, and, as with General Weightman, we had routine videoconferences to talk about issues not just related to Med Holdover but to the BRAC, to A–76.

Mr. WAXMAN. You had these conversations complaining about how you were treated in the articles. Did you say in any of your conversations, we have to do something, we have to investigate this problem and straighten it out?

General KILEY. I am sorry. To who, sir?

Mr. WAXMAN. To the head of the Army with whom you talked.

General KILEY. Oh, to Secretary Harvey?

Mr. WAXMAN. Yes.

General KILEY. Yes, sir. We talked about getting engaged and finding out what was going on, getting an action plan together to fix those immediate problems we could fix and starting to look at the long-term issues, some of which we had already been taking on, to include my TBI task force, mental health task force, and issues at looking specifically at the MEB/PEB process.

Mr. WAXMAN. Now, the chairman asked about this contracting out. And this contracting out, according to the memo that was prepared—which I presume you saw, is that correct?

General KILEY. Colonel Garibaldi's memo?

Mr. WAXMAN. Yes. You saw it and, General Weightman, you saw that memo as well.

General WEIGHTMAN. Yes, sir.

Mr. WAXMAN. That memo warned about mission failure; in other words the failure to provide care that Walter Reed was supposed to provide because of the loss of personnel. There were 350 government employees working here. The A–76 process decided to contract out that work to a private organization. So they didn't start

for a whole year, and during that year, the people who knew they were going to lose their job started leaving. They went to the private sector, they went to other places in the Department of Defense, they went to wherever they could find new jobs. So by the time the new contractor took his place a year later, as I understand it, there were only 60 employees left of the 350. Do you know whether that is an accurate statement, either of you?

General WEIGHTMAN. Sir, I think I addressed that earlier, and I believe that the lower number was 100, not 60. And I think we had 180 people earlier in the year. So it didn't go from 300-plus down to——

Mr. WAXMAN. You didn't think it was 350? You think that is an inaccurate figure?

General WEIGHTMAN. I believe so, sir.

Mr. WAXMAN. So how many do you think were here when the contract was let out?

General WEIGHTMAN. When the actual—was about 100, sir.

Mr. WAXMAN. About 100?

General WEIGHTMAN. Yes, sir.

Mr. WAXMAN. How many people were still here when the contractor a year later took over?

General WEIGHTMAN. I am sorry, sir. I misspoke. When the actual contractor took over on February 4, 2007, that is when we had 100.

Mr. WAXMAN. The memo said that you are short of staff, the contractor has taken over, you are short of staff, the mission is threatened, and asked for more staff to be hired. Was more staff hired?

General WEIGHTMAN. Yes, sir. I think I addressed that previously. We did get permission to hire more staff. Our ability to hire those additional 80 people was not successful, in that they knew that the contract was coming up, and if they got hired it would only be for 4 months.

Mr. WAXMAN. So did the memo ask you to hire 80 more?

General WEIGHTMAN. Yes, sir. I believe it did.

Mr. WAXMAN. How many did you actually hire?

General WEIGHTMAN. Ten, sir.

Mr. WAXMAN. When did they come onboard?

General WEIGHTMAN. Sir, I don't have that information, but it would be between October and November 2006.

Mr. WAXMAN. Mr. Chairman, the only thing I would raise is we have contracted out so much of this war, we have mercenaries instead of U.S. military. We have contractors instead of the work that can be done by checking very carefully what kind of job they are doing. And here at Walter Reed we had contracted out as well. And the result of all of this is we are, in Iraq, overpaying for the work of the contractors, and here we are underserving our military and something has to be done about that.

Mr. TIERNEY. I thank the gentleman. I remind you that the Comptroller General of the Government Accountability Office has made that same point, that the contracting out has raised a problem. I suspect we will be exploring that in future hearings.

But, General Weightman, you said there were 180 when it first went down, and down to 100 when it finally kicked in. So I think those are the numbers, at least as opposed to the 350 and 60.

General WEIGHTMAN. Yes, sir.

Mr. TIERNEY. Thank you. Mr. Shays.

Mr. SHAYS. What I wrestle with is that there is not anyone involved in this that didn't know there were challenges. Mr. Waxman has gone through a whole host of reports, which he and I both can read and do read. How can we know when a problem is being addressed? In other words, this committee has had hearings, and the word is back, you know, it is getting taken care of. Is it something where we need to have hearings every 2 months? And is there a mindset that to be a good soldier you have to basically, you know, stiff upper lip and just tell Congress, you know, we are taking care of it and so on, when you know you don't have the resources necessary to take care of it?

That is what I am wrestling with. I feel like in some ways some people are going to take the hit on this, and are they taking the hit on this because they didn't tell us? Because frankly, I will just make this last point. These problems are huge. The only reason why this story got attention is there was something visual, there was mold on a wall, but the mold on the wall is, in fact, the tip of the iceberg. And so help me out because you are going and people are going to say it is going to be taken care of, and then 2 weeks from now or 2 months from now, how do we know it is?

General KILEY. Sir, I agree with you. The mold is a brick-and-mortar issue. We have it—we have it fixed in Building 18. We are examining all the rest of the brick and mortar in Medical Command to make sure we don't have those kinds of issues.

Mr. SHAYS. See, I think that is the easy part.

General KILEY. Yes, sir. The second piece is the thing I referenced, is the heretofore not fully realized complexity of the injuries of these great young Americans. I am a cochair of the Mental Health Task Force with Senators Boxer and Lieberman and are coming to closure on our work this last year. The issues of mental health, PTSD, late emerging PTSD, the issues of TBI, traumatic brain injury, how to diagnose.

Mr. SHAYS. I don't know what you are saying to me.

General KILEY. What I am saying is these are very complex patients that are severely injured in multiple emotional, physical, and mental ways.

And then finally, sir, we are going to have a long-term challenge to continue to care for these soldiers and their families over time.

Mr. SHAYS. I know that. I guess what I am trying to understand is how does it get solved? How many caseworkers do we have? What is the workload of each caseworker?

General WEIGHTMAN. Sir, those average about 1-to–25 to 1-to–30.

Mr. SHAYS. OK. Under oath you are saying that is what it is?

General WEIGHTMAN. Yes, sir.

Mr. SHAYS. So why would a, you know, Sergeant Shannon basically have to find his own way and have to find his own caseworker without his caseworker finding him? I feel like these men and women are almost in prison in the bureaucracy. They could be here. It is kind of like the old song of the Kingston Trio, you know, in the subway underneath the streets. That is the way it feels to me. So explain that to me.

General WEIGHTMAN. Sir, it is absolutely right. We did not have a foolproof system to hand off our inpatients to the outpatient care. We had a system that probably was accurate about 80 percent of the time. And about 20 percent of the time—and I assume Sergeant Shannon falls into that group—we did not do a good handoff of those patients. So he went from being an inpatient on one of our wards to his platoon sergeant and his case manager picking him up.

Mr. SHAYS. So, Ms. Bascetta, maybe you could help me out. You write these reports. They are available to Congress. They are available to the press, even the press. So this is nothing new. All of us, in a sense, are made aware of these problems. How do you know when the problem is being addressed? And how do you get around—and how do we deal with people telling us they are being addressed when they are not?

Ms. BASCETTA. Well, when we make recommendations, we always followup on those recommendations to ensure that they have been implemented. But in this case, we have been very frustrated that we bring things to DOD's attention over and over, and we see that they fix certain problems on an individual basis, but the systemic fixes don't seem to happen. And sometimes I think that part of the problem is that the rules and regulations are so monumental that we are focused more on that and not on the patients.

Mr. SHAYS. This is what I think, and I will conclude with the few seconds I have left. I believe that basically it is part of your mindset that says if you are not going to get the resources, your job is to basically come to Congress and say, we are getting the job done. And that I feel like—and frankly, that is almost—not almost—it is being dishonest. It is being dishonest to yourself, and it is being dishonest to us. And I will look forward to the day when someone who is in a uniform comes to us and says under oath, I am not getting the resources I need to do my job.

General KILEY. Mr. Chairman, may I respond to that?

Mr. TIERNEY. Briefly.

General KILEY. I said this, sir, in public. The Congress has given the U.S. Army Medical Command under my command everything I have asked for in terms of resources. The challenge is in some of the issues that we are addressing, which is how do we best apply those resources to best care for soldiers and then hand them off to the VA. I agree with you there are issues, there are gaps in the system, both electronic medical records, handoffs. I have assigned Army personnel——

Mr. SHAYS. I understand. My time is up. But what you are saying, though, under oath is that you have all the resources necessary. And I honestly don't believe that. I don't believe it.

General KILEY. OK.

Mr. TIERNEY. I think Mr. Duncan made the point of $450 billion in the Defense budget and I think maybe there is some truth to the matter that there are resources there and there are priorities. But I hear your point as well. Mr. Lynch.

Mr. LYNCH. Thank you, Mr. Chairman. First of all, I just want to say I have read this record pretty thoroughly. And, General Weightman, I have to say that you, having only been in this position for 6 months, you probably have a little bit more blame being

laid at your doorstep than I think is probably appropriate. I just want to get that on the record from my reading of this.

Ms. Bascetta, you are aware that GAO conducted a review of the Army's system for evaluating the fitness of wounded soldiers to stay in the service.

Ms. BASCETTA. Yes.

Mr. LYNCH. OK. I am just stuck on this number. I noticed that the Navy has an approval rate of about 35 percent for those who apply for, you know, retirement through disability. And the the Air Force, their approval rate is around 24 percent. Then I noticed the Army, which has a greater number of individuals applying, has an approval rate of about 4 percent.

Now, I am just curious if you looked at that. I know you just did the Army. But did you look as a comparison as to what is going on and could you help me with this? Could you explain why those numbers look the way they do?

Ms. BASCETTA. What I can tell you is that in our review of the disability system, we noticed first of all that the services don't always follow the same procedures. But, more importantly, they don't have a quality assurance mechanism in place to assure that the decisions that are made are consistent across the services. And without knowing that, it is difficult to explain whether the variations that you are seeing and those award rates are reasonable or not.

Mr. LYNCH. OK. Let me ask you this. Recently the Secretary of Defense appointed an independent panel to review all of this. Now, it is an independent review commission. It is headed by former Secretary Togo West and also former secretary Jack Marsh, both outstanding individuals. But I just question whether it is independent. Both of these men are just—they are just top notch, but they are Army to the core. And I am just wondering if we are looking for an independent review, truly independent, someone that can be critical of this whole process. I just question, in your own mind, in conducting a review like this, and while I have—again, I have enormous respect for Togo West and Jack Marsh, but I wonder if these are the best people for an independent and impartial review, since these two men I know absolutely love the U.S. Army. And I am questioning whether or not they can be objective about the problems here.

Ms. BASCETTA. I can certainly understand your concern. I can tell you that there is a lot of work going on reviewing the disability systems both in the VA and in the DOD. There is a Veterans Benefits Commission that is looking at those issues now and the discrepancies between the ratings that are given in the DOD, comparing them to those that are given in the VA for the same service members.

Mr. LYNCH. OK. And last, before I yield back, General Kiley, I don't always trust the newspapers. But the Post had some quotes that you thought that the story was unfair. I know that Chairman Waxman mentioned it a little earlier, and that you felt that this was not a failure or a horrible situation at Walter Reed. Your comments were in conflict with the Secretary of the Army on the same issue. He said there was definitely a failure and that it was inexcusable. "Inexcusable" was the word he used.

Are your own thoughts the same as you sit here today, that you thought this was a one-sided report and that it didn't fairly represent the situation?

General KILEY. Sir, just to make sure I am clear on this, the original reports about the soldiers and the conditions of Building 18, again, I did not label that as yellow journalism. There was a follow-on article later that was focused on me that I had some concerns about and did say, in a private conversation with the Secretary, that I thought it was yellow journalism.

What I did say and what you referenced, Mr. Lynch, was earlier on, my concern that the issues in Building 18 which were clearly unacceptable, clearly unacceptable, and were a failure of leadership at the junior level in that building. My concern for the American people and for the Army and for soldiers was that some of the descriptors in the larger articles would be construed as if the entire Walter Reed system was a failure and that soldiers were being left to languish, were forgotten and lost, and that Building 18 emblemized that. And I don't disagree that a visual image makes a big difference. But I know that——

Mr. LYNCH. I don't have much time. Let me just ask you, these are the words and you can tell me, sir.

Mr. TIERNEY. Your time has actually expired, but we will let you ask one quick question.

Mr. LYNCH. The quote here is that "I am not sure if it was an accurate representation. It was a one-sided representation. It is not the Ritz-Carlton at Pentagon City. I want to reset the thinking. And while we have some issues here, this is not a horrific catastrophic failure at Walter Reed."

I just want to know if that is—I don't trust news stories generally, and I just want to know if that is your thinking.

General KILEY. I did say that and I was not attempting to be at odds with Secretary Gates. I think we have some issues of leadership here, but we have great facilities and a great medical system, and I was concerned that the whole thing would come down on the basis of some of these specific issues.

Mr. TIERNEY. I thank the gentleman. Mr. Waxman, you had one followup.

Mr. WAXMAN. I would like like Generals Kiley and Weightman to answer yes or no, in light of the memo by Mr. Garibaldi and the experience we have seen, do you think it was a mistake to have contracted out the services as was done?

General KILEY. Certainly, we must, with our ability to look at when has happened, I think it may, we probably could have done it better, maybe we shouldn't have done it at all.

General WEIGHTMAN. Sir, I don't think it was a mistake. I think we suffered from having a prolonged period from when we had the switchover. Since February 4th, the contractor has done very well.

Mr. WAXMAN. I wasn't arguing the contractor didn't do well. Do you think it was a mistake to contract it out——

Mr. TIERNEY. The gentleman's time has expired. Mr. Davis.

Mr. DAVIS OF VIRGINIA. There was congressional interference in that as well wasn't there.

General WEIGHMAN. Yes, sir.

Mr. DAVIS OF VIRGINIA. And some doubt and that stretched out the time period, is that correct?

General WEIGHTMAN. Yes, sir.

Mr. TIERNEY. General Kiley, apparently there are those who feel differently than you and I did about this. They asked if they could get you somehow removed from this thing as quickly as possible. I was hoping the remaining Members who have not asked questions yet, if you have questions you would like to ask specifically of General Kiley, perhaps indicate that and then we will recognize Members and then we will let General Kiley, go and then ask General Weightman and ask Ms. Bascetta to stay longer if that is OK with them.

Mr. Cooper, you had a question.

Mr. COOPER. Thank you, Mr. Chairman.

General Kiley, in today's Washington Post, it says, this referring to you, "his last concern was his concern for the patient," said retired Colonel Robert Tabachnikoff chief of obstetrics and gynecology under Kiley in Landstuhl in mid 1990's. Tabachnikoff said "Kiley wanted him to discharge new mothers within 24 hours of delivery to keep beds free and counted phone calls as office visits.

"He was more concerned for meeting requirements and advancing his own career. At last, it is catching up with him. His leadership style is being exposed."

Do you have a comment?

General KILEY. Well, needless to say I don't think that is a fair characterization of what we were doing at Landstuhl regional Medical Center at the time. I would be happy to address the specifics of the 24-hour discharge program which mothers called for. They want to go home. Workload and capturing what we do instead of ignoring it. And by the way, I would differentiate a mother who wants to go home at 24 hours from one that has to go home at 24 hours. We never did that. But, you know I don't—I'm not sure I need to comment any more on it than that. The doctor worked for me at Landstuhl, as I remember, back in the 90's.

Mr. COOPER. How about office visits becoming telephone calls?

General KILEY. Well, the question there was my providers felt frustrated that the the work they did talking to patients wasn't counting as part of the workload that the hospital did that they got credit for, so that we could get more money, that there was an issue of, you know, if I spend 20 minutes on the phone with a patient, that ought to be an office call. And we had no way to capture that data, as I remember, and get credit for it—which is not necessarily a game and it is not necessarily about workload.

I have spent my entire life taking care of patients, training doctors to take care of patients. And I am committed to Army medicine and committed to taking care of soldiers and their families. I take exception to his view of me as doing all this just for a career and not caring about patients. I don't think that is correct.

Ms. FOXX. Mr. Chairman, I had one quick question.

Mr. TIERNEY. Yes, Ms. Foxx.

Ms. FOXX. Thank you. Thank you, General Kiley. I want to ask, you mentioned at the beginning that what needs to be done is simplification.

General KILEY. Yes, ma'am.

