



THE SECRETARY OF VETERANS AFFAIRS

WASHINGTON

DEC 23 1993

The Honorable John D. Rockefeller IV
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

Your predecessor as Chairman of the Committee requested an historical analysis of the policy foundations of the current system of statutory and regulatory presumptions for service connection under the compensation program.

I am pleased to submit to you our analysis. We have presented our views regarding the current status of presumptions and have also addressed, within the context of the analysis, the specific issues mentioned in the former Chairman's request.

Mr. Chairman, I know you can appreciate the effort that goes into an analysis of this nature, which covers many decades of legislative history and medical science. I am very pleased to recognize the authors of the analysis. Mr. Richard Hipolit and Ms. Tresa Schlecht of the Office of the General Counsel drafted the legal analysis, Dr. Susan Mather of the Veterans Health Administration wrote the medical analysis and Ms. Carol Wheeler of the Office of Policy and Planning coordinated the effort.

The analysis is also being sent to the Ranking Minority Member and to Senator Alan K. Simpson.

Sincerely yours,

A handwritten signature in black ink that reads "Jesse Brown". The signature is written in a cursive, flowing style.

Jesse Brown

ANALYSIS OF PRESUMPTIONS OF SERVICE CONNECTION

Department of Veterans Affairs

ANALYSIS OF PRESUMPTIONS OF SERVICE CONNECTION

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EXECUTIVE SUMMARY, PRESUMPTIONS OF SERVICE CONNECTION

HISTORICAL

Generally, a legal presumption is a procedural device which shifts the burden of proof by attaching certain consequences to the establishment of certain basic evidentiary facts. When the party invoking a presumption establishes the basic fact(s) giving rise to the presumption, the burden of proof shifts to the other party to prove nonexistence of the presumed fact. A presumption, as used in the law of evidence, is a direction that if fact A (e.g., manifestation within the specified period of a disease for which a presumption of service connection is available) is established, then fact B (service connection) may be taken as established, even where there is no specific evidence proving fact B (i.e., no medical evidence of a connection between the veteran's disease and the veteran's military service).

A classic example of a presumption is the rule which requires the conclusion that a person is dead when it is shown that the person has disappeared for seven years without explanation, even though the specific evidence normally used to prove death (a body or a death certificate) is not available. The presumption of death relieves the party attempting to prove that death has occurred of the burden of producing positive evidence of death. In the case of a presumption of service connection, a claimant can establish a relationship between one event, i.e., military service, and another event, i.e., subsequent development of a particular disability, without the burden of providing medical evidence establishing a connection between military service and the disability.

The current system of presumptions of service connection had its origins in the enactment of legislation in 1921 creating presumptions for active pulmonary tuberculosis and neuropsychiatric disease. These presumptions were intended to mitigate the difficulty of proving a connection between these disabilities and military service. Establishment of these early presumptions was soon followed by legislation creating presumptions for other diseases and by administrative regulations providing a presumption of service connection for a number of "chronic constitutional diseases." Regulations issued under the authority of the Economy Act of 1933 provided a presumption of service connection for various chronic diseases becoming manifest in wartime veterans to a degree of ten percent or more within one year of service separation. In 1948, Congress enacted legislation providing statutory presumptions of service connection for twenty-one chronic diseases or disease categories and sixteen tropical diseases. That legislation extended coverage of the tropical-disease presumptions to veterans of peacetime service.

Subsequently, the laws governing presumptive service connection have been modified and expanded on numerous occasions to reflect the changing circumstances of military service, developments in medical knowledge, and changing perceptions of the Government's responsibility to address the needs and concerns of veterans. Among the most significant of these changes was the extension, in 1966, of the chronic disease presumptions to peacetime veterans.

Currently, service connection can be established on a presumptive basis for over forty chronic diseases or disease categories, seventeen tropical diseases, and fifteen diseases, conditions, or disease categories associated with prisoner-of-war status. In addition, statutes provide presumptions for fifteen diseases arising in certain veterans exposed to ionizing radiation in service and three diseases or disease categories found in Vietnam veterans. VA regulations provide additional presumptions applicable to certain veterans exposed during service to mustard gas and to veterans suffering cardiovascular disorders following certain amputations.

MEDICAL

The concept of presumptions is not entirely foreign to medical practice which makes use of presumptive diagnoses when more specific diagnostic tests are not necessary for treatment. For disability determinations, presumptions address two areas of medical uncertainty: (1) diseases of unknown etiology and (2) diseases of known etiology where there is uncertainty regarding the incubation period or early manifestations.

Presumptions were enacted into law in response to difficulties veterans experienced with their claims for service connection. The suggestion that VA base determinations regarding service connection on "sound medical principles," while appearing reasonable, fails to recognize that medical science does not always know the exact cause, the time of onset or the aggravating circumstances of a condition.

There is no incontrovertible evidence that any of the presumptive conditions could not be aggravated or have the onset precipitated by military service. Likewise, there is no scientific basis for questioning the manifestation periods set by law.

The current list of "chronic" presumptive conditions includes archaic terms and general categories of diseases. A list reflecting modern terminology and eliminating redundancies is included. Such changes would be unlikely to change the outcome for any specific claims for service connection.

