

STATEMENT OF  
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BEFORE THE  
SUBCOMMITTEE ON HEALTH  
COMMITTEE ON VETERANS AFFAIRS  
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO  
THE DEPARTMENTS OF DEFENSE (DOD) AND  
VETERANS AFFAIRS (VA) IMPLEMENTATION OF  
LESSONS LEARNED FROM THE PERSIAN GULF WAR

WASHINGTON, DC

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MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.7 million members of the Veterans of Foreign Wars of the United States and its Ladies Auxiliary, I would like to thank you for the opportunity to participate in today's important hearing. We also appreciate that after 11 years, the Veterans Affairs committee's interest in the health and well being of our nation's Persian Gulf War veterans has never wavered.

In its 1998 Report of the Special Investigation Unit on Gulf War Illness, the Senate Committee on Veterans Affairs stated that the "Gulf War experience can be seen as a microcosm

for continued concerns regarding our nation's military preparedness and ability to respond effectively to health problems that may arise after deployments.” We agree.

Among others, the report pointed out that “U.S. military forces were unprepared to fight a war in which chemical or biological weapons might be used” and “both [DOD] and [VA] gave insufficient priority to matters of health protection, prevention, and monitoring of troops when they [were] on the battlefield and thereafter when they [became] veterans.” Further, and in our opinion, the most grievous finding was the failure of both agencies to “collect information adequately about, keep good health records on, and produce reliable and valid data to monitor the health care and compensation status of Gulf War veterans” who were ill following their deployment to the Persian Gulf. As a result, basic research questions could not be answered and thousands of Persian Gulf War veterans continue to suffer from undiagnosed illnesses.

So the question now remains: Are DOD and VA implementing lessons learned from their handling of the Gulf War Illness issue in their current operations?

With your permission, I would like to summarize some relevant background information. Soon after the revelation that coalition forces were exposed to low-level nerve agents from the destruction of Iraqi ammunition stores at Khamisiyah, Iraq, DOD formed the Office of Special Assistant for Gulf War Illness (OSAGWI). OSAGWI was established to determine causes of Gulf War illnesses and to recommend to the Secretary of Defense changes in policy to reduce future risks.

Three years later, in the fall of 1999, the Special Oversight Board for DOD Investigations of Gulf War Chemical and Biological Incidents recommended, “OSAGWI consider transitioning from an organization that conducts retrospective investigations to a more prospective agency that would ensure that the military services successfully apply the force health protection lessons learned in the Gulf and elsewhere.”

The new Office of the Special Assistant for Gulf War Illnesses, Medical Readiness, and Military Deployments (OSAGWIMRMD) is charged with continuing to search for answers to Gulf War illnesses, however, as its name suggests it is now responsible for a much broader role within DOD to change and update doctrine and policy surrounding force health protection before, during and after deployments.

In your invitation to testify you identify six areas of overlapping concern. I will confine my remarks to those areas as they were identified then and according to OSAGWIMRMD, as they are being practiced now.

THEN: Baseline troop health assessments were not systematic.

NOW: To assess troops state of health before and after deployments, they are required to fill out forms DD Form 2795, Pre-Deployment Health Assessment and DD Form 2796, Post-Deployment Health Assessment. We note the absence of occupational specialty as a question.

THEN: Information on troop movements was scant.

NOW: DD Form 2796, Post-Deployment Health Assessment, asks the troop for their deployment location, country and name of operation. This is too broad. We would hope for specific Global Positioning System data, especially after the difficulty DOD had in identifying troops exposed at Khamisiyah.

THEN: Determination of exposure to biohazards was problematic.

NOW: DOD conducts medical surveillance. Medical Surveillance is defined as the regular or repeated collection, analysis, and dissemination of uniform health information for monitoring the health of a population. Therefore, DOD should be able to determine if troops are exposed. DOD has also sought to improve chemical detection monitoring equipment.

THEN: Vaccines were administered haphazardly and vaccine records were unclear.