Ms. FOXX. We are interested in again in accountability and I think simplification needs to be done too. Do you feel confident that you can institute simpler measures of accountability, simpler ways of getting the job done, that will stick? I think most people are concerned, as some of the previous witnesses said, that all we are doing is going to paint over this issue. What I am interested in, again, is systemic change. And systemic change is not just going to work here at Walter Reed, as you said, but it is going to work throughout the system, and that perhaps could be a model for other Government agencies.

So tell us how we are going to know—as some of the other questions have been asked—how are we going to know that this process is better? How can we monitor it? How can we make sure that it is going to go systemwide?

General KILEY. I think that is a very good question. I think we need transform it first, because if we just apply more yardsticks and bells and whistles to the present process, we will just get much better at measuring bells and whistles.

I think we need to relook at the relationship between the MEB and the PEB which is, in fact, in many regards, despite the best the efforts of both groups of people, adversarial. The physician is attempting to capture all the data, make sure the soldier is as healed as he or she is going to be, and make sure you have an accurate record with tests etc., hand it to the Physical Evaluation Board, which is driven by law, by DOD regulations and by regs, to apportion out disability in a system that doesn't recognize the whole person, like the VA system does. And all of that sets up an immediate adversarial role, where, frankly, in some cases, nobody wins on this.

I think the Army is taking this on even as we speak. I know I am taking it on to look at the process inside organizations like Walter Reed with the MEB process and the kickback. But I think we are going to have to reduce 22 different forms to fill out to go through this process. It may be as simple as getting rid of the line of duty and commander statement and start giving the benefit of the doubt to the soldier so that when they come back from Iraq missing a limb, that was in the line of duty. It was combat. And we don't need some be to send us a piece of paper to validate it.

I think we also have to understand it is going to take time for these soldiers to heal. Let's give them the benefit of the doubt, retire them and then in 3 to 5 years, if they are fully recovered, we can bring them back and process them.

But what we do now, because we want to give the soldiers the best chance, is we hold on to them so our numbers grow at all our installations. Some of them feel like they are being pushed out too quickly. We say we got it, we figured out what is going on with you.

And then the last piece, again I say, is we have still not come to grips with the PTSD TBI process that most all of these soldiers to one extent or another have to deal with. And those are not particularly well recognized to date, particularly in the physical disabilities system.

I hope to bring some light to that with the mental health task force and the traumatic brain injury task force that I launched last fall to start looking at this.

Mr. TIERNEY. Thank you, General. General, once again your plans have changed and you no longer have an appointment later today. That has been postponed. We are just going to fly right through on our regular order and see if we can't bring this panel to a conclusion and appreciate the time you spent so far. If Members don't feel they have a question to present at this time that has already been asked, that is perfectly fine as well. We'll try to go as quickly as we can. Maybe some Members won't feel as compelled to do as complete a 5 minutes as others. So Mr. Platts.

Mr. PLATTS. Thank you, Mr. Chairman. General Kiley, General Weightman, Mrs. Bascetta, I appreciate all of your testimony and your service to our Nation, and especially generals, your many years of service in uniform.

In a previous question, Representative Shays talked about the bricks and mortar maybe being the easier of things to see and fix and the second challenge is greater. And I kind of put that in the human capital management of how we use people we have to provide the service. And a common theme that seems to come across in the GAO finding and you have talked about is that handoff. And it was well identified in the first panel, and I think we all agree with Staff Sergeant Shannon, Specialist Duncan, Corporal and Mrs. McLeod, their stories are unacceptable and should not happen.

And you look at Staff Sergeant Shannon 5 days after he is shot and seriously injured in Iraq, he is basically put into outpatient here, which speaks volumes about how quickly we got him here, but within 5 days of that traumatic injury that he is on his own and basically given a map. And that handover obviously didn't happen.

How confident are you today that handover first from inpatient to outpatient is not the case anymore, and that there is a smoother transition?

General WEIGHTMAN. Sir, I am absolutely confident that we have a system now in place that we have a physical handoff from inpatient to outpatient——

Mr. PLATTS. To the case manager or to the platoon sergeant?

General WEIGHTMAN. To platoon, the sergeant certainly. But as you spoke to there is multiple handoffs because once they become an outpatient, you have to hand off their care to the MEB process. And then you have to hand off their care to the PEB process. And then you may very well may have to hand off their care to the VA. And those are the transitions that I think that we feel that we need to put a lot more work into. That is where we failed.

Mr. PLATTS. That was my followup. The first one being into outpatient, and then it seems like to the soldiers and their families that once they go there, there is no one place to say, here is where I am supposed to be dealing with to get the care and support I need. And that is very much on the radar now, I am hearing you say and we are seeking to address.

General WEIGHTMAN. Yes, sir.

Mr. PLATTS. Specifically on the handoff VA.

If I understood your oral testimony, Ms. Bascetta, is that in a few weeks back that there was a DOD decision to deny VA physicians access to DOD medical records as part of that handoff? And is that still the case?

Ms. BASCETTA. I can't tell what you what the current situation is. I can tell you that it was reported, I believe it was on February 16th that their access—and these are the VA physicians in the polytrauma centers who had their access cutoff without warning.

Mr. PLATTS. General Kiley, are you aware, is that the situation today?

General KILEY. As I understand it as I sit here today yes, sir, it is. I think the access that was denied to the VA physicians comes out of the joint patient tracking system. And that is a data base that picks up patients, troops as they enter into the system coming out of theater of operations through Landstuhl and back to Cohens-based facilities. And in that system, doctors that have access to JPTA and are authorized to be entering clinical data about patients enter clinical data.

As I understand it, just through a couple of e-mails, at some point, someone recognized that all physicians in the VA had access to the joint patient tracking system and that our lawyers—and I don't mean my lawyers—but I believe it was DOD, health affairs lawyers—I don't know that for sure—but that is my suspicion, said that had the potential to be a HIPAA violation because if a soldier coming back is not necessarily a designated patient for a VA physician, then that physician really doesn't have a need to know about that data.

Mr. PLATTS. Are we getting in to make sure that the VA physicians who do have a need to know retain the access? Because it sounds like what we have done is shut off everybody.

General KILEY. I think we have sir and I don't know where we are.

Mr. PLATTS. If we could have a followup——

General KILEY. Yes, sir. Yes, sir.

Mr. PLATTS. That would be very helpful. If I may a final quick question on the case manager issue.

In the earlier testimony, Ms. McLeod talked about a case manager denying an MRI that a doctor had ordered. Is that permissible and does that occur? Because it seems contrary to everything we want where the medical professionals are making the decisions.

General WEIGHTMAN. Sir, that is not permissible. And it should not occur. It does. And how that probably manifests itself out is that case manager is responsible for scheduling that exam. So if that case manager does not schedule the exam, it is essentially denied. But they do not have the ability to overrule that.

Mr. PLATTS. Is there disciplinary action if that comes to light that they overrule——

General KILEY. Absolutely because doctor's orders take precedence.

Mr. PLATTS. Thank you, Mr. Chairman.

Mr. TIERNEY. Mr. Yarmuth.

Mr. YARMUTH. Thank you, Mr. Chairman.

In listening to both this panel and the panel that preceded it, it seems like we have two problems we are dealing with. One is find-

ing out about problems and whether there is an adequate system in place to uncover these problems, and the second problem, of course, is how we find out what to do about it and who is responsible for that.

In today's Washington Post story, for instance, there was a mention that we are getting reports now from all over the country, people calling and families calling journalists even from my own State, Fort Knox and Fort Campbell, and reporting similar problems.

My question is, one could infer from listening to this that the Army relies on people telling the next level, the next rank, about problems rather than there being some kind of accountability, some kind of mandate on the commander to say, this is part of our job to find out whether proper service is being rendered at every level.

Is there a deficiency there? Are we relying on a bottom up type of reporting mechanism? Do you see that as a problem or not?

General WEIGHTMAN. Sir, I think there has been a failure. We have three or four different mechanisms here at Walter Reed for patients and patient family members to tell us about issues that they have, whether it is IG complaints, whether it is commanders open door policy, whether it is surveys that come out that we do periodic surveys, the town hall meetings, the new comers orientations you have heard about. Based on those, I feel that for whatever reason, we were not getting an adequate feedback from the patients and from the patients family members about all of the concerns that they had.

Mr. YARMUTH. Don't you think that proper management technique would be that the highest level of management—and I am not necessarily putting it on your desk. Maybe it should be in the Pentagon—has to create ways and actually has to make an affirmative effort to find out whether proper service is being given at every level? Is that not a responsibility of the highest command?

General KILEY. Yes, sir. My role as MEDCOM commander, I have accountability at the Army across all installations similar to Walter Reed holding my commanders both the regional flag officers and the individual local hospital commanders accountable for the health care delivery in conjunction with, you know, General Wilson, who manages, often manages the infrastructure solutions. And I send teams out—the assistant secretary of the Army sends teams out.

I send my IG out. And we visit all the posts and camps over the year, getting assessments. Additionally, we talk to the commanders. We talk to the regional commanders, ask them how things are going and they report data up to us about processes.

I will say that I don't get involved at my level. And I am not sure of the regional commanders would get involved at their level at an individual issue like a case manager who denies an MRI. But I would agree with General Weightman. We need to do a better job—and we will do a better job of defining the roles and missions of the case managers and platoon sergeants. And we have evolved these processes so we don't have cases like this come up.

General WEIGHTMAN. Sir, if I may add on to that. Under General Kiley's direction over the last 4 months, there's been a survey conducted every couple of weeks looking at patient satisfaction with their case managers and with their providers. And they take dif-

ferent samples of all the different regions. And that is anonymous. It just goes up.

You know, the most reason one that was done at the end of January showed patient satisfaction with their case manager and with their provider, their physician, to be over 90 percent. But that is not what we have heard here. So are we looking at the wrong population? Or we are we making it too hard for them to tell us what their concerns are?

We had the Army family action plan meeting here recently which had very good representation from the Med Hold and the Med Hold over patients and you know almost none of these issues were raised there. So that is obviously a failure in our sampling technique to get the feedback that we need.

Mr. TIERNEY. Thank you, sir.

Mr. YARMUTH. My time has expired. Thank you.

Mr. TIERNEY. I think Mr. Duncan is out of the room briefly, so Mr. Turner.

Mr. TURNER. Thank you Mr. Chairman. General Kiley, General Weightman, obviously, it is very difficult in listening to the first panel and then listening to the statements that you are making concerning the current status of things that needs to be done. There is a disconnect.

I hear the difficulty that the families and our service men and women are having, and then I hear the—it is not happening now or we will fix it, or a case manager doesn't have that authority, but yet a case manager apparently has gone against a doctor's recommendation with respect to scheduling an MRI.

These things are very troubling. And my understanding from both of you is both of you are saying with respect to Building 18, that neither one of you were aware of the conditions of that building. Is that a correct characterization of what you said?

General KILEY. Yes, sir.

General WEIGHTMAN. Yes, sir.

Mr. TURNER. I guess my question comes to, well, how did you not know? General Weightman, this is not that big of a facility. Did you really testify that there are 371 outpatient rooms?

General WEIGHTMAN. Yes, sir.

Mr. TURNER. And General Kiley, in looking at your testimony, you have, in spite of efforts to maintain Building 18, the building will require extensive repairs if it is going to remain in service.

This is not a question of people weren't satisfied with their accommodation. This is a situation where it doesn't meet our standards.

General KILEY. I agree.

Mr. TURNER. What went wrong? How did you two not know that we had something where we had people being housed not that just that they were satisfied but it doesn't meet our standards and yet they were being housed there? General Kiley.

General KILEY. Sir, I can't explain that. As has been pointed out, I live across the street but I don't do barracks inspections at Walter Reed in my role as MEDCOM commander. I have subordinate commanders across MEDCOM that do those things if they think there are problems and they are aware of them. I would certainly inspect

any barracks if asked to come look at it, or we had a problem that we couldn't fix of one kind or another.

General WEIGHTMAN. During my initial orientation here, when I came I walked through many barracks. I did not walk through Building 18.

Mr. TURNER. General Kiley, this gets back to my question of systems. You said you do not do inspections. I don't think anyone would think that the system that you have in place as a manager of an organization would be sufficient if your answer is that you don't do inspections, but yet you still did not know. There is something wrong with the organizational structure if we all have to hear from the Washington Post versus that there are facilities—and again, not just that they don't meet the standards. It is not like they thought that their accommodations weren't acceptable. They don't meet our standards. But yet they were being housed there and you two gentlemen who were given the responsibility and being in charged—and again, as you said, General Kiley, Congress can only appropriate funds, pass laws and the Government can pass rules and regulations, but there are people, individuals who have to implement this. So you can see why people would be very disturbed.

General KILEY. Yes, sir. I can.

Mr. TURNER. General Kiley, I have one more question for you. I believe you said you were not aware—you were not prepared for the complexity of the injuries that these soldiers—or the complexities or injuries were not fully realized for these soldiers. What was the plan then? What was your expectation?

General KILEY. As a commander at Walter Reed, we had done an assessment when I took over in 2002 of casualty receiving processes that were coming from Operation Enduring Freedom in Afghanistan. When operations started in Iraq, we very quickly had a much larger number of casualties coming in.

We had all the resources we asked for to increase our contract nurses, physicians. We did some shifting of work at Walter Reed out in the community for retirees and elected health care. And we watched inpatient and outpatient work very closely.

A large number of the soldiers over time were healed and returned to the force or were medically boarded through the physical disability system and then moved on to the VA if appropriate.

I think what has happened is over these last couple of years, there is a subset of patients that are complex with more than just one human system engaged in recovery, emotional, physical and mental, organ systems if I can use that term as well as arms and legs, PTSD and TBI. These get to go very complex patients. And it takes a long time for them to heal. Some of the tools in the science of medicine for TBI and some of the tools and science of medicine for PTSD were just starting to develop to diagnose and begin therapies for.

And this is in the face of a continuing stream of casualties. And when we get busy at Walter Reed, we have an ability to move patients, for example, to Brook or down to Eisenhower. Occasionally, we will ask Landstuhl regional Medical Center to hold patients for a day or two.

So we have had a system that has reacted. But over time, the number of soldiers that have arrived here have challenged the system, challenged it with case workers, challenged it through the MEB process and through the PEB process. And it is just a matter of reinventing that simplifying it and getting on with business.

Mr. TIERNEY. Thank you, General. Thank you, Mr. Turner, Mr. Braley, do you have questions?

Mr. BRALEY. I do. Thank you, Mr. Chairman, with all due respect, General Kiley, when you make the comment that some of the tools of the science of medicine for TBI and PTSD were just beginning to be established in the 2002, 2003 timeframe, that is hogwash. I have represented clients with TBI and PTSD disorders for 23 years. This science has been evolving throughout that entire period of time. But the basic medicine for recognizing, diagnosing and treating patients who suffer from those illnesses and disease processes has been out there a long time. And what we are really talking about here today is the failure of planning, isn't that true?

General KILEY. I do—I may have been misinterpreted in my comments. What we are seeing is the—I agree with you that TBI and PTSD have been diagnosed and known. It is the level of these conditions. It is having two or three concussive events in combat were you were actually not knocked out, you were not otherwise hurt, you have the fourth concussive event and now you're starting to suffer from headaches. That is the kind of TBI and sensitivity of diagnoses we have to reach. And we are beginning to understand that there is a crossover potentially between PTSD and TBI. And I have been up on the Hill in my role at Walter Reed to talk about research and support of TBI.

Mr. BRALEY. But it is also part of a greater failure which is to plan for the eventuality of casualties—like we have been talking about here today—including amputations, which you have made a special point of noting in your written comments deserves special note, as an example, some of the initiatives that have been taken here at Walter Reed. Do you remember that?

General KILEY. Yes, sir.

Mr. BRALEY. And, in fact, that is a scenario that is very, very near and dear to my heart, because one of my constituents, Dennis Clark of Clark and Associates Orthotics and Prosthetics was contacted in October 2003 and asked to provide short-term assistance here at Walter Reed, and over the next 18 months, he made weekly trips here at his own expense, staying in hotels in his own expense, shipping prosthetic devices at his own expense over a period of 18 months at great personal sacrifice to himself, his partners and his company.

And I guess the question I have is how do I go back to Dennis and my neighbor, Don Bergen, who made those trips and say to them that your sacrifice was rewarded by the level of care and the planning that is being provided to veterans returning from Iraq and Afghanistan today?

General KILEY. Sir, I was not aware that we had someone who was coming here and providing services like that outside of a contracted service, because the amputee center at Walter Reed was fully funded. It was part of the global war on terrorism budget line

that we were given that was fully funded. And I was just not aware of that.

But my comment about the amputee program and the success was and the design of understanding that we were going to have amputees and we were going to have to take care of them. And their numbers are large. And it takes a long time for them to recover. And as we took care of them, we saw some new developments that have challenged us in terms of heterotopic bone formation, etc.