CONCLUSION

Presumptions play an important role in both the philosophical basis for service connection and in the actual administration of the compensation program. They serve to fill in the holes in scientific and medical knowledge, as well as resolve complex policy questions and simplify determinations of service connection for VA.

INTRODUCTION

I. Background

By letter dated October 11, 1991, Senator Alan Cranston, the former Chairman of the Senate Committee on Veterans' Affairs, requested that the Secretary of Veterans Affairs provide an analysis of the historical development and continued validity of presumptions of service connection in the Department of Veterans Affairs (VA) compensation program. Senator Cranston requested that this review include "the background and history of all presumptions that apply to VA's compensation program, including those based on specific statutes and those established administratively," as well as information regarding the policy foundations of each of these presumptions and the Department's views on the current role and validity of presumptions.

II. What Is a Presumption?

A presumption assists in determination of a question of fact in the absence of sufficient evidence to prove the fact itself. W. Page Keeton et al., Prosser and Keeton on the Law of Torts 38 (5th ed. 1984). A presumption is a procedural device which affects the duty of producing evidence. 9 J.H. Wigmore, Evidence § 2490 (Chadbourn rev. 1981). A presumption attaches certain consequences to the production of certain basic evidentiary facts or combinations of facts. 9 Wigmore, supra, § 2491. Once the party invoking the presumption establishes the basic fact(s) giving rise to the presumption, the other party has the burden of proving the nonexistence of the presumed fact. See Model Code of Evidence Rule 704 (1942).

A classic example of a presumption is the rule which requires the conclusion that a person is dead when it is shown that the person has disappeared for seven years without explanation, even though the specific evidence normally used to prove death (a body or a death certificate) is not available. When the presumption of death is applied, the fact of death is accepted as proved once the evidence of unexplained absence is shown, in the absence of evidence that the individual in question is actually living. The presumption of death relieves the party of the burden of producing positive evidence of death. In the case of a presumption of service connection, a claimant can establish a relationship between one event, i.e., military service, and another event, i.e., subsequent development of a particular disability, without the burden of providing medical evidence establishing a connection between military service and the disability.

A presumption, as used in the law of evidence, is a direction that if fact A (e.g., manifestation within the specified period of a disease for which the presumption of service connection is available) is established, then fact B (service connection) may, in the case of a permissive presumption, or must, in the case of a mandatory presumption, be taken as established, even where there is no evidence directed at proof of fact B (medical evidence of a connection between the disease and the veteran's military service). See Model Code of Evidence Introductory Note, ch. 8 (1942). Both permissive and mandatory presumptions may be rebutted (proved not to be true) by evidence disproving the presumed fact. Id. Presumptions of service connection are mandated by statute and regulations and VA generally has no discretion not to apply them when they are supported by the evidence. However, evidence that there is an intercurrent cause of a disease, e.g., that a cerebral hemorrhage was directly caused by an injury sustained in an automobile accident occurring after separation from service (evidence disproving fact B) may rebut a presumption of service connection. See 38 C.F.R. § 3.307(b).

Some presumptions of service connection are "conclusive." This means that once fact A, e.g., manifestation of a disease within a specified period, is established, a finding of fact B, e.g., service connection, is required, and no evidence may serve to rebut the conclusive presumption. Model Code of Evidence Introductory Note, ch. 8 (1942). This type of presumption has been described as not a presumption at all, but rather, a rule of law. 9 Wigmore, supra, § 2492. Accordingly, VA's regulation providing that if ischemic heart disease or other cardiovascular disease develops in a veteran who has a service-connected lower extremity amputation at or above the knee or service-connected amputation of both lower extremities at or above the ankle, the veteran's cardiovascular heart disease must be held to be service-connected, although not described in the regulations as a presumption, satisfies the definition of a conclusive presumption. See 38 C.F.R. § 3.310(b). See generally Paul F. Rothstein, Evidence in a Nutshell: State and Federal Rules 115-18 (2d ed. 1981) (for a concise, clear explanation of presumptions).

III. Overview of Presumptions Affecting Provision of Veterans' Benefits

This project focuses primarily on statutory and regulatory presumptions of service connection for certain medical conditions which become manifest after a veteran's separation from service. There are several other presumptions which also affect or have affected eligibility for veterans' benefits. Such presumptions include: the presumption of sound condition on entry into service; the presumption of death upon seven years' unexplained absence; the presumption of aggravation of a preexisting disease or injury during service; and, the former presumption of permanent and total disability for pension purposes at age 65.

VA and predecessor agencies have for many years used such presumptions in the adjudication of benefit claims.

EARLY HISTORY OF PRESUMPTIONS AFFECTING VETERANS' BENEFIT DETERMINATIONS

Questions as to whether a disability is or is not the result of military service began to arise soon after pension benefits were first made available to disabled veterans. Pension benefits for veterans of military service date back to 1776, when benefits for veterans of the Revolutionary War were enacted. The 1776 pension laws included benefits for veterans "who 'shall lose a limb . . . or be so disabled in the service . . . as to render [them] incapable afterwards of getting a livelihood". Journals of Congress, 1776, vol. 1, page 454, August 26, 1776, reprinted in Robert Mayo, M.D., Army and Navy Pension Laws and Bounty Land Laws from 1776 to 1861 1-3 (4th ed. 1861).

