

**MILITARY EXPOSURES: THE CONTINUING
CHALLENGES OF CARE AND COMPENSATION**

HEARING
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
ONE HUNDRED SEVENTH CONGRESS
SECOND SESSION

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JULY 10, 2002
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MILITARY EXPOSURES: THE CONTINUING CHALLENGES OF CARE AND COMPENSATION

WEDNESDAY, JULY 10, 2002

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 9:42 a.m., in room SR-418, Russell Senate Office Building, Hon. Arlen Specter, presiding.
Present: Senators Rockefeller, Wellstone, Nelson, and Specter.

Also present: Senator Nelson of Florida.

Senator SPECTER [presiding]. Good morning, ladies and gentlemen. Senator Rockefeller, who is en route, has asked that I begin these proceedings.

This morning the Committee on Veterans' Affairs will hold a hearing on so-called Project SHAD, an acronym for Shipboard Hazard and Defense, a U.S. Navy project in the 1960's. This program was designed to test effectiveness of both delivery and protective systems relating to chemical weapons, and it was comprised of many tests, more than a hundred.

A number of issues have arisen as to the propriety of subjecting U.S. naval personnel to these tests: whether there were deadly biological agents to which they were exposed; whether such exposures were intended, or merely incidental to collecting data on animal subjects; whether VX and sarin—very lethal agents—were used; and whether the U.S. personnel were really, in effect, guinea pigs, which the Department of Defense has denied.

There is a problem in the present of identifying the people who were subjected to these exposures, and this committee has decided to convene this hearing to try to make a determination as to what the facts are, whether the action taken by the Department of Defense was proper, what exposures there were, and what were the circumstances of those exposures. There has been an assertion that consent was given, but no formal written consent forms have been located.

[The prepared statement of Senator Specter follows:]

PREPARED STATEMENT OF HON. ARLEN SPECTER, U.S. SENATOR FROM PENNSYLVANIA

Thank you, Mr. Chairman, for convening this important hearing. You have done so, at least in part, at my request. I appreciate that consideration.

With this hearing, the Chairman and I hope to shed some light on an episode in the history of the Cold War—so-called “Project SHAD”—that has, at minimum, some unfortunate features. Project SHAD—an acronym referring to “Shipboard Hazard and Defense”—was part of a larger Department of Defense effort—labeled Project 112—designed to identify and test defenses against potential chemical and biological weapons.

Of course, the identification and testing of potential defenses against potential chemical and biological weapons was a salutary goal—one that has relevance to this day. Unfortunately, the way DOD went about Project SHAD testing appears to have been, at minimum, less than salutary. Based on material we have seen—and I hasten to add we have seen information related to only 12 of 103 tests, and that information has been “scrubbed” by the Pentagon to include only information that DOD deems to be “medically relevant”—we are not looking at a “horror story” here; it does not appear that, as a general proposition, DOD used Naval crews as “guinea pigs” to test the efficacy of highly dangerous weapons or of protective devices.

It is clear, however, that Naval crews were exposed—likely, needlessly exposed—to the deadly chemical warfare agents sarin and VX. It is clear, further, that Naval personnel were directly and intentionally exposed to biological agents—ones less deadly, it appears, than sarin or VX, but agents that are hardly harmless. Finally, Naval crews were exposed to supposedly harmless “simulants”—agents designed to mimic the properties of sarin and VX.

These exposures raise significant questions relating to informed consent. Was consent actually sought and gained? Was it truly “informed” and freely given? Was consent properly documented? And perhaps most importantly, was it proper to conduct these experiments at all—even with consent? These are questions I look forward to exploring with our DOD, and other, witnesses.

I am pleased, also, to see that VA is present today. For whatever judgments might be made on the propriety of DOD actions in the 1960s, the Federal Government surely must rectify the situation now. And just as it was the case after Vietnam and after the Gulf War, VA is—once again—the agency left to pick up the pieces. I am interested to learn of VA’s assessment of the health status of Project SHAD veterans. I am also interested in learning of VA’s experience in notifying them, treating them, and in processing their claims for compensation.

It is imperative that the Pentagon do better in getting information to VA relating to Project SHAD, and other, exposures to dangerous chemical or biological agents by service members. VA must have this information so that it might provide Project SHAD veterans with medical treatment and, if appropriate, compensation. In this regard, I note that of the approximately 2800 service members who were exposed in 12 of 34 Project SHAD tests—only the tip of the Project 112 iceberg—just 622 have been notified. For DOD to state that it cannot usefully identify more than 622 veterans by Social Security number is wholly inadequate. If DOD has no way of cross-referencing Service Numbers to Social Security Numbers, it must find a way—and it must do so now.

Mr. Chairman, I look forward to hearing this testimony and questioning the witnesses. So let us proceed.

Senator SPECTER. And now I yield to the distinguished chairman of this committee, who has arrived.

Chairman ROCKEFELLER. No. You go ahead.

Senator SPECTER. Now I do not yield to the distinguished chairman. [Laughter.]

I call on Senator Nelson for an opening statement.

Senator NELSON of Nebraska. Thank you very much, Mr. Chairman, and I certainly want to thank you, the chairman, Senator Rockefeller, for holding this hearing today and the witnesses for appearing to help us understand the hazards which our men and women have been exposed to during these past several decades.

As you know, the United States is not only a great country but a compassionate country, so the men and women who serve in the military do understand that there are certain risks that are assumed. But sometimes there are risks that are assumed unknowingly. And in spite of the risks that are there, the men and women of the military serve our Nation with distinction and with great sacrifices. And that is why it is so disheartening when we hear from veterans today who feel that the country isn’t honoring the commitment that has been made to them when they pledged to give their lives and their commitment to our country.

So it is difficult to understand why some veterans aren’t being told what they have been exposed to in order to ensure that they

can get proper treatment. If they don't know, they can't followup on it.

Additionally, it is important that health care providers know what these hazards are that their patients have been exposed to so that they can build a knowledge base on how to treat their current patients and similar patients in the future. It is apparent that the veterans service organizations, the Department of Defense, as well as the Department of Veterans Affairs need to communicate better and more openly on this issue of military exposure.

I truly believe that the improved communications will benefit the veterans who are suffering by allowing them to get the care that they need and that they deserve. And so I want to again thank the chairman and ranking member for this hearing today and look forward to as much of the testimony as I might hear today, and we will follow the written testimony as well. So thank you very much, and thank you, Mr. Chairman.

Senator SPECTER. Senator Wellstone, would you care to make an opening statement?

Senator WELLSTONE. Thank you, Mr. Chairman. You know what I think I will do is I will include my opening statement in the record and make about 2 minutes of remarks. And I have talked to Senator Nelson about this, and as I look at this experience with Project SHAD—

Senator SPECTER. Which Senator Nelson?

Senator WELLSTONE. You are right. Both. How about both? Both of them, both Nelsons, Senator Nelson from Florida, but I also was listening to the comments of my colleague from Nebraska, and I agree.

The only thing I want to say besides the statement that is in the record—and Jay and I have, I think, talked about this as well—this is—we have this kind of awful record. I mean, I remember the work with Atomic veterans, and this just reminds me of Atomic veterans, Gulf veterans, Agent Orange, and it is this awful record of excessive secrecy and sort of people, you know, veterans and their families feeling like the Government is not being honest with them, they are put in harm's way, and, you know, they keep asking for some recognition of what has happened. They keep asking for some compensation. They keep asking for treatment, and over and over again they come up against this wall of—I don't know whether it is the secrecy or whether it is just sometimes incompetence. But I really hate to see this again, and I really believe that this is an extremely important hearing. Finally, because of Secretary Goyer and Secretary Principi, we are able to get the compensation for the Atomic veterans.

The other point is it is just an awful thing when veterans feel like, you know, they haven't been dealt with honestly by their Government and they were put in harm's way and now no one is really listening to them.

My other point is, assuming that the scientific evidence, Mr. Chairman, both chairman and ranking minority member, remains ambiguous, that you don't know for sure, then it seems to me the policy question is which side do you err on. And it seems to me that we have got enough experience here to know that we ought to err on the side of these veterans and their families. And that is my

second point and last point. It is a very important hearing, and I thank my colleagues and the Chair for this.

Senator SPECTER. Senator Nelson of Florida has introduced legislation on this subject, and while he is not a member of this committee, we welcome him here and invite him to make any comments at this time as he may choose to make.

STATEMENT OF HON. BILL NELSON, U.S. SENATOR FROM THE STATE OF FLORIDA

Senator NELSON of Florida. Mr. Chairman, the Nelson boys are here, and I might say, just prior to my remarks, that this Nelson is a very honorable Nelson because we both had a stake in the national championship in the Rose Bowl. [Laughter.]

And we had a little friendly bet: a crate of Florida oranges versus a box of Omaha steaks. And I am certainly enjoying those steaks.

Senator SPECTER. Thank you very much for those relevant comments. [Laughter.]

Senator NELSON of Florida. I thought you would enjoy that.

Senator SPECTER. Do you have anything to say on the subject at hand?

Senator NELSON of Florida. Mr. Chairman, I have quite a bit to say about this issue. In the 1960's and 1970's, sailors were gassed on ships in the Pacific. It is unclear as to whether or not they were told. It is unclear as to whether or not they were given the protective gear. Thirty and forty years later, those sailors are now receiving letters saying, "You may have some ill health effects, and we want you to go into a veterans' medical facility."

As a matter of fact, there were 113 of these tests that were conducted in those two decades, and only 6 of those 113 tests have been declassified. And of those 6 tests, there is an approximate population of 4,300 veterans that are to be notified, but of which only 622 have been notified by mail by the Veterans Administration. Fifty-one of those 622 happen to be in the State of Florida, and I would say to each of the Senators here there is a list of how many veterans have been notified in your State. I know that in Senator Wellstone's, of those 622 there are some 14 or 18, and, of course, those numbers will just increase as the various tests are declassified and as the notification process continues.

So the question is: What happened? In fact, if the issue needs to be kept classified, then it can certainly be handled within the bosom of the appropriate committees. In the DoD authorization bill that we just passed before the break, Mr. Chairman, we added an amendment that would require the DoD to come forth and explain what happened in these tests, not only in SHAD but in a host of other tests.

For example, in the 1950's, in Boca Raton, FL, there were tests being conducted on developing a toxin that would destroy the Soviet wheat crop. And when I inquired as to this, because there is an 85-acre parcel at the old Boca Raton military air field, which, by the way, is now the site of Florida Atlantic University, one of our State universities, and the very busy Boca Raton Airport, the general aviation airport. But that 85-acre site is still untouched.

And so when I wrote after having heard a number of the comments come out of that area, the Department of Defense says it is

classified. So we just added an amendment to the DoD authorization bill that said if you have to come forth, you are going to come forth, Mr. DoD, and report to us, and if it has to be classified, so be it. But we need to know what happened. We need to know were people exposed, both civilian and military. And if so, as these first 622 letters have been sent out by the Veterans Administration on the declassified SHAD experiments, then what is the medical problem that would now two and three decades later having the Government suggest that these veterans come in.

So I just wanted to come, and I thank you for the opportunity of holding this hearing. It is extremely important to how we honor the people who wore the uniform of this country and have protected this country when it was in harm's way, and we need now, if they are in harm's way, to respond appropriately.

Thank you, Mr. Chairman.

Senator SPECTER. Well, thank you, Senator Nelson. I think it is worth noting that it was not until May of this year that the Defense Department acknowledged that these tests used real nerve and biological agents, and I think it is not just a matter of coincidence—Senator Rockefeller and I were exchanging notes on this—that yesterday afternoon at 5 o'clock the Department of Defense announced an expanded investigation on this issue. That is an anticipatory advantage or an anticipatory benefit of congressional oversight. Or perhaps it is just a coincidence.

Chairman ROCKEFELLER. I don't think so.

Senator SPECTER. And now the chairman speaks. Senator Rockefeller?

Chairman ROCKEFELLER. Thank you very much, Senator Specter. I am always a little bit late, as you know, those of you who come to these meetings. I am not usually this late. But I was held up by a lot of traffic, and the more I was held up, the less I cared because my Department of Defense friends—not my VA friends who have been terrific on this—make people wait, and you make them wait forever. I don't know where you get the guts.

I think back to an American hero, General Norman Schwarzkopf, in one of the more ignominious moments of this committee's history. He kept diaries on the Persian Gulf War, including a little incident called Khamisiyah, where a lot of chemical bombs had been blown up by the Americans, and he went over to look at them. He was really mad at the committee because he didn't like the idea of the committee demanding that he turn over his diaries because, you know, generals and people who fight wars don't truck or give in to mere politicians. He considers that an insult to his integrity. He came up here and he said, you know, I looked at those bombs, and they had these little yellow ribbons around the front of them. But the problem, he said, was that everything was written in Arabic. And how was I meant to know what was going on?

These were his words, if you want to go back and check the record. And, of course, he probably didn't have more than 30 people surrounding him who could have read those things to him. But was he willing to admit a single mistake, a single error, a single anything? Nothing.

And that is my view of DoD. I used to get into this subject. Now I just get mad about it. VA has been terrific. Anybody from VA

here has been terrific. Tony Principi has been terrific. They have shoved this, they have pushed this. This press release that Senator Specter referred to is a joke. And you are going to answer to it. At 5 o'clock yesterday, DoD expands SHAD investigation. Well, congratulations, 5 o'clock yesterday. I am sure that was a coincidence.

Now, I am just a politician, you understand? People like you don't have to worry about people like me. You can disdain people like me. Because I represent people, I have to go back to the Persian Gulf War just like Senator Wellstone and all the rest of us have. You saw people who couldn't move, who had lost their wives, who had lost their jobs, who couldn't sleep, who couldn't pick up a newspaper, who you couldn't touch because they would scream in agony. Did DoD have anything to say about it? No.

And we had an atomic war veteran come in. He had been through these tests earlier in the 1940's and 1950's. He testified. And you know what he testified about? He testified: I want to tell you what it is like to die, to be in the process of dying—which he did shortly thereafter—knowing that the Government never told us anything, and the Government refuses to because it said you can't prove you got cancer because of us. He's a soldier or a sailor and he's dying.

A couple years ago we got something done about that. What did it take to do something about Agent Orange? You know what it took to get someone to look into Agent Orange exposures? Not anybody here, nobody from the Defense Department, I will guarantee you, because you never make mistakes. You never make mistakes.

You know what it took? It took Admiral Zumwalt to come in here because his son was dying, and that got the Congress finally to wake up. His son was dying from Agent Orange, and that got Congress to wake up. And then we passed legislation, 20 years too late.

There is a lot of talk about the CIA and the FBI not cooperating, but there is no talk about either of them not caring. They just have cultural problems. The FBI investigates crimes that have already taken place. The CIA is looking forward to try and prevent crimes. Those are two different cultures, and they don't mix very well. But nobody doubts that they care.

I doubt you care unless you can prove to me otherwise this morning.

Now, you, Dr. Winkenwerder, are a young man. But one of these days, you are going to be a veteran and you may care how you are treated, or you may not. You may be rich enough by your retirement that you don't really care because you can handle it on your own.

But the State that I come from and the States that most of us come from have veterans who can't afford to take care of themselves, and they depend upon the VA, which in this case had to depend upon you, the DoD. Because the Department of Defense never makes a mistake, can't make a mistake because they are over there fighting wars. You can't make mistakes, psychologically you can't admit mistakes.

And maybe you will just care. Maybe you will be a little bit nervous. Maybe you will understand what some of these veterans have to go through.

I don't know if there is a disdain in the Department of Defense for veterans, the people who fought, who kept your freedom.

I don't know if you care. Really, one of the things I am going to probe is how you care. How do you insult us with something like this press release? How do you insult us? You know, we are elected. You are not. You get appointed. You go, you apply for a job, and you get a job. You are good enough to get a job, you pull strings to get a job, you are qualified to get a job, you get a job and you keep that job. You are accountable to the person above you, but you are not accountable to the people. You are not accountable like we are accountable.

We spend our weekends, we spend our time with people. You go home at 5, you go home at 7, you play golf on weekends. We don't. We work. We go back and we spend time with our people.

We are responsible to our people, and we take it seriously. There is not one person here who doesn't take what we do seriously. You don't have to face them. They are numbers to you. They are papers. They are things that come across. You don't even see veterans. Now, you make policies, or you refuse to make policies, or you make policies the day before the hearing because you know you are going to have to testify. You would have done better not to have put this out, in my judgment. I would have had more respect for you, to come in and say, you know, we really haven't done this very well and we are going to do a better job rather than something like this.

Now, I am a temperate person, believe it or not. But I am not temperate when it comes to veterans getting shafted by inattention. And I have about eight questions for you, and I can't wait to ask them.

Could I give my statement now, Mr. Chairman?

Senator SPECTER. Yes, we understand that was just an introduction.

Chairman ROCKEFELLER. Yes. I don't know how much of this I have to give. It is the same old story, and Bill Nelson pretty much gave it: waiting, waiting, waiting, refusing to do anything, getting pressure from the VA, Tony Principi doing a good job, and then, of course, DoD is too busy to do anything about it.

You know, you are getting lots of money. You are not under a restrained budget like veterans health care is under. We can't stretch our budgets. You can.

So I suppose what we are here is to find out whether veterans are endangered by all of this. I suspect they are. I don't know, Doctor, if you were around during the PB investigations. Were you?

Dr. WINKENWERDER. No.

Chairman ROCKEFELLER. OK. Well, that is just too bad. You know that? Because you might have learned something from that. Because what the military was doing, they were taking an investigational drug that had not been approved by the FDA, forcing soldiers to take it. The smart ones didn't. And the ones who did may have paid a terrific price for it, many of them. And then all kinds of studies come up showing that, no, there is no particular connection, including reports from the National Academy of Sciences. You know, who am I to talk about the National Academy of Sciences? I don't buy any of it. I think there is a direct connection.

And all during this time, we had to fight DoD for everything we wanted to do, including demanding that the esteemed General Schwarzkopf make a trip all the way from his comfortable home in Florida up here to Washington to talk to a terrible group of politicians who he so totally disdains, who dared to question the wisdom of the way he won his war, which is partly how you handle your soldiers and what you do about them. Do you stand up for your soldiers, your men and women, or don't you?

Dr. WINKENWERDER. I do.

Chairman ROCKEFELLER. I am not asking you. I was talking about him. And I don't think he did.

Now, he is a big American hero, but when I think of him, I think of what he did to a lot of veterans by his inaction. He wouldn't even release the notes he had kept. That is why we had to threaten to subpoena him, to try and get at his notes. It wasn't anything about him. It was just trying to get at his notes. When he finally turned them over, he only gave us a few pages.

So this is about the Department of Defense attitude. I mean, do you guys care? I am not sure. I am not sure. It is just too big a building, too many cultural problems, and you have got other problems. You are fighting wars. And then there are veterans. Oh, yes, we have veterans, but you are not veterans and you are out there fighting the war. Well, VA takes care of veterans. We try to take care of veterans. We are not a big and famous committee. But we can get really ticked off sometimes, and I hope this thing is on television somewhere. And I hope there are a lot of people listening because you have got some explaining to do. I will be looking forward to your statements.

[The prepared statement of Chairman Rockefeller follows:]

PREPARED STATEMENT OF HON. JOHN D. ROCKEFELLER IV, U.S. SENATOR FROM
WEST VIRGINIA

Good morning. I wish that I could say that this is the first time the Committee has gathered in this room to talk about the struggles of veterans who might have been exposed to hazardous agents during their military service. I wish that it were the first time that veterans and officials from the Departments of Defense and Veterans Affairs have met to talk about the legacy of battles and tests long over but still not resolved. Unfortunately, it is not.

First, I want to acknowledge that my colleague, Ranking Member Arlen Specter, requested this hearing based on his outrage over the Project SHAD revelations to date. I was pleased to accommodate his request, especially given my long history of investigating military exposures and the consequences for veterans.

In 1994, I chaired a hearing in this room on the legacy of military research, on the double battle that veterans must wage with illnesses that may have resulted from service and with the shroud of secrecy that bars them from the care and the benefits they so desperately needed. We talked about the hazards that military research posed to veterans' health, and the lessons we have learned from World War II until today. The transcript from that hearing is in front of me, and contains a lot of good ideas and good intentions and regrets about the way veterans have been treated in the past. Eight years later, we still haven't learned those lessons.

DOD recently released information on Project SHAD—Shipboard Hazard and Defense—tests that took place in the 1960's. That information was released only after pressure from veterans and Congress spurred VA to look for answers, and after VA in turn pressed DOD for details that had remained quietly hidden for decades. Two years after VA asked for information on SHAD, for a simple list of who and what hazards might have been involved, DOD finally released information on one-third of those tests.

While a delay of thirty years for this trickle of information is appalling, sadly it is no longer shocking. Veterans have had to struggle to learn about the consequences of exposures that were no secret at all—the tests that exposed American

forces to radiation during and after World War II, Agent Orange in Vietnam, and the myriad chemical and biological hazards of the Gulf War.

We are here to learn whether Project SHAD endangered veterans' health, but we are also here to address the military culture that still fails to keep good medical records and to share those records with servicemembers and veterans in a clear and timely way. When confronted with questions from veterans, VA, and Congress, DOD first obfuscates, and then delays. This is unacceptable.

I don't want to hear about difficulties in sorting and declassifying records, I want to hear about how we can streamline that process so that veterans do not have to wait years for answers. I know that SHAD took place decades ago on somebody else's watch, but I want to hear what we are doing to understand whether veterans are now at risk because of those tests, and what we can do to help them if they are at risk. Most importantly, I want to hear what all of us can do to guarantee that we don't perpetuate this cycle of delay and dismay again.

We are not sitting in this room today because I want answers to these questions, or because Congress wants answers, but because veterans want—and deserve—answers.

Senator SPECTER. Our first witness is Daniel Cooper, Under Secretary for Benefits of the Department of Veterans Affairs. So let us proceed. We have a long list of witnesses. We will hear from you, Mr. Secretary.

STATEMENT OF HON. DANIEL L. COOPER, UNDER SECRETARY FOR BENEFITS, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY ROBERT EPLEY, ASSOCIATE DEPUTY UNDER SECRETARY FOR POLICY AND PROGRAM MANAGEMENT, VETERANS BENEFITS ADMINISTRATION, AND SUSAN MATHER, M.D., CHIEF OFFICER, PUBLIC HEALTH AND ENVIRONMENTAL HAZARDS

Mr. COOPER. Yes, sir. Thank you. I will make a brief statement if I may.

Mr. Chairman, members of the committee, I am pleased to be here to talk about SHAD and the services that VA must provide our veterans to ensure they are given proper notification, necessary claims filing assistance, and medical attention, when required.

Having just recently studied the situation and attempting to define a path that we can follow, I will state that the process has been developed in fits and starts and must be improved. The problem is, as you know, greatly exacerbated by classification of the operations. That has severely hampered our getting the names of the units, the tests, and the individual participants.

Once we get those names, we have some difficulty because we get the names along with the military ID numbers. We have to get SSN's, so we have to go through a whole process. Then, when we try to notify them, we have to go through OSHA in order to have the IRS release their addresses. So the notification process is a rather onerous one that we are trying to work through and do properly.

The participants are being identified by name but, unfortunately, quite slowly. Once we determine the Social Security numbers, we submit those numbers, get them to the IRS, get the addresses back, and then finally get notifications sent out.

Despite the difficult problems, as both a veteran and a VA official, I must state that we could have and should have done better. The problems cited, and particularly the certification firewall, caused a very difficult situation which has hampered, in my opin-

ion, well-intentioned people within the organization who are trying to do the job properly.

By mid-May of this year, we had identified by name just over 2,700 participants in 3 of the 12 tests. We have been able to locate and send letters to 622 of those that we could identify sufficiently. In this last week, we have submitted 800 more names to the IRS through the circuitous OSHA path in order to try to get the addresses and notify those people.

Every step taken has been difficult. We received the first set of names in April to July of last year, but we didn't receive information on the tests until September. In January through May of this year, we received the names of other participants. Again, we have had to cull through the whole list to find out exactly where they were stationed and when.

Finally, on 22 May, we sent a letter to the people that we could properly identify. When I signed that letter, I was assured it had been well coordinated and that the veterans service organizations had had input. I learned later that they did have a problem with one of the sentences in our letter, and we will change that with the next letter that we send out to ensure that everybody is satisfied that we are doing it properly.

We presently have a hotline to receive calls. We have carefully trained the people on that hotline. But occasionally we have some problems with the information they put out. We have given them strict guidelines as to what to tell the veterans, primarily to go to a medical center and get an examination, and we give them the name of an individual there. We are continuing to test that hotline to ensure that we are being properly responsive.

Since the 622 letters were sent, we have received approximately 100 calls from potential participants in response to those letters. I might add that in my statement for the record I have an incorrect number on page 6. I would like to have that corrected, please, for the record.

Senator SPECTER. Without objection, it will be placed in the record.

Mr. COOPER. As I stated, we in VA must and will remain focused and work more closely. Secretary Principi has taken steps to ensure better coordination within VA. Similarly, VA and DoD must work more closely both on information availability and information transfer between the two of us.

We must continue to improve the system as effectively as we can while adhering to the laws of the land. We strongly welcome any assistance possible from any source, particularly veterans services organizations.