NOW: As part of military preventative medicine, DOD's 1993 Directive 6205.3 established policy and guidance for immunization for biological warfare defense. Unfortunately, we were unable to access this document, so we will reserve judgment. SF 601, Health Record-Immunization Record, which is part of the troops permanent outpatient record, is still the primary source of recording vaccines. SF 601's information is supplemented by the entries on the International Certificate of Vaccines.

THEN: Physical assessments of troops were not comprehensive.

NOW: As required by Section 765 of PL 105-85, DOD is required to perform pre-deployment medical examinations and post-deployment medical examinations to include the drawing of blood. All of these exams are to be retained in a centralized location to improve future access. We would be interested in knowing if every troop deployed in the current Operation Enduring Freedom received this type of physical.

Taken at face value, it would appear that DOD has addressed its past problems by implementing lessons learned. We believe it important to note, however, the recent finding by the Institute of Medicine's (IOM) report, *Protecting Those Who Serve*, (the recommendations of which the VFW concurs) which stated, "few concrete changes have been made at the field level... the most important recommendations remain unimplemented, despite the compelling rationale for urgent action." Additionally, a January 8, 2002, New York Times article, seems to back this finding up. A Pentagon official in deployment health described the new mind-set in military health care as "trying to train people to ask questions, which is a change in military culture... Senior leaders need to understand that there is a major shift." While OSAGWIMRMD and DOD have received input from numerous expert panels, and have sought to implement changes based on lessons learned, it is our opinion that they have failed to carry out DOD wide changes in an effective and efficient manner. They are not entirely to blame though, as institutional barriers are oftentimes hard to overcome. We know that change comes slowly, and even slower in the military.

We believe that only a total commitment from the highest levels of the Department coupled with aggressive congressional oversight can ensure swift enactment. The Secretary and his subordinates must make this a priority and hold commanders accountable for implementing change. We concur with the chair of the IOM Committee on Strategies to Protect the Health of Deployed U.S. Forces that “while the accomplishment of the mission always will be the paramount objective, soldiers must know that their health and well-being are taken seriously. Failure to move briskly to incorporate these procedures (improved medical surveillance, accurate troop location, exposure monitoring, etc...) will erode the traditional trust between the servicemember and the military leadership, and could jeopardize the mission.”

Up to this point, our testimony has focused primarily on DOD, and rightly so, because in order for VA to properly care for and compensate a veteran it depends on accurate and timely information from that veteran’s military health record. We believe that every veteran is entitled to a comprehensive life-long medical record of illnesses and injuries they suffer, the care and inoculations they receive and their exposure to different hazards. Further, the transfer of this record from DOD to VA should be seamless. While we recognize the efforts of the Military and Veterans Health Coordinating Board, communication between the two agencies needs to be streamlined so that data can be given to front-line health care and benefit providers. Because that is not always the case, the problem experienced by veterans in the past, and not just Persian Gulf veterans, has been their inability to convince VA that their disability is service connected. According to Title 38 USC, the burden of proof is placed upon the veteran.

In cases such as these, Congress has a long history of creating presumptives for specific cases such as Vietnam veterans and exposure to Agent Orange and presumption for service connection due to undiagnosed illnesses for Persian Gulf veterans. VA's regulatory process, however, interpreted the intent of the Persian Gulf law differently and left many veterans still fighting for compensation benefits. We note with disappointment that the argument between VA and Congress lasted until just last month. We are, on the other hand, pleased that a solution was found. This committee must be prepared to offer timely solutions in the future.

In addition, we are very pleased with Secretary Principi's recent action to get out in front of science and service-connect Persian Gulf veterans with ALS. We would hope that future Secretary's would act similar given the situation. Further, it is our understanding that the Congressionally mandated Persian Gulf Illness Public Advisory Committee is soon to become a reality. This is a positive step and we believe future deployment specific advisory committees would be useful.

The VA, however, must remain vigilant in its role as the chief advocate for our nations veterans and once again, Congress must use its powers of oversight and legislation to ensure that future generations of veterans receive the care that they were promised by a grateful nation. As a Persian Gulf veteran and VFW member, I can only hope that we have helped make the road for future veterans a little easier to travel.

This concludes my testimony and I will be happy to answer any questions you or members of this subcommittee may have at this time.