No presumptions were specifically included in these early pension laws. However, the same policy considerations which are the current basis for use of presumptions were addressed in early decisions regarding military pensions. In 1815, the Secretary of War asked the Attorney General to interpret a pension law of March 16, 1802, providing pension for veterans disabled "by wounds or otherwise." The Attorney General indicated that illnesses, such as heat stroke, as well as wounds occurring during service, were within the meaning of the act. The Attorney General also noted that:

[t]he connexion [sic] between the inflicting agent and consequent disability need not always be so direct and instantaneous. It will be enough if it be derivative, and the disability be plainly, though remotely, the incident and result of the military profession. Such are the changes and uncertainties of the military life . . . that the seeds of disease, which finally prostrate the constitution, may have been hidden as they were sown, and thus be in danger of not being recognized as first causes of disability in a meritorious claim.

Opinion of Richard Rush, Attorney General of the United States, April 6, 1815, reprinted in R. Mayo, M.D., supra, at 337. As this comment from the Attorney General makes clear, although no specific evidentiary presumptions were included in the early pension statutes, it was recognized that disease or injury resulting from military service may not be immediately apparent, but that disability resulting from such disease or injury may be service-connected when it does become manifest.

Two of the earliest presumptions specifically provided in the veterans' benefit statutes were the presumption of death upon seven years' unexplained absence and the presumption of soundness

upon service entry. Both of these presumptions date back to the 19th century. The presumption of soundness at the time of acceptance for service and the presumption of death upon unexplained absence serve an evidentiary function in the adjudication process similar to that served by the presumptions regarding service connection of disease.

I. Presumption of Death

The Act of March 13, 1896, ch. 54, 29 Stat. 57, provided that "death of an enlisted man or officer shall be considered as sufficiently proved if satisfactory evidence is produced establishing the fact of continued and unexplained absence . . . from . . . home and family for a period of seven years." Prior regulations governing Army and Navy pensions had provided a somewhat more difficult evidentiary standard applicable to deaths in service, that:

If the person on account of whose death claim is made was missing, and no positive knowledge of his death exists, the claimant must state under oath the supposed place and date of death, and swear that there is no reason for believing he did not die at the time and place alleged; and the testimony of a commissioned officer must, if possible, be furnished, showing all the circumstances justifying the belief that death actually occurred in the service and line of duty.

Commissioner of Pensions, Regulations Relating to Army and Navy Pensions, with Statutes 21 (1871). The modern seven-year presumption of death appeared in the veterans' benefit laws in 1940 in the National Service Life Insurance Act of 1940, § 610, 54 Stat. 974, 1013, and was subsequently extended to apply generally in claims for benefits under laws administered by VA by the Act of June 5, 1942, ch. 351, 56 Stat. 325.

II. Presumption of Soundness

The Act of March 3, 1885, ch. 340, 23 Stat. 361, provided that, "all applicants for pensions shall be presumed to have had no disability at the time of enlistment; but such presumption may be rebutted." A similar presumption, generally referred to as "the presumption of soundness," was later included in the Act of June 25, 1918, ch. 104, § 10, 40 Stat. 609, 611, which amended section 300 of the War Risk Insurance Act (the Act of September 2, 1914, ch. 293, 38 Stat. 711, as amended). This presumption, used in determining entitlement to death and disability benefits under the War Risk Insurance Act, provided that individuals having active service in the military "shall be held and taken to have been in sound condition when examined, accepted, and enrolled for service." In 1921, the presumption of soundness was amended to exclude "defects, disorders, or infirmities, made of record in any manner by proper authorities . . . at the time of, or prior to, inception of

active service." Act of August 9, 1921, ch. 57, § 18, 42 Stat. 147, 153.

The presumption of soundness was included in War Risk Insurance legislation for the protection of veterans in recognition of inadequacies in physical examinations at the time of mobilization. President's Commission on Veterans' Pensions, Staff Report No. VIII, Part B, The Veterans' Administration Disability Rating Schedule: Historical Development and Medical Appraisal, H.R. Comm. Print No. 275, 84th Cong., 2d Sess. 16 (1956). The impact of the sudden mobilization of large numbers of troops was summarized in Federal Laws Relating to Veterans of Wars of the United States, S. Doc. No. 131, 72d Cong., 1st Sess. 117 (1932), as follows:

[P]hysical examinations were hurried and, in many instances, incomplete. As a consequence men were taken into the service with physical and mental defects. The changed life and rigors of service, whether of an active fighting nature or simple employment in and around the military establishment, in many cases, aggravated these defects so that upon discharge these veterans were in need of financial relief and medical treatment.

The presumption of soundness was thereafter included in Veterans' Regulation No. 1(a), part I, paragraph I(b) (Exec. Ord. No. 6,156, June 6, 1933, reprinted in 38 U.S.C.A. § 745, ch. 12A (West 1952)). Vet. Reg. No. 1(a), part I, paragraph I(b), applicable to wartime service, provided that persons employed in active military or naval service for 90 days would be presumed to have been in sound condition at the time of enrollment "except as to defects . . . noted at the time of examination, acceptance and enrollment, or where evidence or medical judgment is such as to warrant a finding that the injury or disease existed prior to acceptance and enrollment." A slightly less generous presumption applied to peacetime service under part II, paragraph I(b).