Finally, I would say I have two personnel with me today who are much more expert than I: Dr. Susan Mather, who is the Chief of VHA's Office of Public Health and Environmental Hazards; and Mr. Robert Epley, the Associate Deputy Under Secretary for Policy and Program Management in VBA. I am ready to answer any questions you may have, sir.

[The prepared statement of Mr. Cooper follows.]

PREPARED STATEMENT OF DANIEL L. COOPER, UNDER SECRETARY FOR BENEFITS,
DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee, thank you for the opportunity to testify today on the efforts of the Departments of Defense (DoD) and Veterans Affairs (VA) to provide health care information and support to veterans who were exposed to environmental hazards during military service. Accompanying me today is Dr. Susan Mather, Chief Officer, VA Office of Public Health and Environmental Hazards, and Mr. Robert Epley, Associate Deputy Under Secretary for Policy and Program Management.

War and training for war have always exposed America's men and women in uniform to a wide variety of health hazards. Each war in the last century has produced unique hazardous exposures. In World War I, chemical warfare agents, including chlorine and mustard gas, were used. World War II saw the first deployment of nuclear weapons. Korea exposed many American POWs to psychological brainwashing techniques and to extremely cold weather conditions. The widespread use of herbicides during the Vietnam War is now associated with several adverse health effects. Military personnel encounter a broad array of environmental hazards, infectious disease, and psychological health risks any time they deploy outside the United States.

During peacetime, America's Armed Forces prepare for health hazards through research and by developing better preventive measures and conducting appropriate training. Many of these efforts have been well publicized, while others have been conducted in secret. For example, the testing of nuclear weapons during the Cold War exposed many American veterans to increased levels of radiation. Similarly, VA became aware in 1991 of approximately 4,000 American servicemen who had been exposed to high concentrations of mustard gas in both study chambers and field tests as a part of a larger chemical defense research program begun in World War II. In response, the National Academy of Sciences assessed the medical literature on health effects from those exposures, leading to new VA compensation regulations.

Following the Gulf War in 1991, Congress identified thirty-three separate hazardous substances to which Gulf War veterans may have been exposed. Public Laws 105-277 (signed Oct. 21, 1998) and 105-368 (signed Nov. 11, 1998) required VA to establish an agreement with the National Academy of Science to review and evaluate the medical literature on possible health outcomes from these exposures. The first phase of this study was published in 2000 and additional studies are underway. In addition, extensive analysis has been conducted to determine the potential health effects of exposure to sarin and cyclosarin at Khamisiyah following the Gulf War.

Most recently, VA became aware of the exposure of an undetermined number of U.S. service members to a variety of biological and chemical agents in secret tests called Project SHAD (Shipboard Hazard and Defense) conducted during the 1960s.

Because of this long history of hazardous exposures of U.S. military populations, we must carefully examine our methods for identifying exposed veterans, studying the potential effects of the contaminants, and for providing our veterans with appropriate health care and deserved disability compensation.

In the past, VA has established special programs for specific groups of veterans potentially exposed to environmental health hazards. For instance, VA responded to Gulf War health issues through a comprehensive program of health care, research, outreach, and special compensation for "undiagnosed illnesses." About 12 percent (84,000) Gulf War veterans have participated in a clinical registry program. The principal finding from this clinical evaluation program is that these veterans are suffering from a wide variety of recognized illnesses that respond to conventional treatments. Subsequent research studies have supported these findings, as have similar results from studies conducted in the United Kingdom and Canada among their Gulf War veteran populations.

Although special programs are useful, VA has learned many lessons since the Gulf War and is now taking a more pro-active approach in establishing policy and programs that will address environmental health concerns as early as possible.

LESSONS LEARNED

Clinical Practice Guidelines

Special clinical programs, such as the Gulf War Registry reach only a limited number of eligible veterans. Therefore, the VA, in cooperation with DoD, has taken concrete steps to better understand and to routinely manage post-deployment health problems. A further goal is to improve veterans' satisfaction with their health care. VA is using an evidence-based approach to develop clinical practice guidelines for the evaluation of military veterans following hazardous deployments. Just completed in collaboration with DoD are a "Post-Deployment Health Evaluation and Management Guideline" and a second clinical practice guideline for unexplained fa-

tigue and muscle pain, which was recently released. These guidelines will provide VA physicians with the best medical practices for dealing with veterans following deployment. A clinical guideline for PTSD, now in the planning stage, will be the next step in the development of a sound strategy for the screening, assessment, and care of all veterans returning from military deployments.

The regular use of standardized clinical practice guidelines that outline the best medical practices will decrease the need for ad hoc registries. Troops will be specifically screened early in the primary health care setting for illnesses that may be related to a military deployment. The Gulf War registry programs only reached a minority of veterans and the clinical findings from examinations of self-selected populations were difficult to interpret. In contrast, the post-deployment clinical practice guidelines will ensure that the health problems of all veterans returning from hazardous deployments are addressed whenever they seek care in the DoD or VA health systems. These new Guidelines will give VA primary care providers the tools they need to diagnose and treat veterans who had participated in hazardous deployments.

War-Related Illness and Injury Study Centers (WRIISC)

For veterans with severe symptoms that remain unexplained after examination, the local VA physician can refer them to one of VA's two War-Related Illness and Injury Study Centers (WRIISC) (formerly known as Centers for the Study of War Related Illnesses). Many of these veterans are concerned that their illnesses are related to environmental hazards they encountered during deployment. The two Centers are located at the VA medical centers in Washington, DC, and East Orange, NJ. They are charged with identifying current effective treatments, developing new treatments, providing environmental hazard health risk communication to veterans and their families, and promoting education for VA health care personnel on the "difficult-to-diagnose" illnesses found among veterans from all military deployments.

Veterans Health Initiative / Independent Study Guides

Recognizing the need to educate health care providers about the unique medical care needs and concerns of veterans—including the effects of environmental hazards—VA began an ongoing training program known as the Veterans Health Initiative (VHI). Two key products are our independent study guides "A Guide to Gulf War Veterans' Health," and "Vietnam Veterans and Agent Orange Exposure." In addition, VA has developed other new independent study guides on a broad range of unique veteran health issues, including Cold Injury, Hearing Impairment, Post Traumatic Stress Disorder (PTSD), Prisoner of War (POW), Radiation, Spinal Cord Injury, Visual Impairment, and Traumatic Amputation and Prosthetics.

Enhanced Outreach

The Gulf War emphasized to us the value to veterans and their families of timely access to reliable information about the environmental health risks during military deployment. Acting on these lessons, VA developed a new brochure that addresses common health concerns for military service in Afghanistan and South Asia. It answers questions about health care and eligibility for VA benefits that veterans, their families, and their health care providers will have following this military deployment in the war on terrorism. The brochure also describes relevant medical care programs that VA has developed in anticipation of the health needs of veterans returning from combat and peacekeeping missions abroad. This outreach material has been distributed to all VAMCs and Regional Offices.

PROJECT SHAD

The recent revelations concerning a series of Cold War tests known as Project SHAD reinforces the potential environmental hazards that our military forces face. This project was part of a DoD chemical and biological warfare test program conducted between 1963 and 1970 to evaluate the vulnerabilities of U.S. warships to attacks with chemical or biological warfare agents. Project SHAD exposed veterans to potentially harmful biological and chemical agents.

VA first learned of SHAD when a veteran filed a claim for service connection for disabilities he felt were related to his participation in Project SHAD. In two meetings held with DoD in late 1997, VA was advised that all material was classified and access to material was not assured and could only be given on a case-by-case basis. VA was able to grant that particular veteran's claim without reliance on classified information.

In May 2000, the Under Secretary for Benefits responded to a Congressional inquiry requesting assistance for veterans involved in Project SHAD. A VA/DoD workgroup was subsequently established and met the first time in October 2000.

Since that time, DoD and VA have worked together collaboratively to develop the facts surrounding Project SHAD.

DoD began the formal process of declassification, compiling rosters of participants, and providing VA with names and service numbers of test participants. Initially, information was provided for 1,149 veterans involved in the tests Autumn Gold, Copper Head, and Shady Grove. Over a period of several months, VBA engaged in the labor intensive task of identifying the participants of those three tests identified initially. The social security numbers of 703 veterans were found. Using social security numbers, VA worked through the National Institute for Occupational Safety and Health to obtain from IRS the current addresses for 622 of these individuals. On May 21, 2002, outreach letters were mailed to the 622 identified participants involved in the three initial tests.

VA has initiated a significant outreach program to contact Project SHAD veterans once they are located. For SHAD veterans we have so far been unable to identify, VA has established a SHAD Hotline (at 1-800-749-8387), Internet web-site (at www.VA.GOV/SHAD), and e-mail address (at SHADHELPLINE@VBA.VA.GOV). The VA Internet website provides veterans with information currently available and a link to DoD's web page. To date, approximately 125 SHAD hotline inquiries and 43 e-mail messages have been received. Approximately 14 SHAD related claims for service connection are currently pending.

Since the beginning of calendar year 2002, DoD has provided VA with information on nine additional tests. Information on three tests was provided in January:

- Eager Bell I
- Eager Bell II
- Scarlet Sage

VA received information on six additional tests in May of this year:

- Fearless Johnny
- Flower Drum Phase I
- Flower Drum Phase II
- Purple Sage
- DTC Test 68-50
- DTC Test 69-32

DoD has identified one hundred and three potential SHAD tests. However, the number of tests actually conducted is unknown. Furthermore, the total number of service members involved in these tests is not known at this time. Unfortunately, the number of veterans who participated in multiple tests, the names of those tests, and the potentially harmful agents to which they may have been exposed cannot be determined until all relevant documentation has been collected, reviewed, and declassified.

DoD continues to review documentation and declassify additional SHAD tests. As names and service numbers or social security numbers are provided, VA will conduct the efforts required to identify the individuals who participated in these tests and then to locate their current address. We will engage in an aggressive outreach program to provide appropriate information to SHAD veterans.

Project SHAD information has been provided to VA medical staff through annual publication of Information Letters from VA's Under Secretary for Health. The Information Letters provide VA health care personnel with background information on Project SHAD, along with information about the potential short- and long-term health effects of the specific chemical and biological agents that DoD tells us were used in these tests. This information has been made available on our SHAD web site at www.va.gov/SHAD, including the information letter and other relevant information. As more information becomes available, satellite video-conferences are planned to broadcast relevant information to all VA health care facilities.

In addition, VA will begin to work with the National Personnel Records Center in St. Louis to review personnel and medical files for individuals listed as participants in tests for whom we have been unsuccessful in finding social security numbers. This represents approximately half of all the known participants provided to date. We are not particularly optimistic that this search will be fruitful but we believe that it represents a possible source of at least a few numbers otherwise unknown.

Importantly, a contract with the Medical Follow-up Agency of the National Academy of Sciences is being developed to include a formal epidemiological study of mortality and morbidity among SHAD participants. In contrast to a clinical registry, which cannot provide scientific data, this independent study will give us the clearest picture of the health status of SHAD veterans and tell us whether their health was harmed by prior chemical and biological exposures.

In the meantime, it should be stressed that there are no markers or laboratory tests for the exposures currently known to have occurred in Project SHAD. However,

the provision of appropriate medical care for any of the conditions that have developed in the ensuing 40 years since the SHAD tests were begun is not dependent on specific information about prior exposures. High quality medical care can be provided right now for each SHAD veteran who seeks a clinical evaluation in the VA.

SERVICE-CONNECTED COMPENSATION

In order for VA to make accurate rating decisions on claims for service connection for disabilities associated with SHAD, complete evidence is necessary when the issue is first decided. Because of the piecemeal and fragmented approach of declassifying and providing information, VA may be required to readjudicate claims as additional evidence becomes available for those service members involved in multiple tests. Likewise, as evidence is declassified and made available, VA may find that the new evidence regarding SHAD tests supports grants of service connection previously denied.

VA will continue to send outreach letters to participants as additional tests are declassified and participant names and Social Security numbers are made available. Because it now appears that many of the service members participated in more than one test, our initial outreach efforts run the risk of being incomplete until DoD's declassification efforts are finished. It should be noted that in those cases where inquiries have come from veterans regarding tests not yet declassified, VA has been able to provide names to DoD and they have responded by providing relevant information on a timely basis.

VA also realizes that we cannot understand all the potentially hazardous exposures experienced by members of the Armed Forces without consultation and cooperation with other government agencies, particularly DoD, but also HHS, EPA, and DOE. This coordination is being addressed at the highest levels in VHA through the VA/DoD Executive Council.

In conclusion, the Department of Veterans Affairs shares this Committee's concern about the adverse effects of hazardous exposures during military service and will continue to aggressively address them. VA sponsors research to assess the effects of these exposures; is actively contacting veterans of Project SHAD to notify them of potential exposures; and has developed numerous studies with the Institute of Medicine to determine the health effects of hazardous exposures.

This concludes my testimony. My colleagues and I will be happy to answer any questions that the Committee may have.

Senator SPECTER. Thank you very much, Mr. Secretary.

We turn now to Dr. William Winkenwerder, Assistant Secretary of Defense for Health Affairs. Dr. Winkenwerder, we are very much concerned about—and focused on—what happened and why nothing was done up to this point. But at this point, we will invite your opening statement.

STATEMENT OF WILLIAM WINKENWERDER, M.D., ASSISTANT SECRETARY FOR HEALTH AFFAIRS, U.S. DEPARTMENT OF DEFENSE; ACCOMPANIED BY ELLEN EMBREY, DEPUTY ASSISTANT SECRETARY FOR DEFENSE FOR FORCE HEALTH PROTECTION AND READINESS, AND MICHAEL E. KILPATRICK, M.D., DIRECTOR, DEPLOYMENT SUPPORT, FORCE HEALTH PROTECTION AND READINESS

Dr. WINKENWERDER. Thank you. Senator Specter, Mr. Chairman, and members of the committee, thank you for the opportunity to appear today and to provide this testimony. I have a written testimony that I will provide for the record. I just want to start by making a couple of comments.

First, in response to your comment, Senator Rockefeller, the first is that I do care. I care greatly about these men and women, not only today but those of the past, the veterans. They are an important and critical part of the whole DoD responsibility. When it comes to veterans, over half, for example, of all the people we care for in the defense health program are veterans. We care for vet-

erans, and I consider it a high responsibility, an important responsibility. That is why I am here today. I could have ignored this hearing. I chose not to because it is an important issue.

I came upon this information not too long ago, certainly after I started, which was just after September 11th. I left my job in the private sector to come work here——

Senator SPECTER. Dr. Winkenwerder, how could you have avoided this hearing?

Dr. WINKENWERDER. Pardon?

Senator SPECTER. You say you could have avoided this hearing but chose not to.

Chairman ROCKEFELLER. Nobody has ever said that to us before.

Dr. WINKENWERDER. Well, I am just saying, you know how you can certainly say someone else go testify. I wanted to testify.

Senator SPECTER. Well, whom would you have sent? Secretary Rumsfeld?

Dr. WINKENWERDER. No. There are others that could represent the Department on this issue.

Chairman ROCKEFELLER. So we should be pretty grateful then that you are here, shouldn't we?

Dr. WINKENWERDER. No. I am telling you I wanted to be here. I wanted to be here.

Chairman ROCKEFELLER. You had a duty to be here.

Dr. WINKENWERDER. Absolutely, and I want to be here, period.

Chairman ROCKEFELLER. Well, then, why did you point out to us that you didn't have to come? I am going to give you a hard time, OK?

Dr. WINKENWERDER. OK. Fine.

Chairman ROCKEFELLER. But I will accept your point. You are here. And I can't argue that.

Dr. WINKENWERDER. I care about this issue. I came upon this information, and I can assure you that I am fully engaged and that the other people that are with me are fully engaged.

Senator SPECTER. Dr. Winkenwerder, we will accept that. Proceed with your statement.

Dr. WINKENWERDER. OK. Well, that is in essence—that is the main message. I want to assure you that the Defense Department is committed to working with VA and sharing medically relevant information from Project 112 and SHAD so that veterans who were involved can be notified and receive appropriate care.

When we started our investigation into Project SHAD, which was, as I understand it, a couple of years ago, we encountered several challenges, as it has been explained to me. But I think today it is fair to say the investigation has established a format for sharing that information with the VA, has created a system to declassify this information in a relatively expedited way, and has determined the locations of the necessary documents. These documents, again, as it is explained to me, are spread out in many places. They have not been well catalogued. This is a problem. This is an issue. I fully accept that. And we are working with the respective services to look at literally boxes of information that are in warehouses and various places around the country to get the information catalogued and to get it back and to declassify it rapidly so that we can provide this information.

We provide test information as fact sheets to the VA as soon as it is declassified. However, in order to expedite the VA's notification process, we are forwarding to the VA the names of service members involved in each test we identify before the declassification process ensues.

To date, we have produced fact sheets on 12 SHAD tests, which involved about 2,700 or 2,800 service members, and so far our investigation indicates that most of these tests were done using simulants and not live agents or real agents that were thought and believed at that time to be harmless, not something that would cause any medical harm.

Those service members involved in using live test agents appear from the information that we have been provided to have been appropriately protected from those agents. Since the Gulf War, the services each have made efforts to fulfill today's requirements, which are much greater and appropriately need to be, of medical recordkeeping and to include documenting potentially harmful exposures. And we plan to consolidate all of these efforts into something we are calling—a software and a data collection system we are calling Theater Medical Information Program. TMIP will provide an electronic record of care in theater that can be entered into the individual's permanent medical record and it can be then provided to the VA.

Our commitment is to get this information literally from the start of a service member's experience in the service so that we have it and then subsequently the VA would have it as well.

Senior leaders from DoD and VA are working closely together on these efforts, and let me just close by saying that I am very interested in getting to the bottom of this as quickly as possible and getting the information out.

Thank you, and I would be glad to answer your questions.
[The prepared statement of Dr. Winkenwerder follows:]

PREPARED STATEMENT OF WILLIAM WINKENWERDER, M.D., ASSISTANT SECRETARY
FOR HEALTH AFFAIRS, U.S. DEPARTMENT OF DEFENSE

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

As Assistant Secretary of Defense for Health Affairs, I want to stress that the Department of Defense is committed to ensuring that we deploy fit and healthy military personnel, that we monitor their health and environmental exposures while they are deployed, and that we assess their health status and address their health concerns when they return. My Deployment Health Support Directorate is conducting the investigation into Project SHAD. Today, I would like to explain some of the challenges we face in the investigation into Project SHAD, and why I think problems associated with that situation, particularly in regard to medical record keeping, are not likely to occur for post-Gulf War operations.

As you know, Project SHAD (Shipboard Hazard and Defense) was a chemical and biological weapons vulnerability testing program conducted in the 1960s by the Desert Test Center in Utah. In August of 2000, the Secretary of Veterans Affairs requested that the Secretary of Defense provide information concerning three classified Project SHAD tests: Autumn Gold, Copper Head and Shady Grove. In September 2000 DoD assigned responsibility for fulfilling that request to the Deployment Health Support Directorate. Within a month, VA and DoD personnel began meeting regularly to define what medically relevant information the VA needed to address veterans' concerns. This collaborative effort established a communications process, coordination for the exchange of information between the agencies, and a format for fact sheets to inform the VA, veterans and the public about the nature of these exposures and the agents used.

SHAD was part of a larger program called Project 112, which was itself one of many projects run by the Deseret Test Center. Project 112 consisted of 103 chemical and biological warfare agent tests. SHAD involved thirty-four planned tests, many of which were never performed. These were not clinical trials, but rather were done for operational preparedness purposes. Leaders at the time thought they were appropriate tests given the information they then had available. So far, our investigation indicates that most of the tests were done using simulants that were thought to be harmless. Moreover, service members involved in tests using live agents were appropriately protected. Nonetheless, the Deployment Health Support Directorate quickly recognized the necessity to investigate all Project 112 and SHAD tests, and expanded the scope of the original effort.

The first year of this investigation we discovered the difficulties in obtaining the needed medically relevant information and put systems in place to overcome them. First, we had to find the needed documents. In the 1960's, joint operations were not so common. The Army planned the SHAD tests, but for the most part the Navy and Marine Corps conducted the tests, with assistance from the Air Force. The primary planning was done at the Deseret Test Center, a facility that closed in the early 1970's. Records that were kept were stored at different facilities in different geographic areas, ranging from Dugway Proving Grounds, Utah, to Aberdeen Proving Ground, Maryland. Remember, these test plans and reports are not computer files but paper records stored in boxes or folders in file cabinets, so finding what you need is a painstaking manual process.

Learning who may have been involved in a particular test involves finding personnel records in the Navy archives. Navy deck logs aren't found in the military system at all, but are maintained by the National Archives and Records Administration. At this point our investigators believe they have established the locations of most of the relevant records. Of course, the ongoing search could lead to new locations and we will pursue those leads until we have all relevant data.

When the desired test reports are located, there is still the task of declassification. Most of the operation plans and results of these tests remain classified. These documents contain operational information about ship vulnerability to and defenses against chemical and biological weapons. These agents remain a threat to our forces today so, as you can understand, these records can not be casually declassified. DHSD developed a solution. Investigators with appropriate clearances comb through the documents to identify the medically relevant data. Early on, VA staff members who also held appropriate clearances joined our investigators to verify that the information being sought was what they needed to help settle benefits questions. Following the identification of these specific topic areas, our investigators requested that specific information be declassified. The Army has greatly expedited this declassification process.

When we first provided data to the VA we learned that DoD and VA computer systems were not compatible. Both agencies have made the necessary adjustments to allow the smooth transfer of this information. We now have the data the VA needs formatted in such a way that they can use it immediately and easily. In fact, I believe that one positive outcome of this investigation has been a new level of cooperation between the VA and DoD that is focused on providing the information our veterans need and deserve.

To date we have produced fact sheets on 12 SHAD tests, which involved between 2700 and 2800 servicemembers. The VA has a process in place for notifying the servicemembers, however, we understand the VA has a significant challenge in identifying them because at the time they served, they were identified by service numbers, not their social security numbers. The process to translate service numbers to social security numbers is also labor intensive. So, to give the VA time to make positive identifications, we are implementing a process to provide the VA with the list of names and service numbers as soon as we have them, before the investigation of a particular test is completed. And as soon as complete information becomes available, we will continue to share it with the VA and the public.

At the time of the project SHAD tests, there was little awareness of the possible long-term effects of low level toxic exposures. Our recognition of the importance of individual assignments, unit locations and documenting medically relevant exposures following the Gulf War have dramatically changed our processes. Today, DoD monitors the servicemember's environment closely. The U.S. Army Center for Health Promotion and Preventive Medicine and the Naval Environmental Health Center maintain environmental surveillance wherever our military forces go. For example, you may have seen news reports of possible chemical warfare agent exposures at Karshi Khanabad Air Base in Uzbekistan. Routine environmental monitoring discovered what appeared to be traces of possible chemical agents on the base. The base commander immediately cleared the areas where the contamination

was suspected and notified troops of the situation. Closer investigation proved that the substances that caused the alert were not chemical warfare agents. However, that example does demonstrate that we have procedures to protect our people from environmental dangers, and that we keep them aware of possible risks.

We are also dedicated to improvements in medical record keeping. In this area, DoD has stepped boldly into the 21st century. The services have made individual efforts to fulfill today's requirements. We plan to consolidate those efforts into a joint program under the Theater Medical Information Program, or TMIP. TMIP, which is being tested right now, is a tri-Service system designed to provide information to deployed medical forces to support all medical functional areas, including medical logistics, blood management, patient regulation and evacuation, medical intelligence, health care delivery and more. TMIP will integrate several existing and developmental systems into a single system that can be easily used by theater commanders and medical personnel in combat environments. It will also provide an electronic record of care provided in theater that can be entered into the individual's permanent medical record and provided to the VA.

DoD is in the process of setting up a system that will monitor the health of all military members for the duration of their service. It will begin with the Recruit Assessment Program, which will collect comprehensive baseline health data from all U.S. military personnel. That program is in pilot testing right now.

After deployments, servicemembers now receive care based on a set of clinical practice guidelines for post-deployment evaluation and treatment developed jointly by DoD and VA medical personnel. The guidelines are designed to assist health care providers in screening and evaluating service members and veterans with health concerns following deployment.

At the other end of the system is a joint DoD/VA exit physical for service members who are returning to civilian life.

We already have a number of initiatives working through our VA/DoD Executive Council, co-chaired by myself and my colleague Dr. Roswell, the VA Under Secretary for Health. This council provides the forum for senior health care leaders, including our Surgeons General, to proactively address potential areas for further collaboration, and resolve obstacles to sharing.

We are building on the success of our health care council through the newly established VA/DoD Benefits Council, which is examining ways to expand and improve information sharing, refining the process of records retrieval and identifying procedures to improve the benefits claims process. The VA/DoD Joint Executive Council, co-chaired by the Under Secretary of Defense for Personnel and Readiness and the Deputy Secretary of the VA, brings the leadership of the Health and Benefits councils together quarterly to demonstrate their commitment to improving inter-departmental cooperation at all levels. As Under Secretary of Defense David Chu said of the first meeting, "Our concern for the well-being of servicemembers extends beyond just their time on active duty." The two panels will work together to improve coordination between the departments in such areas as health care services, benefits delivery, information sharing and capital asset coordination. The future will hold increased cooperation between our departments, because our focus is the health of our servicemembers throughout their military careers and throughout the rest of their lives.