Mr. BRALEY. Ms. Bascetta, I have one followup question for you about PTSD. One of the big concerns that I have is the impact of PTSD on returning veterans like Joshua Amvig, who took his own life in his family driveway in Grundy Center, Iowa. And his mother was a client of mine. Congressman Leonard Boswell has a Joshua Amvig Suicide Prevention Act that is currently pending in Congress to require a more detailed analysis of PTSD patients at risk for being suicidal. And I was wondering if you think that would be a helpful screening process that would be a supplement to the current PTSD rating that is supposed to be taking place at our veterans facilities?

Ms. BASCETTA. Yes, I think that would be very helpful. One of the problems with PTSD is that it doesn't necessarily manifest as soon as the soldiers come home, that there could be significant delays in their symptoms, and there could also be confusion or misdiagnosis of TBI and PTSD. And if there is misdiagnosis and the PTSD goes untreated, it certainly worsens to the point where this kind of tragedy could happen.

Mr. BRALEY. Thank you, Mr. Chairman. I would encourage all members of the committee to sign on as original cosponsors of that bill.

Mr. TIERNEY. Thank the gentleman.

Ms. BASCETTA. May I also just add that Congressman Braley is correct that there is a lot known about PTSD and TBI. In fact, VA has had a National Center of Excellence on PTSD for many years. They also have their four TBI Centers of Excellence and that, in fact, is why the polytrauma centers for active duty service members were put there because of VA's specialized expertise.

I would readily admit that the science is still evolving. There is still a lot that we don't know yet. But this is one of the reasons that we think it is so crucial for VA and DOD to work better together. They have started working together on things like clinical guidelines, but much more needs to be done.

And in fact, those polytrauma centers, in response to those comments that General Kiley made, DOD had actually installed DOD computers in those polytrauma centers so that VA physicians could use the DOD computers to access their data. They were not accessed from VA's own computers. So it is hard to understand how there could have been a systemwide access problem.

And we have been very frustrated about DOD raising the HIPAA issue repeatedly. The House VA committee had many hearings on the failure to reach a data sharing agreement. HIPAA was raised in virtually all those hearings. And we believe that when there is such a significant need for continuity of care with soldiers who are going back and forth between the VA and the DOD, that certainly

there must be a way to overcome this HIPAA barrier if it is indeed a barrier.

Mr. TIERNEY. Thank you Ms. Bascetta. General Kiley, can we assume that you're going to get on that issue and find a way to get over that barrier?

General KILEY. Yes, sir. I will take that on. I'll certainly ask. I'm not in charge of it, but I'll take care of it. That is a DOD decision, not my decision.

Mr. SHAYS. Mr. Chairman.

Mr. TIERNEY. Yes, Mr. Shays.

Mr. SHAYS. Mr. Chairman, I'm going to the burial of Sergeant Richard Ford, who lost his life in Iraq in Arlington at 2, so I ask to be excused.

Mr. TIERNEY. Yes, of course.

We still have about eight other Members that have the right to ask questions here if they want. But again, I say if you have a question that has already been answered, you may want to pass. Otherwise, we are happy to have your comments. Ms. McCollum.

Ms. MCCOLLUM. Thank you, Mr. Chairman. I am confused by just followup on the HIPAA issue. It seems to me that could be very easily cleared up by asking the patient if their information can be shared between the DOD and the VA.

Mr. BRALEY. That is one way. That is an individualized way to approach the problem. We think there might be broader ways to allow access.

Ms. MCCOLLUM. But for right now, just telling a patient, you know, in order to make sure you have seamless continuity of care, is it OK that the VA and the Department of Defense share your medical records? I think that could be a yes or no.

General KILEY. I don't think there is a problem with that. The issue that came up was every VA physician having access to every soldier's medical records, whether they had a requirement to care for that soldier or not. That, again, I think this is a DOD decision. I think that is what concerned the DOD, was that this was a kind of a broad sweeping access to medical records that until the patients come to the VA, the VA doctors really don't have a need to know, when there is coordination——

Ms. MCCOLLUM. As a person in the private sector with health insurance, you sign broad agreements when you go in to have a radiology test done. So I think there is a way you folks can figure that out.

General KILEY. Yes, ma'am.

Ms. MCCOLLUM. Could I ask a question about Building 18. What has been the remediation for the mold in Building 18? I saw it being painted over, so.

General WEIGHTMAN. Ma'am the remediation there was mold in seven rooms in Building 18. Two rooms had mold on the walls and five rooms had mold in the shower/bathtub area. For those that was, had mold in the showers and bathtubs that was scrubbed off. For those two rooms that had mold on the walls underneath the wallpaper, the wall covering was stripped, mildewcide was applied, and it was painted over after that.

The bigger problem on Building 18 is a moisture problem. And that is why we keep getting mold back and forth. So the ultimate

fix for Building 18, which has been started, is in the process of being started, is to put a new roof so that we don't have so much moisture coming into the building as well as fixing some of the leaking plumbing that we have that also allows moisture to come in.

Ms. MCCOLLUM. So in that room by just—you are confident that the mold has been eradicated in that room just by stripping top off the wallpaper and not replacing carpeting, not replacing ceiling?

General WEIGHTMAN. No, ma'am. You know what I said is we killed the mildew that was on the wall and repainted over it and put another wall covering, but I am telling you that it will come back until we fix the moisture problem.

Ms. MCCOLLUM. So you had it tested and you know it is just mildew. You tested the mold and you know it is just mildew?

General WEIGHTMAN. Ma'am, I cannot address that.

Ms. MCCOLLUM. I ask a question about the testimony, there was submitted by Annette McLeod and her husband where they talk about his process of going through of having his brain injury addressed. Quotes such as, he didn't try hard enough because he was under medication when the test was administered to see what his cognitive disorder level might be. His paperwork, even noting the fact that he had been in Title one, which is done primarily at the grade school level in this country in reading and math, then being labeled a special education class, then being labeled as retarded. Who is doing this case management?

Do we have physicians and nurses doing this case management? Because if we do, to have charts that would radically change like this with health care professionals surprises me.

And what about those individuals who aren't looking at their charts and then, as I said, at the end of the day, sign off as to what their disability is and how that can effect future benefits in the VA? Could you tell me how this happens to an individual how they go from admitting the fact that they had Title one to being labeled as retarded by our governmental system?

General WEIGHTMAN. Ma'am, I totally agree with you that if the soldier was good enough to come in the Army, then he was—he should be treated as such. The case manager for this patient is a registered nurse and activated reservist. And then he saw many health care professionals from being social workers and psychologists and psychiatrists.

I do not have the particular details on who said what to whom. And I actually don't have their permission to talk about that case.

But I think it points out the problem that we raised earlier about the handoff between the various—between the medical treatment to the Medical Evaluation Board to the Physical Evaluation Board who does make that ultimate determination on what degree of disability that he has.

Mr. TIERNEY. Thank you very much. Ms. Foxx, you asked questions earlier. Do you need another minute?

Ms. FOXX. Very quick question. The issue of HIPAA was mentioned, and it sounds to me like a lot of the problems that you all have run into, for example, the sharing of information, it sounds like it is above, again, your all pay grade. And sometimes it sounds like it is coming directly back to Congress. I have only been there

one term, but it sounds to me like some of the things that have been created have caused problems are coming from us.

And what I want to ask you and encourage you to do is to make sure that where the problems lie with the Congress, that those issues will be brought back to us so that if we have an opportunity to solve some problems we can help solve those problems. Do we have your assurances on that?

General KILEY. Yes, ma'am. Thank you. The whole issue of Department of Defense and Veterans' Affairs computer systems electronic medical records talking to each other is very important to both groups. And I talk routinely with the VA and VA physicians and both of us want our systems to talk together. But they don't. They are incompatible to date, but they are moving closer together.

You know the standard answer that it takes time and money, it would make it a transparent electronic medical record for our soldiers. And we would like to see that.

The specific JPTA was, and the HIPAA issue associated with that, was a very narrow issue. And I have it.

Mr. TIERNEY. Mr. Davis.

Mr. DAVIS OF VIRGINIA. Would the gentlelady yield? General Kiley and General Weightman, you heard the testimony of the previous panel. And we have McLeods are right behind you. Do you have anything you want to say to them who were caught up in this?

General KILEY. I feel terrible for them. I know I have walked the halls of Walter Reed daily for 2 years and talked to soldiers and family members and I know this is very hard for them. And we have to double our efforts, redouble our efforts to make these kind of cases disappear in the system. And we have to simplify it. And we have to give the benefit of the doubt to the soldier and his family instead of working through a bureaucracy.

Mr. DAVIS OF VIRGINIA. General Weightman, I guess you met them at Burger King before.

General WEIGHTMAN. I would just like to apologize for not meeting their expectations, not only in the care provided but also in having so many bureaucratic processes that just took your fortitude to be an advocate for your husband that you shouldn't have to do. I promise we will do better.

Mr. TIERNEY. General Weightman, apparently Mrs. McLeod didn't have any difficulties with you and I think you should note that. And General Kiley, you didn't know that General Farmer was not allowing Mrs. McLeod to make any statements——

General KILEY. No, sir. I didn't know anything about that. No, sir.

Mr. TIERNEY. I am going to yield just briefly to Mr. Braley who wanted to clarify one thing under HIPAA.

Mr. BRALEY. General Kiley, it is my understanding that HIPAA is designed to make sure that down stream providers of health care, that is, those who are providing care later on in continuity of care systems, have access to those records without the need for a new and separate release. Is that your understanding of the HIPAA requirements?

General KILEY. To be honest with you, I don't know about the downstream access. It would make sense to me, sir, but I can't give you an accurate answer on that.

Mr. BRALEY. Ms. Bascetta, is that what you were referring to earlier that this is really an obstacle that is not an obstacle.

Ms. BASCETTA. Yes. That is my understanding of the situation. I am not a lawyer and HIPAA is very complicated and there could be unintended consequences, but my understanding is that there is a way to overcome this problem within the confines of the current law.

General KILEY. Sir, if I may, Mr. Chairman, I agree that any physician who has a requirement to care for a soldier in the VA has total access that was not the issue that we ran into between JPTA.

Mr. TIERNEY. Mr. Cooper, you had questions earlier. You have 1 minute.

Mr. COOPER. One quick question. This is a busy, sometimes overcrowded hospital. We are involved in the global war on terror, which has already lasted longer than most people anticipated. We consistently underestimated the number of casualties. Do we have any business shutting down this hospital?

General KILEY. Sir, I made my recommendations concerning the future of Walter Reed during the deliberative process for the BRAC. I personally recommended against closing Walter Reed. The decisions were made by the Secretary. President approved it.

My tack was then twofold, to begin the process of merging Walter Reed with the National Naval Medical Center and begin—continue to articulate that the risk associated with that was of properly funding it. It is a very expensive decision to be able to take all the health care that is provided here and move it.

Subsequent to those decisions and consistent with the discussions we have had all day today, I certainly think that we might want to reopen the national discussion on this that maybe now is not the right time, but that is really not my call. It is in the law. And from my perspective, I would be happy to provide information and observations about it. But, I am here to execute the law in that regard.

Mr. COOPER. But you recommended against closing Walter Reed?

General KILEY. I did, sir. It was a deliberative process. Looking at two major medical centers 8 miles apart, and there was a committee that worked through the discussions, the pros and cons and the committee's recommendation up the chain in the department was to close it and realign it over at Bethesda. I didn't agree with that. But after the decisions were made, it doesn't do any good to continue to subvert that process.

Mr. COOPER. Shouldn't we at least make sure the new facility is better before we close this one?

General KILEY. Well, that is the challenge, because it is going to cost a lot of money to open the new—to expand the Bethesda campus and build the new facility at Belvoir, which will capture all the work that is going on here at Walter Reed. Yes, sir, that will take a lot of money.

Mr. COOPER. Thank you, Mr. Chairman.

Mr. TIERNEY. Thank the gentleman.

Mr. Hodes.

Mr. HODES. Thank you, Mr. Chairman.

General Kiley, I understand that you ran Walter Reed from 2002 to 2004. You are now the surgeon general of the Army.

General KILEY. Yes, sir.

Mr. HODES. And Major General Weightman, you ran Walter Reed for 6 months, from August to recently, and you have been demoted, sent somewhere else——

General WEIGHTMAN. Sir, I have been relieved of command.

Mr. HODES. General Kiley, I want you to know that I think this is a massive failure of competence in management and command. And do you agree that the buck stops with you on these problems?

General KILEY. Yes, sir.

Mr. HODES. Now I want to know when the first time it was that you heard about the kinds of problems we have heard about today? When was the first time you heard about these kind of problems, sir?

General KILEY. These specific problems I heard about when I saw the articles in the Washington Post.

Mr. HODES. Now, sir, it is my understanding that former Congressman Bill Young and his wife approached you to talk about problems with soldiers lying in urine on mattresses. Do you recall that?

General KILEY. I recall that specific case. And I recall my conversation with Mrs. Young.

Mr. HODES. And she said that you had skirted these problems for 5 years. You understand she said that?

General KILEY. I understand she said that.

Mr. HODES. And in December of this year, you met with a fellow named Mr. Robinson. Do you recall that?

General KILEY. I wouldn't characterize it as meeting with him. Mr. Robinson briefed the DOD congressionally mandated mental health task force along with three or four other officers in his organization.

Mr. HODES. And you heard graphic testimony during that briefing from him consistent with what we have heard today from Mrs. McLeod and Staff Sergeant Shannon, isn't that correct?

General KILEY. He briefed us about his concerns about the welfare of soldiers across the whole system and Marines as part of his role for his organization, some of which was focused at the Fort Carson installation. But the issues that he talked about, and the issues that Mrs. Young talked about, have been issues that we have been challenged with and dealt and fixed on a case-by-case basis since I took command 2002.

Mr. HODES. What did you do after the briefing on December 20th? Did you launch an investigation? Did you immediately go for yourself to make your own personal investigation of the conditions that Mr. Robinson was telling you about?

General KILEY. I did visit Fort Carson. I talked to both the installation command. And I had talked not only with—listened to Mr. Robinson's brief, but I also talked to him after that conference about specific issues that I could talk to. We then, as part of the task force mission out at Fort Carson, talked to soldiers and had other discussions to analyze what was going on at Fort Carson.

Mr. HODES. Is it still your testimony that it wasn't until the Washington Post published accounts that you knew of the failures that had occurred at Walter Reed?

General KILEY. By failures at Walter Reed, if you are talking about the individual soldiers' stories in Building 18 at Walter Reed in the timeframe that was described in the article, I was unaware that those—that those specific cases were going on.

Mr. HODES. And nothing you had heard up until that point led you to question whether or not you were overseeing a system that was completely dysfunctional and wasn't serving the soldiers?

General KILEY. Well, no, sir. I did not characterize my view of either Walter Reed, the North Atlantic or my other regions as being dysfunctional. We have always had concerns that the large numbers of soldiers that we have had to manage across the installation create a challenge for the command.

The deployment of soldiers, the redeployment of soldiers, the deployment of PROFIS fillers creates challenges for the commanders in terms of their own assets, some of very short nature. We have had issues with the MEB and PEB process. We continue to work those solutions.

Mr. HODES. And so that is why when you were asked about the Post reports, you essentially said that it is not a systemwide problem, our health care system is treating our soldiers well.

General KILEY. Well, I think our health care system in terms of the delivery of medicine across U.S. Army medical command and here at Walter Reed is outstanding. As I said earlier in my paper in my presentation, the bureaucracy complexity and adversarial nature of the MEB-PEB process is something that we need to take on and fix.

Mr. HODES. Sir, if we find, this Congressman finds that your failure to acknowledge earlier the problems that have existed are a serious problem, how then can we take what you say about your proposed fixes and how do we know that is going to happen?

General KILEY. I guess I am trying not to say that I am not accountable because I am accountable. And I am trying to say that we have known that these soldiers are injured, they are emotionally and physically vulnerable, that they need help and health care, that they need a system that cares for them continuously right into their either retirement or return to duty. It happens all over America. And not just at Walter Reed. I command by commanding through my commanders entrusting them to execute the mission right down to the hospital commanders. And I give them the resources. And then we do inspect them and check them.

I did not personally inspect some of the issues at Walter Reed. I will redouble my efforts on this. I am not denying that we don't have challenges. We had challenges when I was the commander here. We had stories were I talked walked up to a lieutenant. I said, do you have any money? He said I have it in my wallet. I said where is your wallet? He said it is in my pants. I said where are your pants? He said I guess they are in Iraq.