The Act of July 13, 1943, ch. 233, § 9, 57 Stat. 554, 556, amended Vet. Reg. 1(a), part I, by removing the requirement of 90 days' service and, as to defects or disorders not noted at the time of examination and acceptance, by limiting rebuttal of the presumption of soundness to cases where there is clear and unmistakable evidence that the injury or disease preexisted service and was not aggravated by service.

The presumption of soundness was incorporated in title 38 United States Code, in 1957 in substantially similar form, see Pub. L. No. 85-56, 71 Stat. 83 (1957), and now appears as 38 U.S.C. §§ 1111 and 1132. Current VA regulations implement the presumption of soundness and provide specific principles for use of the presumption in adjudication. See 38 C.F.R. §§ 3.304(b) and 3.305(b).

III. Use of Presumptions in Establishment of Levels of Disability

The War Risk Insurance Act, as amended, contained the statutory origins of current compensation and pension benefits and use of presumptions in administering those benefits. The War Risk Insurance Act initially provided only for insurance of American vessels and cargoes against war hazards. This insurance program was administered by the Bureau of War Risk Insurance in the Treasury Department. However, with the passage of the Act of June 12, 1917, ch. 26, 40 Stat. 102, the program of war-risk insurance was expanded to include insurance of the crews of such vessels against the risk of disability or death. That statute, in effect, created an irrebuttable presumption that certain specified injuries gave rise to certain levels of disability. The insurance payment was linked to the level of disability presumed associated with the specified injury. In this act, for example, an individual was presumed to be totally disabled by the loss of both hands, both arms, both feet, both legs, or both eyes, or the loss of any two of the specified body parts.

A few months later, the Act of October 6, 1917, ch. 105, 40 Stat. 398, 405, added compensation benefits to the death or disability insurance benefits previously available, providing a program of compensation for death or disability resulting from injury suffered or disease contracted by persons in the active military service. For use in this program, the October 6, 1917, amendments to the War Risk Insurance Act directed the Bureau of War Risk Insurance to develop "[a] schedule of ratings of reductions in earning capacity from specific injuries or combinations of injuries . . . based, as far as practicable, upon the average impairments of earning capacity resulting from such injuries . . . and not upon the impairment in earning capacity in each individual case." Id. § 2, 40 Stat. at 406 (adding § 302(2)).

The rating schedule which derived from this authority was not described as establishing presumptions and is generally not considered a system of presumptions. However, the provisions of the rating schedule, as originally established and as currently used, are similar in function to presumptions in that, once an individual veteran establishes the existence of an illness or injury in a degree specified in the rating schedule, the individual's percentage of disability is presumed to be as listed in the schedule, and the individual need not provide medical or other evidence of the actual percentage of disability occurring in his or her case. However, in contrast to presumptions of service connection, the rating schedule serves less to overcome difficulties of proof than to objectivize the rating process and to avoid penalizing persons able to overcome their disabilities and pursue gainful employment.

DEVELOPMENT OF PRESUMPTIONS OF SERVICE CONNECTION
FOR CERTAIN MEDICAL CONDITIONS

I. The First Enactments and Regulations: 1921-1933

The first legislation explicitly providing a presumption of service connection to mitigate the difficulty of proving a connection between military service and development of a disability was the Act of August 9, 1921, ch. 57, 42 Stat. 147. This act established the Veterans' Bureau and, in section 18, 42 Stat. at 153, amended section 300 of the War Risk Insurance Act by adding presumptions of service connection for active pulmonary tuberculosis and neuropsychiatric disease. This bill provided that the specified diseases developing to a degree of disability of more than ten percent within two years following separation from active military service would be considered to have had their origin in service or to have been aggravated by service.

Addition of a presumption of service connection for tuberculosis and neuropsychiatric disease was adopted as a floor amendment after hearings on the 1921 legislation amending the War Risk Insurance Act had been completed. During Senate debate on July 20, 1921, Senator Walsh proposed the amendment as a means of overcoming what he termed "the sharp and altogether unjustifiable annoyance in requiring the disabled soldier to prove that the disease from which he is suffering was contracted in line of service." 61 Cong. Rec. 4105 (daily ed. July 20, 1921).

Senator Walsh went on to state:

In my opinion, that provision of the law which places the burden upon the disabled veteran of connecting his disease with his service has been responsible for more complaints, dissatisfaction, and disappointment . . . than any other single provision

Consequently, I propose to offer an amendment to section 18 which will shift the burden of proof in the case of two classes of disease only--tubercular and neuropsychiatric. I propose that when it is proved by an incapacitated soldier that he has either of these two types of disease he shall immediately be entitled to compensation unless the Government proves--the burden thus being shifted to the Government--that he has contracted the disease since the time of his discharge and it is not traceable to service in line of duty.

Id.