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

Senator SPECTER. Doctor, is it a fact that Navy personnel were exposed to VX and sarin, both lethal agents?

Dr. WINKENWERDER. It appears in one of the tests that that is the case. They were, in my review of this information. I may turn to Dr. Kilpatrick, who has been directly involved in this effort—that people—

Senator SPECTER. Was that exposure—

Dr. WINKENWERDER [continuing]. Were wearing all the protective—appropriate and necessary protective equipment, and it was in part to test the ability of that equipment to protect. Not something we would do today, obviously, but I think it reflects in my judgment, looking back on this, certainly not the level of informed consent that we would expect today, but it is—

Senator SPECTER. Well, let's just establish a few basic facts.

Dr. WINKENWERDER. OK.

Senator SPECTER. They were exposed to VX and sarin, lethal agents, correct?

Dr. WINKENWERDER. That is correct.

Senator SPECTER. All right. Now, they were wearing—

Dr. WINKENWERDER. Let me turn to Dr. Kilpatrick.

Senator SPECTER. And you say that they were—

Dr. WINKENWERDER. It was on a barge, not populated with people.

Senator SPECTER. And you say that they were wearing protective clothing?

Dr. WINKENWERDER. Protective gear, yes.

Senator SPECTER. Protective gear.

Dr. WINKENWERDER. Everything that would—

Senator SPECTER. Was it determined that they so-called protective gear was adequate to protect them?

Dr. WINKENWERDER. I don't know what the people at that time—my understanding, again, these were 40 years ago. The records are not great in terms of all the details here. But that would have been my inference that they believed that the masks, equipment and so forth were protective. I can't imagine—

Senator SPECTER. Well, Dr. Winkenwerder, you can't testify as to what they believe. We have to make a factual determination what the protective gear was. Have you made a search to determine if any of the naval personnel involved in these tests are still alive? A lot of people are alive from the 1960's.

Dr. WINKENWERDER. Yes, I believe many of these people are alive, and we have had contact with some of them.

Senator SPECTER. Well, have you questioned them—

Dr. WINKENWERDER. Yes.

Senator SPECTER [continuing]. As to the exposure and the adequacy of the protective gear?

Dr. WINKENWERDER. Yes. Let me turn to Dr. Kilpatrick, who is here with me, and who has actually had some of those conversations with those service members.

Senator SPECTER. Let me stick with you, Dr. Winkenwerder, for just a few minutes to outline the scope of what this committee is looking for. We want to find out what the facts are. We have already said Navy personnel were exposed to lethal agents. We want to find out the specifics as to what they were exposed to. And we want to find out the specifics as to what the protective gear was, whether the protective gear was adequate.

The issue of consent is a very important one. We understand that there are no documents around which would verify that there was written consent. Is that correct?

Dr. WINKENWERDER. I cannot answer that question for you today. We will try to provide an answer for you.

Senator SPECTER. Well, would you please find out?

Dr. WINKENWERDER. Yes.

Senator SPECTER. There are a great many questions to be answered, and we would not be surprised if you don't have all the answers today. But let us give you an outline as to what we expect from you and what we want to have determined. We want to get into the question of informed consent. Then a central issue is what

happened from 1963 to the present as to informing these people about the risks that they were exposed to.

Senator Rockefeller sees red about the subject, and, frankly, so do I. We went through great pains. I chaired the committee back when we had the hearings in 1995 and 1996 and what happened with Gulf War Syndrome and how the Department of Defense did not tell the truth.

It seems to be endemic and epidemic, happens all the time. And our oversight function—you can leave my red light on. Don't turn the lights off. It reminds me to conclude.

We want to know what happened in the interim. Every time this committee turns around, it is Agent Orange or some other substance, and it is always the same thing about the records being inadequate. But there are people who were around. Senator Rockefeller and I were around in 1963. I was conducting, helping conduct, an investigation about what the Government did in 1963. And we want to know what efforts are being made now—Secretary Cooper will respond to this in part—by the Veterans Administration but also by the Department of Defense. You have 12 tests, 2,700 to 2,800 people involved. They ought to be notified, they ought to be found, they ought to be located so they can be apprised as to what they were exposed to. They may have some lingering symptoms. They may have some lingering illnesses. We all wonder why we respond in certain ways, but if that is part of a medical history, they are entitled to know about it.

But, most fundamentally, we want to probe the question of why the Department of Defense did nothing from 1963 until a couple of years ago. We want the precise date when the investigation started. And we want to know why the probe was expanded and an announcement made just yesterday. Does it really take congressional oversight and a congressional jar to get the Department of Defense to do a little something? We want to know that because we expect affirmative and positive responses.

Dr. WINKENWERDER. We will provide all of that information. We would be glad to do so.

Senator SPECTER. We would like to know also if you hadn't come, who would have come. We are not too fondly disposed to having witnesses tell us that they could have avoided the hearing.

Dr. WINKENWERDER. I apologize for suggesting that.

Senator SPECTER. Because we are not only going to want to hear from you, Dr. Winkenwerder, but we are going to want to hear from your superiors. And when your superiors come in, Senator Rockefeller is really going to get tough.

Mr. Chairman?

Chairman ROCKEFELLER. Thank you.

You indicated that you came, and we are very grateful that you made that choice. Dr. David Chu, however, decided not to, and I would like a little explanation from you. He is Under Secretary for Personnel and Readiness, and we had requested that he come testify. Now, this committee has oversight over veterans' care, and I am going to ask you what you think oversight means and how you react to the word "oversight." What do you think the relationship between congressional oversight and the Department of Defense, as well as any other agency, might be?

DoD has not been at all enthusiastic about this hearing, and I understand that. But only late last week we were told that Dr. Chu could not attend.

Now, that is not to dishonor any of you because I think all of you are experts on this subject, and we are very pleased that you are here. But, you know, you said you decided to come. Dr. Chu decided not to come. Could you give me a reason for that? Is he busy?

Dr. WINKENWERDER. Mr. Chairman, I don't know if it was a schedule issue—

Chairman ROCKEFELLER. Could you find out for me?

Dr. WINKENWERDER. I can.

Chairman ROCKEFELLER. Because I don't think he wanted to come. I don't think he wanted to face the music. That is my interpretation. I would love to have you prove me wrong. But I would love to have you ask him why it was that he declined late last week to show up at this hearing on the second day of Congress being back in session.

Dr. WINKENWERDER. We will do it.

Chairman ROCKEFELLER. I am going to give you a hard time, because I care about veterans. I am not doing this because of you. You look like a fine person. But you talked about caring for veterans and that you take care of them. Well, you take care of them because the Congress told you to by law back in 1982. Yes, you do take care of them, but don't make this into a big humanitarian gesture. We told you to. And so you have sharing of some facilities. So that is straight, right? Did you know that?

Dr. WINKENWERDER. I am sorry, but I did not hear you.

Chairman ROCKEFELLER. That we passed a law saying that you had to share resources with VA?

Dr. WINKENWERDER. I could only have assumed that the Congress did pass a law.

Chairman ROCKEFELLER. You didn't know, but you know now.

Dr. WINKENWERDER. I certainly know now, yes.

Chairman ROCKEFELLER. In a sense, like Senator Specter said, this Project SHAD to me is just a perfect example—that is why it is so upsetting—of how DoD has historically responded to service-related exposures. You have got a war to fight, and you get people to do things, don't take records, there is no time, people get fired, people don't talk. But it is OK because you are not veterans. You are the warfighters. The veterans are the people that come home, if they come home.

Now, as has been said, the Department of Veterans Affairs first contacted DoD about SHAD in 1997, and I note from your written testimony that only after Acting Secretary Goyer formally requested information in August of 2000 did DoD begin to work on compiling this information. So that is 2 years, and DoD can only guess that it has established the locations of most of the relevant records.

You indicate that DoD has contacted the SHAD planners, but the retired technical director of those tests told this committee personally that he had never received a phone call from DoD. So, again, there is something askew here. It is so easy to sort of mislead, so easy to say you are going to do something, you did do something,

but then you start digging in and you find someone who knows the situation and life isn't quite so easy.

You know, this task could have been hurried up. DoD could have chosen to contact retired staff, sort of a creative thing to do—but you have to think about it—such as the former Technical Director of Planning and Evaluation for Project 112, who might have helped sort the wheat from the chaff.

You do have many competing demands, but can you please tell me why, when DoD first investigated VA's request for information on SHAD back in 1997, it did not lead to any broader, more aggressive effort? Why must DoD wait until there is a congressional inquiry before it does, or starts to do, more aggressive investigations?

Dr. WINKENWERDER. Mr. Chairman, I cannot give you an explanation for why in 1997 or between 1997 and 2000 there wasn't more prompt, expedient response on the part of the Department. What I can tell you is that I am very committed to getting this information out, that upon learning about this effort and its importance and what it means, that I have directed, am directing that every effort be made to get this information out quickly, accurately, appropriately, and that I believe that, yes, there is information that needs to be classified, but the public and our veterans need to know about what went on.

And so I am very committed to that, and that is my assurance to you. We will keep you regularly informed or provide, you know, whatever information you think would be useful to know more about this as this investigation goes along.

Chairman ROCKEFELLER. Obviously, some materials have to be classified in order to protect national security. That becomes a huge issue in all kinds of fields. People don't want to risk national security. You get that with the FBI and the CIA. The FBI is doing this; they need some information, an intercept from the CIA. The CIA doesn't want to give it to them because it would compromise sources, et cetera. So there are all kinds of built-in conflicts, and we understand that.

However, many of the details of deployment of tests, including unit location, are classified when prepared, but need not remain so after completion. I am assuming that is true.

The importance of this information to VA in determining eligibility for benefits and appropriate health care and research obviously cannot be overestimated. So what can DoD do to expedite the declassification process that you talk about?

Dr. WINKENWERDER. I have requested the assistance of each of the Secretaries of the services—the Army, Navy, Air Force—with respect to their part in this. They maintain and actually have responsibility for the storage of the records, and so finding the locations of them and then actually getting the people who can go in and physically get boxes out and have them catalogued, as I described earlier, I have requested their assistance on this. I expect them to respond and to give us the help that we need to get the job done.

I have asked Ms. Embrey, my Deputy for Force Health Protection, who has responsibility for this and has oversight responsibility for Dr. Kilpatrick in the deployment health support area that is responsible for the direct work here, that this is a priority to get

this done, and to get it done properly. And I have asked to be informed on a regular basis, and by that I mean, you know, every couple of weeks, on our progress on this.

I think we have got a job to do, and we need to get it done. We wanted to give some evidence of our recent efforts that we have not been standing—or sitting on our hands here the last few months with this effort. We hope for release of 27 tests within a month or so. We are very hopeful that we will have that additional information, and then we want to speed along to get the rest of it.

Chairman ROCKEFELLER. I have been handed a note here which I would like your response to. It says that what you have been saying is not a SHAD-specific problem. Declassification will be an ongoing issue, particularly for special forces. Would you agree with that?

Dr. WINKENWERDER. Could you restate—I am not sure what the question is there.

Chairman ROCKEFELLER. I am asking if you agree with the statement—

Dr. WINKENWERDER. The statement—

Chairman ROCKEFELLER [continuing]. That this is not—what you have just said is not a SHAD-specific problem, that is, limited only to.

Dr. WINKENWERDER. Correct.

Chairman ROCKEFELLER. Declassification will be an ongoing issue, particularly for special forces.

Dr. WINKENWERDER. I am going to turn—yes.

Chairman ROCKEFELLER. Would you agree with this statement: With regard to SHAD, DoD declassified documents for VA on a limited case-by-case basis upon VA request, but this did not trigger a larger examination of related issues—in other words, the de minimis: you ask me a question, I will give you an answer, but no kind of larger approach. Since the military quit keeping morning reports, unit locations are frequently the only data available to determine where a veteran may have been—and this brings back many memories of the Gulf War Syndrome fiasco. Forget the fiasco part. Would you agree with the rest of the statement?

Dr. WINKENWERDER. I am not sure I would agree with the statement that we are only responding to what is very specifically and, in a very exquisite, targeted way is asked for. We have an understanding that there is a whole set of tests, these 103 tests under Project 112 and SHAD. I understand there are two different names, two different sets of tests, SHAD being a subset of the Project 112. Our job is to get all of this information that is available.

Our understanding is that some of these tests, even though there were 103 that were planned, may have, in fact, never been performed. We don't know how many there may be of that number—what the final number may be that were never performed. Again, it is a matter of getting the information out, reviewing and finding out if the test was ever done. But we have clear information on the roughly 52, I think, of the 103—I am sorry, 55 that we know that were either done or we know that they were not done. But we are trying to get this additional information on the other 48. We believe a fair amount of that information may be at the Dugway

Proving Ground record storage site. We have requested to get to that site, to get to that information. We believe we will be there next month and into those records, and we will know more at that time.

But that is the best answer I can give you right now.

Chairman ROCKEFELLER. Part of what is coming through is what has come through so many times before. You have only been here a short time, and I understand that. That has nothing to do with you or who you are, what your makeup is. But you just don't have any sense of how many times we have been through this exact same conversation. I would have given anything if you could have seen that atomic veteran describe dying while his Government didn't care because he couldn't prove—penniless—that the cancer 50 years later had been caused by what happened 50 years before. And just on and on and on and on, and it always comes back to the same questions. You know, sometimes the VA is slow. The VA are good guys, as far as I am concerned right now, but sometimes they are slow. But they are underfunded, too. They don't have the ear of the President like Donald Rumsfeld does. You know, if you at DoD need more money, you can go get more money.

Now, I understand you think it doesn't work that way, but VA can't do that. They can't do that. Tony Principi can't walk into the Oval Office—he might not get into the Oval Office—to fight for more money for health care, for researchers that do things. DoD has got a whole different posture in the culture of this Nation. And so when you don't take efforts to find out what it is that happened to people who are no longer yours but theirs, please understand the anger of the people who represent those people, who see those people. You don't see those people. You don't go to their homes. You may see them in hospitals if they ever get there, but most of them never get there.

You didn't go through the aftermath of the Persian Gulf War when VA discovered that returning troops were reporting all kinds of unexplained symptoms. That was kind of a surprise to people. Now, VA has to take care of those folks. DoD didn't seem to know anything about it, and we couldn't get any information for them. So this frustration is not personal. It is professional and it has built over a long period of time. I have been on this committee for 18 years, and I have never seen a change in DoD attitude. I have never seen a change in DoD attitude. And I don't like that, and there is no reason why I should. Because, you know, we get you your money, and you can think of us what you want. You probably don't like politicians, and you think we just are here for show.

I am not here for show. I am here because I represent one of the poorest States in the Nation which has the highest participation of veterans anywhere. So I fight for them like I fight for our steel industry. So I have got to fight for my people. The question is: Are you fighting for our people, too?

There is no ancient history here. Many of the participants and planners are still alive and active. They are still out there. One of the planners informed my staff that he had filmed every test and knew the names and codes assigned to each, but that no one from DoD had contacted him to help with finding or sorting any records. Other veterans and scientists involved in these tests have no prob-

lems openly discussing the agents used or what the tests looked like and express the belief that only the technical aspects and vulnerability assessments are classified. Why is this so difficult? Why is this so difficult? What do you need to do to more efficiently separate sensitive intelligence information from personal exposure histories?

Dr. WINKENWERDER. Mr. Chairman, if I could ask if you have that and are willing to share the name of that individual, I will ensure that we make the contact with that person. I would welcome the chance.

Chairman ROCKEFELLER. The Veterans' Affairs Committee will do anything they can to help you.

Dr. WINKENWERDER. And if I might, sir, I would just say I sense your level of frustration and that of the committee and others, and I don't have that experience. But what I can tell you is I am committed to trying to put into place at this point in time—and other things have been done in the past—the sort of systems of collecting this information, good records systems so that, you know, 15 years from now or 10 years from now we are not here asking these same kinds of questions with the inability to know really what happened. I am a big believer in records systems. I think we have made improvements. We have some other things that we can do. But I think this is really important. I think it cuts to the very core of what can help us avoid the problem in the future. That and a sensitivity to the fact that we do put people in harm's way and we do put people at or near exposures—I am talking about in the war battle situation. We need to do everything we can to protect people from those kinds of risks and injuries, and when they happen, we need to be as forthcoming as we can given the constraints of where it occurs, the security constraints, to get the information out. I think we are all better served if we do that. That is going to be my tack during my tenure in my job.

Chairman ROCKEFELLER. Clifton Spendlove is the person you want to talk to.

Under Secretary Cooper, one of the problems here is that we have put the cart before the horse to some degree. Because of the delay in releasing this information, the VA is under time constraints to notify aging veterans long before the potential clinical effects of the SHAD test can be looked at by scientists.

Now that VA is notifying veterans that they may have been SHAD participants, what will you do with claims for benefits from these veterans whose chronic illnesses may or may not be due to chemical or biological exposures?

Mr. COOPER. The answer to that, Senator, is that we will look at their claims and find out whether we can adjudicate the claims even beyond the SHAD. If we don't have all the information, at least we can see if there is some compensation we can provide, based on their medical history, to at least get the process started. Beyond that, as, we are going through a process with the National Academy of Sciences, which will take time.

I think the important thing is to try to look at the claim as submitted. There have been a couple of cases of people who came in who had been, in fact, involved in SHAD. We were able to get their claim processed based on other events that took place. These vet-

erans were able to receive compensation without being dependent upon SHAD information. So we will do everything we can to adjudicate the claim properly and fairly. Other than that, I think we really have to wait as far as SHAD-specific things until we get the necessary information.

Chairman ROCKEFELLER. How long do you expect that will be?

Mr. COOPER. I am sorry, sir. I cannot answer that. I will try to answer for the record, but it is through this laborious process of getting the technical information back from the medical community, from the National Academy of Sciences, and whoever else is doing that type of a test. It is a medical research type of problem as far as getting a justification. And of course, we have to do it as the law requires as far as justifying the claim. But we will do everything we can with the ones that are coming in, even though they are SHAD-related, to get them justified and adjudicated based on the medical information we have. I think that is the best information I can provide right now, sir.

Chairman ROCKEFELLER. Ellen Embrey, do you know how many veterans die every day?

Ms. EMBREY. No.

Chairman ROCKEFELLER. A thousand. Just think about it.

Senator Specter has indicated it might be good to go on to the next panel, and I agree. Thank you all very much.

Senator SPECTER. Before you depart, Dr. Winkenwerder, we outlined the scope of the issues which we have in mind, and what we would like you to do is to report back to the committee in 30 days as to what you have found on your record searches as to those issues. I don't want to have to repeat them now. And we want to see what you have found with a view to followup.

And, Mr. Secretary, with respect to your pursuit of the medical records, we would like to be apprised also within 30 days as to what you have found on ailments from people who were identified, and you talk about the laborious process of establishing a causal connection between what this exposure was, and we would like to know what you find. We don't want to see this eventuate into something like Agent Orange when it took more than a decade before there was legislation on a presumptive service-connection, because we may have to move on that route, too. These people have been waiting for almost 40 years. And if they are going to be subjected to the kinds of scientific analyses which customarily turn out to be inconclusive—because of the nature of the investigation, you just can't establish a causal connection—leading to the burden of proof being put on the veteran, nothing is going to happen. That is why this committee has taken the lead on presumptive service-connections, on presumptive causation.

So report back to us, if you would, in 30 days so we can take a look at what we ought to do further.

Mr. COOPER. Yes, sir.

[The information referred to follows:]

VA HEALTH CARE AND COMPENSATION FOR PROJECT SHAD VETERANS

Report to the Senate Veterans' Affairs Committee (August 5, 2002)

EXECUTIVE SUMMARY

Project SHAD (Shipboard Hazard and Defense) was part of the joint service chemical and biological warfare test program conducted by the Department of Defense (DoD) during the 1960s. During a hearing before the Senate Veterans' Affairs Committee on July 10, 2002, the Honorable Arlen Specter asked the Department of Veterans Affairs (VA) to send the committee a report on what we currently know about the ailments afflicting veterans who participated in Project SHAD.

The benefits portion of this report is based on analysis of data extracted electronically from VA's Beneficiary Identification and Records Locator Subsystem (BIRLS) and the Compensation & Pension (C&P) Master Record file for those veterans identified, to date, who have filed claims. For health care, the report reflects preliminary data from VA's computerized health databases. DoD continues to search and declassify documents associated with Project SHAD. As additional test information and participant names are made available to VA, we will continue to analyze data and update our findings.

Thus far, VA has identified 1,739 Project SHAD veterans having VA claim numbers. Social security numbers were associated with 1,419 of the 1,739 names and that information was provided to the Veterans Health Administration (VHA).

On May 21, 2002, VA mailed letters to 622 veterans who participated in the initial three Project SHAD tests declassified by DoD (i.e., Autumn Gold, Copper Head, and Shady Grove) for whom social security numbers and addresses had been obtained. The letter informed the veterans of potentially hazardous exposures during military service and encouraged them to seek an evaluation at a local VA medical center, if they had any concerns.

Review of health care data shows that of the 622 SHAD veterans, 226 have received health care from VA for a very wide array of common diagnoses. Preliminary data shows that the most frequent infectious disease diagnosis was dermatophytosis, a fungal infection of the skin like athlete's foot. The most frequent neurological diagnoses were disorders of refraction (needing eye glasses) and deafness.

Using BIRLS and C&P Master Record file data, VA identified 299 veterans who were SHAD participants having at least one service-connected disability. There were many similarities between the disabilities of the 299 SHAD participant veterans and the total service-connected veteran beneficiary population. For both SHAD participants and the total service-connected veteran beneficiary population, the majority of the disabilities were associated with the following four body systems: musculoskeletal system, skin, impairments of auditory acuity, and the digestive system. The most common disabilities were defective hearing, scars, and generalized skeletal conditions.

In order to determine whether SHAD veterans are experiencing particular health problems due to prior exposures during military service, a formal epidemiological study will have to be conducted. To answer this question, the Secretary requested the Institute of Medicine (IOM), Medical Follow-Up Agency, to develop a formal proposal which is expected by the end of August 2002.

VA treatment data in this report is preliminary and based on the initial 622 veterans identified with social security numbers. VA will submit a more extensive assessment of treatment and diagnoses based upon existing computer records.

BACKGROUND

On July 10, 2002, Senator Specter, Ranking Member, Senate Veterans' Affairs Committee, requested a report back to the Committee within 30 days about what VA has found out regarding the ailments of Project SHAD veterans. The information requested was for the ailments of Project SHAD veterans who have been treated in VA health care facilities and the medical conditions of Project SHAD veterans who have submitted compensation claims.

Project SHAD was part of the joint service chemical and biological warfare test program conducted by DoD during the 1960s. Project SHAD encompassed tests designed to identify US warships' vulnerabilities to attacks with chemical or biological warfare agents and to develop procedures to respond to such attacks while maintaining a war-fighting capability. Although classified, DoD is in the process of declassifying relevant medical information.

At this time, the exact number of Project SHAD tests actually conducted is unknown. As of July 5, 2002, DoD has provided VA with declassified information relat-

ing to twelve tests. In addition, DoD has provided VA with test names and participant information for two tests not yet declassified. Approximately 4,684 participants were involved in the fourteen tests known as:

- Autumn Gold
- Big Tom
- Copper Head
- DTC Test 68-50
- DTC Test 69-32
- Eager Belle I
- Eager Belle II
- Fearless Johnny
- Flower Drum I
- Flower Drum II
- Half Note
- Purple Sage
- Scarlet Sage
- Shady Grove

Some veterans participated in more than one test. Based on current information, approximately 2,938 unique service members participated in these fourteen tests.

IDENTIFICATION OF VETERANS WHO RECEIVED HEALTH CARE TREATMENT AND FILED COMPENSATION CLAIMS

VA used the names and service numbers of SHAD participants provided by DoD to identify veterans who have been treated in VA health care facilities and/or filed compensation claims. That data was matched against information available in VA's Beneficiary Identification and Records Locator Subsystem (BIRLS). The Veterans Benefits Administration (VBA) matched 1,739 records identified with VA claim numbers against the June 2002 Compensation & Pension Master Record and May 2002 BIRLS inactive compensation/pension data and extracted information about SHAD veterans who have filed compensation claims. Of the 1,739 records, we were able to associate social security numbers with 1,419 names and provide that information to VHA to match against their databases for health care utilization.

REPORT FINDINGS

The benefits portion of this report is based on analysis of data extracted electronically from BIRLS and the C&P Master Record file for those veterans identified, to date, who have filed claims. For health care, the report reflects preliminary data. DoD continues to search and declassify documents associated with Project SHAD. As additional test information and participant names are made available to VA, we will continue to analyze both VBA and VHA data and update our findings.

I. Project SHAD Veterans Who Have Been Treated in VA Health Care Facilities

VA HEALTH DATABASES

VA is engaged in a complex process to augment its medical record system and to connect computerized health databases into a coherent network. Because of progress in integrating VA's computerized health databases, VHA can now track health care utilization by special groups of veterans such as the veterans who participated in Project SHAD.

In this regard, VA is developing the Health Data Repository (HDR) to provide the support for a full electronic patient medical record. VHA will use a combination of the existing Vista system and a commercial clinical repository product to record all patient data, thereby creating a "longitudinal" record covering all care received from VA. In addition, the HDR will provide the means to electronically receive data from other health care entities, such as DoD, private health care, and any reference facility (such as specialty laboratories).