We would walk up to a young spouse with a baby in her arms and her husband is lying there paralyzed from the waist down from an accident. Tears your heart. And you look to the system. It doesn't necessarily give you a good sense that we are going to be

able to take care of this family as well as we have come to expect in America and in our soldiers and their families. And some of these things I can effect at my level as a hospital commander or as a MEDCOM commander. I can give resources for case managers and doctors and BEDLOs. Some of these other things I have to work with larger and Army and DOD to get some of this bureaucracy out of the way.

Mr. TIERNEY. Thank you gentleman, Mr. Welch.

Mr. WELCH. Thank you, Mr. Chairman. There was a report recently in the Army Times that soldiers here have been intimidated basically and discouraged from speaking directly to the media about their conditions.

General Kiley, do you have any knowledge as to whether this is true?

General KILEY. Sir, I spoke to the brigade commander after this article was released and asked you know——

Mr. WELCH. That being whom?

General KILEY. Colonel Hamilton. And asked what happened. And the article had said as I remember the article now because I had a whole series of points I wanted to validate. I asked were all the soldiers going to have to get up at 6 o'clock to have a room inspection at 7? He said no, that is not going to happen.

He had asked the soldiers that if they had issues they needed to know that the chain of command was open and ready to take those—work those.

I can't remember all the other issues in the article right now. But it was my sense in talking to the commander that some of the fears or concerns or issues about the soldiers that were addressed at the formation by the commander that you know he was not in any way threatening them or saying other than, look, we are here to help you and get this thing fixed. But there was not——

Mr. WELCH. If I understood you correctly, you just said that the soldiers were told to take their complaints through the chain of command.

General KILEY. Well, I don't want to put words in Colonel Hamilton's mouth and the conversation was very short. I was led to the impression that what Colonel Hamilton had told the soldiers in the formation was that they could come to him, that they can bring their complaints to him.

I don't want to give the impression that meant that they had to or that was their only option. We have IGs. We have chaplains. We have a whole system for——

Mr. WELCH. Obviously, it is important for the soldiers to have confidence that they will be heard. And I am not certain you have clarity. At least, I am not clear from your own answers whether you have confidence that if a soldier wants to speak out directly perhaps to a reporter about the circumstances of his care, that is acceptable as far as you are concerned or not.

General KILEY. I think it is very acceptable. You know, I wear this uniform in support of the Constitution and freedom of press. And I have never told soldiers that they can't talk to the press and——

Mr. WELCH. Can you clarify that with—I forget the name of——

General KILEY. Colonel Hamilton?

Mr. WELCH. With Colonel Hamilton.

General KILEY. I don't want to give incorrect information here. But it is my impression that he did not put any kind of a proscription on soldiers. He did not threaten reprisal or retribution in any way with his discussion with soldiers.

Mr. WELCH. Were you consulted about who would take command of this facility after General Weightman was relieved of the command?

General KILEY. No, sir, I was not—first, I was not consulted because I was told not to take the command until we could find someone and then I was informed that General Schoomaker would replace General Weightman.

Mr. WELCH. Is it on the basis of your experience both your 2 years of command here and your subsequent experience and other responsibilities that the conditions that have been reported and described have been in existence for over 6 months?

General KILEY. Well, I would say that there are two 15–6 investigations going on at Walter Reed right now, one looking my chain of command issues specifically health and safety, and who in the chain of command knew what, when they knew it. And there is another 15–6 looking at the clinical process of medical boards, MEB, PEB process. I can't say right now, whether this was a short-term or long-term problem, I think the number of soldiers that were here would lead you to believe that General Weightman was working through these solutions.

Mr. WELCH. So if I understand your testimony, you were here for 2 years, then General Farmer, then General Weightman. The information you have to date is that General Weightman, in fact, was trying to work through these problems. He has been fired. Is that an appropriate response to the situation that has been presented to us?

General KILEY. Sir, that is a decision for the civilian leadership of the Department of the Army of the Department of Defense.

Mr. WELCH. I guess it is—I am sorry, the rank of——

General KILEY. Major General, sir.

Mr. WELCH. Hamilton.

General KILEY. Colonel.

Mr. WELCH. Colonel Hamilton is here. He is not sworn in, Mr. Chairman, but he might be able to clarify the question about what was told to these soldiers about whether they could or couldn't speak, or whether there was any impression that the soldiers recently could have sustained that they were discouraged from speaking directly to the press.

Mr. TIERNEY. We can contemplate swearing him in with the next panel for that one question if you need to, but otherwise maybe the next panel can address that question.

Mr. WELCH. Thank you. I yield the balance of my time.

Mr. TIERNEY. Thank you very much. Ms. Norton.

Ms. NORTON. Thank you, Mr. Chairman. I have a question about the twin pressures here at Walter Reed, as the crown jewel as it has always been called, where you send the most injured soldiers always and certainly from Iraq and Afghanistan. The BRAC pressure is clear what it does is send a signal to everybody go look for another job because we think it is going to close down.

If I may say so, I think Congress would be insane to pump $2 or $3 billion into building a new hospital in the middle of a war. And I don't expect we will come up with those funds. But I do think that is a signal that sends out on top of the BRAC pressure which says scatter get a job if you can somewhere else, there was the privatization pressure where you Mr. Kiley and Mr. Weightman have privatized all of the base operations, except as I understand it, for medical care.

Now, of course, those would be the very base operations that Mr. Kiley, General Kiley, would have to do with the upkeep you have testified about, of $400 million in renovations, $269,000 in renovations, lots of money. But of course, what difference does that make if there is not staff on board to keep the facility up?

These employees came to see me, because I represent the hospital here. Many of them don't even live here. Your own publication, by the way, said that there were 350 employees. I don't know if all those positions were filled, but 350 employees, and that is exactly what the representatives of the employees told me.

These were workers who have had competed for their own jobs and had won the competition and the Army overturned the competition, if I may say so, the notion that therefore the Congress interfered and that must have elongated the process. On the contrary, some of them thought they might prevail because, in fact, we got an amendment through the House that would have restored the status quo and it just did not get through the Senate.

My question goes to the wisdom of privatizing everything except the clinical and medical matters in the middle of a war, especially since you, Mr. Kiley, in the first year where privatization started and then when you were at MEDCOM and they asked you for more staff, denied more staff, even as the staff was dwindling. In that same memo from Colonel Spencer, you are both put on notice due to the uncertainty associated—well, first of all, they talked about critical issues, and I am here quoting retaining skilled clinical personnel. See that scares me. Skilled clinical personnel for the hospital and diverse professionals for the garrison.

Those are the people who are to be privatized who just thinned out and went wherever they could find a job. Then it says, while confronted with increased difficulties in hiring—because how who in hell—excuse me—who, in fact, would want to be hired in the middle of that? Due to the uncertainty associated with this issue, Walter Reed continues to lose other highly qualified personnel.

Could I ask you whether you believe that it would have been better not to privatize the entire garrison work force when the facility was already undergoing pressures from BRAC and faced with those uncertainties? When you surely would have known it would scatter that work force, that experienced work force, and that your own workers had won the competition for, in fact, keeping this facility up, including Building 18? Would it not have been better in light of all the uncertainty simply to go with the work force you have? Why did you seek to privatize the work force in light of the BRAC uncertainty and add to that with the uncertainty that always attends privatization?

General KILEY. First, I would like to say that the requests of Colonel Garibaldi through General Weightman, I approved those at

MEDCOM and we resourced those requirements for him. He was unable to execute them, which was the issue. I gave him the money he needed. But you have already articulated the challenge. You identified the issue when you are not going to have a job much longer, why should you hire one?

Ms. NORTON. Therefore, why should you privatize? Which started on your watch, General Kiley?

General KILEY. Actually it started, as I understand it, in 2000, when it was identified as one of the privatization efforts under A–76. And once that installation was identified to the Army as a process——

Ms. NORTON. I am trying to get an answer to this because I know they want to move on. Would it have been the better side of wisdom not to privatize everything here except the clinical and medical work force, and therefore add to the stability or the instability of that inevitably comes with BRAC?

General KILEY. It did increase the instability.

Ms. NORTON. Thank you. General Weightman.

General WEIGHTMAN. Absolutely between BRAC and A–76 it was two huge impacts on our civilian work force, which is two thirds of our work force here at Walter Reed.

Mr. TIERNEY. I want to thank all of you but before I let you go, General Kiley, in one of your written submissions, you indicated that you were having people look into these matters both the physical condition of the buildings but also the MEB, PEB situation and that you would report back to us. We would like to schedule a hearing for the purpose of this entire discussion, those matters in particular. Is 30 days' time, 45 days?

General KILEY. 45 days I can certainly give you more in 45 than in 30. But the team I have sent out to those facilities should be done within the next 2 weeks. The process of looking at the MEB the term we use, lean six sigma concept, and we put personnel experienced in that on to the process here at Walter Reed is going to take longer than 45 days. But I can give you an interim report at that time.

Mr. TIERNEY. Thank you. I want to thank all of our witnesses for the testimony here today and we appreciate your being here and being willing to answer all the questions and we will let you go at at this time. Thank you.

If we could ask our members of the third panel to accept their invitation to come to panel please.

Mr. BRALEY. Mr. Chairman point of order. While the third panel is being seated, can you clarify the point made in the committee memorandum about the request for information that was made on behalf of yourself and the ranking member of the subcommittee for documents related to the inqiry today and whether we received any response to that.

Mr. TIERNEY. I can say that was question No. 1 coming up in the next panel. We have not yet received that documentation. We are going to ask the next witnesses on this panel to ensure us that they would be coming as well as additional documents that are going to be requested.

Thank you, gentlemen. We will have a very brief introduction, and I will allow you gentlemen to introduce yourselves as you speak.

General Schoomaker, you are sort of a late entry here; and we appreciate your being willing to come testify today.

General Cody, we appreciate your appearance, also. Mr. Geren is the Under Secretary you have asked to sit on this panel. But I understand there is no opening statement that you are providing, and I think our questions will probably be directed to the generals.

Do you have an opening statement, General?

STATEMENTS OF GENERAL PETER SCHOOMAKER, CHIEF OF STAFF OF THE ARMY; AND GENERAL RICHARD A. CODY, ARMY VICE CHIEF OF STAFF

STATEMENT OF GENERAL PETER SCHOOMAKER

General SCHOOMAKER. Sir, only to say that I appreciate your agreeing to allow me to appear today.

I am the senior uniformed officer in the Army. You know, the buck stops with me when it comes to uniform. And General Cody is the point man in the Army for what we are doing here, and I wanted to be here to make sure that we understood, you know, where the responsibility and accountability lived. Thank you.

Mr. TIERNEY. Is that your entire statement?

General SCHOOMAKER. It is.

Mr. TIERNEY. General Cody.

STATEMENT OF GENERAL RICHARD A. CODY

General CODY. Thank you, Chairman, Congressman Shays and distinguished members of this committee. Thank you for the opportunity to discuss the outpatient care of our Nation's wounded warriors here at Walter Reed Medical Center and as well as throughout our Army.

Every leader in our force is committed to ensuring the Army healthcare for American soldiers is the best this Nation can provide. From the battlefield through every soldier's return home, our priority is the lifelong, expedient delivery of compassionate, comprehensive, world-class medical care.

I am here today as the Vice Chief of Staff of the Army, but I am also here as a simple soldier who spent over 34 years serving and leading our men and women in uniform through peace and in war, through health, injury and the ultimate sacrifice that our soldiers are willing to make on behalf of this great Nation.

Like many of our general officers and senior noncommissioned officers, I am the father of two sons who are soldiers, each of whom have served multiple tours in combat. I am the uncle of two nephews who have also served in harm's way. And I can tell you I have never been prouder than I am today to serve with our incredible soldiers who motivate me every day and who remain the focus of everything we do in our Army.

As Americans, we treasure the members of our all-volunteer force who have raised their right hand and said, America, in your time of need, send me; I will defend you. We all understand that in return for their service and sacrifice, especially in a time of war

and demanding operational tempo, we owe these soldiers the quality of care that is at least equal to the quality of service they have provided this Nation.

I frequently visit Army medical facilities around the world; and in the last year I have met with soldiers, staff and patients in Iraq, Afghanistan, at Landstuhl in Germany, at installations across the United States and, at every opportunity, here at Walter Reed and Brooke Army Medical Center in Texas. Without exception, the people I encounter inevitably remind me that the United States is truly a special Nation blessed with incredible sons and daughters who are willing to serve and offer all of themselves in our defense. In them I have witnessed unparalleled strength, resilience, generosity; and I am humbled by their bravery.

Even if all our facilities were the best in the world and every process and policy were streamlined perfectly, our soldiers and families still deserve better. And, without a doubt, they deserve better than what we have provided.

Today, we have 248,000 soldiers in more than 80 countries around the world for the Army. When injured or wounded, every one of these soldiers begins a journey through our medical treatment facilities with top-notch care delivered by Army medics, Army surgeons, nurses and civilians in forward-operating facilities. There, soldiers receive extraordinary acute care that has drastically lowered our died-of-wounds rate in this war and is readily cited as being without peer.

But it is after that incredible life-saving work has been done and the recovery process begins that our wounded soldiers are subjected to a complex medical and disability evaluation process that can be difficult to negotiate and manage. Due to a patchwork of regulations, policies and rules, many of which have not been updated in nearly 50 years and have been stressed by 5 years of this war, soldiers and staff alike are faced with the confusing and frequently demoralizing task of sifting through too much information and too many interdependent decisions and bureaucracy.

Our counselors and case managers are overworked, and they do not receive enough training. We do not adequately communicate necessary information. Our administrative processes are needlessly cumbersome and, quite frankly, take too long. Our medical holding units are not manned to the proper level, and we do not assign leaders who can ensure proper accountability, proper discipline and well-being of our wounded soldiers and their health, welfare and morale. And our facilities are not maintained to the standards that we know is right.

Many of these issues we are fixing now and we can repair ourselves and we are working aggressively to do so. Others will require your support and assistance to resolve.

In conjunction with the Office of the Secretary of Defense we will work to identify and recommend to Congress changes in law or statutes that may be required to ensure our wounded warriors and their families receive the fair compensation commensurate with their service and sacrifice. I am confident that, with the support of the American people, passion and dedication of veterans who have come before us, the resolve of this Congress and our administration

and the strengthened commitment of the U.S. Army, we are going to make this right.

Addressing our shortfalls and implementing changes that will drastically improve the health and well-being of our soldiers and families for the next generation is a matter of urgency. Now is the time for our Nation and for our Army to recommit and reinvest in the facilities, compensation and the programs our wounded warriors deserve.

During my visits with our wounded warriors at our medical facilities throughout the world, what has struck me most is the humble and resilient spirit of our soldiers and their families. They ask very little in return for all that they have given. They ask not to be forgotten, they ask that their families be cared for and that we will do all we can to support their brothers and sisters in arms and that they tell and we tell their story to the American people. For that, these soldiers deserve the preservation of their dignity, their pride in being soldiers and the knowledge that their leaders and their country know that there is no compensation, no awards, no words that can measure their and their family's gift to this Nation and to our Army.

We will do what is right for our soldiers and their families. They can be assured that the Army leadership is committed and dedicated to ensuring that their quality of life and the quality of their medical care is equal to the quality of their service and their great sacrifice.

With that, Mr. Chairman, I look forward to your questions.

Mr. TIERNEY. I thank you. I thank all you have on the panel.

I forgot to swear you all in originally.

[Witnesses sworn.]

Mr. TIERNEY. Thank you to all the witnesses. You are recorded as answering in the affirmative.

General, your statement is well taken. But I have to tell you, the first thing that pops into my mind is, where have you been? Where has all the brass been on this?

All we have heard and read about earlier today, clearly, this can't all be pushed down at the lower level. Clearly, this is not some junior officer's responsibility that nobody else has to claim anything for.

I think one of the earlier witnesses on the first panel said this well, you need to have some supervision here. People have to be responsible. You don't just send them off to do that.

And these issues, from what I can see, have gone back to General Kiley's day, General Farmer's day and General Weightman. What is it that General Weightman did that was so different from what General Farmer or General Kiley did? Will one of you tell me why he got the axe and why the others walk on the earth today? You know, why are they still in uniform and still going on?

I don't see any difference between the conditions, 125-to–1 ratio and the difficulties people were having getting around to the different systems. Can you tell me why it is that one sort of is being transferred out and the others are not even recognizing that the problem existed, but we know it existed all this time?

General SCHOOMAKER. General Weightman was relieved of his command by the Secretary of the Army. I supported that decision.

The Secretary of the Army felt he had lost trust and confidence in General Weightman.

Mr. TIERNEY. Let me interrupt you. He lost trust and confidence because he is the one who reduced it from 125 to 1 to 25 to 1? You lost trust and confidence because he is the one who put more attention into the PTSD issue?