Senator Walsh noted the great number of ex-servicemen afflicted with tuberculosis and nervous disorders and suggested

that the generation in question could not be expected to be so afflicted naturally. He stated:

It is very apparent to me that this wave of tuberculosis and of nervous and mental diseases that has taken such a deadly hold and grip of late upon our ex-service men must have been contracted in the service. I feel, therefore, that we ought not continue this requirement of endless affidavits, necessarily involving long delay, in demonstrating the fact that their illness is of service origin. The delays resulting from this affidavit requirement have often resulted in men dying before they ever got their compensation

Id.

While noting that "a large percentage of the people of the country at some time in their lives have had tuberculosis," Senator Robinson pointed out that "[i]t would be almost a physical impossibility for any person afflicted with tuberculosis to fix the time when the process became active." Id. at 4106.

Senator Pomerene expressed the view that, even if certain veterans had undiagnosed cases of the listed diseases before they entered service, "they ought not to be deprived of the benefit of the fact that they have served their country, and therefore are entitled to this relief." Id. at 4105. The amendment was agreed to in the Senate following this debate. Id. at 4106.

Discussion of the amendment as modified in conference with the House indicated that medical advisors of the Bureau of War Risk Insurance, when heard by the conference committee, strenuously objected to the broad nature of the original amendment on the basis that tuberculosis could not be traced to military service when the disease developed more than a year and half after discharge from the service. 61 Cong. Rec. 4474 (daily ed. Aug. 1, 1921). As a result of these comments and further medical consultation, a two-year presumptive period was agreed upon. Id.

As further justification for the provision, Senator Robinson stated:

[I]t is frequently true that tuberculosis is an active process, and yet the person afflicted with it does not have knowledge of the fact that he has tuberculosis. As a matter of fact, most tubercular patients think that they have something else or think they are not afflicted with tuberculosis.

Id. Senator Walsh added:

I think really the most humane feature of this amendment is the assistance it will render to those afflicted with nervous and mental disease in obtaining their compensation. When it is considered that the most important proof, the essential proof, to establish a claim for compensation must come from the man himself, and when it is realized that he is mentally afflicted and therefore can not, for instance, file affidavits from officers and service men with whom he served--since memory is usually defective and he can not remember whom his officers or comrades were--it becomes apparent how important is the change made by the bill.

Id.

The House of Representatives agreed to the amendment on August 2, 1921, noting the difficulty many veterans had in proving that tuberculosis or neuropsychiatric disease was acquired while in service. 61 Cong. Rec. 4560 (daily ed. August 2, 1921).

The requirement that disability develop to a degree of more than ten percent within two years following separation from service was added in the conference committee and was approved by both Houses without explanation or discussion.¹

¹ Reference to a ten-percent level of disability or reduction in earning capacity was first included in veterans' benefit legislation when the War Risk Insurance Act was amended by the Act of October 6, 1917, ch. 105, art. III, 40 Stat. 398, 405, to provide compensation for death or disability resulting from injury suffered or disease contracted in the line of duty. Section 2 of that enactment added section 302(2) to the War Risk Insurance Act, providing that there would be no compensation payable for a reduction in earning capacity rated at less than ten percent. 40 Stat. at 406. No specific explanation for use of ten percent as the minimum level of disability is included in the legislative history of that Act. Apparently, draft legislation had originally provided that disabilities of ten percent or under would not be compensable, but the bill was revised to exclude only disabilities under ten percent upon the recommendation of an advisory committee of insurance-industry representatives which assisted the Department of the Treasury in developing the legislation. See Report Submitted by the Comm. of Insurance Representatives Appointed by the Secretary of the Treasury to Consider Plans for Insuring and Indemnifying Officers and Enlisted Men of the Army and Navy of the United States, To Amend the Bureau of Insurance Act so as to Insure the Men in the Army and Navy: Hearings Before the House Comm. on Interstate and Foreign Commerce on H.R. 5723, 65th Cong., 1st Sess. 23, 26 (1917). The insurance committee expressed the view that "it

In addition to providing a statutory presumption of service connection for two diseases, the Act of August 9, 1921, gave the Veterans' Bureau extensive powers to administer the veterans' benefit laws, including broad regulatory powers. In this regard, the act provided the Director of the Veterans' Bureau with "full power and authority to make rules and regulations not inconsistent with the provisions of [the] Act, which are necessary or appropriate to carry out its purposes." This broad regulatory authority of the Veterans' Bureau was amplified in section 5 of the World War Veterans' Act of 1924, ch. 320, 43 Stat. 607, 608, which authorized the Director to "adopt reasonable and proper rules. . . to regulate and provide for the nature and extent of the proofs and evidence and the method of taking and furnishing the same in order to establish the right to benefits . . . provided for in this Act." These powers are very similar to those currently delegated to the Secretary of the Department of Veterans Affairs under 38 U.S.C. § 501(a).

The Veterans' Bureau made use of its regulatory authority under the Act of August 9, 1921, to promulgate Regulation No. 11, issued on November 12, 1921, governing service connection of chronic constitutional diseases. Regulation No. 11 provided that chronic constitutional diseases, other than active pulmonary tuberculosis or neuropsychiatric disease, becoming manifest within one year following the date of separation from active service would be considered as incurred in service or aggravated by service unless there were affirmative evidence to the contrary or evidence establishing that some intercurrent disease or injury which is a recognized cause of the disorder was suffered between the date of separation from service and the onset of the chronic disease. 1 United States Veterans' Bureau, Regulations and Procedure: Active and Obsolete Issues as of December 31, 1928 81

would be reasonable to pay for a rating of 10 per cent, cutting out ratings below that per cent." Id. at 26.