For evaluating the health of Project SHAD veterans who come to VA for health care, the use of these standard health care databases provide several important advantages over clinical "registries," which have been used in the past to evaluate particular cohorts of veterans, such as Vietnam and Gulf War veterans. The use of VA's health databases allows VA to evaluate the health of veterans every time they obtain care in the VA, not just on the one occasion that they elect to have a registry examination. This will provide a much broader and longer-term assessment of the health status of these veterans because many veterans return frequently for VA health care, and because veterans are often seen in different clinics or even different parts of the country for specialized health care.

STATUS OF SHAD VETERANS SEEN BY VA

On May 21, 2002, VA mailed letters to 622 veterans who participated in the initial three tests declassified by DoD (i.e., Autumn Gold, Copper Head, and Shady Grove) for whom social security numbers and addresses had been obtained. The letter informed the veterans of potentially hazardous exposures during military service and encouraged them to seek an evaluation at a local VA medical center, if they had any concerns.

VA's health databases were used to assess SHAD veterans who received VA health care, including how many had newly enrolled in the VA health care system, what percentage had previously obtained care within the VA, and the general types of diagnoses that SHAD veterans received at VA medical centers, with the following results:

- Between May 1 and July 24, 2002, eleven or 1.8 percent of the 622 veterans who had been mailed letters, enrolled for VA health care for the first time.
- The letter VA sent to SHAD veterans may have had an impact on the number of veterans seeking VA health care. On average, 15 of these 622 veterans were seen at a VA health care facility each month from October 2001 to May 2002. A larger number (48) of these SHAD veterans were seen at VA health care facilities in June 2002, the month after the notification letters were mailed.
- Of the 622 SHAD veterans, 226 have received health care from VA at some time in the past and with a very wide array of common diagnoses. This is to be expected in a cohort of veterans who are 50 years of age and older. The most frequent infectious disease diagnosis was dermatophytosis, which is a fungal infection of the skin like athlete's foot. The most frequent neurological diagnoses were disorders of refraction (needing eye glasses) and deafness, which also are common diagnoses among aging veteran populations.
- It is not possible to determine whether any particular diagnosis is occurring at higher rates than normal because this is a highly select group of veterans who have sought health care in the VA system.
- The number of SHAD veterans being evaluated by the VA is too small to assess individual diseases.

VA HEALTH CARE UTILIZATION AMONG SHAD PARTICIPANT VETERANS

In fiscal year 2002, 102 of the 622 SHAD veterans who had been mailed letters were obtaining health care in the VA system. This is a 16 percent rate of health care utilization, which is comparable to the 15 percent rate of VA health care utilization by the entire U.S. military veteran population in FY 2002.

The social security numbers of 797 additional veterans who participated in subsequent declassified tests have been obtained. None of these 797 veterans were included in the original group of 622 SHAD veterans contacted by mail in May 2002. The addresses of veterans associated with this new group have been obtained and, in the near future, VA will notify them of potential exposures.

Within the constraints of this report, the only health information that VA has been able to assess for the more recently identified 797 veterans is their VA health care utilization. Among these veterans, 124 (16 percent) received health care from the VA during the current fiscal year. This is similar to other groups of U.S. veterans.

INITIAL CONCLUSIONS REGARDING UTILIZATION OF VA HEALTH CARE

To date, the 622 Project SHAD veterans have not demonstrated higher utilization of VA health care services compared to other veterans. However, Project SHAD veterans directly notified by mail of potentially hazardous exposures appear to have been prompted to seek health care from the VA. Eleven new veterans who sought health care from the VA for the first time may have done so because of the notification letters.

EPIDEMIOLOGICAL STUDY TO EVALUATE SHAD VETERAN HEALTH STATUS

In order to determine whether SHAD veterans are experiencing particular health problems due to prior exposures during military service, a formal epidemiological study will have to be conducted. Neither VA health care databases nor a clinical registry can assess rates of disease or possible causes because veterans receiving care in the VA do not constitute a representative sample for research purposes. As an example, evaluation of over 100,000 Gulf War veterans in VA and DoD clinical registries has not answered scientific questions about the health of this population. Both veterans receiving care from the VA and veterans receiving health care from other providers have to be sampled in order to conduct a valid scientific study and determine the nature and causes of their health problems.

The Institute of Medicine (IOM), Medical Follow-Up Agency, has developed a proposal to conduct this independent, epidemiological study, and this proposal is currently undergoing internal review by the IOM. The VA expects to receive the formal proposal in August 2002.

FURTHER USE OF EXISTING VHA DATABASES

While this will not be a substitute for the well designed epidemiological study described above, further information on medical conditions of SHAD veterans is available with some limitations. Medical conditions are not stable over time. Some improve while others get worse. Some are cured while others become chronic. This complicates any analysis of health status over time. Databases are maintained by fiscal year and not all patients are seen every year. The two automated databases containing diagnostic information are the patient treatment file (PTF), which covers inpatient hospitalization from FY 1970, and the outpatient file (OPC), which contains diagnostic data beginning in FY 1997. These data files are extremely large but an analysis of the medical diagnoses of the SHAD veterans identified with social security numbers as of July 2002 has begun and will be made available as soon as possible. VA will submit a more extensive assessment of treatment and diagnoses based upon existing computer records.

II. Project Shad Veterans Who Have Submitted Compensation Claims

VETERANS WITH AT LEAST ONE SERVICE-CONNECTED DISABILITY

As of June 2002, of the 1,739 veterans for whom VA claim numbers were matched, VA identified 299 veterans who were SHAD participants having at least one service-connected disability. This group included:

- Those veterans receiving compensation (159),
- Those evaluated at less than 10 percent for service-connected disabilities (74),
- Those who had at least one service-connected disability evaluated at 10 percent or more, but with inactive records¹ (61), and
- Those with service-connected disabilities, but receiving disability pension (5).²

VETERANS WHO FILED FOR BENEFITS WHO DID NOT HAVE A SERVICE-CONNECTED DISABILITY

Of the 1,739 veterans for whom VA claim numbers were matched, 78 veterans did not have a service connected disability.

- Sixty-six veterans had all non service-connected disabilities.
- Twelve veterans were receiving disability pension and had no service-connected disabilities.

COMBINED SERVICE-CONNECTED EVALUATION

The following chart shows the distribution based on the combined service-connected evaluation for the 299 service-connected veterans. The largest number (76 or 25.4 percent) of the veterans had a combined service-connected evaluation of 0 percent followed closely by 23.4 percent with a 10 percent evaluation.

Number of Veterans With Combined Service-Connected Evaluation

Combined Evaluation	Number of Veterans	Percent of Total
0%	76	25.4%
10%	70	23.4%
20%	33	11.0%
30%	25	8.4%
40%	21	7.0%
50%	13	4.3%
60%	18	6.0%
70%	8	2.7%
80%	5	1.7%
90%	3	1.0%
100%	27	9.0%
Total	299	100.0%

¹In 55 (90%) of these cases, the veteran is deceased.

²Two veterans receiving pension had service-connected disabilities evaluated at 0% and three had service-connected disabilities evaluated at 10%.

SERVICE-CONNECTED DISABILITIES

The 299 veterans had 724 individual service-connected disabilities. The following chart shows the number of disabilities for each veteran. For example, 84 veterans had two service-connected disabilities; 11 veterans had five service-connected disabilities. On average, each had 2.4 service-connected disabilities.

Number of Service-Connected Disabilities
[Per Veteran]

Number of Service-Connected Disabilities	Number of Veterans	Number of Disabilities
1	108	108
2	84	168
3	43	129
4	27	108
5	11	55
6	26	156
Total	299	724

SERVICE-CONNECTED DISABILITIES BY BODY SYSTEM

The 724 service-connected disabilities were associated with 14 of the 15 rating schedule body systems. The following chart shows the number of service-connected disabilities associated with each and the percentage of total. None of the disabilities were gynecological.

Number of Service-Connected Disabilities Associated With Each Body Systems

Body System	Number of Disabilities	Percent of Total
Grand Total—All SC Conditions (Codes 5000–9999)	724	100.0%
Musculoskeletal System (Codes 5000–5399)	225	31.1%
Digestive System (Codes 7200–7399)	102	14.1%
Impairment of Auditory Acuity (Codes 6100–6299)	97	13.4%
Skin (Codes 7800–7899)	76	10.5%
Cardiovascular System (Codes 7000–7199)	61	8.4%
Respiratory System (Codes 6501–6899)	44	6.1%
Neurological Conditions (Codes 8000–8999)	26	3.6%
Genitourinary System (Codes 7500–7599)	25	3.5%
Mental Disorders (Codes 9200–9599)	25	3.5%
Endocrine System (Codes 7900–7999)	17	2.3%
Eye (Codes 6000–6099)	14	1.9%
Infectious Diseases, Immune Disorders, Nutritional Disorder (Codes 6300–6399)	5	0.7%
Dental and Oral Conditions (Codes 9900–9999)	5	0.7%
Hemic & Lymphatic Systems (Codes 7700–7799)	2	0.3%
Gynecological Conditions (Codes 7601–7699)	0	0.0%

NON SERVICE-CONNECTED DISABILITIES BY BODY SYSTEM

This group of 299 veterans also had 257 disabilities determined to be non service-connected. The non service-connected disabilities were associated with 13 of the 15 rating schedule body systems. The following chart shows the number of non service-connected disabilities associated with each body system and the percentage of total. None of the disabilities were gynecological or dental/oral conditions.

Number of Non Service-Connected Disabilities Associated With Each Body system

Body System	Number of Disabilities	Percent of Total
Grand Total—All NSC Conditions (Codes 5000–9999)	257	100.0%
Musculoskeletal System (Codes 5000–5399)	62	24.1%
Impairment of Auditory Acuity (Codes 6100–6299)	28	10.9%
Cardiovascular System (Codes 7000–7199)	26	10.1%
Mental Disorders (Codes 9200–9599)	25	9.7%

Number of Non Service-Connected Disabilities Associated With Each Body system—Continued

Body System	Number of Disabilities	Percent of Total
Digestive System (Codes 7200–7399)	23	8.9%
Skin (Codes 7800–7899)	21	8.2%
Respiratory System (Codes 6501–6899)	19	7.4%
Neurological Conditions (Codes 8000–8999)	15	5.8%
Endocrine System (Codes 7900–7999)	14	5.4%
Eye (Codes 6000–6099)	12	4.7%
Genitourinary System (Codes 7500–7599)	9	3.5%
Hemic & Lymphatic Systems (Codes 7700–7799)	2	0.8%
Infectious Diseases, Immune Disorders, Nutritional Disorder (Codes 6300–6399)	1	0.4%
Gynecological Conditions (Codes 7601–7699)	0	0.0%
Dental and Oral Conditions (Codes 9900–9999)	0	0.0%

MOST COMMON SERVICE-CONNECTED DISABILITIES

The following chart shows the 15 most common service-connected disabilities, their associated diagnostic codes, frequency, and the percent of total. For example, 64 or 8.8 percent of the 724 service-connected disabilities were for defective hearing/hearing loss.

Most Common Service-Connected Disabilities

Service Connected Disabilities	Diagnostic Codes	Frequency	Percent of Total
Total Disabilities	5000–9999	724	100.0%
Defective hearing/Hearing Loss	6100–6101– 6102–6282– 6288–6289– 6292–6293– 6296–6297	64	8.8%
Scars	7800–7801– 7802–7604– 7805	47	6.5%
Generalized, Skeletal condition	5299	41	5.7%
Hemorrhoids, external or internal	7336	28	3.9%
Intervertebral disc syndrome	5293	26	3.6%
Tinnitus	6260	26	3.6%
Hypertensive vascular disease (essential arterial hypertension)	7101	23	3.2%
Hernia, inguinal	7338	20	2.8%
Lumbo-sacral strain	5295	17	2.3%
Arteriosclerotic Heart Disease	7005	16	2.2%
Duodenal ulcer	7305	16	2.2%
Arthritis, Degenerative, Hypertrophic or Osteoarthritis	5003	14	1.9%
Diabetes Mellitus	7913	14	1.9%
Arthritis, Due to Trauma, substantiated by x-ray findings	5010	13	1.8%
Other impairment of knee	5257	11	1.5%
Fifteen disabilities accounted for 51.9% of total disabilities	376	51.9%

MOST COMMON DISABILITIES (SERVICE-CONNECTED AND NON SERVICE-CONNECTED)

This group of 299 veterans had a total of 981 disabilities (both service-connected and non service-connected). The following chart shows the 15 most common disabilities, their associated diagnostic codes, frequency, and the percent of total. For example, 83 or 8.5 percent of the 981 disabilities were for defective hearing/hearing loss.

Most Common Disabilities

Most Common Disabilities	Diagnostic Codes	Frequency	Percent of Total
Total Disabilities	5000–9999	981	100.0%

Most Common Disabilities—Continued

Most Common Disabilities	Diagnostic Codes	Frequency	Percent of Total
Defective hearing/Hearing Loss	6100-6101- 6102-6282- 6288-6289- 6292-6293- 6296-6297	83	8.5%
Scars	7800-7801- 7802-7804- 7805	51	5.2%
Generalized, Skeletal condition	5299	50	5.1%
Hypertensive vascular disease (essential arterial hypertension)	7101	34	3.5%
Tinnitus	6260	33	3.3%
Intervertebral disc syndrome	5293	32	3.3%
Hemorrhoids, external or internal	7336	30	3.1%
Diabetes Mellitus	7913	27	2.8%
Arthritis, Degenerative, Hypertrophic or Osteoarthritis	5003	26	2.7%
Lumbo-sacral strain	5295	26	2.7%
Arteriosclerotic Heart Disease	7005	23	2.3%
Hernia, inguinal	7338	23	2.3%
Generalized, The Skin	7899	21	2.1%
Arthritis, Due to Trauma, substantiated by x-ray findings	5010	17	1.7%
Duodenal ulcer	7305	17	1.7%
Fifteen disabilities accounted for 50.2% of total disabilities	493	50.3%

Appendix A lists in descending order of frequency the 981 disabilities associated with the 299 veterans.

DISABILITY EVALUATIONS WITHIN BODY SYSTEM

The following chart shows the distribution of 724 service-connected disabilities based on assigned evaluation and percentage of total for each of the eleven levels (i.e., 0 percent-100 percent). For example, 93 musculoskeletal disabilities are evaluated at 0 percent and 17 disabilities associated with skin are evaluated at 10 percent. Forty-eight percent of the total disabilities are evaluated at 0 percent and 25.1 percent of the disabilities are evaluated at 10 percent.

Number of Disabilities Based on Individual Evaluation

Body System	Number of Disabilities	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Musculoskeletal System (Codes 5000-5399)	225	93	68	30	9	12	1	9				3
Eye (Codes 6000-6099)	14	8	2		2							2
Impairment of Auditory Acuity (Codes 6100-6299)	97	55	35	5		1	1					
Infectious Diseases, Immune Disorders, Nutritional Disorder (Codes 6300-6399)	5	3			1			1				
Respiratory System (Codes 6501-6899)	44	21	8		6		1	4				4
Cardiovascular System (Codes 7000-7199)	61	8	17	6	8	1	1	11		1		8
Digestive System (Codes 7200-7399)	102	80	12	4	5					1		
Genitourinary System (Codes 7500-7599)	25	14	3	1	1			2		1		3
Gynecological Conditions (Codes 7601-7699)	0											
Hemic & Lymphatic Systems (Codes 7700-7799)	2				2							
Skin (Codes 7800-7899)	76	55	17		3		1					
Endocrine System (Codes 7900-7999)	17	3	1	11		1		1				
Neurological Conditions (Codes 8000-8999)	26	3	11	3	1	2		1				5
Mental Disorders (Codes 9200-9599)	25	2	7		5		4					7
Dental and Oral Conditions (Codes 9900-9999)	5	4	1									
Grand Total (Codes 5000-9999)	724	349	182	60	43	17	9	29	0	3	0	32
Percent of Total	100.0%	48.2%	25.1%	8.3%	5.9%	2.3%	1.2%	4.0%	0.0%	0.4%	0.0%	4.4%

SHAD COMPENSATION CLAIMS PENDING

As of August 1, 2002, there were compensation claims pending decisions for 28 veterans alleging disabilities due to exposure to agents and substances while participating in Project SHAD. Sixteen of these claims were received subsequent to the May 21, 2002, letter VA mailed to veterans informing them of potentially hazardous exposures during military service. Only seven of the 16 claims are from veterans who actually received the letter. The claims are for service connection for a wide array of disabilities.

CONCLUSIONS REGARDING COMPENSATION CLAIMS

The data obtained from this review was based on a relatively small sample 299—cases where veterans had filed compensation claims. Nothing unique came to light regarding the disabilities of these SHAD participants. There were many similarities between the awards/disabilities of the 299 veterans identified as participants of Project SHAD and the total service-connected veteran beneficiary population.

- *Average Number of Disabilities* On average, the 299 SHAD participants had 2.4 service-connected disabilities compared to 2.57 disabilities³ for the total service-connected beneficiary population.

- *Majority of Service-Connected Disabilities were Associated with Four Body Systems* For both SHAD participants and the total service-connected veteran beneficiary population, the majority of the disabilities were associated with the musculoskeletal system, skin, impairments of auditory acuity, and the digestive system. Sixty-nine percent of the disabilities for SHAD participants were associated with these four body systems compared to 68.9 percent⁴ for the total service-connected beneficiary population.

Body System	Percent of Disabilities SHAD Participants	Percent of Disabilities Total Service-Connected Beneficiary Population*
Musculoskeletal	31.1%	40.4%
Digestive	14.1%	7.3%
Impairment of Auditory Acuity	13.4%	8.9%
Skin	10.5%	12.3%

*VBA Annual Benefits Report, Fiscal Year 2001, dated May 2002, Table 7 Chap. 3.

- *Majority of Individual Service-Connected Disabilities Evaluated at 0 percent and 10 percent* For both SHAD participants and the total service-connected veteran beneficiary population, the majority of the disabilities were evaluated at 0 percent and 10 percent. That is, 73.3 percent of the disabilities for SHAD participants compared to 72.9 percent⁵ for the total service-connected beneficiary population.

Evaluation Assigned Individual Disabilities	Percent for SHAD Participants	Percent for Total Service-Connected Beneficiary Population
0% Evaluation	48.2%	35.0%
10% Evaluation	25.1%	37.9%

- *Common Disabilities* For both SHAD participants and the total service-connected veteran beneficiary population,⁶ the following disabilities were among the most common:

- Arthritis due to trauma
- Defective hearing/Hearing loss
- Degenerative Arthritis
- Diabetes Mellitus
- Duodenal ulcer
- Hemorrhoids
- Hypertensive vascular disease

³ VBA Annual Benefits Report, Fiscal Year 2001, dated May 2002, Table 6 Chap. 3.

⁴ VBA Annual Benefits Report, Fiscal Year 2001, dated May 2002, Table 7 Chap. 3.

⁵ VBA Annual Benefits Report, Fiscal Year 2001, dated May 2002, Table 8 Chap. 3.

⁶ VBA Annual Benefits Report, Fiscal Year 2001, dated May 2002, Table 10 Chap. 3.

Intervertebral disc syndrome
 Knee impairments
 Lumbo-sacral strain
 Scars
 Skeletal conditions
 Tinnitus

APPENDIX A.—FREQUENCY OF DISABILITIES ASSOCIATED WITH 299 COMPENSATION CLAIMS

Frequency	Diagnostic Codes	Description of Disability
83	6100-6101-6102-6282-6288-6289-6292-6293-6296-6297.	Defective hearing/Hearing Loss
51	7800-7801-7802-7804-7805	Scars
50	5299	Generalized, Skeletal condition
34	7101	Hypertensive vascular disease (essential arterial hypertension)
33	6260	Tinnitus
32	5293	Intervertebral disc syndrome
30	7336	Hemorrhoids, external or internal
27	7913	Diabetes Mellitus
26	5003	Arthritis, Degenerative, Hypertrophic or Osteoarthritis
26	5295	Lumbo-sacral strain
23	7005	Arteriosclerotic Heart Disease
23	7338	Hernia, inguinal
21	7899	Generalized, The Skin
17	5010	Arthritis, Due to Trauma, substantiated by x-ray findings
17	7305	Duodenal ulcer
14	5257	Other impairment of knee
11	9411	Post-Traumatic Stress Disorder
10	6600	Bronchitis, chronic
10	7399	Generalized, Digestive System
9	5002	Arthritis, Rheumatoid (Atrophic), as an active process
9	7527	Prostate gland injuries, infections, hypertrophy, post-operative residuals
9	7819	New growths, benign, skin
8	7346	Hernia, hiatal
8	7599	Generalized, Genitourinary System
7	5099	Generalized, Acute, Subacute, or Chronic Diseases of the Musculoskeletal System
7	5290	Limitation of motion of cervical spine
7	6899	Generalized, Nontuberculous Diseases
6	5203	Impairment of clavicle or scapula
6	5271	Limited motion of the ankle
6	6099	Generalized, Disease of the Eye, Impairment of Central Visual Acuity, Impairment of Field of Vision, Impairment of Muscle Function (eyes)
6	6599	Generalized, Disease of the Nose and Throat
6	7017	Coronary Artery Bypass Surgery
6	9405	Dysthymic disorder; Adjustment disorder with depressed mood, Major depression without melancholia
5	6034	Pterygium
5	6603	Emphysema, pulmonary
5	7099	Generalized, Diseases of the Heart
5	7806	Eczema
5	7813	Dermatophytosis
5	7816	Psoriasis
5	8018	Multiple sclerosis
5	8099	Generalized, Organic Diseases of the Central Nervous System
5	9400	Generalized anxiety disorder
4	5015	Bones, New Growths of, Benign
4	5017	Gout
4	5020	Synovitis
4	5227	Ankylosis of any other finger
4	5285	Vertebra, fracture of, residuals
4	6079	Defective visual acuity
4	6510	Sinusitis, paranasal, chronic
4	6602	Asthma, bronchial

Frequency	Diagnostic Codes	Description of Disability
4	6819	New growths, malignant, any specified part of the respiratory system exclusive of skin growths
4	7007	Hypertensive heart disease
4	7116	Claudication, intermittent
4	7120	Varicose Veins
4	7318	Gall bladder, removal of
4	7341	Stomach wound
4	7528	Malignant neoplasms of the genitourinary system
4	8008	Brain, vessels, thrombosis of
4	8045	Brain disease due to trauma
4	8515	Paralysis of the median nerve
4	8599	Generalized, Diseases of the Peripheral Nerves (Paralysis)
4	9203	Schizophrenia, Paranoid type
4	9499	Generalized, Anxiety Disorders, Dissociative Disorders, Somatoform Disorders, Mood Disorders
4	9999	Generalized, Dental and Oral Conditions
3	5165	Amputation of Leg at a lower level permitting prosthesis
3	5201	Limitation of motion of arm
3	5211	Impairment of Ulna
3	5215	Limitation of motion of the wrist
3	5262	Tibia and fibula, impairment of
3	5276	Flatfoot, acquired
3	5292	Limitation of motion of lumbar spine
3	5309	Group IX Intrinsic muscles of hand
3	6018	Conjunctivitis, other, chronic
3	6200	Otitis media, suppurative, chronic
3	6731	Tuberculosis, pulmonary, chronic, inactive
3	6799	Generalized, Diseases of the Lungs and Pleura—Tuberculosis
3	7299	Generalized, Digestive System
3	7307	Gastritis, hypertrophic
3	7308	Postgastrectomy syndromes
3	7339	Hernia, ventral, postoperative
3	7344	New growths, benign, any part of digestive system, exclusive of skin growths
3	9399	Generalized, Delirium, Dementia, and Amnesic and Other Cognitive Disorders
2	5019	Bursitis
2	5209	Elbow, other impairment of Flail joint
2	5212	Impairment of radius
2	5224	Ankylosis of thumb
2	5225	Ankylosis of Index Finger
2	5253	Thigh, Impairment of
2	5279	Metatarsalgia, anterior (Morton's disease)
2	5294	Sacro-iliac injury and weakness
2	5296	Skull, loss of part of, both inner and outer tables
2	5314	Group XIV—Anterior thigh group
2	5319	Group XIX—Muscles of abdominal wall
2	5399	Generalized, Shoulder and Girdle Muscles, the Forearm and Hand, the Foot and Leg, the Pelvic Girdle and Thigh, the Torso and Neck
2	6029	Aphakia
2	6210	Auditory canal, disease of
2	6211	Tympanic membrane, perforation of
2	6299	Generalized, Diseases of the Ear
2	6310	Syphilis, unspecified
2	6399	Generalized, Infectious Diseases, Immune Disorder and Nutritional Deficiencies
2	6513	Sinusitis, maxillary, chronic
2	6699	Generalized, Diseases of the Trachea and Bronchi
2	6723	Tuberculosis, pulmonary, chronic, minimal, inactive
2	6833	Asbestosis
2	7199	Generalized, Diseases of the Arteries and Veins
2	7312	Liver, cirrhosis
2	7323	Ulcerative colitis
2	7345	Hepatitis, infectious
2	7504	Pyelonephritis, chronic
2	7508	Nephrolithiasis
2	7512	Cystitis, chronic, includes interstitial and all etiologies, infectious and non-infectious