General SCHOOMAKER. Sir, I think the issue was the Building 18 issue and the fact that a Building 18 existed when nobody knew that it had existed.

We are out here continuously. We are across the Army continuously with these soldiers and their families continuously, get nothing but the most outstanding feedback from the way that they are treated and the medical care that they receive here.

Mr. TIERNEY. So we assume Building 18's conditions arose only in August 2006? It didn't exist before?

General SCHOOMAKER. No, it is very clear that it existed before. What I am trying to say is the fact that, you know, nobody knew of a Building 18 until it arises this way. Certainly begs the question of why. We didn't know it. And of course, you know, I mean, I will tell you, I was extraordinarily angry and embarrassed by the fact that we would have a Building 18.

Mr. TIERNEY. I would think that would be the case, sir.

But we go beyond the bricks and mortar issue which I think is going to be resolved without as much difficulty as the other issue of what has been happening in terms of their care. The hand-offs and the going through the process there, that has been all the way back to 2004, 2005.

General SCHOOMAKER. Medical care here——

Mr. TIERNEY [continuing]. The whole idea of the post-medical care.

General SCHOOMAKER. Outpatient care is a problem, a challenge that was anticipated. I would have told you before these hearings, based upon the feedback that we had gotten at the level that we are, that this would have been a bright spot in our history in terms of how soldiers have been cared for.

Now, you know, my father was a World War II, Korean War and Vietnam veteran. I was commissioned 38 years ago. I have a brother who is now in command of Walter Reed who is a major general. I have a daughter and a son-in-law that are on their way to combat. This is not something about people don't care, and I am not going to sit here and have everybody tell me we don't care.

Mr. TIERNEY. We haven't said anything about people not caring. We will put that red herring aside, and if I can calm you down and get you back to the issue here, this——

General SCHOOMAKER. This isn't a red herring.

Mr. TIERNEY. Sir, nobody said anything about not caring. The question was and continues to be, if these situations have been occurring since 2004, 2005, 2006, why weren't they resolved and why weren't they addressed?

General SCHOOMAKER. That is a great question. And the issue is, is you asked me the question of why General Weightman was relieved by the Secretary of the Army. It is because these issues hadn't been surfaced, and General Weightman was in a position of accountability and responsibility. And the Secretary of the Army

didn't have trust and confidence in him and relieved him, and I supported that.

Mr. TIERNEY. Is your testimony, sir, then, all of the reports that Mr. Waxman read earlier, the several GAO reports, the newspapers going back to salon.com articles, the Inspector General's reports going back several years now that all speak to these issues which were addressed today, none of them came to the attention of anybody higher than General Weightman?

General SCHOOMAKER. That I cannot speak to. I would certainly say they didn't come to my attention.

Mr. TIERNEY. General Cody.

General CODY. I have been the Vice Chief since 2004. Prior to that, I was the Operation Officer of the Army. And so I can't speak before that because I was busy getting the Army ready for the war back in 2002. But when I became the Vice Chief in charge mostly of the day-to-day operations for the Chief of Staff of the Army and the Secretary of the Army and the Under Secretary of the Army, occasionally we would get reports about medical hold, occasionally we would get reports about process. In each case, the Secretary of the Army or the Surgeon General of the Army had sent teams out to work through the process.

I am not aware of the reports that I heard Chairman Waxman talk about. I have not read those reports. But we did know that the process for the MEB and the PEB are very, very complex. I am now very well aware of it. I have studied it now for the last 2 weeks.

But, before that, I have come to this hospital several times since 2002 when this war began and did not know of Building 18. That is not an excuse, just didn't know it was there. Because I spent most of my time on ward 57, ward 58 and the neurosurgeon wards and stuff like that. Each time I heard about these problems they were being addressed and trying to take care of it.

I think that the size and scope—let me just say one thing. From 2002 until now, we were handling about 6,000 MEB and PEBs in the Army. About 2004 until now, it rose up to 11,000 a year, and that has been a problem, and we have to address it. But I was not aware of the size and scope of this issue.

Mr. TIERNEY. Who in your chain of command would you have expected would have been aware of those reports Mr. Waxman talked about?

General CODY. Certainly the Surgeon General and certainly the commander of our region, not just this region but our other regions.

Mr. TIERNEY. Would it have been fair to suspect that they would have done something about it, at least looked at the systemic and complex issues and made recommendations to you?

General CODY. Well, they would have made recommendations to the Secretary of the Army on some of these. We did note—we did—in 2005 and 2006, I am aware that the Department of the Army Inspector General was ordered by the Secretary of the Army to go and look the MEB and the PEB process. And their latest report was just briefed out to me—excuse me—today.

Mr. TIERNEY. We have all of these reports, and we have, apparently, nothing happening on the ground here that is really impacting the patients yet and their families on that. And I think that is what upsets people and what surprises them on that.

You know, we have had a surge. Everybody knows that we apparently didn't expect or certainly our civilian leaders didn't expect they were going to have that kind of casualties in the situation. That has increased and, at the same time, we have a decrease in personnel here.

My time is pretty much up, so I am going to pass it on and hope somebody else will get into that.

As we are ramping up the number of people here for service, we are having all kind of difficulty with the personnel. I will also leave it to somebody else to ask, what do we do in terms of planning for what may occur with an additional 25,000 troops going into combat?

With that, I will leave it to Mr. Davis.

Mr. DAVIS OF VIRGINIA. Thank you very much.

I am not sure where to start here. But, General Schoomaker, if you think this is about Building 18, we have missed the point here. This is about a far more systemic problem.

This committee, as Mr. Waxman noted and a number of GAO reports, published reports, our hearings, guardsmen not being paid in the field appropriately, computers that don't talk to each other. It is a systemic problem. And Building 18 was the visual that was just kind of waiting to happen. It encapsulates all the other problems.

But the witnesses today, the testimony was less about Building 18 than it was they couldn't get proper medical attention. They would come back from the war, they are injured, and nobody is there to take care of them. They have to navigate a maze of regulations and procedures and paperwork that a lawyer couldn't navigate. You know, so you are not going to be able to Scotch tape this over, which we have tried to do, and Band-Aid it. It takes a systemic problem.

We have had wave after wave of people come before our committee over the last 4 years saying they are going to fix it. I have here the last two Army medical holdover operations reports; and we always get, well, we are going to do better. But we always seem to find a new manifestation for these systemic problems. We saw it in the pay, we saw it in the collection, we saw it in the people falling through.

What makes this round of promises any different? How are you going to be more successful at integrating all of these different Army command responsibilities and processes so they are seamless and provide a better standard of care? What makes this different from what we have heard before each time we get an embarrassing situation?

General SCHOOMAKER. First of all, let me be very clear. My statement was not intended to say this is about Building 18. There is no question that this is bigger than that. It was about when this thing, you know, first came to our attention. And clearly that is what it is, and it clearly has become a metaphor for a much bigger problem.

But I believe, as the Vice Chief has said, there is a Department of the Army Inspector General report that he has read now that it has taken time to do. There is a very detailed action plan that has being put together under his purview that we fully intend to

support. I believe that there is a great deal of desire and emphasis to make this happen because it has to happen, sir. It is the right thing to do.

I told you I couldn't be madder and I couldn't be more embarrassed and ashamed of the kinds of things that have turned up, because, clearly, it is not what my impression would have been based upon the feedback that I have gotten as I have talked to soldiers and their families.

Mr. DAVIS OF VIRGINIA. I mean, these are heroes, these people that are coming back here.

General SCHOOMAKER. Absolutely.

Mr. DAVIS OF VIRGINIA. They put their lives, their families at stake, and some of them will never be the same, and they are languishing. And they are not nuisances or things that we have to check off, but they have been treated this way.

I will tell you, I was a Reserve officer, retired first lieutenant. I never got any higher. But I think it is time the generals at the very top be held accountable, because that is where the systems come from. You can't even have a commanding general here be able to patch together all of the different systems that are dysfunctional within the Department of Defense and the Veterans Administration. So I think we may be looking at the wrong scapegoats. This is a far bigger problem that we failed to look at.

I just want to know, what are we doing systematically to make these——

General CODY. Let me take that on, Congressman.

First off, we are taking accountability across the board. Since this problem was highlighted, one of the issues I found very, very clearly when I went and looked through, it wasn't just Building 18. It dealt with how we treated and took care of the health, welfare and morale of these soldiers in a very vulnerable transitional piece, having served our country so well.

So I clearly understood that we didn't have the right structure here at Walter Reed. So we have changed it immediately.

We have taken the Medical Service Corps out of taking care of our medical hold and medical holdover. I selected a colonel, a combat veteran, as well as a commandant sergeant major. These are combat arms soldiers.

We have taken and put about 27 new E7s that are coming in to fix that structure, because the rooms weren't being inspected. That is not a big issue, but the appointments were not being taken care of. There was no followup to make sure they were on the right meds, there was no followup in what type of training, there was no followup in getting back to their units and checking with them. That piece is being fixed immediately.

The systems you are talking about is the Medical Evaluation Board TT and that does not talk to the PD caps, which is the back side of the Physical Evaluation Board. We are trying to get that fixed now.

In between that is the liaison officers. These liaison officers are the ones who take the soldiers from the MEB process and hand them and work them through the Physical Evaluation Board processes. Clearly, we don't have enough. The training is not good enough, and there was no quality control to see if certain liaison

officers were adequately trained and taking care of the soldiers all the way through the process. We are now fixing that as part of the action plan.

And it is not just the production timeline. It is the quality control timeline. And we have raised the rank structure of liaison officers. That, right now, is our immediate work, but there is work to be done making these two systems talk to each other.

On a larger scale, when you talk about Walter Reed in particular, this is not a spike that we are in. This is a global war. This war has gone on now for 5 years. And when the decision was made I believe to look at Walter Reed for BRAC and to look at the A–76 process in a crown jewel that is going to support our wounded warriors all during this war, I think we need to take a look and then readdress whether we sanctuary Walter Reed during this long war.

We need to have to ask the hard questions. Because, clearly, when you take a look at a hospital that has been put on the BRAC list and you are trying to get the best people to come here to work and they know in 3 years that this place will close down and they are not sure whether they will be afforded the opportunity to move to the new Walter Reed national military center eight miles away, that causes some issues. The A–76 process that I heard discussed, we have to ask ourselves the question, is that the right thing to do at a hospital right now that is supporting this war?

So, from a larger scale, these are the things that the two-star general and the three-star general were having to wrestle with. And these are both laws. I am not complaining about them. But when those things were discussed, everybody thought that this war was going to ramp down in 2005 and 2006. And the Chief and I have said for a long time, this is not a spike. This is a global war on terrorism, and we are going to be at this level for some time. So I think we have to have a national discussion about that.

Mr. DAVIS OF VIRGINIA. Thank you.

Mr. TIERNEY. Thank you.

Mr. Waxman.

Mr. WAXMAN. General Schoomaker, last Friday, the Secretary of the Army, Francis Harvey, was fired and, preceding him, General Weightman was fired. Now, the Secretary of the Army looked to you as his Chief of Staff to try to understand what was going on, to try to give him the information to make sure he knew what he had to know to make the system work.

Now, the chairman asked you about some of these reports. There was in February 2005 an article in Salon magazine describing appalling conditions and shocking patterns of neglect in ward 54, Walter Reed's inpatient psychiatric ward. Were you aware of that?

General SCHOOMAKER. I was not. I have been in that ward, and I have visited that ward.

Mr. WAXMAN. There was another report in 2006 that warned the soldiers with traumatic brain injuries were not being screened, identified or treated and others were being misdiagnosed, forced away for treatment or called liars. Did you know about that report?

General SCHOOMAKER. I did not know about the report, but I certainly know and we have been very concerned and working on traumatic brain injury and PTSD.

Mr. WAXMAN. In 2005, RAND issued a report finding that the military disability system is unduly complex and confuses veterans and policymakers alike. Were you aware of this report?

General SCHOOMAKER. I was not aware of the report, but I do agree with the synopsis or the conclusion that it states.

Mr. WAXMAN. Over the past 2 years, the Government Accountability Office has issued a number of reports. In January 2005, they found inadequate collaboration between the Pentagon and VA to expedite vocational rehabilitation services for seriously injured service members; and in February they reported on gaps in pay and benefits that create financial hardships for injured Army National Guard and Reserve soldiers. Did you know about the GAO reports?

General SCHOOMAKER. The GAO reports I probably was aware of but have not read, but I have visited these VA centers. I was recently at one down in Florida near Tampa that is a polytrauma center, have observed it, have been watching the good work that has taken place to make the transmission right in places like Tripler, where they are actually converting a wing to the VA to walk them across, and so I think these things are known and have been being worked on.

Mr. WAXMAN. You went to the passive use of the English language. What were known and were being worked on?

General SCHOOMAKER. Are known and are being worked on. I am talking about——

Mr. WAXMAN. There is a chain of command in the military.

General SCHOOMAKER. That is correct.

Mr. WAXMAN. The Secretary of the Army, Francis Harvey, would have looked to you to get the information. Who do you look to to get the information?

General SCHOOMAKER. In medical situations, I look to the Surgeon General.

Mr. WAXMAN. Who is the Surgeon General?

General SCHOOMAKER. My purview is over the entire Army.

Mr. WAXMAN. Who is the Surgeon General?

General SCHOOMAKER. General Kiley, sir.

Mr. WAXMAN. General Kiley just told us—and even though he was in Walter Reed, no one told him about some of the things that were happening in Building 18. Who was supposed to report these things to him?

General SCHOOMAKER. The Commander of Walter Reed, who is responsible.

Mr. WAXMAN. And the Commander, who was the Commander of Walter Reed?

General SCHOOMAKER. General Weightman was the Commander of Walter Reed.

Mr. WAXMAN. General Weightman. But he was only Commander for a short period of time.

General SCHOOMAKER. He had been Commander since of summer of 2006. General Farmer before him was retired. The Commander before him was General Kiley.

Mr. WAXMAN. I guess I share the concerns that Congressman Davis expressed. We have all these reports, we have all these alarm bells going off in articles from popular magazines or informa-

tion sources like Salon to GAO reports, and the information doesn't seem to get up the line of command.

General Cody, you gave us an excellent statement, but how much of those problems that you have outlined for us were you aware of before the Washington Post report, before all of this became such a focus of attention? You personally.

General CODY. Sir, I was aware of in—because of my time as the G–3 of the Army coming to this hospital and visiting soldiers, I was aware of the severely wounded warrior problem, and I was concerned about it. And we set up what you know now as the Army Wounded Warrior Program back in 2004, early 2004, because we were concerned with the numbers of injuries, amputations and traumatic brain injuries. We were concerned that, if we medically retired a severely wounded soldier, we wanted to make sure that the Army stayed with that soldier through that whole process.

Mr. WAXMAN. That was 2004. This is now 2007. Today, the Washington Post says, it is not just Walter Reed. They gave very heartbreaking stories about broken wheelchairs at a California VA hospital, rooms overflowing with trash and swarming with fruit flies in San Diego Naval Medical Center, mold, peeling paint, staff shortages in Knoxville, KY.

I guess my question—and my time is up—is the same question that Congressman Davis asked you. If you didn't know and you didn't do, why are we going to believe that it is going to get done in the future? Why should we feel confident because a couple of heads have rolled that the job is going to get done, not just at Walter Reed but in this whole system?

General CODY. As I said, we started the Army Wounded Warrior Program because we knew that part was going to be the piece that we were most concerned about. And that program has been run now for 2, 2½ to 3 years, and it is working very well.

The MEB and PEB process and the extent of what has happened here at Walter Reed I did not have oversight or visibility of. I do now. I have been directed 2 weeks ago to shift my attention from my other duties, which is the reset of the Army and the training of the Army and other things, to put me as the No. 2 guy in the uniformed services. My full attention is to fixing these issues.

Mr. TIERNEY. Thank you.

Mr. WAXMAN. General Schoomaker, what do you say? Why do you feel confident this is going to change?

General SCHOOMAKER. Well, because we are going to change it.

Mr. WAXMAN. You should have changed it before, but it didn't happen.

General SCHOOMAKER. There is no question. There is no argument with you about what should have happened. It clearly didn't happen.

As I said earlier, that if somebody had asked me 3 weeks ago, what was one of the bright spots, it would have been the way that we are now treating our wounded soldiers because of things like the Wounded Warrior Program, because of the kinds of wonderful things that are happening with the wonderful people that are medically caring for our wounded soldiers.

Mr. WAXMAN. You were very wrong about what was going on.

Mr. TIERNEY. Thank you. The gentleman's time has expired.