In a 1923 hearing on legislation which became the Act of March 4, 1923, ch. 291, 42 Stat. 1521, Dr. Frank F. Hutchins, Consultant and Clinical Director in Neuropsychopathy, Veterans' Bureau, commented that "[t]he term 'less than 10 per cent' really means a small disability. . . . Ten per cent . . . simply recognizes that there is something there." To Amend and Modify the War Risk Insurance Act: Hearings Before the House Comm. on Interstate and Foreign Commerce on H.R. 14003, 67th Cong., 4th Sess. 129 (1923). Dr. Hutchins went on to comment that, while it was theoretically possible to have a degree of disability of less than ten percent, "[i]f a man has a disease at all involving him in any way you would certainly give him more than 10 per cent." Id.

(1930). The regulation specified no minimum degree of disability necessary to trigger application of the presumption.

An explanation of Regulation No. 11 offered to Congress years later indicated that the regulation was issued in the interest of uniformity of adjudication, in light of concern that service connection had been established in a number of cases where the only evidence was a diagnosis made long after discharge from service and "the probability of inception" of the disabling condition after service discharge was "clearly apparent" under accepted medical principles. Letter from General Omar N. Bradley, Administrator of Veterans Affairs, to Eugene D. Millikin, Chairman, Senate Committee on Finance (Nov. 18, 1947), S. Rep. No. 1536, 80th Cong., 2d Sess. (1948), reprinted in 1948 U.S. Code Cong. Serv. 2114, 2117. According to General Bradley's letter, the regulation was designed to preclude the granting of service connection where the disease arose more than one year after discharge, except where medical evidence in the case affirmatively established that service connection was warranted. In other words, the regulation was for the purpose of outlining the scope of application of medical judgment in determining service connection to a period within which generally accepted medical principles would support a rebuttable presumption. Id., S. Rep. No. 1536, supra, reprinted in 1948 U.S.C.C.S. at 2117-18.

The language of Regulation No. 11 made it clear that the availability of presumptions of service connection was not intended to preclude any veteran from establishing direct service connection when medical evidence to support direct service connection was available. Paragraph 2 of Regulation No. 11 stated, "[n]othing in this regulation shall be construed to prohibit connecting with the service a chronic constitutional disease becoming manifest more than one year from date of separation from active service where medical evidence in the case affirmatively establishes that a conclusion of service connection is warranted." ²

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Presumptive periods are not intended to limit service connection to diseases [diagnosed within a specified presumptive period] when the evidence warrants direct service connection. The presumptive provisions of the statute and [VA] regulations implementing them are intended as liberalizations applicable when the evidence would not warrant service connection without their aid.

38 C.F.R. § 3.303(d); see also 38 U.S.C. § § 1113(b) and 1133(c).

Regulation No. 11 did not specify which diseases would be categorized as chronic constitutional diseases. According to a 1980 VA task force study, Regulation No. 11 was followed one month later by issuance of a memorandum from the Medical Service categorizing twenty-two (22) diseases as "constitutional."³ Studies and Analysis Service, VA Office of Planning and Program Evaluation, Study of Former Prisoners of War 105 (1980).

In 1922, the Veterans' Bureau issued regulations providing that where active pulmonary tuberculosis "of ten per cent degree" develops within two years from service separation, the disease would be considered service connected. Regulation No. 20, April 10, 1922; Regulation No. 20-A, July 12, 1922; 1 United States Veterans' Bureau, Regulations and Procedure: Active and Obsolete Issues as of December 31, 1928 92-95 (1930). The regulations also provided that if active pulmonary tuberculosis were diagnosed in certain degrees, e.g., "moderately advanced," at various periods up to 32 months after service discharge, the disease would be considered to have been active to a degree of ten percent within two years of discharge. Id. The maximum period was extended to 36 months by Regulation No. 20-B, January 5, 1923. 1 Regulations and Procedure, supra, 95-97.

The Act of March 4, 1923, ch. 291, § 2, 42 Stat. 1521, 1522, extended the presumptive period for active tuberculosis and neuropsychiatric disease to three years. The presumption was expanded to include all forms of active tuberculosis, not just active pulmonary tuberculosis. This statute also revised the percentage of disability requirement from "more than" ten percent to ten percent "or more." However, the statute required that the diagnosis be based upon an examination within three years after separation from service by a Veterans' Bureau medical officer or a "legally qualified physician."

The record of hearings concerning presumptions held the following year indicates that the House Interstate and Foreign Commerce Committee had inserted the requirement of medical examination into the statute and fixed the presumptive period at three years by statute in 1923 to restrict the regulatory discretion of the Veterans' Bureau, in light of the Bureau's action in allowing presumptive service connection for tuberculosis diagnosed up to three years after service in some cases. Hearings Before the House Committee on World War

³ According to the VA study, the Medical Service classified the following diseases as "constitutional": acidosis; anaemia, primary (all types); arterio-sclerosis; beri-beri; diabetes insipidus; diabetes mellitus; endocrinopathies; gout; haemochromatosis; hemoglobinuria (paroxysmal); hemophilia; Hodgkin's disease; leukemia (all types); obesity; ochronosis; pellagra; polycythemia (erythemia); purpura; rickets; scurvy.