Frequency	Diagnostic Codes	Description of Disability
2	7706	Splenectomy
2	7799	Generalized, Hemic and Lymphatic Systems
2	7999	Generalized, The Endocrine System
2	8100	Migraine
2	8512	Paralysis of lower radicular group
2	8520	Paralysis of sciatic nerve
2	8621	Neuritis of external popliteal nerve (common peroneal)
2	9304	Dementia associated with brain trauma
2	9410	Other and unspecified neurosis
2	9413	Anxiety disorder, not otherwise specified
1	5012	Bones, New Growths of, Malignant
1	5013	Osteoporosis, with Joint Manifestations
1	5021	Myositis
1	5022	Periostitis
1	5024	Tenosynovitis
1	5055	Knee Replacement (Prosthesis)
1	5110	Loss of use of both feet
1	5111	Loss of use of one hand and one foot
1	5154	Amputation of middle finger
1	5155	Amputation of ring finger
1	5199	Generalized, Combinations of Disabilities and Amputations of the Musculoskeletal System
1	5202	Other Impairment of Humerus
1	5219	Two digits of one hand, unfavorable ankylosis of
1	5222	Three digits of one hand, favorable ankylosis of
1	5223	Two digits of one hand, favorable ankylosis of
1	5255	Femur, Impairment of
1	5270	Ankle, ankylosis of
1	5278	Claw foot (pes cavus), acquired
1	5284	Other foot injuries
1	6007	Hemorrhage, intra-ocular, recent
1	6013	Glaucoma, simple, primary, non-congestive
1	6019	Ptosis, unilateral or bilateral
1	6026	Neuritis, optic
1	6062	Blindness both eyes having only light perception
1	6080	Impairment of Field vision
1	6304	Malaria
1	6311	Tuberculosis, military
1	6501	Rhinitis, atrophic, chronic
1	6502	Septum, nasal, deflection of
1	6519	Aphonia, organic
1	6604	Chronic obstructive pulmonary disease
1	6802	Pneumoconiosis, unspecified
1	6820	New growths of, benign, any specified part of respiratory system
1	6821	Coccidioidomycosis
1	6825	Diffuse interstitial fibrosis (interstitial pneumonitis, fibrosing alveolitis)
1	6847	Sleep Apnea Syndromes (Obstructive, Central, Mixed)
1	7003	Adhesions, Pericardial
1	7006	Myocardium, infarction of, due to thrombosis or embolism
1	7015	Auriculoventricular Block
1	7100	Arteriosclerosis, general
1	7118	Angioneurotic edema
1	7304	Gastric ulcer
1	7315	Cholelithiasis, chronic
1	7325	Enteritis, chronic
1	7326	Enterocolitis, chronic
1	7327	Diverticulitis
1	7332	Rectum and anus, impairment of sphincter control
1	7335	Ano, Fistula in
1	7343	New growths, malignant, exclusive of skin growths
1	7502	Nephritis, chronic
1	7507	Nephrosclerosis, arteriolar
1	7509	Hydronephrosis
1	7518	Urethra, stricture of
1	7522	Penis, deformity, with loss of erectile power

Frequency	Diagnostic Codes	Description of Disability
1	7523	Testis, atrophy complete
1	7524	Testis, removal
1	7815	Pemphigus
1	7903	Hypothyroidism
1	7914	New growths, malignant, endocrine system
1	8004	Paralysis Agitans
1	8108	Narcolepsy
1	8199	Generalized, Miscellaneous Diseases of the Central Nervouse System
1	8207	Seventh (Facial) cranial nerve, paralysis of
1	8516	Paralysis of the ulnar nerve
1	8910	Epilepsy, grand mal
1	8999	Generalized, The Epilepsies
1	9204	Schizophrenia, Undifferentiated type
1	9205	Schizophrenia, Residual type; Schizoaffective disorder, other and unspecified types
1	9206	Bipolar disorder, manic, depressed or mixed
1	9303	Dementia associated with alcoholism
1	9310	Dementia due to unknown cause
1	9326	Dementia due to other neurologic or general medical conditions (endocrine disorders, metabolic disorders, Pick's disease, brain tumors, etc.) or that are substance-induced (drugs, alcohol, poisons)
1	9403	Phobic disorder
1	9404	Obsessive compulsive disorder
1	9432	Bipolar disorder
1	9434	Major depressive disorder
1	9502	Psychological factors affecting gastrointestinal condition
1	9904	Mandible, malunion of
981	5000-9999	Total Service-Connected & Non Service-Connected Disabilities

Senator SPECTER. And now we will move to panel two. Thank you.

Chairman ROCKEFELLER. Let me just introduce them. Our second panel of witnesses are Steven Smithson of the American Legion; and then Rick Weidman of the VVA, who is accompanied by Dr. Linda Schwartz of the VVA Healthcare Committee. The VVA has worked very diligently to bring attention about Project SHAD to us in Congress. And, finally, we will hear from Dr. Leonard Cole, an expert in informed consent and military, biological, and chemical weapons testing, who testified before the committee on these subjects in 1994. So, Dr. Cole, welcome back.

I guess we will stick with the 5-minute rule. All of your testimony is included, and we are very glad that you are here.

STATEMENT OF RICHARD F. WEIDMAN, DIRECTOR OF GOVERNMENT RELATIONS, VIETNAM VETERANS OF AMERICA; ACCOMPANIED BY LINDA SPOONSTER SCHWARTZ, PH.D., CHAIR, VIETNAM VETERANS OF AMERICA HEALTHCARE COMMITTEE

Mr. WEIDMAN. Good morning, Mr. Chairman.

Chairman ROCKEFELLER. Good morning.

Mr. WEIDMAN. First, Vietnam Veterans of America, we salute your leadership and that of Senator Specter in holding this hearing today to begin to unravel a very complicated story. I ask that our statement be submitted for the record, as submitted, and I will try and cover a couple of points that highlight things.

It turns out to be a rather complicated story, and it really was almost like an investigation on our part. I must tell you that I was

sardonically amused last night when I first saw that press release about DoD expanding the investigation, and I just started to laugh and said, Is John Dean the head of this investigation? I mean, what investigation? The only investigating that has really been done into these exposures was done by you, Senator, and folks on the Hill and one small veterans service organization—actually, two.

I want to salute Senator Nelson for introducing the veteran's right to know law, and that will take us some direction toward a solution.

A little bit of chronology. Last fall, it came to our attention the whole deal about SHAD existing and that there being many more questions, and we thought when we first started looking into it that we had a small throw rug, and the more we pulled on the strand, the larger and larger the picture became.

Project 112, we kept saying to ourselves as we toiled on this, in addition to other duties, often until 9 or 10 in the office, that it had to be larger than just this one Navy project. And that is how we found out about Project 112. The most important thing about that press release that was issued last evening by DoD is for the first time they are acknowledging that Project 112 took place. Heretofore, they had not acknowledged that Project 112 took place.

A number of things were talked this morning about classification, and I just want to go into that, if I may, just to correct the record a little bit.

The muster rolls and the deck logs that contain all of the names of all of the people on all of the ships involved in all of the SHAD tests were, in fact, in the public domain, in the Archives. So was the accident reports of the ships involved also, in a different part of the National Archives. All of that was true until we started going over to the National Archives seeking this information, and suddenly 1 day they had it, and the next day it was sealed. In other words, this wasn't classified information. It was public information, had been so for 40 years, and only when we started to unravel that there may have been deliberate damage—or deliberate exposures, excuse me, done to American military personnel was it suddenly classified.

We would point out, sir, that all of the ships in the fleet involved in the SHAD test and, indeed, all of the classes of ships involved in the test are out of the fleet. They no longer exist. The only ones that exist, because there were some aircraft carriers involved, have either been mothballed or completely rebuilt keel up in the 1980's and the 1990's. Therefore, there can be from our point of view no national security consideration here, and that title has been used or that label has been used of national security to really engage in bureaucratic protectionism of the worst order. In other words, don't admit we ever made a mistake. We couldn't possibly have exposed our troops, inadvertently or in this case, many cases, we believe, deliberately, to all of these toxins.

I want to commend the cooperation that we have had throughout and the attitude of Secretary Principi and Admiral Cooper and Nora Egan, who is chief of staff to the Secretary, for their willingness to get at the bottom. While we would agree with you about VA, many people in VA being very dedicated to veterans, I will tell you, sir, that the institutional response at 810 Vermont Avenue

and within the higher levels of Veterans Benefits Administration was not what it should be, by any stretch of the imagination.

Beginning in October, in the fall of 2000, the request went over verbally, and then finally in January of 2001, a formal letter went from the Acting Secretary of Veterans Affairs to DoD's Secretary at that particular time. A response was made, although no letter was ever sent back to the Secretary of Veterans Affairs. But folks out of DoD did, in fact, call Dr. Mather. Dr. Mather said she didn't want the names, that that was really Veterans Benefits Administration work and, therefore, referred them over there. They were delivered, in fact, February 2001, to the Veterans Benefits Administration, the first 1,200 names. They didn't do anything with them. They put them in a drawer, and it wasn't until October when we started pressing that the Secretary's office found out that the names actually had already been furnished, the first batch, by DoD and nothing had been done with them. It took from October of 2001 until May of 2002 to reach out to these first 622 veterans.

We have since that time worked with Admiral Cooper, and they understand now how to use common search engines available on the Internet in order to locate most of these veterans very quickly and not wait for IRS, where you can shorten those months into just a couple of days before you can put those letters into the mail. Once again, we believe that the top political leadership at VA has, in fact, acted with alacrity and with a determination to say we don't know what is wrong but we are going to find out what is wrong and we are going to try and fix it. But that has not been true of the corporate cultures of VBA and VHA, the Veterans Health Administration and Veterans Benefits Administration, which needs to change in a dramatic way toward being proactive. Instead of deny, dissemble, and wait for an army to die or, in this case, wait for the Navy to die, it needs to be on a proactive basis of we don't know what is wrong but, by gosh, we are going to find out everything we can and move to provide Americans who serve their country in the U.S. military with the health care and with the benefits that they earned by virtue of that service, if, in fact, they were harmed by that service.

That is the attitude that we believe that we can expect from people who are GS-14's, 15's, and SES's, Senior Executive Service folks. But that is not what we got in this case. At every step of the way, we had to go to the chief of staff of the entire VA and with the weight of the Secretary's office to get key individuals in Environmental Hazards and Public Health to respond and move forward and for the senior people in VBA—and I am not including Admiral Cooper in that because he actually during much of this was not on board yet.

We should expect better from people whom we pay, in some cases, because of ways of getting around the cap, earn more than U.S. Senators.

Senator SPECTER. Mr. Weidman, we agree with you about that. We have your point.

Mr. WEIDMAN. OK. Thank you, sir.

The point is that much of this declassification investigation can proceed much more quickly, literally in a matter of weeks, if they made the determination to do it, because the muster rolls and the

deck logs, they know where they are. They pulled them out of the Archives. All they need to know is the names of the ships, and we believe that the names of the ships are much more readily available than they say. So it is only a matter of putting the manpower on it in a systematic way and turning the information over to VA. At the rate they proceeded so far—for the first 622, it took 19 months to do that. At this rate most people will be dead before we get to them.

In terms of the things that we would propose to do, we would be glad to work with the committee on those particular questions, and we have made some proposals directly, seven proposals to Secretary Principi's office, which they are considering now, including establishing a real registry. A real registry is one that is directly connected to the patient treatment records.

So I thank you very much, Mr. Chairman, and I know that I went over my 5 minutes and I apologize. It just does become a very complicated story. Many of the things said today were inadvertently, we believe, untrue by Mr. Winkenwerder, but he didn't know that.

[The prepared joint statement of Mr. Weidman follows:]

PREPARED JOINT STATEMENT OF RICHARD F. WEIDMAN, DIRECTOR OF GOVERNMENT RELATIONS AND LINDA SPOONSTER SCHWARTZ, CHAIR, VVA HEALTHCARE COMMITTEE, VIETNAM VETERANS OF AMERICA

Mr. Chairman, Ranking Member Specter, distinguished members of the committee, Vietnam Veterans of America (VVA) is very pleased to have the opportunity to share our views with you today on a topic that has been at the very core of VVA's mission from day one: investigating toxic exposures among America's veterans. On behalf of Tom Corey, VVA National President, and all of us in VVA, we thank and congratulate you and your colleagues for demonstrating strong leadership on these vital veterans issues.

First, let us briefly summarize the 60-year history of the Pentagon's use of American military personnel as human guinea pigs:

- Mustard gas testing on servicemembers during WW II
- Atomic testing on servicemembers during the early Cold War period
- LSD experiments on servicemembers during the 1960's
- Herbicide use and concomitant exposures among troops in Vietnam, Panama, and stateside
- Chemical exposures during and immediately after the Gulf War
- The use of investigation chemical/biological warfare drugs and biologics during the Gulf War
- The ongoing use of the controversial (and likely unsafe) anthrax vaccine

The most recent revelations about Project 112—the Pentagon's master chemical/biological warfare agent testing program from the 1960's—have only added to our sense of legitimate moral outrage over the permanent bureaucracy in the executive branch's cavalier approach to troop health and safety.

Two days after the attacks on the World Trade Center and the Pentagon, Department of Defense (DoD) officials invited representatives of the veterans service organization's (VSOs) to a briefing on what has since become known as Project Shipboard Hazard and Defense (SHAD). Rather than provide the VSO's with declassified documents, officials from what was once known as the Office of the Special Assistant for Gulf War Illnesses (OSAGWI) provided sanitized, derivative documents labeled "Fact Sheets" regarding three test series: AUTUMN GOLD, COPPERHEAD, and SHADY GROVE.

As VVA began doing our own research into this issue, we uncovered a number of important facts:

- SHAD was only part of a much larger testing initiative, known as Project 112. According to the U.S. Army's unclassified history of its biological warfare program, Project 112 was initiated by then-Secretary of Defense McNamara in September 1961 at a funding level of \$4 billion. When Pentagon officials originally briefed us on Project SHAD, we were told that as many as 113 tests may have been conducted. We have recently learned that Pentagon officials are now backing off of that figure,

claiming that 113 total Project 112 tests were planned but that SHAD only accounted for 34 of the tests.

- Testing activities were coordinated through a headquarters established at the Desert Test Center at Ft. Douglas Utah in 1962. The overall program was governed by National Security Action Memoranda 235, signed by President Kennedy on April 17, 1963. Testing allegedly began in 1962 and continued through at least early 1969.

- Our research indicates that Project 112 tests took place off the east and west coasts of the United States, in Alaska, and in Panama. VVA believes that additional test sites were used but because of the Pentagon's refusal thus far to declassify the records neither we nor the affected veterans have a full understanding of the true number and scope of the tests nor the potential health risks that may have resulted from their participation in Project 112 testing activities.

Without the original documentation before us, we are being asked to trust the Pentagon's good word about the scope, duration, and potential hazards associated with the tests. Based on the 60+ year history of the Pentagon's role in other such tests, we have good reason and ample precedent to believe that the "Fact Sheets" were and are an exercise in risk-minimization and public relations, and the odds are that said "Fact" sheets may not be a legitimate effort to come clean on the potential consequences of the tests. We have recently obtained a document that fully validates our concerns as to the lack of a corporate culture that promotes and rewards organizational integrity and veracity of OSAGWI and its activities.

"PRSA Bronze Anvil Entry," a partial copy of which is attached for your review, was (and probably remains) OSAGWI's media battle plan for minimizing the damaging impact of Gulf War illness-related exposure issues, and, now, Project 112. Let me quote a passage from the page of this document that I think showcases DoD's approach to military toxic exposure-related episodes:

Following the war, many veterans began to complain of health problems they associated with their service in the Gulf. They clamored for health care and answers, and the news media and some legislators picked up the battle cry. The President ordered a thorough review and finally, DoD conceded that America's finest might have been exposed to low levels of chemical warfare agent.

For five years, the DoD had denied the possibility of chemical warfare exposure during the Gulf War. With this new information in the news, the DoD faced charges of a cover-up and conspiracy. Finally, in late 1996, a special office was created and charged to "turn over every stone" and find out what was making Gulf War veterans sick.

The Gulf War lasted only 100 hours. The public relations battle is still on-going.

"Bronze Anvil Entry" is rife with such language, Mr. Chairman: talk about "tactics" and "strategy" for dealing with the media, the veterans, the Congress. By their own admission, the [Bronze Anvil Entry] "communications plan is the basis, guide, and baseline for almost everything the organization does, from investigating what happened in the Gulf War, to media relations and responding to veterans concerns."

In other words, everything OSAGWI has done has been guided not by a quest for the facts and the truth but by a media-driven PR-strategy designed to absolve the department of any and all responsibility for the illnesses reported by the veterans. Some might well maintain that this is a self-serving bureaucratic protectionism strategy that has absolutely nothing to do with either true national security concerns nor with the health and welfare of the many decent Americans serving in the Armed services at the time who may well have been affected.

What has this exercise apparently driven by public relations concern cost the American taxpayer? Over \$150 million since FY1996. For this amount of money, not one single peer reviewed scientific article has been produced, making all of the "materials" and so-called "case studies not worth the paper they are written on. The American tax payers have decidedly NOT gotten their money's worth from this exercise in appearing to do something.

What has it cost the veteran? Continued pain and suffering, compounded by a relentless less than forthcoming, forthright, and honest Pentagon spin-machine that has effectively obstructed genuine scientific inquiry and debate over Gulf War illnesses.

How effective was the OSAGWI "spin machine"? The document boasts that "Media relations have matured with national press calling to ask if controversial issues are 'news' before determining level of coverage."

Earlier this year, Secretary Rumsfeld said that the proposed Office of Strategic Influence had been abolished. In fact, it has been operating since 1996 and continues operating to this day. Once known as the Office of the Special Assistant for

Gulf War Illness, it now masquerades under the title of “Deployment Health Support Directorate.”

VVA believes that the permanent bureaucrats and seemingly permanent agents of contractors that staff this “Deployment Health Support Directorate” continue to deliberately mislead the Secretary and his office as to the truth about this operation, as it is in their immediate pecuniary interest to do so, and they appear to be unfettered by sense of duty and loyalty to the good American men and women who honorably served our Nation in military service who may have been harmed by this course of action/inaction.

In the near term, Congress can best serve ill veterans by striking the Deployment Health Support Directorate’s funding from the TRICARE Management Activity (where it is currently funded) and prohibiting the Pentagon from any further expenditures on this office, pending GAO’s examination of this office and its activities over the past several years. VVA believes that any such GAO investigation should be spearheaded by GAO’s Strategic Issues or Applied Research Methodologies divisions, which have very good track records in investigating DoD activities.

To restore the trust and confidence of the American people, and particularly American veterans in the federal government’s response to these kinds of exposure-related controversies, more sweeping changes will be required.

There are four common themes that run through nearly all of the historical examples I’ve enumerated thus far:

1. In nearly every case, servicemembers who were test subjects rarely if ever were informed of the potential health consequences of the exposures;

2. The tests were almost invariably deemed “secret” or a “national security issue” by the Pentagon bureaucracy, which routinely classified the tests and prohibited affected personnel from discussing the tests or seeking medical treatment for symptoms associated with exposures;

3. Medical record keeping and follow up of the affected personnel was nonexistent;

4. When evidence of a nexus between potential service-connected toxic exposures and subsequent illnesses veterans emerges, the Pentagon (and Department of Veterans Affairs) immediately seeks to denigrate or minimize any such connection.

At VVA, we have a phrase to describe this phenomenon: the disposable soldier syndrome.

In our view, the Pentagon has always viewed us—the soldiers, sailors, airman, Marines, Coast Guardsmen—as nothing more than disposable cogs in the giant military machine. In reality, we are the most critical component of the machine: the literal flesh-and-blood that gives this machine its ability to defend America, her citizens, and her interests. We will not be treated as one more consumable, disposable, National Stock Number item. We never did, and would hope the distinguished Senators on this Committee will disavow this latter day version of Robert McNamara’s “spare parts” theory of American military personnel.

Mr. Chairman, you and other distinguished colleagues in the Congress have begun to recognize the need for fundamental reform in this area. We applaud Representative Thompson and Senator Nelson for offering the “Veterans Right to Know Act of 2002,” which addresses the Project 112/Project SHAD controversy by charging GAO to thoroughly investigate and oversee the declassification and dissemination of the test records. The Congress must do much more, however, if we are to ensure that no such episodes occur in the future.

Because DoD and VA bureaucrats have politicized the medical research arena and monopolized control over research funding decisions, it is completely impossible for most non-federal researchers with unconventional or controversial theories about the origins of Gulf War illnesses to receive federal funding. Moreover, both DoD and VA have an inherent conflict of interest when it comes to investigating these kinds of issues.

Consider the following analogy. When the Bridgestone/Firestone “exploding tire” scandal erupted, the Congress did not tell the manufacturer, “We trust you: go investigate yourself, make recommendations for change, then implement those changes—you have our blessing!” Congress held hearings and monitored the National Highway Transportation Safety Administration’s investigation of Bridgestone/Firestone. The same model applies to airline crashes. Congress does not rely on the aircraft manufacturers crash report; it listens to the National Transportation Safety Board’s investigators, who are independent of both the manufacturer and the aviation industry as a whole. Congress set up this system to ensure that no conflict of interest would compromise safety investigations, a wise and sensible approach to transportation safety policy.

Yet for the last decade, the Congress has allowed the agency that most likely created the Gulf War illness problem (DoD), and the agency charged with paying for the problem (i.e., the VA, through health care and disability payments to sick vet-

erans), to both investigate Gulf War illnesses and their own role in responding to sick Desert Storm veterans. This is an obvious conflict of interest, one that has prolonged the suffering of the veterans, destroyed their trust in the federal government, and resulted in the waste of at least \$150 million over the past five years through OSAGWI, as the Defense Department has “investigated” its own response to Gulf War illnesses. It is also how the Pentagon and the Air Force have managed to spend over \$180 million on Agent Orange-related Ranch Hand research that has produced less than half-a-dozen peer-reviewed scientific papers over the last 15 years. Even those few peer reviewed articles were produced just recently under extreme pressure by the Congress to produce tangible scientifically valid results.

To end this conflict of interest and restore integrity to the process of investigating and treating veteran’s medical conditions, last year VVA called for the creation of a National Institute of Veterans Health (NIVH) within NIH. This notional NIVH would not only eliminate the conflict of interest problem outlined above, it would provide a vehicle for establishing a medical research corporate culture focused on veteran health care, in contrast to the current VA medical corporate culture of “health care that happens to be for veterans.”

VVA recognizes that the VA has established a reputation for providing advanced care for blinded veterans or those with severe ambulatory impairments. However, the VA has never truly developed a corporate culture focused on the diagnosis and treatment of the full range of environmental and occupational hazards that are unique to military service. This is especially true of the VA’s Research and Development Office, where the overwhelming majority of VA-funded research programs are geared towards medical problems found in the general population, not those specific to the veteran patient population or those with military service. Even though it is possible at virtually no additional cost to collect veteran specific variable information on all the studies funded through this section, the current leadership of VA Research & Development refuses to do so.

By establishing a new NIVH with veteran advocates serving on the peer-review panels that make research funding decisions, the Congress would be creating a research institute that would be truly focused on the unique medical needs of veterans. Locating the NIVH within NIH would ensure that the full medical resources of the federal government and private sector could be marshaled in a rational, veteran-friendly environment, free of the politicizing and conflict-ridden influences that have for more than 20 years precluded effective research into the unique environmental and occupational hazards that have impacted the health of American veterans.

One of the first lines of inquiry that should be pursued by this proposed entity is what we term “the in-country effect,” the idea that the totality of the military experience in a theater of operation has a cumulative effect on the health of the veteran. We believe that more than enough epidemiological research exists to show that both Vietnam and Gulf War veterans display higher rates of illness than their nondeployed counterparts. Researching the mechanisms that produce these higher morbidity rates among those who serve in theater should be a top research priority for the notional NIVH.

Additionally, this proposed NIVH must be supplemented by the creation of a Congressionally directed mandatory declassification review panel, whose purpose would be to screen (on both a historical and an ongoing basis) and declassify any operational or intelligence records for evidence of data that would have an impact on the health and welfare of American veterans. The need for such an entity—completely independent from the Pentagon and the U.S. intelligence community—is obvious.

Even today, thousands of pages of Gulf War-related records remain classified. In January 1998, the CIA admitted that its own internal review had identified over 1 million classified documents with potential relevance to Gulf War illnesses. Virtually no documents associated with the 1960’s era SHAD program have been declassified, and DoD has thus far rebuffed VVA’s FOIA requests that the documents be made public. Through the experience of the Kennedy Assassination Review Commission and the Nazi War Crimes Declassification Review panel, we have learned that such specialized declassification panels work well. If we are to be certain that all data that may effect the health of American veterans is to be available for the veterans and their physicians, the Congress must create such a standing declassification review panel immediately. Such a move would also help to restore trust and confidence among veterans in the federal government and its response to veteran’s health issues.

VVA believes that the VA should remain in the veteran health care business, but only if there is a dramatic change in the corporate culture of the Veterans Health Administration (VHA).