Mr. Lynch. I am sorry. Mr. Platts.

Mr. GEREN. Mr. Chairman, can I just say one thing briefly in response?

The only way to prove it to you is to show you. And I can assure you from the top of this—from the Department of Defense down to the folks working on the ground here in this hospital, there is a commitment that is heartfelt. The Secretary of the Army appointed a committee that is looking at it. Not only——

Mr. TIERNEY. The Secretary of the Army that is gone?

Mr. WAXMAN. What is your job? Liaison to the Congress?

Mr. GEREN. No, sir. It is not. It used to be. I am Under Secretary of the Army.

Mr. WAXMAN. Did you know about all of these problems before?

Mr. GEREN. No, sir, I did not. Friday night——

Mr. WAXMAN. You just want to underscore that the commitment is there for the future.

Mr. GEREN. No, I would like——

Mr. WAXMAN. Even though the commitment should have been there for the past.

Mr. GEREN. Yes, sir. We have no excuse for the past.

Mr. TIERNEY. Thank you, Mr. Geren.

Mr. Platts.

Mr. PLATTS. Thank you, Mr. Chairman.

Appreciate the witnesses' testimony and again all of your storied service to our Nation in uniform and, also, Mr. Secretary, your service on the civilian side.

I think part of what this hearing has been about is to get to the bottom of what happened, why, and how we move forward positively and specific action, some that is breaking borders, some that is human capital management and reallocation.

I think there is also a morale issue. We heard it certainly from our first panel, where two soldiers who have served us courageously, spouse of a soldier who, you know, understandably maybe have lost some faith in their government, their Army, their Nation, how we have treated them.

To that point, I would hope that you would consider—we heard the term "open door policy" here at Walter Reed. We heard town hall meetings. Is that—you know, as Chief of Staff, as Acting Secretary, the new Commander of Walter Reed, perhaps a town hall that—you are appearing before us as a congressional committee, but to go out and do that town hall meeting with all of the senior staff, with the families, with the personnel here today to say, you know, we are listening. This shouldn't have happened, and we are going to make sure it never happens again.

I think, for morale, that certainly would be good, and not just to the families and patients but to the staff of Walter Reed, that they hear from the senior people that if you see wrongs like Building 18 you don't have to wait for a patient to complain about it as a staff member. Come forward. You know, we want you to tell us what is going wrong.

Your staff is certainly going to be, you know, probably in the best position to know what isn't going right and that they know they have the full support of the senior staff. I hope you will consider that.

I do want to touch on an issue that was touched on earlier about the issue of Guard and Reserve coming through versus Active Duty. In my previous role in the last two terms as chairman of the Subcommittee on Financial Management, we dealt a lot with the challenges of the Army, dealing with this huge service of surge Guard and reservists, from a pay issue to travel reimbursement and the challenge of the systems just not being ready to deal with the volume that was going through it. My worry is there was a little bit of that here at Walter Reed on the medical side, and Staff Sergeant Shannon touched on it, because of the soldier having to deal with their home State and their status, Active Duty or on medical hold.

Are we comfortable and, again, confident that we are doing right by every soldier, regardless of Guard, Reserve, Active Duty, with their medical care and then as we move forward addressing the problems for all of them, regardless of their status before being activated?

Mr. GEREN. We are one Army, whether you are Guard, Reserve or Active Duty. It is the duty of this Army to treat everyone the same.

In the past, the Guard and Reserve were a strategic Reserve. They are now part of the operating force of the U.S. Army. We count on them every single day, and they cannot be treated differently when it comes to healthcare or anything else, pay or benefits. And that is a change. That is requiring culture change in some regards in the U.S. Army, but we are committed to that. And in the healthcare, absolutely, There should not be any distinction. Everyone deserves the highest quality care.

Mr. PLATTS. If we can prioritize as we go forward and especially with the physical evaluations, because of the complexity of our systems, these legacy systems you are dealing with, that didn't necessarily account for this volume that we really give special attention.

I have a Guard unit just came back from a year in Balad Air Base in Iraq where we are doing right by them, the same as all of our troops over there.

I know I am going to run out of time here quickly.

The one issue that General Kiley just touched on, but it seemed to be out above his level, is the issue of the hand-off between the Army, DOD and the VA and the issue of access to information. It sounded from General Kiley that it was here at the Army department level or DOD itself on physicians at the VA having access to medical records of those being transferred to those VA—specifically, the four centers dealing with the more traumatic cases. Do we have any knowledge from the three of you about where that stands? Is it an Army decision or is it DOD?

General CODY. I don't know if it is a decision by Army, OSD, but I will say that in the last 2 weeks as I have poured through this, Congressman, the teamwork between the VA and all the services is better than I have seen it in the past. I think we owe it, as Army, to make sure that we do that hand-off and we not wait—I don't think we need any laws or anything else. I think we owe it to the soldier to walk them through and hand off, and that is why I talked about the Wounded Warrior Program.

Once that happens, our caseworkers stay with the wounded warrior when we hand them off to the VA for 5 years. We have caseworkers around the country now located—on the Army payroll located at each one of these places so that we can continue to monitor our soldiers even though they are in the VA system. So I don't think it is anything more than better execution and better followup and probably some more caseworkers.

Mr. PLATTS. I think that human capital issue is where we come back to again.

Mr. TIERNEY. Time has expired.

Mr. Lynch.

Mr. LYNCH. Thank you, Mr. Chairman.

I want to thank the panelists for helping us again with our work.

I do want to qualify some earlier remarks I made. While I generally do not trust everything I read in the newspaper, I think that the reporters in this case, Dana Priest and Anne Hull, did a remarkable job; and I think a lot of service families are going to benefit by the work that they have done.

We talked a little earlier with General Weightman about the survival rates. One of the good things that is happening right now is our survival rates are the highest they have ever been. That means the soldiers that would have perished on the battlefield years ago now are coming home and we are saving them.

However, having been—you know, Mr. Platts and I actually followed troops who were injured in Iraq, taken to Balad, then to Landstuhl and then back here to Walter Reed. My concern is that, because we are saving them now, perhaps that is why we are seeing PTSD as a more profound dimension of disability and recovery; and I am wondering if we are not paying a great enough attention to it.

My specific question is, to followup on Chairman Tierney's question, we heard from General Weightman earlier that, in light of the President's plan on a surge, this adding 21,500 troops into Baghdad, that the result of that plan could potentially result in much, much higher casualties. What are we doing today here at Walter Reed, given the fact that we are—let's just say we are maxed out or we are at the point of being overburdened here. What are we doing right now to prepare for that possibility?

General SCHOOMAKER. Well, first of all, I would like to address one piece of this and that is about the PTSD that you gratefully brought up.

I have been testifying and concerned for quite some time about the up tempo on the Army. I have testified to my concerns about the readiness of the Army. I have testified to my concerns about the fact that we have compressed now down to a year, and maybe less in some cases, of reset time for soldiers.

PTSD is real; and it had another name, another age. But combat affects people, and it will always affect people, as it always has, and it needs to be paid attention to. Part of my concerns is that resetting the human dimension, not just the hardware but the fact that people's recuperation time, their time to reintegrate and to do those things, is one of the very real concerns that I have about the level at which we are asking our soldiers to operate.

In terms of what we are doing in anticipation of casualties and management of casualties, I believe that—you know, I believe what I have been told by the medical professionals that are looking at such issues as different distribution across the country of those that we could distribute. Overflight when it is not necessary to bring somebody to Walter Reed. It may be able to be dealt with someplace else. And there are probably a lot of other techniques, things out in the medical regulation system, how they regulate casualties, and maybe perhaps the Vice has some ideas on what else.

General CODY. Yes, sir. We, too, are worried. We have been very, very fortunate right now that we haven't had mass casualties. Every time—I will just say that every time a large aircraft flies, we are concerned, as well as any type of suicide bombers; and what we are doing right now is we are hiring many more caseworkers.

I put that out as part of our action plan. I talked about restructuring the Med Hold Brigade, the Wounded Warrior Brigade. I have a colonel, a sergeant major and 126 leaders coming in in the next 2 weeks to, one, get the ratio between a platoon sergeant to the number of soldiers in the med hold we have right now.

We have directed that Building 18 be evacuated—not evacuated but everybody leave it, and we are going to rebuild that facility and then have the permanent party soldiers live at Building 18, which gives us more on-campus capacity for our med hold so we don't have to put our soldiers off post. We are doing that.

The Soldier Family Assistance Center, we have increased the number of finance people there, increased the number of caseworkers there so we can surge very quickly.

I will pick and check with the Under Secretary by Friday a Deputy Commanding General, one-star, to be the Deputy Commanding General here at Walter Reed to help the new Commander with his duties not just at Walter Reed but he has seven other hospitals in the Northeast region. And my assessment is that he needs to have a Deputy Commanding General. So we are going to have that.

This week, I will meet with all the hospital commanders; and we are going to talk about these things we are discussing right now. This is throughout the country as well as what happens if we have a mass casualty event.

Mr. LYNCH. Thank you, General.

I know my time is used up, but, General Schoomaker, I just want to say I am heartened about your remarks regarding PTSD, and I hope that is a reflection of the entire armed services on that issue, because I think we need a lot of help on that.

Thank you. I yield back.

Mr. TIERNEY. Mr. Lynch.

Mr. Turner.

Mr. TURNER. Thank you, Mr. Tierney.

General Cody, your ending statement about the mass casualties leads into my question. To both General Schoomaker and General Cody, we have all heard some very disturbing things in the testimony that we have had today; and it is just as disturbing of the conditions of the circumstances as it is the round of "I didn't know," "I didn't know" that relate to a system failure.

It is not a policy failure. It is not a funding failure but a system failure when people say I don't know that a system was violating

our policy or violating our standards. And that goes to leadership, which is why it has been characterized as a leadership failure because it is not an issue of what people were handed. It is what they did with it.

The most disturbing, I think, statement that I heard today was from General Kiley when he said, we were not—he said, the complexity of the injuries of these soldiers was not fully realized. General Schoomaker, you have been the Chief of Staff since August 1, 2003, and, General Cody, you just described a scenario to us that would be catastrophic, and I guess I am just at a loss as to what types of injuries could the system have been anticipating if it didn't anticipate these types of injuries? Because I didn't hear of any injury in the testimony today that was not anticipatable.

And, General Schoomaker, certainly from the beginning of this conflict these types of injuries would have been those that would have easily been projected; and, General Cody, you just gave us a scenario that you think might occur in the future. We have, we were told, 371 outpatient rooms that are caring for individuals who were transferred from inpatient to outpatient and still General Kiley is saying that the complexity of these injuries were not fully realized. Can't we anticipate this?

General Schoomaker. Sir, I didn't hear General Kiley's statements, so I don't know from what context they were in. But from what you are saying it sounds like it is not that we didn't anticipate the fact that we would have traumatic injuries. It is that the people that have survived some of these injuries, that in the past never would have survived them, people that—I mentioned that I have been down to the polytrauma center where people have traumatic brain injuries, amputations, lost their sight and hearing, burns, a variety of very complex things that in previous wars they never would have survived.

Mr. TURNER. From what point since August 2003, did that dawn on us?

General SCHOOMAKER. Well, I think that the reason——

Mr. TURNER. Because it wasn't last week. It wasn't 2 weeks ago.

General SCHOOMAKER. Again, I don't know what General Kiley has led off, but 68 Whisky Medic, for instance, who we are training tens of thousands of at Fort Sam Houston that are the old squad medic, are now doing medicine that we would only see in Special Operations before. The combat lifesaver that we are now doing with all of the soldiers, the kind of first aid kit they carry, the kind of training they have, the trauma medicine that we have, the regulation system that gets them to Landstuhl so quickly and places like Walter Reed, the reason we have these things is because we are anticipating them. We are saving these lives; and, like I told you, I have had nothing but compliments about the way that we have been treating the people—the medical treatment of the people inside of our medical treatment facilities.

Mr. TURNER. General Schoomaker, I would invite you to look at that testimony. Because just about everyone on this subcommittee hearing was very surprised by it, and many people asked followup questions. Because to have that be the testimony today of some of the reasons of the circumstances is surprising, because it clearly

seems to me that it is an anticipatable situation. But I appreciate you taking a look at that.

Perhaps you could give us some greater—some additional follow-on to that post this hearing, Mr. Chairman.

General CODY. Could I say something about being anticipatory?

I am not a medical person, and so I can't speak for what Dr. Kiley said, but your Army looked at all the things on that battlefield as it emerged after the fall of Baghdad and when the IEDs first started showing up on the battlefield. That is what changed our ensemble for our soldiers. We used the medical experts here to help us design other things than the SAPI plates, the arm protectors, the lower extremity protectors, as well as the helmet design, as well as the additional plates that we put on the side.

I won't get into details on this because, you know, we don't want to give away all of the things that we have done for the soldier. But the medical community helped us very quickly address those things as well as the type of wounds that we saw with IEDs in Humvees versus other vehicles.

So we weren't as fast as we should have been, but we are certainly anticipatory, and that is why so many of our soldiers are surviving.

The other thing we did back when we looked at the numbers of troops that were going to be needed for this fight, we put more medevac helicopter units than we normally would in country. We put in more forward surgical teams than we would have normally, which is a good thing. We put more combat support hospitals in. And because of that, that magic hour and that magic 2 hours, that is why our soldiers are surviving.

Having that much pushed forward also puts a stress, and I think Dr. Kiley or General Weightman mentioned it, puts stress back here. Because we now have to have medical doctors so far forward, and that is why the medical doctor ratio here at Walter Reed to civilians is a little bit different than we have forward.

So we were anticipatory in a lot of these things, but, clearly, I will go back and look at the testimony and see what he meant by the types of wounds. That is the first I have heard it of it.

Mr. TIERNEY. Mr. Yarmouth.

Mr. YARMOUTH. Thank you, Mr. Chairman.

One of the things that really disturbs me, listening to all of your testimony and the prior panel, is that while you minimize the question of funding, virtually every problem that we have talked about today and the media has talked about, involves something that costs money, whether it is fixing up facilities that have deteriorated, whether it is providing more staff to handle the workload, whether it is having part of your operation reclassifying people so as to minimize the ongoing disability cost. Every aspect of this either would cost more money or it involves an activity that is trying to save the government more money; and I wonder whether this entire problem area involves not necessarily a question of motivation or even a systemic failure but the idea that we are trying to do it on the cheap, as we have done so many other aspects of this war on terror.

I suspect I know what the answer is going to be, but I want to raise that question. Because in one of the Washington Post articles,

a man is quoted named Joe Wilson, not the Ambassador, a clinical psychologist here, who talked about the fact that he said they knew all about these problems, but there was something about the culture of the Army that didn't allow them to address it.

I am wondering whether it is not the culture, that we can't afford to go in and ask anybody for more money because we have to hold the line somewhere, and we are spending it on bullets, and we are spending it in other ways. But it seems astounding to me that you can come here and say, we don't need more money or resources to correct these problems. That is just sounds inconsistent to me.

Mr. GEREN. If I could speak to that. The issues that we have identified so far are not questions of money. We are going to study this and look at some of the long-term policy implications.

And it is possible that we are going to have to come back and redirect additional funding in this area. But our studies so far have indicated that failure of leadership from a very high level all the way down to the enlisted folks that are working with these wounded warriors, it identified just questions of management of the facilities, and then the other issues that we talked about in great length about how the various disabilities systems work together, the transition to the VA.

At the end of the day we may come back. We are going to work within the department. The President has announced a study, the Secretary of the Army 2 weeks ago announced another study. We could come back to the Congress with a package to address this that would involve money. I am confident we are going to come back to the Congress with a package to address some of the policy issues.

But as Mr. Waxman pointed out, what is going on around the rest of this country? Are we making sure we are looking under every rock? We have a tiger team going out—started 2 weeks ago—going to every single major medical facility any place in the country to make sure that the lessons that we have learned now are carried across the country so that we don't have something like this happen again.

The new leader that was brought into Walter Reed was brought in because of his leadership skills, and specifically, to address the issues here. You can be sure he was appointed Friday afternoon, Saturday morning he was here on the ground working this issue and he has worked it nonstop since then.

Will we ask for more money? Eventually, who knows? We can't tell you right now. But we have the resources to meet this need in the short term. In the long term, it raises additional issues and we will be back to you with that.

Mr. YARMUTH. Let me followup just a minute because as Congressman Waxman mentioned, today's Washington Post mentioned problems in San Diego and my own State Fort Dix, North Carolina, Fort Bragg seems like there is a lot of these problems. And I am wondering whether there is some kind of mentality—maybe it is at the lower levels too—that says we know we are strapped. We know we can't have any more money, therefore we are not going to bother reporting these. Is that potentially a problem or not?