Veterans' Legislation on Proposed Legislation, 68th Cong.,
1st Sess. 452-58 (1924).

The Bureau had, however, opposed extending by statute in all cases the presumptive period for tuberculosis and neuropsychiatric disease to three years on the basis that this extension was not supported by any sound economic or scientific basis. Letter from C.R. Forbes, Director, Veterans' Bureau, to Samuel E. Winslow, Chairman, House Committee on Interstate and Foreign Commerce 2 (Nov. 27, 1922).

The amendment to include within the scope of the presumption certain diseases "developing a 10 per centum degree of disability or more" within the specified period was made at the recommendation of the Veterans' Bureau. Letter of C.R. Forbes, Director, Veterans' Bureau, to Samuel E. Winslow, Chairman, House Committee on Interstate and Foreign Commerce 6 (Jan. 27, 1923). The rationale for this change was not explained in the Director's lengthy letter, but the amendment did serve to bring the statute into conformance with the Veterans' Bureau's regulation governing active pulmonary tuberculosis claims.

Recommendations for expanding the veterans' benefit statutes, including the presumption of service connection, were numerous. In a November 5, 1923, letter to David Reed, Chairman, Special Committee of the Senate Investigating the U.S. Veterans' Bureau, Edwin S. Bettelheim, Jr., Chairman, National Legislative Committee, Veterans of Foreign Wars, stated in support of his organization's proposals to extend the presumption of service connection to additional diseases and to extend the presumptive period to five years:

The officials of the Veterans' Bureau will undoubtedly tell you that the present restriction of three years has worked hardship upon a great number of men afflicted with [neuropsychiatric and tubercular] ailments.

.

It is also recommended that this 5-year presumption should not only extend to neuropsychiatric and tubercular diseases, but also to other internal [dis]orders which might be placed in like category, such as heart trouble, cancer, diabetes, sleeping sickness, etc.

Some of these are even very difficult to ascertain or even see by means of X rays. It is hard to determine just when they did commence. Take the instance of a cancer, it is the general presumption that it must be existent in a small state at least a year before it is found, therefore, it is urged that these diseases be included in the 5-year presumption.

During Congressional hearings held in the First Session of the Sixty-eighth Congress, presumptions were discussed at some length. Veterans' organizations, including the Disabled American Veterans, the Veterans of Foreign Wars, and The American Legion proposed various changes regarding presumptions, among them that a presumption of service connection be established for all organic or chronic constitutional diseases becoming manifest within five years of service discharge, that the presumptive period for tuberculosis and neuropsychiatric conditions be extended to five years, and that a conclusive presumption of service connection be established as to tuberculosis, neuropsychiatric disease, amoebic dysentery, an organic disease, or constitutional psychopathic inferiority developing within five years after separation from service. Hearings on Proposed Legislation, supra, 192-193, 277, 548. The American Legion presented to the House Committee on World War Veterans' Legislation statements from numerous medical personnel indicating that tuberculosis and neuropsychiatric diseases were difficult to diagnose with certainty, that the course of such diseases may vary greatly from person to person, that such diseases are insidious in their development, and that a presumptive period of less than five years would be unjust to a certain percentage of veterans. Id. 195-99, 352, 359.

Dr. Earl Holt of the Veterans' Bureau testified before the Committee that available statistics showed that neuropsychiatric disease was no more common in the military population than in civilian populations. Id. at 449. In Dr. Holt's opinion, extension of the presumption was unwarranted as to that disease category due largely to uncertainty over the causes of psychiatric disabilities arising after service. Id. at 446-50. The Veterans' Bureau did endorse a veterans' organization proposal to eliminate the requirement of diagnosis by medical examination within the presumptive period on the basis that the current law created an arbitrary distinction. Id. at 161. However, the Bureau stopped short of endorsing efforts to extend the presumptive period to five years, expressing concern that the presumptions not be broadened to the point where "we could not feel with reasonable certainty that [a] disability was incident to . . . service." Id. at 161-62 (statement of General Hines, Director, Veterans' Bureau); see also Hearings Before the Subcomm. of the Senate Comm. on Finance on S. 2257, 68th Cong., 1st Sess. 113, 133 (1924). While the Bureau supported extension of the statutory presumption to cover encephalitis lethargica, it cautioned against extension of an artificial presumption "beyond a semblance . . . of its relation to medical experience." Hearings on S. 2257, supra, at 134.

Members of Congress made reference to the difficulties in securing diagnosis of certain diseases, Hearings on Proposed Legislation, supra, at 503 (statement of Rep. Snyder), and to the lay impression that military service was likely to aggravate latent neuropsychiatric conditions, Hearings on S. 2257, supra,

at 49 (statement of Sen. Walsh). Further, it was explained that the existing presumptions were based principally on an inference that the high incidence of certain conditions among young men suggested that those conditions were attributable to military service. Id. (statement of Sen. Walsh).