During his tenure as Undersecretary for Health, Dr. Thomas Garthwaite put forward a proposal known as the Veterans Health Initiative (VHI). The purpose of the VHI was to put veteran patient care at the core the VHA's corporate culture. As Dr. Garthwaite testified before Congress in April 2001,

The Veterans Health Initiative was established in September 1999 to recognize the connection between certain health effects and military service, prepare health care providers to better serve veteran patients, and to provide a data base for further study.

The components of the initiative will be a provider education program leading to certification in veterans' health; a comprehensive military history that will be coded in a registry and be available for education, outcomes analysis, and research; a database for any veteran to register his military history and to automatically receive updated and relevant information on issues of concern to him/her (only as requested); and a Web site where any veteran or health care provider can access the latest scientific evidence on the health effects of military service.

VVA's experience is that while some progress has been made in development of curricula by the Office of Public Health and Environmental Hazards, virtually no one at the service delivery level, or at the researcher level know that these exist. After three years, there is still not visible effort to train or enlighten staff at the hospital level or actually doing research of the importance of taking a complete military history and testing for various natural and man-made risk factors that a veteran may have been exposed to based on when, where, branch of service, and what the veteran actually did in the military. VVA maintains that this is what Veterans Health Care (and hence VA) should be all about, not just general health care that happens to be for veterans.

We note that to date, comprehensive clinical practice guidelines and continuing medical education courses in dealing with Gulf War illnesses have yet to be distributed throughout the VA medical system. The visualized cash awards for clinicians passing competency exams in veteran specific health issues has not materialized. We know from internal VA emails obtained via FOIA that senior officials in Public Health and Environmental Hazards resisted creating a registry for Vietnam era SHAD veterans. As many members of this committee may recall, there was tremendous resistance by VHA to the idea of creating a Gulf War registry in the early 1990's; it took an act of Congress to get that effort off the ground. Given this institutional resistance to identifying environmental hazards and their impact on the health of veterans from multiple eras, how can we trust these same office with no apparent change in corporate culture to implement Dr. Garthwaite's well-conceived vision for veterans' health care?

We have communicated these concerns to Secretary Principi, urging him to recognize that changing the existing VHA corporate culture immediately is imperative, and we look forward to working with him towards that end. VVA believes that this committee can play a key role in this process by offering comprehensive legislation to create NIVH and an affiliated declassification body. The VA's Gulf War Research Advisory Committee has already sent such a recommendation to Secretary Principi. VVA hopes the committee will use the Research Advisory Committee's recommendations as a blueprint for changing the way veterans exposure-related health issues are addressed.

Mr. Chairman, this concludes my written statement. On behalf of our national president, Tom Corey, please accept my thanks for allowing VVA the opportunity to share our views on this very important topic.

APPENDIX I: EXTRACT FROM OSAGWI'S "BRONZE ANVIL" COMMUNICATIONS PLAN

Summary

RESEARCH

At the time, the Gulf War appeared to be an overwhelming public relations success. The American public gave whole-hearted support to their military sons and daughters, sending them off to fight the world's largest army. The media provided minute-by-minute coverage from the good-by kisses through the daily military victories to the tearful reunions. Cheering crowds across the nation lined graffiti-filled streets to honor the returning victor.

Following the war, many veterans began to complain of health problems they associated with their service in the Gulf. They clamored for health care and answers, and the news media and some legislators picked up the battle cry. The President

ordered a thorough review and finally, DoD conceded that America's finest might have been exposed to low levels of chemical warfare agent.

For five years, the DoD had denied the possibility of chemical warfare exposure during the Gulf War. With this new information in the news, the DoD faced charges of cover-up and conspiracy. Finally, in late 1996, a special office was created and charged to "turn over every stone" and find out what was making Gulf War veterans sick.

The Gulf War lasted only 100 hours. The public relations battle is still on-going. One of the first actions of the Office of the Special Assistant for Gulf War Illnesses (OSAGWI) was to review the backlog of incoming correspondence and identify the concerns and interests of veterans. Meetings with representatives of 60 national veterans groups (VSOs) were conducted, and congressional interest identified. Goals, objectives, strategies, tactics and messages were formulated. Letters, emails, and telephone contact were all targeted to specific audiences including veterans, veterans' groups, Congress, and other government agencies. Monthly updates for VSOs allowed them to pass information to their millions of members while town hall meetings across the nation provided one-on-one interchange with veterans. An interactive Internet site was created (GulfLINK, TAB X) receiving up to 60,000 "hits" a week. Audience analysis indicated that many might not have access to the Internet, so a newsletter (GulfNEWS, TAB X) was developed. By March 1997, most of the national press and veterans' groups appeared satisfied that the DoD was on the right track and many thought the issue was dead. However, the public relations professionals were not so sanguine.

Based on the textbook model of "lifecycle states of issues." (Tab X), the team projected that there was potential for a second wave of high concern and high interest. Additionally, there was also a strong possibility that the DoD was actually facing two lifecycles—one in the Washington D.C. area, and a second, later one, in "Middle America." (TAB X) The team also analyzed current goals and objectives; strategies and tactics; media coverage; veterans' correspondence; and message delivery and acceptance. Media analysis indicated decreasing interest by national and military press; however, a few influential media continued their negative coverage, which was repeated in regional and local press on a regular basis (Tab X). A few vocal legislators continued to challenge the DoD's commitment to Gulf War veterans. Incoming emails, letters, and telephone calls from veterans, analyzed for content and tone, indicated a shift toward an increase in level of trust and a greater desire for information. Interviews with veterans' service groups indicated similar shifts in interest, focusing more on applying lessons learned from the Gulf War to future operations. Informal surveys indicated that service members still in uniform have a vested interest in the DoD's efforts and the eventual outcome. Conversely, activist groups had formed and were becoming very active.

Research confirmed that the crisis had not been resolved. While some veterans still accused the DoD of cover-up and conspiracy, many simply didn't know what to think—they provided fertile ground for activists.

PLANNING

Following this analysis, the communication plan was updated with two new objectives while strategies and tactics were greatly expanded and energized for a proactive and synergistic effort (TAB X).

New objectives featured DoD's commitment to the health and welfare of Gulf War veterans as well as current and future service members and veterans (TAB X). Target audiences were expanded to include all active duty, Guard, and Reserve and their family members; health care providers in the DoD; plus veterans and community members living and working near military installations. The overall strategy was to create "message redundancy" through personal and second party contact. Military members would become "ambassadors in uniform," influencing other audiences such as neighbors, peers, and extended family members.

The outreach was expanded to target military installations and more conferences, conventions, and seminars. Town halls at each installation would still target veterans and their families, while briefings would reach the new audiences. Briefers were selected and trained for specific venues and audiences. Manned displays were developed for high traffic locations and local media heavily marketed to provide radio, TV, and newspaper coverage. Presentations, brochures, displays, and visual aids were targeted to widely varied audiences, incorporating of risk communication techniques. The brochure was sized to fit in uniform pockets and a pocket added to the tri-fold.

With no dedicated public affairs budget, all research, graphic design, product production and planning was done with the existing staff. The budget for printing had to be greatly increased as well as travel since a large team now goes on each trip.

EXECUTION

The communication plan is the basis, guide and baseline for almost everything the organization does, from investigating what happened in the Gulf War, to media relations and responding to veterans concerns.

INVESTIGATIONS. All investigations of the Gulf War are based on veterans' expressed concerns. Veterans are personally interviewed and their comments incorporated into comprehensive reports, which are then posted on the interactive Internet site, GulfLINK with a request for comment from any reader (TAB X). Many Veterans are personally notified, provided copies, and asked for feedback (TAB X). Fact sheets, news stories, press releases (TAB X) and often a press conference accompany every new report when it is published. Veterans' service organizations (VSOs) are hosted each month for a roundtable discussion on releases, updates, or to discuss other issues and concerns. To date, more than 25 narratives, reports, and information papers have been released (TAB X).

MEDIA. From the beginning, OSAGWI has had a proactive media approach. More than 150 news releases have gone to hundreds of national and local media via the DoD and OSAGWI Internet sites, list servers, and multi-fax/email (TAB X). Press conferences are held regularly. Thousands of media queries receive timely and comprehensive response (TAB X) by public affairs professionals while CBS, MSNBC, ABC, CNN, 60 Minutes, BBC, NPR, Washington Post, etc. interview experts on controversial issues. Extensive media training precedes all interviews and Q&As are prepared for every release and emerging issue. Media relations have matured with national press calling to ask if controversial issues are "news" before determining level of coverage. Currently, approximately 300 local media around the nation are individually marketed resulting in extensive coverage of OSAGWI's outreach efforts. Trade and specialty media are also heavily marketed (TAB X).

PUBLIC COMMUNICATION. OSAGWI is a unique government organization—providing one-on-one interaction via an 800 number 16 hours a day, and more than 200,000 personal responses via emails and letters (TAB X). Q&As for every issue and concern ensure all interactions with veterans provide consistent and correct information.

We work closely with the VA, and other government agencies to provide answers to all veterans' concerns.

GULFNEWS/GULFLINK. All products are posted on GulfLINK and veterans notified about new postings. Nearly 25,000 veterans subscribe to GulfNEWS, a bi-monthly newsletter containing highlights of GulfLINK.

OUTREACH. Most members of the organization participate in the national outreach—whether going to military installations for weeklong visits, or participating in conferences, conventions, or seminars. All receive training on communicating with veterans, family members, or the news media. All are prepared to discuss individual issues while many are trained as briefer for specific audiences. Media are also heavily marketed any time we participate in an event—medical media at medical conventions, local media at base visits, and others whenever possible. Local VA representatives and VSOs actively participate in base visits designed specifically for each unique audience.

PRODUCTS AND DISTRIBUTION. Brochures (TAB X) provide answers to frequently asked questions while the tri-fold is more generic, but contains a pocket to hold a postcard, newsletter, and GulfLINK information (TAB X). Five display panels can be grouped for maximum effect or stand-alone for greater distribution (TAB X). Briefings are tailored for individual audiences and briefer selected for credibility with audience (TAB X). An annual report targets Congress (TAB X). Approximately 5,000 brochures, tri-folds, maps, fact sheets, etc. are individually distributed at each base visit. Additionally, these same products are regularly distributed around the nation to base libraries, clinics, and family support centers; VA clinics and hospitals; veterans' support groups such as VFW chapters; regional veterans' service centers; and even state libraries.

EVALUATION

The Department of Defense and its subordinate units are not funded to conduct formal research in the form of scientific surveys. However, regular analysis of media coverage, correspondence, activist groups' issues, and individual veterans' feedback, can provide insightful information to evaluate the success of public affairs programs.

Evaluation of programs is almost a weekly process. Analysis of correspondence tone and content, media coverage, activist issues, VSO concerns, and informal surveys result in minor modifications of tactics on a constant basis. Focus groups held at four installations helped reshape the products while risk communication professionals also provided their expertise on both products and processes. After each outreach, team members participate in an extensive evaluation of presentations; product and display design and distribution; and audience response. Although the erosion of DoD credibility cannot be rebuilt quickly, analysis indicates that we're on the right track.

Chairman ROCKEFELLER. Dr. Cole, one of the problems with Project SHAD and with the use of many investigational new drugs during the Gulf War has been the niceties of distinguishing ethically between test subjects who have given consent to participate in an experiment and between participants for whom notification is implied rather than secured. Based on your studies of other tests, would you presume that the participants in Project SHAD received sufficient notifications of the hazards of the tests in which they participated? Is the military doing a better job with that now, 10 years after the Gulf War?

Mr. COLE. That is a good question, and the answer is difficult to give. It can't be black and white based on the information we have about SHAD.

What I do see, having looked at the SHAD reports, the fact sheets that were issued by the Department of Defense, is a differentiation they make between what they describe as test subjects as opposed to test conductors.

There is a certain, I think, lack of fairness and realism when you try to differentiate what rights a person should have in terms of informed consent if he or she is designated a tester rather than a subject. So just by changing the category, you are still not changing the fact that the tester is a participant. And if he is in the area of a potentially toxic or lethal material, as part of an experiment, I would think that he deserves the same kind of respect concerning informed consent as a human subject.

Senator SPECTER. Mr. Chairman, might I ask one question here? Because I am going to have to excuse myself in a few minutes.

On this issue the line between a test subject and a test conductor is so vague, if there is exposure, that ought to be the determinant. Does the Department of Defense now have ironclad regulations which require written informed consent if there is exposure?

Mr. COLE. I do not know; when you use the word "ironclad," I do not know. I know that it has been official military policy since 1953 by way of a memorandum which I cite in my written testimony that the Department of Defense is obligated, as is the rest of this country, to respect the Nuremberg code. That code was the outcome of the 1947 trial of Nazi doctors who did horrible experiments on humans during World War II. The Nuremberg code is a 10-item statement. Its sum and substance is that nobody should be participating or permitted to be participating as a human subject in research without being informed of what he or she is getting into. He should have the opportunity to disqualify himself or excuse himself from being a research subject. This is simply summed up in the two words "informed consent."

Senator SPECTER. Well, Mr. Chairman, my suggestion is that we make that inquiry at the staff level, and I don't think we ought to

rely on the Nuremberg code as an enforcement mechanism with the Department of Defense. That is less satisfactory than the International Criminal Court. So this is something which is just baseline fundamental, and in a civil court, without the immunity and protection of the Federal Tort Claims Act, if there isn't informed consent, it is just a major error and imposition on people who are subjected to these sorts of tests. So we will pursue that.

Mr. COLE. May I quickly say something about this? I am aware of tests that did take place in which volunteers were given information and then consented to be experimental subjects under the military experimental program. So this has certainly taken place in some instances.

Ms. SCHWARTZ. Mr. Chairman, if I might, in my research of looking at the Ranch Hand data that the Air Force had, it was—they do have actually an informed consent. The difficulty is it is so broad it would never pass the inspection of any internal review board that we have today. And so if you do embark on this investigation, I suggest that you look at the criteria that is required for any tests or experiments of research funded by the U.S. Government and compare it with some of the informed consents that military members are given.

Senator SPECTER. Thank you very much.

Thank you, Mr. Chairman.

Chairman ROCKEFELLER. Thank you, Senator Specter.

We have not called upon Steve Smithson yet, and you are giving testimony, and I apologize to you.

**STATEMENT OF STEVEN R. SMITHSON, ASSISTANT DIRECTOR,
NATIONAL VETERANS AFFAIRS AND REHABILITATION COM-
MISSION, THE AMERICAN LEGION**

Mr. SMITHSON. Good morning, Mr. Chairman and members of the committee. The American Legion appreciates the opportunity to provide testimony this morning regarding the strategies being pursued by the Departments of Defense and Veterans Affairs to provide appropriate care and support to veterans who may have been exposed to environmental hazards during their military service. As U.S. troops are currently deployed overseas fighting the war on terrorism, this topic becomes even more relevant.

While military service is inherently dangerous and certain risks are to be expected, the Government is obligated to provide proper health care and compensation to those who sustain chronic disabilities as a result of such service. While VA is charged with caring for military members once they leave active duty, its mission is tied directly to information and support received from Department of Defense. Herein lies a fundamental problem. DoD's primary mission is to fight wars and maintain national security. Caring for troops wounded or otherwise injured in the advancement of this mission has often been seen as secondary to its ultimate mission. However, without adequate communication, cooperation, and open sharing of information between these two entities, VA's ability to successfully serve our Nation's veterans is severely compromised.

Prior to the Gulf War deployment, troops were not systematically given comprehensive pre-deployment health screenings, nor were they properly briefed on the potential hazards, such as fallout from

depleted uranium munitions, that they might encounter on the battlefield or in the theater. Additionally, the recordkeeping was very poor. Numerous examples of lost or destroyed medical records of active duty and reserve personnel have been identified. Vaccines were not administered in a consistent manner, and vaccination records were often unclear or incomplete. Moreover, personnel were not provided information concerning vaccines or prescribed medications. Some medications were distributed with little or no documentation or dosage instructions, to include possible side effects or instructions to immediately report unexpected side effects to medical personnel. Physical evaluations, both pre- and post-deployment, were not comprehensive, and information regarding troop movements and locations and possible environmental hazard exposures was severely lacking. This lack of such baseline data and other information is commonly recognized as a major limitation in the evaluation and understanding of potential causes of the multi-symptom illnesses reported by many Gulf War veterans following the war. Unless the failures in the system just cited are corrected, we are doomed to repeat this pattern in the current war on terrorism as well as other future deployments.

To avoid the problems just mentioned, the lessons learned from the Gulf War have precipitated the passage of laws and policies designed to create a concept of force health protection. For example, Section 765 of Public Law 105-85 directed DoD to take specific actions to provide medical tracking for personnel deployed overseas in contingency or combat operations, outlining a policy for pre- and post-deployment health assessments and blood samples. The conduct of thorough pre- and post-deployment examinations, including the drawing of blood samples, was specifically identified in the law. Such action is crucial for the accurate recording of a service member's health prior to the deployment and in documenting any changes in their health during deployment. Moreover, this is exactly the information that is needed by VA to adequately care for and compensate service members for service-related disabilities once they leave active duty.

On the surface the concept of force health protection and related policies appear to have addressed the major problems of the past. However, in reality, as it was learned from recent Institute of Medicine and General Accounting Office reports on the subject as well as in testimony earlier this year before the House Veterans' Affairs Subcommittee on Health, the aforementioned force health protection policies are not being fully implemented, a major breakdown being at the field level. The organizational mechanisms tasked with ensuring implementation of these policies from the command level down to the operational unit are obviously not working. Again, this lack of urgency and compliance with the law appears to be related to DoD's corporate philosophy and culture and directly impacts its ranking of priorities. Unfortunately, the service member and veteran ultimately pay the price for this inaction.

Title 38 of the United States Code places the burden of proof in establishing a service-connected disability on the veteran and establishing service connection directly impacts the veteran's ability to access VA health care. Without adequate DoD health surveillance and documentation of troop locations, environmental hazards,

and other exposures, and timely sharing of this information with VA, this burden is virtually impossible for the veteran to meet. If relevant health and environmental exposure information is incomplete or does not even exist due to previously discussed breakdowns in the system, discussions on how VA and DoD can better share this information is moot. The American Legion believes a total commitment from all levels of the Department of Defense, especially the Secretary's office, as well as strong congressional oversight, are needed to ensure that such policies are actually implemented in a timely and consistent manner.

One other major obstacle that prevents sharing of relevant exposure information has to do with classification issues. In the case of Project SHAD, the mere existence of a potentially hazardous activity, not to mention possible exposure and personnel participation information, was not known for many years afterwards because of national security and classification issues. National security is a legitimate concern, but veterans should not have to suffer undue hardship when national security is used unnecessarily as a justification to withhold information that is necessary for all veterans to pursue health care and compensation from VA. An oversight working group on biological and chemical testing as set forth in the proposed Veterans Right-to-Know Act of 2002 could prove to be an invaluable tool in overseeing the identification and declassification of such tests.

The American Legion also believes that a sincere desire in information sharing and mutual cooperation at the highest level of DoD and VA is needed. A June 2002 letter from the Secretary of Veterans Affairs to the Secretary of Defense, expressing the importance of VA-DoD cooperation in quickly declassifying and releasing additional information regarding SHAD is a good example of such a desire. Such action at this level needs to continue if we are to satisfactorily resolve the hurdles associated with the dissemination of SHAD-related information as well as to avoid such problems in the future.

Mr. Chairman, that completes my testimony. I will be happy to answer any questions you or members of the committee may have. [The prepared statement of Mr. Smithson follows:]

PREPARED STATEMENT OF STEVEN R. SMITHSON, ASSISTANT DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. Chairman and Members of the Committee:

The American Legion appreciates the opportunity to provide testimony regarding the strategies being pursued by the Departments of Defense (DoD) and Veterans Affairs (VA) to provide appropriate care and support to veterans who may have been exposed to environmental hazards during their military service. As U.S. troops are currently deployed overseas fighting the war on terrorism, this topic becomes even more relevant.

While military service is inherently dangerous and certain risks are to be expected, the government is obligated to provide proper health care and compensation to those who sustain chronic disabilities as a result of such service. While VA is charged with caring for military members once they leave active duty, its mission is tied directly to information and support received from DoD. Herein lies a fundamental problem. DoD's primary mission is to fight wars and maintain national security. Caring for troops wounded or otherwise injured in the advancement of this mission has often been seen as secondary to its ultimate mission. However, without adequate cooperation, communication and open sharing of information between these two entities, VA's ability to successfully serve our nation's veterans is severely compromised.

History is ripe with examples of DoD's failure to be forthcoming with timely and accurate information pertaining to toxic exposures such as Agent Orange in Vietnam, radiation exposure from Cold War nuclear detonation testing as well as biological and chemical warfare defense testing, known as Operation Shipboard Hazard and Defense (SHAD), in the 1960s. These are just a few examples of where crucial exposure information was unnecessarily withheld or classified, resulting in additional hardship and suffering for those exposed. Unfortunately, the Gulf War was no different. It took over five years for the Pentagon to publicly admit that U.S. troops were exposed to low levels of nerve agent following the destruction of an Iraqi munitions storage facility—Khamisiyah—in Southern Iraq in March 1991. Recent disclosures by DoD officials regarding Khamisiyah exposure modeling efforts raises serious doubts as to the accuracy of such modeling, bringing into question the actual number of U.S. troops exposed and the level of exposure.

Hints of a possible repeat of this pattern recently surfaced in the war on terrorism with reports that U.S. troops stationed at a former Soviet air base in Uzbekistan may have been exposed to chemical agents that had seeped from old weapons caches stored by the former Soviet Union. Such news, initially reported in early June, was later rebuffed by military officials as a false alarm.

Exposure information pertaining to Project SHAD, a series of experiments designed to test the vulnerability of American war ships to chemical and biological warfare attacks, is slowly being declassified. To date twelve out of a possible 113 tests have been declassified and participants' names provided to VA, resulting in the initial notification this past May of only 622 veterans. In order to ensure that all information relevant to the health and well being of those involved in the SHAD tests is provided to VA in an expeditious manner and all identified participants are notified of the possible health consequences, H.R. 5060 and S. 2704, the Veterans Right-To-Know Act of 2002, was recently introduced. The American Legion fully supports this legislation that specifically addresses the tests associated with Project SHAD and calls for the identification of all DoD tests involving chemical or biological weapons in which military personnel may have been exposed to actual or simulated agents with or without their knowledge or consent. We also note that S. 2514, the Defense Appropriations Bill for Fiscal Year 2003 was recently amended to include a provision addressing the SHAD issue.

In other instances procedural breakdowns, such as improper record keeping, has been the culprit. A perfect example is the poor documentation of possible exposures during the 1991 Gulf War. Prior to the Gulf War deployment, troops were not systematically given comprehensive pre-deployment health screenings, nor were they properly briefed on the potential hazards, such as fall out from depleted uranium munitions, that they might encounter on the battlefield or in the theater. Additionally, as referenced above, record keeping was very poor. Numerous examples of lost or destroyed medical records of active duty and reserve personnel have been identified. Vaccines were not administered in a consistent manner and vaccination records were often unclear or incomplete. Moreover, personnel were not provided information concerning vaccines or prescribed medications. Some medications were distributed with little or no documentation or dosage instructions, to include possible side effects or instructions to immediately report unsuspected side effects to medical personnel. Physical evaluations—pre and post deployment—were not comprehensive and information regarding troop movements/locations and possible environmental hazard exposures was severely lacking. The lack of such baseline data and other information is commonly recognized as a major limitation in the evaluation and understanding of potential causes of the multi-symptom illnesses reported by many Gulf War veterans following the war. Unless the failures in the system cited above are corrected, we are doomed to repeat this pattern in the current war on terrorism as well as other future deployments.

As briefly outlined above, there are numerous obstacles that impede DoD's sharing of relevant information on potentially hazardous exposures with veterans and VA. One major obstruction is that DoD's primary mission, as previously discussed, is inherently at odds with VA's role of providing health care and compensation to veterans. It is not so much that DoD intentionally puts up roadblocks to prevent veterans from being properly served by VA, but rather the fact that this is not a DoD priority. To avoid the procedural problems encountered both during and after the Gulf War, as discussed above, "lessons learned" from the Gulf War, have precipitated the passage of laws and policies designed to create a concept of Force Health Protection. For example, Section 765 of PL 105-85 directed DoD to take specific actions to improve medical tracking for personnel deployed overseas in contingency or combat operations, outlining a policy for pre and post deployment health assessments and blood samples. The conduct of a thorough examination (pre and post deployment), including the drawing of blood samples was specifically identified in the

law. Such action is crucial for the accurate recording of a service member's health prior to deployment and in documenting any changes in their health during deployment. Moreover, this is exactly the information that is needed by VA to adequately care for and compensate service members for service-related disabilities once they leave active duty.

On the surface the concept of Force Health Protection and related policies appear to have addressed the major problems of the past. However, in reality, as was learned from recent Institute of Medicine (IOM) and General Accounting Office (GAO) Reports on the subject as well as in testimony earlier this year before the House Veterans Affairs Subcommittee on Health, the aforementioned Force Health Protection policies are not being consistently implemented. The organizational mechanisms tasked with ensuring implementation of these policies from the command level down to the operational unit are obviously not working. Again, this lack of urgency and compliance with the law appears to be related to DoD's corporate philosophy/culture and directly impacts its ranking of priorities. Unfortunately, the service member and veteran ultimately pay the price for this inaction.