General SCHOOMAKER. I hope not.

Mr. YARMUTH. I hope not too.

General SCHOOMAKER. Anybody that has watched what we have been through over the last several years and has watched the Army fight for money and saw what we did last year pushing back on submitting a program until we could rectify some things and get it through, I believe I heard General Kiley say that he felt that his area of MEDCOM that he was fully funded under the global war on terror. I don't think there is a mentality that we are shy to ask for the resources we want. But I can tell you, it is extraordinarily difficult sometimes to understand what it is that is needed, where it is needed and to work through the process to get it.

And, so, you know, I don't know. You know, perhaps there may be places out there that you could find people don't have confidence that if they ask for things that they can get it, but we certainly been fighting tooth and nail to get the stuff we need.

Mr. TIERNEY. Gentleman's time has expired.

Mr. GEREN. Congress has been very responsive. If we need money for soldiers, you all have stepped up to the plate. We are not shy about asking and you all haven't been shy about delivering.

Mr. TIERNEY. Thank you, Mr. Secretary. Mr. Braley.

Mr. BRALEY. Thank you, Mr. Chairman. General Schoomaker Secretary Geren, General Cody, General Kiley is an obstetrician, and one of the things I learn going through Lamaze classes with my wife is that it is helpful to have a focal point to get you through periods of pain and discomfort and take your mind off what you are dealing with.

And I don't know if the three of you are familiar with this publication, Stripe, but I would encourage you to pick up a copy of it and use this as your focal point in the months ahead. This is the published in the interests of the patients and staff at Walter Reed Army Medical Center. This is the March 2, 2007 issue, the most recent issue. And you will see here in the upper left hand corner, a picture of Secretary Gates visiting Walter Reed to talk about some of the very issues we have been talking about today. And up here in the upper right-hand corner, there is a story about Major General Weightman being relieved of his command. And if you follow down here to what is happening in a real touch of irony, I think you will see that today is patient safety week.

And here in this publication, it is encouraging people to remember this year's theme, patient safety a road taken to together, a collective effort for safer health care. And it talks about the ongoing efforts here at Walter Reed to promote patient safety.

One of the concerns this committee has is that we have heard these claims before. We have heard how post traumatic stress disorder is not perceived the way it was in the movie Patton.

We would like to think that now, post traumatic stress disorder is perceived the way it was portrayed in Band of Brothers when we saw Sergeant Buck Compton, a very real hero, deal with the stress of post traumatic stress disorder.

What I need to know, and what the other members of this committee need to receive assurances on, is how the Army is going to put backbone behind the stories we see on the front page of Stripe and assure the brave men and women in uniform serving this country that their biggest challenge won't be facing the hardships

they face overseas, but the hardships they face when they return to this country.

And one of the things that I am concerned about is in this story that appeared in the Washington Post, General Weightman was quoted as discussing that one of the responses that is going to take care of some of these problems is an increase in the numbers of case managers and patient advocates to help with the complex disability process, which is one of the biggest sources of delay.

And can any of you tell us how many patient advocates currently serve the patients here at Walter Reed?

General SCHOOMAKER. I think we have an exact number on the thing.

General CODY. I don't have it. I do know the case worker load that we are trying to get to, Congressman, is 1 to 35. And it has not been that and I heard the other testimony, and I, quite frankly, I don't have the numbers with me. But we are increasing our caseworkers. But it is not just increasing caseworkers. It is the quality.

Mr. BRALEY. I want to make sure we are talking about the same thing. I am not talking about case managers, which is a separate function. I am talking about case advocates. You understand there is a difference between the two. So when you are talking about that ratio, are you talking about case managers to patients or patient advocates to patients?

General CODY. Case managers to patients. The case managers deal with the process and what we have to do is increase the number of advocates that we have for the patients when they go through this MEB PEB process not just that, but also their stay here. And that is the piece we have to work on.

Mr. BRALEY. Going back to my original question, can any of you tell me how many patient advocates—not case managers—are currently employed to serve the patients at Walter Reed?

General SCHOOMAKER. I cannot tell you.

Mr. BRALEY. That's a crisis that needs to be dealt with because everything we heard during the first panel shows and the news articles that we are reading that is one of the No. 1 obstacles facing veterans returning with disability claims. And I will be working very hard with my staff to see that it gets addressed. And I will welcome your further input on that subject.

Mr. TIERNEY. Gentleman yield back?

Mr. BRALEY. Yes.

Mr. TIERNEY. Thank the gentleman. Ms. Foxx.

Ms. FOXX. Thank you, Mr. Chairman, and thank you, gentlemen, for being here. Again, I have been listening very carefully to the kinds of things that are being talked about here. And it seems to me that in my short time of being in office that I hear very many of the same kinds of complaints from the civilian population when it comes to dealing with disability and how the Social Security system works.

So I do think that it is a widespread problem that we are talking about. I think that what has happened here has gotten the attention of the American people. And it should get the attention of the American people. It should get the attention of Congress.

Again, I want to ask you about your commitment to making this a systemwide effort and say to you, perhaps you can show us out-

side the military how we can improve what happens with disability. Because I know in my office, we have people who are trying to get on disability, we have had people who have died waiting to get on disability through the Social Security system.

Because I think that is a broken system too.

I am not sure your system is as broken as the one that we have outside the military.

So I hope that you will look for ways to fix your system, make it better. And I think it has gotten your attention. And I, again, want to just hear you say—you have said it before—that you are going to work to make it such that the system you have will be a model not just for the military but for the civilian system too.

General SCHOOMAKER. That has always been our objective to have military health care be a model for the world. And that is what is so disappointing about where we find ourselves on this.

Ms. FOXX. Thank you.

Mr. TIERNEY. Gentlelady yield back.

Ms. FOXX. Yes, sir.

Mr. TIERNEY. Ms. McCollum.

Ms. MCCOLLUM. Thank you, Mr. Chairman. Well I asked the question earlier the first panel about ombuds people being able and ombudsmen. And my answer back was that there is zero. There is no one here that is seen as an impartial entity that people can go to where they really feel that sides haven't been taken. And in the VA they have veterans county service offices. But they are being overwhelmed right now with being able to do what they need to do.

I appreciate what you gentlemen have said about working to be better prepared. We were not prepared with the conflict we found ourselves into because of poor planning, and I will say that is my opinion.

But I think it is beared out that this is not the war that many of those who in Congress who voted for thought it was going to be. I am glad I didn't vote for it. We saw injuries to eyes, burns, amputees, all quite often due to equipment failure and not having the right gear available for the soldiers, and yes, the Army and the rest of the service has reacted and tried to address those issues.

But when it comes to the traumatic brain injury and with the post traumatic stress syndrome, I am feeling some alarms going off. And I know that there was discussion about doing further study.

One alarm is, with cognitive skills tests that are being given, as we have lowered the educational standards to meet recruitment needs, we are going to have soldiers coming in who are not going to be high school graduates in all cases. And I don't know what kind of testing you are using, but I don't want to see someone who signs up, who has a GED, penalized later on by a test that is given to decide whether or not their cognitive ability is up to speed.

With post traumatic stress syndrome, it wasn't that long ago that someone was going to sit at a desk and review documentation and take veterans off—off the rolls for being, for having been originally clinically diagnosed with post traumatic stress syndrome.

So I am a little concerned about how these unseen, untouchable injuries are going to be handled.

And so as you are preparing, and I heard what you are going to try to do here, and I pray that you are able to do it, I want to know what you are going to tell the VA that they need to do in order to be prepared. What kind of funding are they going to need? What kind of bed space are they going to have to start reopening? What is their staffing levels going to have to be? What is the handoff here?

Because General Cody, I appreciate the fact, and I think it is magnificent that there is a wounded warrior program. But years after these men and women come home, they are just called veterans by many.

And there are still many of them for Korea and World War II are still waiting to get into the VA system today. What are you telling the VA to be able to hand these warriors off to them for their care?

General CODY. First, Congresswoman, I couldn't agree with you more. We are going to fix this. We have a passion for it. These are our soldiers. These are our veterans.

The ombudsman I brought up I guess a week ago when they started talking about the handoff. And I said well, who is the advocate during this process? And who does the soldier turn to if he agrees or disagrees or has a problem? And I didn't get the satisfactory answer, so I directed that we come up with a ombudsman type program for the soldiers going through the system.

The coordination that we have to do with the Veterans Administration is ongoing. I will have to go look into it. Quite frankly, I have been focused here on Walter Reed, and I have not looked at what our service surgeon generals have done informing the Veterans Administration as to what type of more bed space or what type of more type of specialist they need as our soldiers transition into the Veterans Administration.

I do know on the traumatic brain injury that a lot of work has been done. But PTSD and some of these other types of injuries we will have to go back—I will have to go back and find out what our surgeon generals are telling—all the surgeon generals are telling the VA.

Ms. MCCOLLUM. Thank you.

Mr. TIERNEY. Gentlelady yield back?

Ms. MCCOLLUM. I yield back.

Mr. TIERNEY. Thank you. Mr. Hodes.

Mr. HODES. Thank you, Mr. Chairman. Gentlemen, thank you for being here today.

As you know, the administration has proposed a increase in troop strength in Iraq.

And if that moves forward, it means that folks who have been deployed and redeployed may be redeployed again with increasingly shorter timeframes between their deployments.

What steps are you taking in terms of the medical system to ensure that people with PTSD and traumatic brain injuries are not being inappropriately redeployed to active service?

General CODY. We have a followup, once a—first off, we screen soldiers before they come out of theater. And then we screen them as part of the, if they are active duty soldiers as part of their redeployment back at their home station. And if they are reserve component soldiers, we have a screening upon their—before we demobi-

lize them. Then we have another program, after 120-day followup program to re-evaluate any soldiers that have problems.

Now, I will report to you today that program is not going as well. I just got the Inspector General's report today, the outbriefing this morning before this hearing, and we need to do better at training our leaders. We can put all the medical specialists out there, but our leaders are the ones that are going to see that soldier first and say Specialist Jones has a problem.

And so because of the op tempo, we have not trained some of our leaders as well as we should to be looking for these type of things. And that is something that I have directed that we readdress. But we screen them when we come out. They have a reintegration program right after they come back from combat and then 120-day followup program.

I don't know if those measures are right. That is what our doctors have told me and that is one of the things I am looking at right now.

Mr. HODES. Is the screening that you are talking about being done by physicians, psychiatrists.

General CODY. Yes. We have a questionnaire and they tell me that there is questions there that will indicate that there are problems. And I am not deep enough into it, Congressman, to give you an accurate assessment.

Mr. HODES. What do you think is the timeframe for your figuring out what the problems are with this process and for fixing it?

General CODY. I think we know we have a problem because of the op tempo. As the chief has said, you know we are—the op tempo of the Army is just like you said, 1 year in about 12 months out and then you are going back in. So that puts a stress to make sure that we get this post deployment assessment done.

So I am sure that it is not as good as it should be. I probably will find out here when I talk to our hospital commanders this week and that will be part of our army action plan to address soldiers that would not necessarily be eligible to deploy again.

Mr. HODES. I anticipate that there may be some tension between the need to redeploy people and determining whether or not they are suffering from severity of PTSD or TBI that would, in the order course, prevent or argue against their deployment.

What guidance is coming from the top down the ranks to give our soldiers the benefit of the doubt so that they are not getting sent out with PTSD and TBI that ought to disqualify them from having to go back into active service?

General CODY. I don't know if we have any guidance out. You are talking about leadership 101 here. You are talking about first sergeants, platoon sergeants, company commanders, the first line supervisors. My experience in the last 2 years of being here at Walter Reed and talking to soldiers that are still in units but have PTSD is I am heartened by the fact that our first line supervisors recognize that a soldier has PTSD, and in one case when I was up talking to a soldier and asked him if he was afraid to come forward, he said no, my leadership took good care of me. My platoon sergeant has been here and my first sergeant has been here and they know that I need to get well and they are supporting me.

That is just a small sample size. Clearly we had better go back and check this. But I will tell you we have great leaders in charge and we have a very seasoned set of leaders that has been in combat several times. My son is a company commander getting ready to go back to his fourth combat tour. I am sure he is not going to deploy with any soldier that has these problems and my hope is he and other company commanders will see that and make sure the medical personnel are properly alerted. But it is something we are going to have to go back and check.

Mr. TIERNEY. Thank you Mr. Hodes. Your time has expired. I am sorry. Mr. Welch.

Mr. WELCH. Thank you, Mr. Chairman. Generals I am sure you agree that the cost of the war has to include the cost of paying for treatment for the warrior. And there's a report from Peter Garibaldi, the garrison commander, about the privatization that occurred about services here at Walter Reed. And what I understand the decision to privatize support services, there was 300 Federal employees, doing facilities management and related work and then IAP which is a company run by someone who used to be with Halliburton. They eventually took over and the number of personnel dropped in the range of one report is 60 and I think an earlier witness today said it was closer to 100.

Has the decision to move to privatization and essentially replace contract Government employees who have experience and have been doing a good job as I understand it, with private contractors been detrimental to the delivery of services that our returning veterans need?

General SCHOOMAKER. Sir, if I could take one swing at that, and I am not expert in privatization but I can tell you that there's a lot of demand on the force and we have been trying to grow the operational force of the Army. And there has been a lot of effort to make sure that anyplace that we have soldiers doing things, have soldiers doing things or somebody else could do them, we want soldiers doing things that only soldiers can do.

Now I don't think that is the case here at Walter Reed. I think what we went through at Walter Reed was this A–76 thing, study, that basically competed the DPW against a private entity, and this thing went on, I think, since what, 2004, Dick?

General CODY. It is the A–76 competition against the department of public works which was an entity of Government DA civilians. And they initially won the competition. And then it was protested. And then in the protest, IAP won and then it was protested again. So this thing started from 2004 and finally got to where IAP, which won the contract, I guess they took over about February 7th.

General SCHOOMAKER. That is the point I was trying to make is this was a very unusual kind of transaction that took place. And then you have BRAC on top of this which people then are concerned about their future.

Mr. WELCH. That is my point. It seems very unusual. You have competent employees who won the bid, then their bid was reversed for no explicit or clear reason, and then IAP, which gets $120 million contract, then downsizes further more obviously boosting profits but apparently compromising service that presumably is a concern to you. Correct?

General SCHOOMAKER. Totally a condition. But it is also something that we normally would not have any visibility into or anything you know that we can't influence that process once that starts.

Mr. WELCH. Thank you. I understand that. That goes on outside of you.

You know, General Weightman served here for 6 months and he was the person in charge at the time these reports came out from the Washington Post. But the information that we have received so far is that the conditions pre-existed his arrival and that he was, in fact, taking some concrete steps to address them.

Obviously once this story gets front page news, it creates an enormous amount of anxiety and turmoil and demands a public response. But bottom line question is this: Has General Weightman been treated fairly or has he been a scapegoat?

General SCHOOMAKER. First of all, I wouldn't take part in something that was a charade. I think it addresses one's integrity, OK, and the Secretary of the Army looked at this situation. All of us were very upset with what we saw and concerned about it and felt that the kinds of conditions that were here that we were not aware of should have been highlighted in the timeframe that—regardless of when they started—with the commander that is here.

When you take a look at who is accountable and the Secretary had said he had lost confidence in General Weightman and he made the decision to do it. Nobody pressured anybody to do it. And nobody was lobbying to do it or looking for anything.

But you know it is clear that there were issues here that were bigger than a couple of platoon sergeants and a company commander. Listen, General Weightman has a tremendous reputation. He is a fine doctor. I have known him for a long time. You know, my view is he has a lot that he can do yet for us. But the Secretary of the Army felt that this was what was required and he made that decision. I supported it.

Mr. WELCH. Thank you, General. I yield.

Mr. TIERNEY. Thank you. Ms. Norton.

Ms. NORTON. Thank you, Mr. Chairman. I don't know which of you I should speak to, but I think it is at your level, this GAO report—literally just out—challenges encountered by injured service members during the recovery process. One of the things we have been trying to get to the bottom of is the frustration that we heard in testimony from veterans caught in what I can only call the indecision of the bureaucracy where the soldier doesn't really know his fate and he feels caught in a bureaucratic tangle.

Virtually, all the testimony from the brass has essentially said this was a leadership problem whereas the Members have identified a systemic problem they say is nationwide. Where as the testimony seems to say change the people that will change the system.

The GAO, it seems to me, points to really a quite pregnant example. It says in here, I am quoting, VA's efforts may conflict with the military's retention goals.

Interestingly, I don't know who put this chart here, but there's a chart I tried to find out who it was from, disability rating, different, differences example where they put an example from the VA and an example from the PEB or the health system, and, where

the same soldier with the same disabilities is rated 40 percent disabled by one and 70 percent disabled by another.

Now that says to me that not only do computers not talk to one another, but even freshly injured soldiers—we are not talking about soldiers whose problems may have developed since the release and therefore they have been in the system.

General SCHOOMAKER. I think you will see 2 different laws involved, one for the VA and one——

Ms. NORTON. I am not suggesting that somehow they should be the same, so please don't misunderstand me nor does GAO it says in particular, DOD was concerned about the timing of VA's outreach to service members whose discharge from military service is not yet certain.

DOD was concerned that VA's efforts may conflict with the military's retention goals. It seems, obviously who pays for what between these two agencies comes into play here. And here we have a surge about to happen. In fact, some say the surge may be over by May, then the soldiers may all be there.

Until now, these people were not—our soldiers clearly were not—there was an attempt to keep them out of the middle of what was increasingly a civil war. Now we send them right into the middle of it. And I am concerned we are going to get more people who come back and need to talk to both systems at the same time, and wonder what you can do to keep a soldier from experiencing two different rating systems and then to ask you who in the world—whose job is it to figure out what the soldier finally gets fairly?

General CODY. Madam Congressman, let me take that on, because I am as frustrated with it as you are, and really gets to the heart of the issue. First, let me be clear that it is not just a leadership problem. We understand that when we talk about leadership failure, it dealt with just the one symptom of Building 18 and the Med Hold unit. We all recognize it is a much larger bureaucratic morass that our wounded soldiers have to face.

The chart you just held up is an interesting chart. You are talking about Title 38 for the VA and Title 10 for the military. When we look at a disability rating for the military, it deals with being unfit for service in the military. So if Sergeant Jones loses an eye like we have on that chart, but he has vision in his other eye, we assess him as 40 percent disability. He may have lost hearing. He may have lost some lower teeth, and he may have some scars. Those particular things would not make him unfit for military duty. However—so that is why he get assessed by 40 percent under the rules of Title 10 on how we look at disability. I don't agree with it, but that is how it is.

The VA under Title 38 can assess all those things and so the soldier sits there and says, service will give me 40 percent, VA will give me 70 percent. And that is the first confusion.

The second confusion is depending upon disability, if you are a lower enlisted soldier, you probably fare better under those circumstances than a E 7 or an officer because it is based upon—for the military based upon years of service and base salary.

Ms. NORTON. So does the soldier gets to choose? Who chooses?

General CODY. What we do is and this gets to the point what we talked about between the MEB process and the PEB process, the

process that the last Physical Evaluation Board we have a liaison officer. That is a clutching mechanism. And that is the piece we have to fix. And we have to do a better job educating the soldier, because it is very, very confusing. Let me give you one more that will just upset you.

Ms. NORTON. You haven't answered me who gets to say which—these numbers are——

General CODY. The soldier gets to pick. The soldier picks. And you are sitting there. And it is very complex. I had a 2-hour session on it one night and had to come back and give it to me again just on one thing.

Ms. NORTON. Who advises the soldier who has to pick?

General CODY. The liaison officer. And if he does not like the ruling of the Physical Evaluation Board, then he can appeal it. And then the lawyers—because it is a process, a discharge, the lawyers come and advise him as to what is best for him or her.

But at the end of the day it looks unfair and quite frankly, we are being a little stingy as a Nation. And we have to look at this whole thing.

General SCHOOMAKER. And soldiers have said they feel disrespected because they have to go through that. They have said that.

General CODY. They have to demand and fight for it. And they shouldn't have to.

Ms. NORTON. Thank you very much, Mr. Chairman. If I may say so, we talked about all kinds of computers not talking to one another. We talked about all parts of the system we could understand not being fixed. What concerns me about these soldiers is that they are fresh out of war. And whether or not you can fix this throughout the system and not focus on short-term versus long-term fixes, the burden being on the soldier to then appeal and the rest of it, these were not people who had a mental difficulties.

And it seems to me that one of the first orders of business would be to get your two departments of the government so that they agree on a way to deal with these soldiers that would reduces considerably not only the confusion but the time spent in two systems trying to figure out which one is best for you.

It is more than we ought to ask a soldier to do.

Mr. TIERNEY. Thank you, Ms. Norton.

Gentlemen, I understand all the confusion that has taken place since we started having these hearings scheduled, including our requests for documents that were sent out some time ago. But we, since then, had two commanders out here at the facility. So can I have your assurance that our request for documents will be provided to us in short order? And we have an additional request that will be going out since learning that this may be a little more systemic than we thought of just Walter Reed, we will be expanding that out and we would like to know we will have your cooperation getting the information with respect to complaints that might have been made or efforts to resolve those complaints. Do I have that?

Mr. GEREN. Let me say about the document, I have not had an opportunity to review the document request. And there may be some issues we would have to discuss with the committee. So I

don't want to make a blanket commitment until we have an opportunity to——

Mr. TIERNEY. Too bad. I liked it better when General Schoomaker and General Cody nodded their heads. I understand. I don't believe you will find there is any problem. It is pretty straightforward, and we would expect that they should be met without much difficulty on that.

One last thing, in the privatization process, it is not a decision for General Weightman when he was here. It wasn't a decision for his superior, General Kiley. It wasn't a decision for General Cody. And it is not a decision for General Schoomaker. So this whole thing is what, a political decision? It kicks up to the suits? I mean, who decides whether something is going to get bid off? This is a medical facility within our armed services. I would think that each of you gentlemen and then the surgeon general and then the commander here would have the best idea of what kind of service our patients need.

General SCHOOMAKER. Because it is a legal process, and in this particular case it was challenged, the decision.

Mr. TIERNEY. But it is not your process, you didn't start it.

General SCHOOMAKER. It is not. It is law and policy.

Mr. TIERNEY. The Secretary is the one that operates that process on down?

Mr. GEREN. I don't know how the decision is made to engage the A–76 project for a specific function of government. I will get back to the committee.

Mr. TIERNEY. It is amazing that the people most involved in the care don't.

Ms. NORTON. Mr. Chairman, could I ask that they get back to us on how much privatization of army facilities is going on at this time? We had here the entire base, garrison base being privatized. It does seem to me the committee needs to know how systemic that process is throughout the Army hospitals throughout the United States.

General SCHOOMAKER. We will have to respond for the record.

Mr. TIERNEY. If you would. Thank you.

Ms. FOXX. Mr. Chairman, could I get one clarification, too, on this chart here. Is it such that if a person has 40 percent disability from the left side that they are able to remain in the military and draw their disability as opposed to becoming a veteran and drawing the other disability? Is that the distinction that is being made here?

General CODY. No, ma'am. It is very complex, but 30 percent and above you get to be medically retired. If you are less than 30 percent, you don't get to be medically retired and you could get more percentage from the VA than you could from the military, based upon the VA data tables. And that is the confusion.

But in this case here because this soldier—this is a sample—this soldier lost an eye. He was 40 percent disabled so he was medically retired. However, based upon the other injuries, they did not render him unfit for the military duty so he wasn't scored. Against VA tables he was scored and he would be better off going into the VA as a medical retired soldier.

General SCHOOMAKER. But ma'am, you know there are amputees, for instance, that fight to stay on active duty that have 30 percent and greater, and they have to fight through the process to be able to do that and prove their abilities, their fitness to stay.

Mr. TIERNEY. Specialist Duncan, in fact, was one that was fighting through the process on that.

Ms. FOXX. And how many people do you have currently? Excuse me, Mr. Chairman.

General CODY. I have that number.

Ms. FOXX. You can give that to me later, that is OK.

Mr. TIERNEY. Let us thank Mr. Secretary and Generals, and all those who helped make this facility available and to accommodate us here today. We also want to thank all of the men and women who are patients here and fair families to allow us to use this as a forum to dig deeper into those matters. We appreciate the fact that this is a complex problem, one that we have to work on together. It is not partisan and it is certainly not anything that is going to be done overnight. But we will be come back, as we said to General Kiley, in about 45 days or so looking for followup on this and hoping that we will have good news on that and good news that could come from all of that is that we focus and get to work on it, and together we come to a resolution for our men and women who have served us so well and to whom we owe so much. So thank you very much with that, the meeting is adjourned.

[Whereupon, at 3:30 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

HENRY A. WAXMAN, CALIFORNIA
CHAIRMAN

TOM LANTOS, CALIFORNIA
EDOLPHUS TOWNS, NEW YORK
PAUL E. KANJORSKI, PENNSYLVANIA
CAROLYN B. MALONEY, NEW YORK
ELIJAH E. CUMMINGS, MARYLAND
DENNIS J. KUCINICH, OHIO
DANNY K. DAVIS, ILLINOIS
JOHN F. TIERNEY, MASSACHUSETTS
WM. LACY CLAY, MISSOURI
DIANE E. WATSON, CALIFORNIA
STEPHEN F. LYNCH, MASSACHUSETTS
BRIAN HIGGINS, NEW YORK
JOHN A. YARMUTH, KENTUCKY
BRUCE L. BRALEY, IOWA
ELEANOR HOLMES NORTON,
DISTRICT OF COLUMBIA
BETTY MCCOLLUM, MINNESOTA
JIM COOPER, TENNESSEE
CHRIS VAN HOLLEN, MARYLAND
PAUL W. HODES, NEW HAMPSHIRE
CHRISTOPHER S. MURPHY, CONNECTICUT
JOHN P. SARBANES, MARYLAND
PETER WELCH, VERMONT

ONE HUNDRED TENTH CONGRESS

Congress of the United States
House of Representatives

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

2157 RAYBURN HOUSE OFFICE BUILDING

WASHINGTON, DC 20515–6143

MAJORITY (202) 225-5051
FACSIMILE (202) 225-4784
MINORITY (202) 225-5074

www.oversight.house.gov

TOM DAVIS, VIRGINIA,
RANKING MINORITY MEMBER

DAN BURTON, INDIANA
CHRISTOPHER SHAYS, CONNECTICUT
JOHN M. McHUGH, NEW YORK
JOHN L. MICA, FLORIDA
MARK E. SOUDER, INDIANA
TODD RUSSELL PLATTS, PENNSYLVANIA
CHRIS CANNON, UTAH
JOHN J. DUNCAN, JR., TENNESSEE
MICHAEL R. TURNER, OHIO
DARRELL E. ISSA, CALIFORNIA
KENNY MARCHANT, TEXAS
LYNN A. WESTMORELAND, GEORGIA
PATRICK T. McHENRY, NORTH CAROLINA
VIRGINIA FOXX, NORTH CAROLINA
BRIAN P. BILBRAY, CALIFORNIA
BILL SALI, IDAHO

July 18, 2007

The Honorable Pete Geren
Secretary of the Army
The Pentagon
Washington, DC 20310

Dear Secretary Geren:

I write to ask your assistance in obtaining documents requested over four months ago as part of the Questions for the Record (QFR) for the Subcommittee on National Security and Foreign Affairs hearing entitled "Is This Anyway to Treat Our Troops: The Care and Condition of Wounded Soldiers at Walter Reed," held on March 5, 2008.

Continuous requests by my staff and Subcommittee Chairman Tierney's staff for documents relating to this set of QFRs have met with obfuscation, questioning of the official nature of the request, and unreturned phone calls.

This following information is again, respectfully requested. Anything you can do to insure that we receive this information in one document production, and in a timely manner, would be appreciated.

Question for the Record from Congressman Tom Davis:

Please provide the job descriptions of the personnel listed below. These descriptions should specifically define their roles in the MEB/PEB processes, what decisions they make in terms of soldier care, evaluations and ratings. I also request their training profiles and proficiency and performance evaluations.

LTG Rubin Jones, US Army Physical Disability Agency
COL Leann Nitschke, OIC MEB
COL Ronald Hamilton, Brigade Commander
Dr. Harvey Cohen, COL (ret)

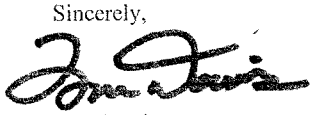
COL George T. Brandt, MEB Psychiatrist
Tammy Price, PEBLO Officer
COL Charles Callahan, (DCCS) Director Clinic Care Services

Please provide copies of any complaints lodged with the Army (or complaints received by the DoD IG of which you are aware) concerning these individuals as well as complaints lodged with patient advocates or other Walter Reed offices responsible for mitigating complaints.

Please provide a copy all standard operating procedures in place on January 1, 2005, and any subsequent revisions, for handling and addressing complaints.

If you or your staff have any questions, please contact Grace Washbourne, Senior Professional Staff Member, Committee on Oversight and Government Reform at (202)225-5074.

Sincerely,



Tom Davis
Ranking Member

DEPARTMENT OF THE ARMY
OFFICE OF THE CHIEF OF LEGISLATIVE LIAISON
1600 ARMY PENTAGON
WASHINGTON DC 20310-1600

REPLY TO
ATTENTION OF

AUG 24 2007

Buffone O.C
Military
Health

Around 91 pp.

The Honorable Tom Davis
Ranking Member
Committee on Oversight and Government Reform
United States House of Representatives
Washington, DC 20515

Dear Representative Davis:

This responds to your letter of July 18, 2007, to the Secretary of the Army. First, let me apologize for any confusion in the staffing process of your request to date.

It is longstanding Department of Defense (DoD) policy that in order for a request for records to be treated as a Committee request, it must be signed by the Chairman of the Committee or Subcommittee making the request (DoD 5400.7-R, para C.5.1.3.). Accordingly, the Army has processed the enclosed request under the standards set forth in the Freedom of Information Act (5 U.S.C. Section 552) and consistent with applicable DoD and administrative guidance.

The releasable agency records we have identified to date are enclosed. The rating sections of the evaluations provided are being withheld under FOIA Exemption 6, 5 U.S.C. Section 552.

With regard to the portion of your request seeking complaints lodged against WRAMC personnel, we are unable to provide this information as it is exempt from disclosure under FOIA Exemption 6, 5 U.S.C. Section 552. The Office of the DoD Inspector General (IG) has informed the Army Inspector General that DoD IG has no complaints on the personnel identified in your request.

If I can be of further assistance, please do not hesitate to contact me.

Sincerely,

for Joseph P. Gurowski
Principal Deputy Chief

Galen B. Jackman
Major General, U.S. Army
Chief of Legislative Liaison

Enclosure

HENRY A. WAXMAN, CALIFORNIA
CHAIRMAN

TOM DAVIS, VIRGINIA
RANKING MINORITY MEMBER

ONE HUNDRED TENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
2157 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6143

Majority (202) 225–5051
Minority (202) 225–5074

August 30, 2007

The Honorable Robert Gates
Secretary of the Defense
The Pentagon
Washington, DC 20301

Dear Secretary Gates:

We write to ask your assistance in receiving documents requested by Committee on Oversight and Government Reform Ranking Member Tom Davis over four months ago and to clear up any misunderstanding that in fact, these were Questions for the Record (QFR). These questions were submitted as part of the official record for the Subcommittee on National Security and Foreign Affairs hearing entitled "Is This Anyway to Treat Our Troops: The Care and Condition of Wounded Soldiers at Walter Reed," held on March 5, 2008.

This following information is again, respectfully requested. Anything you can do to insure that Mr. Davis receives this information in one document production and in a timely manner would be appreciated.

Questions for the Record from Congressman Tom Davis

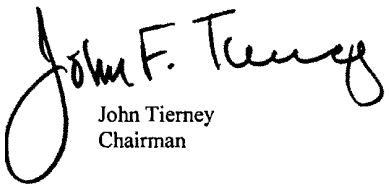
I request the job descriptions of the personnel listed below. These descriptions should specifically define their roles in the MEB/PEB processes, what decisions they make in terms of soldier care, evaluations and ratings. I also request their training profiles and proficiency and performance evaluations.

LTG Rubin Jones, US Army Physical Disability Agency
COL Leann Nitschke, OIC MEB
COL Ronald Hamilton, Brigade Commander
Dr. Harvey Cohen, COL (ret)
COL George T. Brandt, MEB Psychiatrist
Tammy Price, PEBLO Officer
COL Charles Callahan, (DCCS) Director Clinic Care Services

I also request any complaints lodged with the Army or DoD IG concerning these individuals as well as complaints lodged with patient advocates or other Walter Reed offices responsible for mitigating complaints. I request the standard operating procedures for handling and addressing complaints.

If you or your staff have any questions, please contact Dave Turk, Subcommittee Staff Director at (202)225-5051 or Lawrence Halloran, Minority Deputy Staff Director at, Committee on Oversight and Government Reform at (202)225-5074.

Sincerely,



John Tierney
Chairman

Christopher Shays
Ranking Member

○