Title 38 United States Code places the burden of proof in establishing a service-connected disability on the veteran and establishing service connection directly impacts the veteran's ability to access VA health care. Without adequate DoD health surveillance and documentation of environmental hazards and other exposures, and timely sharing of this information with VA, this burden is virtually impossible for the veteran to meet. If relevant health and environmental exposure information is incomplete or does not even exist due to previously discussed breakdowns in the system, discussions on how VA and DoD can better share this information is moot. The American Legion believes a total commitment from all levels of DoD, as well as strong congressional oversight, are needed to ensure that such policies are actually implemented in a timely and consistent manner.

One other major obstacle is the delay in relevant exposure information due to classification issues. In the case of Project SHAD, the mere existence of a potentially hazardous activity, not to mention possible exposure and personnel participation information, was not known for many years afterward because of national security and classification issues. National security is a legitimate concern, but veterans should not have to suffer undue hardship when national security is used unnecessarily as a justification to withhold information that is necessary for a veteran to pursue health care and compensation from VA. An oversight working group on biological and chemical testing as set forth in the proposed "Veterans Right-To-Know Act of 2002" could prove to be an invaluable tool in overseeing the identification and declassification of such tests.

The American Legion also believes that a sincere desire in information sharing and mutual cooperation at the highest level of DoD and VA is needed. A June 2002 letter from the Secretary of Veterans Affairs to the Secretary of Defense, expressing the importance of "VA-DoD cooperation" in quickly declassifying and releasing additional information regarding SHAD, is a good example of such a desire. Such action at this level needs to continue if we are to satisfactorily resolve the hurdles associated with dissemination of SHAD-related information as well as avoid such problems in the future.

Mr. Chairman, that completes my testimony. I will be happy to answer any questions you or members of the committee may have at this time.

Chairman ROCKEFELLER. Thank you, and your testimony was already previously included in the record.

Mr. SMITHSON. Yes, sir.

Chairman ROCKEFELLER. Dr. Cole, you have testimony, and I don't want to keep you from your testimony. And I am really grateful that you are here. We have looked at the Persian Gulf War legacy together, and the business of informed consent for unapproved drugs, and the discipline within the military to make sure that it is written at best, verbal if less than best. What are the rules? Two questions. One is: The law actually, I think, says you have got to sign your name, the soldier has to sign his name. I don't think verbal is enough. I think the soldier has to sign his name. But I am not sure of that because I am not a lawyer.

Second, if you had to—and I am projecting this forward to the Gulf War from SHAD—if you had to estimate the number of mili-

tary who were subject to taking PB, who were told about it, who had to give their informed consent on a daily basis, so to speak, what would that number be? Would it be above 20 percent?

**STATEMENT OF LEONARD COLE, PH.D., DEPARTMENT OF
POLITICAL SCIENCE, RUTGERS UNIVERSITY, NEWARK, NJ**

Mr. COLE. Well, something like 250,000, as far as we know, but that is just an approximation, because as far as I am concerned personally, a lot of what happened can be excused because of, I think, the fear, the worry, the legitimate anxiety that our troops might have been exposed to sarin or, in the case of the anthrax vaccine which was administered, because we were worried about anthrax during the 1991 Gulf War. What I think is unforgivable is that we don't have the records to indicate who got the doses, when, how many of them received it, so now we can't go back and follow their medical history.

Chairman ROCKEFELLER. Isn't that because they didn't actually go collect them? That is what I am trying to get at.

Mr. COLE. Well, I don't know what the reasons were. There was disorganization. There was an unwillingness to do the kind of follow-through that would have—

Chairman ROCKEFELLER. But the military has different sections. They have people who supply the warfighting weapons. They have people who would deploy. They have people who look at radar. They have people who worry about health care. So that the confusion argument has always been sort of a dodge to me. I mean, you have people in the military and DoD, whose only responsibility is health care. They don't make decisions about whether you launch an aircraft to go do something. The only decisions they make are on the health care aspects of what the DoD is doing, are they being carried out properly?

And so unless they are vastly understaffed or if they are ignored when they try to do the right thing, which is always possible, I don't understand it. Am I right, though, that the verbal consent isn't enough, it has got to be written?

Mr. COLE. OK. We have to—

Chairman ROCKEFELLER. Or is that a bureaucratic distinction even if it is legally correct?

Mr. COLE. Well, I think beyond bureaucracy, beyond—it enters into the realm of legality and ethics. Any human subject research where a person is going to be experimented on is the issue. If an experimental drug is not necessarily for his own benefit, as would not be the case with piridostigmine bromide or the anthrax vaccines, but, rather, just simply to see what the effects of a potential agent would be, a person not only must give consent, but must do it in writing after being appropriately informed. Such experimentation on human subjects goes on now in the military.

On the other hand, when you are in a battlefield situation and the troops are imminently threatened, I don't know that there is a requirement for anybody to sign his name and say, "I will take this kind of medication or drug." I just don't know the answer to that.

Chairman ROCKEFELLER. Well, then, what are the implications for the future? I mean, it is one thing to look back at SHAD and

to decry the walking away from all of that. But now we are talking about a whole different kind of warfighting where people are not in large clusters, where they are, you know, in the jungles of the Philippines or Indonesia or they are either tree-covered or they are not tree-covered, or they are 14,000 feet in the air and there are 5 or 6 of them or 8 or 10 of them or 2 or 3 of them, and there certainly isn't going to be a medical officer going around getting informed consent should such a kind of thing be required.

So, I mean, if you take the new type of war into account—you know, al Qaeda is in 70 countries plus all the other terrorist groups, including the ones we have in our own country—what do you see all of this leading to? Because biological and chemical weapons are now on the table. You don't have a discussion about anything without talking about them. It was kind of the surprise back—well, it wasn't a surprise, but it was new back in the Gulf War. Now it is expected.

Mr. COLE. Well, the kind of conversation that you want to have now and that you started having in the 1990's is already a national conversation when you talk about vaccines—smallpox vaccine, anthrax vaccine. Never mind just the military. We are talking about whether every citizen in the United States should receive a smallpox vaccination. That is still under debate. Now there has been a decision that something like 500,000 people ought to get it, those people who would most likely be the first responders in case there is an attack.

We are dealing with really a tough issue. I don't mean to move the locus of discussion from just the Veterans' Affairs Committee concerns to the Nation at large, but the reality is the questions that you are raising have national implications for all citizens, not just for veterans or not just people facing military situations next week or next month. I don't know that there is a good answer, but I do believe that there are good people working on, let's say, the least of the bad answers.

In summary, I think you can take the smallpox vaccination as a model, or piridostigmine bromide, or anthrax, for a whole range of questions. How many people are we likely to save as a consequence of this policy as opposed to how many we are likely to injure or even kill as a consequence of the policy? We don't have the numbers clearly down yet, but it is risk versus benefit.

Chairman ROCKEFELLER. In a sense, what you are saying—and I think I will close with this, with the exception if any of you have anything more that you want to say, which I would welcome. It is a little bit like all of the American people are potentially veterans, so to speak. And we are not just talking about Iraq, we are not talking about other parts of the world. We are talking about this country. So then the whole question of what are we doing to beef up our public health system, the number of vaccines, informed consent for Americans who, you know, aren't at war, who are bringing up children, working, or whatever it is. They have their agendas, and they are also facing a form of danger which is very much up on them. So it suddenly is a different kind of question, isn't it? It is not the warfighters overseas but the American people at home, and all of the ethical and legal questions begin to sort of overlap, don't they?

Mr. COLE. Yes, I have a personal answer, if I may, for what I would say would be appropriate. I don't know that it is necessarily the correct national policy, but I believe that everybody should have the opportunity to take or refuse a smallpox vaccination or an anthrax vaccination, after being given the full panoply of the potential risks and benefits, unless the person is, obviously, not mentally competent or a juvenile. That is what we are about. We are a democracy. Informed consent is more than just about experiments. It is about how we should be living in a democracy.

[The prepared statement of Mr. Cole follows:]

PREPARED STATEMENT OF LEONARD A. COLE, PH.D., ADJUNCT PROFESSOR,
DEPARTMENT OF POLITICAL SCIENCE, RUTGERS UNIVERSITY, NEWARK, NJ

Thank you for inviting me to comment on the ethics of conducting open air testing with biological and chemical warfare agents. Ever since 1976, when the public first learned that the U.S. Army had conducted germ warfare tests over populated areas, new information about such testing has continued to surface. Most recently, in May 2002, the Department of Defense released information about a series of tests undertaken in the 1960s under "Project Shipboard Hazard and Defense," or SHAD. These tests were part of a joint service program to assess the vulnerability of U.S. warships to a chemical or biological warfare attack. Unlike other outdoor biological and chemical warfare tests, these experiments may have deliberately exposed people to actual biological and chemical weapons without their informed consent.

For a 20-year period, from 1949 to 1969, the Army conducted hundreds of mock germ warfare attacks by releasing bacteria and chemicals over populated areas—from San Francisco to New York, from Minneapolis to Corpus Christie, Texas. The test agents, which the army calls simulants, were intended to mimic more lethal bacteria and chemicals that would be used as weapons. The purpose was to see how the bacteria and chemicals spread while people went about their normal activities.

The Army contends that none of the exposed population was at risk because the agents were harmless. Furthermore, it did not consider those people to be human subjects with the right of informed consent, but rather people who just happened to be in the area. Belatedly, the Army recognized that some of the bacteria and chemicals, including *Serratia marcescens* and zinc cadmium sulfide, posed health risks. In consequence, by the late 1960s, those agents were no longer being used as simulants. [Leonard A. Cole, *Clouds of Secrecy: The Army's Germ Warfare Tests Over Populated Areas* (Lanham, MD: Rowman and Littlefield, 1990).]

In other tests, the Army targeted individuals with actual warfare agents, such as the microorganism *Coxiella burnetii*, the cause of Q fever. In these instances, the targeted people were volunteers who were treated as human subjects. They were given information in advance about the tests, and were assured of quick medical treatment if they became ill. [Leonard A. Cole, *The Eleventh Plague: The Politics of Biological and Chemical Warfare* (New York: W.H. Freeman, 1998).]

Recent reports about SHAD suggest that, unlike in these other tests, people were deliberately exposed not only to simulants, but to bio/chem weapons, and that the exposed people were not treated as human subjects. This is evident, for example, in material released by the DoD about a SHAD test called "Shady Grove."

The report indicates that *Coxiella burnetii*, as well as simulants, were sprayed at ships in open Pacific waters. The report also says:

The crews who participated in Shady Grove were not test subjects, but test conductors. Participants should have been fully informed of the details of each test. . . . Under actual test conditions, test conductors should have worn appropriate nuclear, biological, and chemical (NBC) protective equipment and should have taken extensive safety precautions to prevent any adverse health effects from the testing. [Fact Sheet, Office of the Special Assistant to the Undersecretary of Defense (Personnel and Readiness) for Gulf War illnesses, Medical Readiness and Military Deployments. Provided at the request of the Department of Veterans' Affairs. N.d., circa May 2002.]

No reference is made to the participants' right of informed consent, apparently because the crews were not considered to be "test subjects," but "test conductors." Moreover, the statement is not clear that crew members received appropriate information about risks and protection, only that they "should" have received such information.

In SHAD tests titled "Flower Drum, Phase II" and "Fearless Johnny," VX nerve agent was sprayed at ships to assess the resulting contamination and the effective-

ness of decontamination efforts. The DoD's fact sheet indicates that VX is "one of the most toxic substances ever synthesized," and that it is able to kill "within 10–15 minutes after absorption of a fatal dose." But the fact sheet does not say whether crews were properly protected from the agent. Nor is it clear that anyone involved with the decontamination was informed about the nature of VX. [Fact Sheets, Office of the Special Assistant to the Undersecretary of Defense (Personnel and Readiness) for Gulf War illnesses, Medical Readiness and Military Deployments. Provided at the request of the Department of Veterans' Affairs. N.d., circa May 2002.]

How much danger the crews faced during these tests remains uncertain. In fairness, it is important to recognize that today's standards and values are not necessarily the same as those of earlier periods. In the 1950s and 1960s, the culture appeared less sensitive than it is today to the rights of patients and of humans research subjects. Still, even with that understanding, and with due recognition of the Soviet threat that prompted the tests, ethical questions remain.

During World War II, the Germans used thousands of Jews and other concentration camp inmates as involuntary experimental subjects. The experiments commonly caused pain, disfigurement, and death. In 1947, doctors who performed the experiments were tried in Nuremberg, and the verdict included a code of conduct for research with human subjects. The Nuremberg code enshrines the requirement that people be fully informed and give consent before becoming test subjects. The code became a standard in all civilized societies. In 1953, a DoD memorandum to the Army, Navy, and Air Force affirmed the code as policy and began with the admonition that "the voluntary consent of the human subject is absolutely essential." [U.S. Secretary of Defense, Memorandum for the Secretary of the Army, Secretary of the Navy, Secretary of the Air Force, subject: Use of Human Volunteers in Experimental Research, Washington, DC, February 26, 1953.]

Thus, any supposition that rules for human research subjects were different in the 1950s or 1960s than today would be untrue. Researchers may have been less sensitive to the requirement of informed consent. Patients and subjects may have been less informed generally about their rights. But the requirement of informed consent was official military policy.

In the context of the SHAD tests, several conclusions seem appropriate.

- Deliberately exposing people to biological or chemical weapons without some level of informed consent, would have been contrary to official policy. Ignoring the right of informed consent would also have been inconsistent with the military's treatment of human subjects in other tests in which actual weapons (as opposed to simulants) were used.
- The requirement of informed consent should apply to everyone put at risk in such tests, whether the participants are designated as testers or subjects.
- The United States government has a particular responsibility to people who were placed at risk by its experiments. The responsibility should include providing medical care and financial compensation to any participant made ill by the tests.

Chairman ROCKEFELLER. Any other comments? Yes, please?

Ms. SCHWARTZ. Just to let you know, I am retired from the U.S. Air Force, and I am on the faculty of the Yale School of Nursing, and I am in epidemiology. And basically one of the things about—you asked the question about did they go around and get informed consent before they give medications. Not necessarily, if it is something that has been, you know, a protocol that has already been established by the DoD, by the Air Force or so forth, but you do keep records of who gets what. Nurses do have to chart, and people who are giving those injections do have to chart.

And Dr. Cole brought out a very important part. You wish that you could give the military member the option to have this injection or not, but that is not what happens because there is a certain commitment to mission readiness, and along with that the person has the right to know, the military person has the right to know what it is they are going to be doing.

But the reality of what has happened here, both with SHAD and what you have been talking about this morning, is one thing. When everything is all said and done, whatever happened to those people on those ships, whatever happened to the people in the desert, this

country owes them. We owe them. The Veterans Administration is the workmen's comp for people who go to war, for the men and women that have been exposed. And it is—and I know you have been a leader, and I thank you so much for it, Senator Rockefeller. But the truth of the matter is that every day veterans around this country have to beg for help. They have to beg for the care and consideration that they deserve for putting their life on the line every single day.

We owe them the honor and respect of not making them beg for this help. We also have to look at the world today. This country has been jolted every day by something new—the Catholic Church, Arthur Andersen, Wall Street. It is unbelievable to me that we trust these men and women to defend our country and we will not—we will question their honesty, we will question what they say happened to them. And it is left to them, left to them and their families and their children, to make sense out of the sacrifice.

We recently did—we looked at the deaths of over 5,000 Vietnam veterans who served in Vietnam. The average age at the time of death was 51 years old. And as poignant and as striking as that might be, the saddest part of all is many of them died without knowing that they died for their country.

Chairman ROCKEFELLER. The hearing stands in recess. Thank you.

[Whereupon, at 11:24 a.m., the committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF HON. BEN NIGHTHORSE CAMPBELL, U.S. SENATOR FROM COLORADO

Thank you, Mr. Chairman. I appreciate your convening this hearing and welcome everyone here today as we continue our efforts to investigate toxic exposures among our nation's veterans.

Recently, we have received new information concerning the use of and exposure to chemical and biological agents as part of a warfare testing program in the 1960's. We continue to hear of Gulf War veterans who are suffering from a host of unexplainable symptoms. And now, we have American soldiers involved in another war—the war against terrorism.

As our knowledge of scientific methods and research improves, we learn of the glaring errors we made in the past. There should be no question that our government should provide the necessary care and restitution for injuries caused by these errors.

One might think that after the debacles of the Vietnam and Gulf Wars, accountability for illnesses incurred from exposure to chemical agents during war time would be a pretty clear issue. Unfortunately, however, the Department of Defense has not made the task of obtaining all of the data an easy one.

Treating those who protect our nation's security as human guinea pigs for research purposes is inexcusable. Not only must we discontinue such practices, we must also make every effort to see that such exposures do not take place accidentally.

Our primary concern should be to take the steps necessary for caring for the health of our veterans. I am hopeful that through careful analysis of the available data, we can understand precisely the causes of and the treatments for illnesses due to exposures. Then, we must implement policies to make sure that such exposures do not take place either intentionally or unintentionally.

I believe it is imperative that we restore the trust and confidence of America's veterans in the federal government's response to these kinds of exposures.

Again, I thank the chair, and look forward to today's testimony.

PREPARED STATEMENT OF JOY J. ILEM, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. Chairman and Members of the Committee:

I am pleased to present the views of the Disabled American Veterans (DAV) concerning strategies of the Departments of Defense (DoD) and Veterans Affairs (VA) to provide the most appropriate care and support to veterans who might have been exposed to environmental hazards during their military service.

The health and well-being of the men and women who put themselves in harm's way in defense of our Nation continues to be one of our foremost concerns and is of great importance to the DAV's more than 1.2 million members and their families. We appreciate the Committee's efforts to identify obstacles that prevent DoD from sharing relevant information on potentially hazardous exposures with veterans and VA. We strongly agree with the Committee that veterans deserve assurance that DoD can work productively with VA to identify, treat and, when possible, prevent potential long-term health consequences of their military service.

The hazards of military service are well documented and include possible exposure to radiation, chemical and biological agents, herbicides, a variety of environmental hazards, infectious diseases, and a host of other toxins. Each new battlefield presents a unique set of health hazards. Many soldiers suffer life-long disabilities as a result of their military experience, due to blindness, spinal cord injury, cold injury, traumatic amputation, hearing impairment, and post traumatic stress disorder.

Following the terrorist attacks on the World Trade Center and the Pentagon, the United States began to deploy troops to Afghanistan, Pakistan, and neighboring former Soviet Republics. To date over 30,000 active duty personnel have been deployed and over 50,000 Reserve personnel have been called to active duty in support of operations in South Asia. According to DoD, these troops may experience high-altitude health hazards, and exposure to a variety of infectious diseases and environmental hazards to include agricultural and industrial contamination of food and water supplies, air pollution, and severe sand and dust storms.

During Operations Desert Shield and Desert Storm, the United States deployed 697,000 military personnel to the Persian Gulf. Serious health concerns related to service in the Persian Gulf were reported as Gulf War veterans began to return home in 1991 with complaints of vexing symptomatology and the development of unexplained illnesses. More than 100,000 troops who served in the Gulf War report they continue to suffer from a range of maladies including chronic muscle and joint pain, fatigue, headaches, memory loss, balance problems, and sleep disturbances. The complexity and controversy surrounding Gulf War illnesses immediately became apparent as the VA attempted to medically treat and compensate veterans who had become ill following their military service in the Gulf War. Controversy over this issue still exists today, more than ten years later, as scientists and medical researchers continue to search for answers and contemplate the various health risk factors associated with service in the Gulf War and reported illnesses affecting many veterans who served there.

Following the Gulf War, 33 separate hazardous substances were identified to which Gulf War veterans may have been exposed. DoD was heavily criticized for failing to provide explanations about Gulf War veterans' health concerns or respond in a prudent manner. Faith in the government's commitment to ensuring the safety of servicemembers' and veterans' health and providing appropriate care was seriously eroded. After intense pressure, DoD admitted its shortcomings and failure to properly communicate with troops during the Gulf War about health concerns relating to smoke from oil well fires, required vaccinations and medications, exposure to depleted uranium, and other chemical hazards.

Most recently, veterans service organizations (VSO) were notified that veterans who participated in a series of Cold War tests known as Project SHAD (Shipboard Hazard and Defense), a program encompassing several tests initiated in the 1960s to determine the vulnerabilities of United States warships to an attack with chemical or biological warfare agents, may have been exposed to potentially harmful biological and chemical agents. Only after intense pressure from veterans and Congress did DoD finally begin to release information about the tests conducted. VA and DoD, in a joint meeting, informed VSOs that both agencies would work collaboratively to develop the facts surrounding Project SHAD and accomplish declassification of materials, compile rosters of participants and inform them of potential exposures and possible short and long-term health effects. To date DoD has identified 103 potential SHAD tests. However, the total number of servicemembers involved in the tests is still unknown. In May 2002, VA initially notified 622 of about 4,300 veterans already identified as participants in project SHAD about potential exposures. The Veterans Right To Know Act of 2002 (H.R. 5060 and S.2704), was recently introduced in part to expedite the process of gathering all essential information related to SHAD and test participants. DAV fully supports this legislation, which calls for full disclosure of each DoD test involving chemical or biological weapons in which members of the Armed Forces or civilians were or may have been exposed to actual or simulated hazardous agents, whether with or without their knowledge or consent.

In November 1998, President Clinton directed the establishment of the Military and Veterans Health Coordinating Board (MVHCB), an interagency body including the Secretaries of Defense, Health and Human Services, and Veterans Affairs, to ensure coordination among the respective agencies with respect to clinical, research, and health risk communication issues related to the health of military members, veterans, and their families during and after future deployments. The MVHCB is responsible for making recommendations to minimize adverse health consequences of deployment and to coordinate an interagency information management (IM), and information technology (IT) task force, to ensure that all IM/IT requirements including record keeping are addressed by the agencies. A Deployment Health Working Group (DHWG) was also designed to determine interagency priorities for the assessment and prevention of deployment and post-deployment health issues. The work group is focusing on pre- and post-deployment health assessments, medical surveillance during deployments, combat stress control, and individual environmental exposure assessments. The group is responsible for providing recommendations to the various agencies concerning research, clinical findings, prevention, diagnosis, and clinical care. Another component of the group is to help ensure lessons learned from

previous military combat operations are translated into effective preparation for future missions.

Last year, a new Office of the Special Assistant to the Secretary of Defense for Gulf War Illnesses, Medical Readiness and Military Deployments (OSAGWI-MRMD) was formed to continue the support for appropriate health care for sick Gulf War veterans while promoting changes in existing military doctrine, policy and procedures that will minimize any future hazardous exposures during deployments. DoD recognized it must properly train military personnel in the use of chemical detection equipment, effectively communicate safety precautions for depleted uranium, the use of pesticides, and other chemical hazards future troops may encounter on the modern battlefield.

Military officials claim they have a new mind set concerning the long-term health of their troops and have indicated that they are taking measures to improve medical monitoring of personnel sent overseas to fight the war on terrorism, in an attempt to avoid lingering health problems like those experienced by Gulf War veterans. Officials claim they are keeping careful records for troops and requiring servicemembers to complete a simple medical screening before and after they are deployed. One report indicated that the Armed Forces are beginning to convert medical records for each servicemember to an electronic database. The report also noted that the Pentagon has started environmental monitoring for areas where its sends its troops. Certainly, we hope these measures are being carried out. However, only time will tell if the appropriate agencies have fully addressed the lessons learned in the Gulf War and if efforts have been effectively coordinated to protect the health of our troops.

The DAV believes military personnel should have complete medical examinations prior to deployment and after completion of an assignment to include collection of blood samples. This would allow clinicians and researchers to ascertain changes in health status in individuals and groups of servicemembers if health concerns become apparent following a particular deployment. It is also important that accurate record keeping during deployment is accomplished and accessible, especially if a servicemember becomes ill during the deployment. Many sick Gulf War veterans were unable to access field health treatment records once they returned home. DoD reported that many veterans could not obtain records because they were filed by the name of the hospital that retired the records and veterans could not furnish the name of the field hospital to which they were admitted. This documentation can be crucial to a veteran's medical treatment and application for VA disability compensation benefits.

It is essential that all appropriate agencies work together to integrate deployment health-related lessons learned with regard to future doctrine and policy. This will help to assure that servicemembers and their families understand the possible health risks they face and how they can best protect themselves and their families' health and get the assistance and care they need as they transition into veteran status. The appropriate federal agencies must share responsibility for force health protection before, during, and after deployments. Without coordination, future veterans will likely experience problems similar to those that Gulf War veterans faced. DoD is obligated to provide accurate information about the health risks servicemembers face. The Department needs to be proactive rather than reactive concerning risks servicemembers may encounter during future deployments from the modern battlefield and environmental conditions. Likewise, the Veterans Health Administration must focus its scientific research, medical treatment, and outreach on veterans who become ill as a result of their military service. Disabled veterans must have access to appropriate treatment regimes so they can try to regain their health and well-being following military service.

It is the government's obligation to provide veterans who suffer from service-related disabilities with health care and compensation. However, for VA to make accurate rating decisions on claims for service connection for disabilities associated with toxic exposures, it must have access to all relevant documentation. The current system in place makes it nearly impossible in some cases for veterans to obtain relevant exposure information in support of their claim for service connection, i.e., barriers reported by DoD in getting relevant Project SHAD information declassified expeditiously. It is essential that DoD practice good record keeping, especially for high-risk military exercises, and shares that information with the VA, servicemembers and veterans in a timely manner. Excessive delays for information are unacceptable. A veteran's health and well-being should not be put at further risk due to institutional barriers in information sharing between VA and DoD. This process must be streamlined and veterans must be immediately made aware of exposure to hazardous toxins and possible health effects.

DoD's past failures in providing servicemembers and veterans with important information about potential toxic exposures and possible health effects is well documented. Project SHAD is just one more example. In the mean time, these veterans may have been denied treatment from the VA for health problems or compensation for disabilities that may only now be linked to their military service. DoD says it is concerned about the health and well-being of its troops; however, veterans believe actions speak louder than words. DoD reports it is now trying to streamline its medical record keeping process through the collection of pre- and post-deployment physicals, medical intelligence, health care delivery and other important documentation. This action is long overdue. Veterans who have sacrificed their good health in defense of our Nation deserve more than just promises. It is essential that DoD overcome institutional barriers and aggressively pursue initiatives that will ensure veterans who have suffered severe health consequences as a result of their military service have access to critical information related to hazardous exposures so they can be properly compensated for service-related disabilities and afforded timely and appropriate medical treatments. Without a true collaboration between the involved agencies we are doomed to repeat the past. Unfortunately, it is veterans who will needlessly suffer and continue to pay the price for inaction.

We urge the Committee to closely monitor the federal agencies responsible for coordinating force health protection. We sincerely appreciate the opportunity to present our views on this important issue and its relationship to the health status of the veteran population.

JOINT PREPARED STATEMENT OF THE DESERT STORM JUSTICE FOUNDATION, PAUL LYONS, PRESIDENT; DESERT STORM BATTLE REGISTRY, KIRT P. LOVE, PRESIDENT; AND AMERICAN VETERAN JUSTICE FOUNDATION, DANNIE WOLF, PRESIDENT

Dear Committee Members

At the time in late 2000, OSAGWI had the opportunity to respond to a question posed to them concerning Project SHAD. Kirt Love and Venus Hammack were present at this Pentagon NSO meeting to hear CPT. Mike Kilpatrick and UNSECDEF Dr. Bernard Rostker say they would reply to the question of project SHAD. It would be nearly 2 years before anything else was said by this agency.

This stall tactic is on going with other investigations, as it does with Gulf War issues. It started with Warren Rudmans' statements on behalf of PSOB (investigating OSAGWI) that OSAGWI should change from investigation to medical deployment. Then it produced heavily biased data that was unresponsive of veteran "benefit of the doubt" as to incidents and medical issues.

The moment that Dr. Bernard Rostker left office in 2001 they changed that policy, they summarily cut all ties with any Gulf War grass roots groups and dealt strictly with the National Service Organizations. They stopped returning phone calls and emails, and dodged veterans at public events throughout 2001. The issue fell silent until the Anthrax incident of October 2001.

OSAGWI has 6,000,000 records related to the Gulf War of which 1,200,000 are of medical relevance. From that they post 57,000 they claim have relevance, and never produce evidence that the other 6,000,000 are even real. 12 years later these materials (mainly CIA and CENTCOM) are 99% classified SECRET or higher—and not releasable.

It is our firm belief that having viewed some records outside DOD intelligence main frame that many of the records are of HIGH relevance—like DIA's unwillingness to discuss its highly classified records on the 9 Nuclear Reactors in the 1991 Gulf War supplied by the Russians. That the Russians recommended we NOT bombed them, and we did.

If Deployment Health Support Directorate is given the opportunity to run the SHAD investigation like it did the Gulf War investigation, it will deliberately stall and with hold vital data to keep damage to a minimum. Without Non-Military oversight, DOD is NOT capable of regulating or investigating itself internally.

Our organization has had interaction with OSAGWI since 1997, and we are very familiar with their team having interacted with them on every level to include Public Town Hall Meetings. Every where they went around the United States, the veteran groups treated them same—"You have NO credibility with us". From observation we also supported that conclusion, they do NOT provide answers to FOIA's of medical relevance or even basic request.

Acknowledging medical conditions is one thing, but VA's "Burden of proof" policy is punitive in nature, and if DHSD is allowed to continue as is—it will make sure that SHAD veterans have as much trouble proving their claims as Gulf War veterans have theirs. Exposure dictates treatment, and so far the Deployment Health

Clinical Center supported by DHSD is largely psychiatric research. They run on the basis that Somatization is the answer, which does not support lab baseline data.

As a veteran of the Gulf War, we have first hand knowledge of OSAGWI interaction. On that basis we recommend Oversight investigation into their operation at this time for the protection of other soldiers currently deploying that are NOT protected from lessons learned by this agency.

MILITARY EXPOSURES

Many Veterans have been failed by the DESP: deployment environmental surveillance program

[1] Info related to service members health and deployments status—was incomplete or inaccurate, according to GAO Report 02-478T.

[2] DoDs' numerous databases, including those that capture health info, currently are not linked.

- This transfer of data to a common electronic system, that will document, archive and

- Access medical surveillance data is poor at best

[3] The Secretary of the Army is responsible for medical surveillance for all of the DoD's deployments; this should be consistent with DoDs' medical surveillance policy.

[4] Without this info, troops may not recognize potential side effects of exposures or take prompt precautionary actions, including seeking medical care.

- Current Policies and Lessons Learned Programs have NOT been full Implemented today.

- The (CHCS II) Composite HEALTHCARE system needs to be audited, according to GAO Report -02-173T

THE CONTINUING CHALLENGES OF CARE

[1] We have also reported that not all medic encounters in theater were being recorded on individual records.

- So why are veteran's today, still having to prove to adjudicators their exposures?

- Benefit of the doubt is almost never granted, impart because of DOD's stalling of actual exposures and events that surface nearly 30 years later.

[2] VBA considers the VCAA's implementation a significant factor in the recent growth of its inventory of Compensation and Pension claims awaiting decisions—from the law's enactments.

- Please read PL 106-475, Nov 9 2000.

[3] Despite VBA's efforts, recent results from its quality assurance reviews indicate a significant decrease in rating accuracy, due in large part, to improper regional office implementation of VCAA requirements.

[4] This law obligated the VA to assist a claimant in obtaining evidence that is necessary to establish eligibility for service connected benefit's being sought.

Question—what is being done when claimants are informed relevant records are unable to be obtained?

[5] This lack of data by design, negatively impacts the STAR system, Systematic Technical Accuracy Review for the Regional Office.

Today many claimants have not received notification request for evidence from V.A. federal service officers, and were not obtained by the VBA for evidence. Yet many vets have been failed by lax Industrial hygiene and sanitation in the Gulf War Theater; and very sadly, few have been evaluated in this manner.

We, the above mentioned Gulf War Veteran's groups, insist the proper review of statistics and the number of claimant information, as seen by doctor's licensed by The American Board of Industrial Hygiene or Industrial Health Foundation. Those who are specialized in Environmental Medicine and/or Environmental Health could also treat us.

Environmental Medicine is the medical discipline which studies and assesses the effect of environmental factors upon individuals with particular emphasis on the effect of foods, chemicals, water, indoor and outdoor air quality at home, work or school. It considers each patient as a unique individual exposed to a unique set of circumstances and needing an individualized therapy.

Veterans seek this type of this evaluation for their claim.

Once the cause of the health problem is uncovered, treatment is as direct as possible with minimal use of pharmaceutical drugs, which can often have adverse side effects and also often only mask other symptoms.

Treatment consists of environmental controls, diet, nutritional supplements, correction of hormonal or metabolic deficiencies or imbalances, education and immunotherapy; (injectable and/or sublingual) where indicated. The amount of phy-

sicians in this area working at VAMC's is insufficient to support the number of post Vietnam deployed patient population.

COMPENSATION

DVA will find it difficult to assist in conducting research should troops be exposed to environmental or occupational hazards, and identify legitimate service connected disabilities to adjudicate veterans disability claims.

Service Connected disabilities adjudication have been hampered by a lack of 1.1 completed baseline health data of GWV

2.2 assessments of their potential exposure to environmental health hazards and 3.3 specific health data on care provided before, during and after deployments.

VSO officials we spoke with at the regional offices we visited expressed concern about the clarity and necessity of VCAA pre-decision notification letters.

- Some VSO's are having trouble understanding these letters. There is not a way for a claimant to be sure the training and skill of the VSO who represents them.

PAUL LYONS, President, Desert Storm Justice Foundation

KIRT P. LOVE, President, Desert Storm Battle Registry

DANNIE WOLF, President, American Veteran Justice Foundation

PREPARED STATEMENT OF THE NATIONAL GULF WAR RESOURCE CENTER

Mr. Chairman and other distinguished members of the committee; the National Gulf War Resource Center (NGWRC) is pleased to discuss this issue from the Gulf War veteran perspective. Understanding how members of the U.S. military have been exposed to chemical, biological, radiological or hazardous material, no matter how the exposer happened, is critical to developing a strategy for treatment. We thank you in advance for holding this important hearing.

In your invitation for testimony you wrote "Veterans deserve assurances that DoD can work productively with the VA to identify, treat and if possible-prevent potential long-term health consequences from their military service"

We agree with this statement. It is a simple request. However, with regard to Gulf War veterans, assurances and productivity have been lacking. We characterize DoD's efforts as unacceptable, bordering on deception.

In keeping with the goals of this committee we have divided our testimony into three sections. Each section covers what we believe is the historical barrier that prevents the flow of information. The barriers we have identified are DoD Culture, Information Dominance, and Burden of Proof.

DOD CULTURE

DoD has a demonstrated 50-year history of mitigating its failures with delay, denial and obstruction. Especially when it comes to exposures and what I call "bad policy, resulting in self-inflicted wounds." It is this bad policy, and culture that produced a thirty, forty and fifty year waiting period for admissions of guilt and corrective action from DoD.

The DoD culture is a mindset demonstrated over time and developed into a pattern of expected results based on whatever the external pressure is. Corporate cultures can be a good thing when they are developed to be mutually beneficial to the organization, the worker and consumer. Examples of organizational cultures that are bad are in the news today, in these organizations; losses and mistakes are hidden with strategic spin to delay the inevitable outcome. The company that is built on perception rather than truth will always find it-self in a credibility argument.

Veterans have always understood what they were up against when taking on DoD.

How can this committee change the DoD Culture? How can we help DoD develop its credibility with veterans?

We start by holding the spin experts accountable. There should be hearings that investigate and prosecute those who would lie to delay the inevitable truth. Why is it acceptable, why do these spin experts continuing to receive taxpayer dollars?

Veterans are the consumers; we demand that the practice of deception be stopped. We deserve truth and an honest broker. Our health is at risk because of Public Relations tactics. Truth would go a long way toward fixing this problem. Not truth in 30 years but truth now. Veterans have a right to know when they have been exposed to anything harmful.

If DoD knows then why shouldn't the veteran. SHAD is a classic example of DoD Culture gone amuck. DoD knew of the exposures in the SHAD test for many years,

certainly during the time that veterans like Jack Alderson were making inquiries into his health status.

What was the response he was given when he asked for information? He was told that no such test ever occurred. He was blatantly lied to. Even as this lie began to fall apart DoD's Office of the Secretary of Defense for Gulf War Illnesses (OSAGWI) continued to lie to media and veteran service advocates. When asked if a list of names containing those potentially exposed were available, Mrs. Barbara Goodno and her public relations experts at the OSAGWI denied the existence of any such list on more than one occasion.

I do not speculate on this subject. I worked in this organization and saw the list of names before I retired. The question is: What is it about the DoD Culture that allowed this person to continually lie to the media and to veterans when she knew full well that a list was available and it contained the names of veterans who had been exposed?

I believe that she did it because of the DoD culture of striving for Information Dominance. It is the nature of DoD to mitigate and control the damage of a story even if being less than honest harms the public.

I often tell my young nephew that lying is wrong, and dumb. Telling the truth is always better. Lying becomes even worse when you do it and you know you're wrong, because eventually, in 30 or 40 years the institution will be caught. I tell my nephew that a person who lies when they are obviously caught is twice the fool.

Risk communication, the buzzword of DoD public relations should not mean, let me deceive you, let me delay the outcome for the benefit of protecting my organization. It should mean that you understand your audience, you understand your message and you deliver it with truth and honesty demonstrating your commitment to solving the issue and addressing the public concerns.

Our suggestion to this committee is to change the DoD Culture. If DoD won't change on its own then we need to establish oversight with teeth. Terminate, prosecute and ban from governmental contact anyone who would purposely deceive America. We expect high standards from our soldiers, why not the same from the civilian leadership of DoD. Veterans can't be held hostage to public relations anymore. A bill recently introduced, S. 2704 and HR. 5060 is an attempt to establish an oversight mechanism that will protect veterans and allow information to flow both ways.

INFORMATION DOMINANCE

It should be of no surprise to anyone on this committee that when dealing with DoD you are subjecting yourself to a multitude of tactics and techniques that are battle tested and designed for one purpose, domination of the battlefield. It does not matter if the enemy is a country or a "perception," the strategy is the same. DoD Information Dominance is an obstacle that prevents veterans from gaining the truth about their battlefield exposures.

Information dominance may be defined as superiority in the generation, manipulation, and use of information sufficient to afford its possessors dominance over the full spectrum of an issue or conflict.

For DoD, information dominance has three sources. DoD Public Affairs representatives use these sources to "Control the Message." This control becomes the barrier that veterans face when trying to obtain information. The three sources of Information dominance are:

- Command and Control that permits everyone to know where they are in the battlespace, and enables them to execute operations when and where they choose. They understand that no matter what you may want they can wait you out. They are the sole source provider.

- Intelligence that ranges from knowing the enemy's dispositions to knowing the location of enemy assets in real-time. It also means knowing the expected outcome of a course of action. DoD weighs the cost of admitting the truth now or later based on the desired outcome. If DoD has done something wonderful you cant make them stop talking about it. If they have done something wrong they will "get back to you later," even if they know the answer already.

- Information Warfare that confounds enemy information systems at various points (sensors, communications, processing, and command), while protecting one's own. Here is the meat of the problem. When you confront DoD in any form you are the enemy. Confounding the issues with disinformation or one-sided information is a primary tactic of DoD. Using SHAD as an example we have seen the DoD message develop over time. First they said the test never happened. Then they said it happened but no list were available. Then they said the list is available but only simulants were used. Now they admit live agent was used in some test but they

say people wore protective clothing. This is a pattern of information dominance that allows DoD to eek out information and mitigates the story. They have known all along what the exposures are.

Interestingly, the organization conducting the SHAD investigation is also responsible for producing the Gulf War Investigation. The reports produced from OSAGWI for the Gulf War are about mitigating the exposure.

Recently a full 11 years after the Gulf War Dr. Michael Kilpatrick of OSAGWI admitted during a public hearing, that its chemical warfare agent reports from the Gulf War on Khamisiyah were—in *his exact words*—“A wild ass guess.”

The VA used this report and others to deny treatment, benefits and compensation to veterans. Why did it take 11 years to admit what veterans knew immediately after the war? Why has it taken SHAD veteran's 40 years to hear the truth?

DoD proudly sees itself as second to none in the use of information. Controlling the message is information dominance. This power is the barrier, which prevents soldiers and veterans from learning the true nature of exposures. The idea of acceptable losses, and no remorse, coupled with strategic spin has become the norm from DoD. Veterans demand a “no excuses” policy from DoD when they hold the information key to understanding exposures and health consequences. I implore this committee to establish some method to ensure information cannot be used as a weapon against our own veterans, so this type of “bad policy” never happens again.

BURDEN OF PROOF

More than decade ago, U.S. Forces were deployed to fight in a war that would be won in a matter of hours rather than years. The speed of battle and the technology that was employed ensured our success as we achieved our objectives. Today we are beginning to hear the familiar rhetoric in preparation for a new war with Iraq. We are seeing stories of how important our soldiers are and how well trained and magnificent they are in the conduct of their duty to protect America.

This sentiment is true and deserved but for some the feeling that “soldiers matter” only comes out in time of war much like people who turn to prayer only when they find themselves in dire straights. Serving veterans of the Gulf War has taught me how much soldiers fade from the conciseness of America when the war is over. 300,000 out of 700,000 in theater Gulf War veterans have sought treatment from the VA for what they believe to be service-connected disabilities. Now in this time of great need and demand on our military I would like this committee to consider the burden of proof and how the DoD's culture and spin control of information has denied veterans health care.

Under the current policies of the Veterans Administration (VA) soldiers who are called to war and then return home are required to present evidence of exposure or injury to the VA— before they become eligible for care and compensation from the VA. This policy places the burden of proof on the service member to insure that DoD does its job. Some examples of the DoD failures in obtaining this burden of proof during the Gulf War include: Poor record keeping both in and out of theater, poor unit location management, lack of environmental monitoring, lack of useful chemical and biological agent monitoring, lack of predictive analysis and consideration of downwind hazards resulting from pre ground-war bombing, lack of knowledge on the effect and use of investigational new drugs and vaccines, poor enforcement of and adherence to pesticides use, lack of standards and methods when using or working around depleted uranium, the list goes on and on.

The soldier would have needed to be a journalist, lawyer, environmentalist, scientist, chemical and biological weapons expert, meteorologist and doctor to obtain the proof required by the VA for service-connected disability.

Interestingly enough, the military has all these occupational specialties in its ranks but the DoD and the VA still requires the individual to be responsible for obtaining and maintaining the required information. This is the crux of the problem: In obtaining access to the entitlement of medical treatment and services from the VA the burden of proof is improperly placed on the veteran when it should be placed on DoD.

Lessons learned from the Gulf War were supposed to address this problem and as a result of “Lessons Learned” from studying the events of the Gulf War. The DoD and the JCS developed a plan that would prevent an event like “Gulf War Syndrome” from ever occurring again. This proactive policy was called Force Health Protection or (FHP). FHP is a protocol and the congress wisely established it in a public law designed to conduct a series of physical test on soldiers, before, during and after deployment. It also requires DoD to maintain medical data, exposure and event reports, and movement and location data. During my last assignment in the military I briefed this policy to numerous active duty soldiers around the United

States. The Office of the Special Assistant for Gulf War Illnesses (OSAGWI) now called the Special Assistant for Gulf War Illnesses, Medical Readiness and Military Deployments (SAGWI/MR/MD) was then and is still today the lead agency on the investigation into Gulf War exposures and has also transitioned into Deployment Health Policy. The DoD is still ignoring this law, with no implemented policy. I would welcome your questions for the record to enable me to justify this statement.

The problem of how to improve sharing of information between DoD the VA and the veterans is two fold:

1. DoD is not enforcing the policy enacted into law as a result of lessons learned from the Gulf War (PL.105-85, Section 762-765).
2. The burden of proof for service-connected disabilities is obviously misplaced and should fall on DoD and not the individual.

There have been many initiatives that have been suggested in order to speed the effectiveness and delivery of health care to veterans, however none have taken the shape of actual implementation. Despite pressure from two presidents, both the VA and DoD have made little headway in combining their health-care programs or sharing critical information. If they took those two simple actions, it would relieve the burden of proof from the individual. "Most of the sharing initiatives are more illusory than real," said Stephen Joseph, assistant secretary of Defense for Health Affairs during the Clinton administration.

"VA and DoD created several joint facilities in recent years, but most of the management and operational functions at the facilities continue to be run separately," Joseph said.

Joseph further stated, "The biggest hindrance to greater cooperation and coordination between the two departments is their diverging missions. Delivering quality health care to veterans is the VA's primary mission. DoD's health programs are focused on keeping the military healthy and ready for the next engagement."

However there is a flaw in the belief that these missions are different or competing. They should be complimentary. DoD gets the soldier at the reception station, builds the medical record and in some cases sends the soldier to war. The VA is the recipient of the veteran when they return from war or leave the service. In order to take care of the soldier DoD must take responsibility for the burden of proof from day-1 through the soldiers end of service. The reason that VA health care has been limited for Gulf War veterans is the lack of commitment from the DoD to do its job while the soldier is engaged in the conduct of his or her duty.

Let me give an example of how this flaw has impacted Gulf War Veterans. Upon their return from the Gulf War, veterans began complaining of various illnesses and diseases that they believed were attributed to their service in the Gulf region. Veterans themselves began to organize and ask for assistance from DoD, the VA and others. No matter which direction veterans pointed to try and understand their illness the DoD and its selected scientists refuted veterans claims by making bold unfounded statements that were not backed up by scientific research.

Even today DoD requires veterans and the public to simply believe them because they say so. Poor policies, weak protective measures, lack of records and other failures forced DoD to go back into time and write reports about the events of the Gulf War to try and explain the multitude of exposures. These reports are "no more than guesses" at what actually happened. Their conclusions can be easily refuted. The final reports were then used by the VA as evidence to substantiate lack of service connection to the exposures Gulf War veterans faced. Instead of actually fact finding for the purpose of helping veterans the reports have been used as weapons to prevent access to care and compensation. Today, science has caught up with the DoD, and we are discovering that these illnesses are absolutely service connected exposures and injuries. Allowing DoD to go back in time and guess about exposures and then give this information to the VA to deny benefits places the veteran in a double jeopardy. It makes as much sense as letting Enron investigate itself or asking the fox to guard the hen house.

What are the obstacles and how do we improve benefits and services for Department of Veterans Affairs beneficiaries?

We must first eliminate the DoD culture of delay, denial, and obstruction. Then Congress must demand that the DoD obey the Force Health Protection law's already on the books. This law also extends to the reserve component of the military. The DoD can accomplish this today, with its existing force structure. The civilian leadership simply needs to issue the order, and follow-up to insure that it's accomplished. The Secretary of Defense, on a monthly basis, should brief the Congress until there is compliance. The VA should be involved in the process proactively not retroactively.

It's often said, "the first casualty of war is truth." Our veterans are not demanding a big bag of money; they are demanding that which could be granted today. Truth. The whole truth, and nothing but the truth

PREPARED STATEMENT OF PAUL A. HAYDEN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. Chairman and members of the committee:

On behalf of the 2.7 million members of the Veterans of Foreign Wars of the United States (VFW) and our Ladies Auxiliary, I would like to thank you for the opportunity to comment on the strategies being pursued by the Departments of Defense (DOD) and Veterans Affairs (VA) to provide the most appropriate care and support to veterans who might have been exposed to environmental hazards during their military service.

Throughout the past century, in peace and war, our military men and women have been exposed to a wide variety of environmental and manmade hazards. Aside from normal deployment exposures such as diseases endemic to certain geographical locations, troops in WWI were exposed to mustard gas among others agents; in WWII they exposed to radiation from atomic explosions; in Vietnam they exposed to herbicides designed to defoliate the jungle, and; in the Gulf War, they were exposed to low levels of toxic nerve gas.

In fact, this Committee found in its 1998 Report of the Special Investigation Unit on Gulf War Illness, 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 . . . as "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."

Now, as a result of DOD's recent disclosure regarding a group of Cold War chemical and biological tests commonly referred to as Project Shipboard Hazard And Defense (SHAD) that exposed veterans to dangerous and harmful agents, our Nation's attention is once again focused on how DOD and VA can "collect information adequately about, keep good health records on, and produce reliable and valid data to monitor the health care and compensation status of veterans."

Seeking to apply lessons learned from the past, DOD's current efforts in this arena revolve around the concept of Force Health Protection. One of the ways they accomplish this is by having the servicemember, not a physician, assess their state of health before and after deployments, by filling out forms DD Form 2795, Pre-Deployment Health Assessment, and DD Form 2796, Post-Deployment Health Assessment. In addition, DD Form 2796 asks the troops for their deployment location, country, and name of operation.

In the Spring 2002, Vol. 1, Issue 4, Deployment Quarterly magazine, a DOD health official in response to a question regarding whether a soldier "should get a complete physical examination after [they] return from a deployment" replied, "complete physical examinations are not necessary for most people who are returning from a deployment." This answer clearly contradicts and undermines the intent of Congress, not to mention the safety of the servicemember, when they authored Section 765 of PL 105-85. Under this law, 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.

Aside from DOD's failure to implement current law, the Institute of Medicine (IOM) in its report, Protecting Those Who Serve, (the recommendations of which the VFW concurs) stated that DOD has made "few concrete changes 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 further illustrate this point. 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."

We believe the chair of the IOM Committee on Strategies to Protect the Health of Deployed U.S. Forces articulated the position that senior leaders are failing to grasp when he stated, "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.” While DOD has received input from numerous expert panels, and has 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.

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 the 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. 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 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. This is an inherent inequity of the system that demands correction.

In cases such as these, Congress has a long history of creating presumptions for specific cases such as Vietnam veterans and exposure to the herbicide Agent Orange and presumption for service connection due to undiagnosed illnesses for Persian Gulf veterans. If DOD provided proper data to VA then there would be no need for corrective Congressional action and veterans who have a right to know if their illnesses were caused by exposure while in service would not have to wait decades to properly address their valid concerns.

The VFW believes that only a total commitment to Force Health Protection from the highest levels of DOD can ensure accurate health data collection and dissemination. Further, the VA must remain vigilant in its role as the chief advocate for our nation’s veterans; and once again, Congress must use its powers of oversight and legislation to ensure that future generations of veterans receive the care they were promised by a grateful nation.

This concludes my testimony.