In June 1924, three more diseases were added by statute to the list of diseases for which the presumption of service connection was available. Paralysis agitans, encephalitis lethargica, and amoebic dysentery developing to a ten-percent degree of disability were added to the list of diseases for which service-connection could be presumed. World War Veterans Act of 1924, ch. 320 § 200, 43 Stat. 607, 615. This act provided that if any of the listed diseases became manifest to the required degree prior to January 1, 1925, a date roughly six years after the close of hostilities in World War I, the disease would be presumed to have been acquired or aggravated in service between April 6, 1917, and July 2, 1921, the dates respectively of the United States declaration of war for World War I and approval of the peace resolution for that war. The presumption was conclusive in the case of active tuberculosis and rebuttable by clear and convincing evidence as to the other listed diseases. Subsequent legislative history suggests that the date of January 1, 1925, was specified in order to tie the presumptive period to the period of wartime service rather than the date of discharge, which may have been several years after the cessation of hostilities. Independent Offices Appropriation Bill for 1935: Hearing before the Subcomm. of the Senate Comm. on Appropriations, 73rd Cong., 2d Sess. 118 (1934) (statement of Sen. Reed).

As part of the 1925 schedule of disability ratings, the Veterans' Bureau promulgated a list of chronic constitutional diseases for which service connection would be presumed if the disease became manifest within one year of separation from service. This presumption was rebuttable by evidence of intercurrent causes. Thirty-one diseases or categories of diseases were included in the list. ⁴ Schedule for Rating

⁴ Constitutional diseases listed in the 1925 Schedule of Ratings were: acidosis; anaemia, primary (all types); arteriosclerosis; arthritis, deformans; arthritis, chronic; beri-beri; diabetes insipidus; diabetes mellitus; endocrinopathies; endocarditis, chronic; carcinoma, sarcoma, and other tumors; cardiovascular-renal diseases, including hypertension; cholecystitis, chronic, proceeding to gall stone formation; gout; haemochromatosis; hemoglobinuria, paroxysmal; hemophilia; Hodgkin's disease; leukemia (all types); leprosy; myocarditis, chronic; nephrolithiasis; nephritis, chronic forms; obesity; ochronosis; pellagra; polycythemia (erythemia); purpura; rickets; scurvy; and, valvulitis, chronic.

Disabilities 75 (1925). Although rickets, acidosis, and obesity were included in the 1925 listing of constitutional diseases, the Schedule noted that "rickets is never active in adolescence," that "acidosis is not a chronic disease," and that "most cases of obesity are due to overeating or insufficient exercise, or both [and] hence not of service origin." Id.

In 1928, by an extension to the rating schedule, gastric or duodenal ulcers were added to the list of chronic constitutional diseases at the recommendation of the Veterans' Bureau's medical council. Schedule of Disability Ratings, Extension 6 (Nov. 2, 1928). . . .

An amendment to the World War Veterans' Act in 1926 added a conclusive provision of service connection for spinal meningitis appearing to a degree of disability of ten percent or more by January 1, 1925. Act of July 2, 1926, ch. 723, § 7, 44 Stat. 790, 793. The amendment was added on the Senate floor without debate. Information provided in a letter from the Director of the Veterans' Bureau and by Senator Swanson, who proposed the amendment, indicated that only five veterans were known to need the benefit of this presumption, and that no new claims were expected to arise in the future. 67 Cong. Rec. 12,095 (daily ed. June 28, 1926). The Director's letter further explained that spinal meningitis was considered a neuropsychiatric disease for which a rebuttable presumption of service connection was available, but that this presumption was subject to rebuttal by evidence of an intercurrent disease, such as pneumonia or typhoid fever, believed to trigger meningitis. Id. The conclusive presumption was apparently intended to preclude such rebuttal.

Thus, by 1929, statutory presumptions of service connection were available for six diseases or categories of diseases and regulatory presumptions of service connection were available for thirty-two additional diseases or categories of diseases. These presumptions remained in effect until 1933.

II. Presumptions Under Executive Order: 1933-1948

A. Chronic Diseases

Due to economic depression, Congress enacted the Economy Act of 1933, ch. 3, 48 Stat. 8. Section 17 of the Economy Act, 48 Stat. at 11, generally repealed all prior laws providing for payment of compensation for service-connected disability. That law established no new provisions governing presumptive service connection. Section 17 contained a grandfather clause applicable to veterans and survivors of veterans receiving compensation or pension for disability or death resulting from disease or injury directly connected to military service "without benefit of statutory or regulatory presumption of service connection." Cost savings associated with eliminating all veterans' benefits for disabilities not "directly attributable to service," including both compensation and medical benefits, were estimated at nearly

\$300 million. See Letter from Frank T. Hines, Administrator of Veterans Affairs, to Reed Smoot, Chairman, Senate Committee on Finance (Mar. 8, 1933). (Benefits were later restored to a large degree to veterans who had entered service on or before November 11, 1918, pursuant to the Independent Offices Appropriations Act, 1935, ch. 102, §§ 27 and 28, 48 Stat. 509, 524 (1934) (hereinafter cited as "Pub. No. 141, 73d Cong."); see also the Independent Offices Appropriations Act of 1934, ch. 101, § 20, 48 Stat. 283, 309 (1933) (creating special boards to review cases of veterans who entered service prior to November 11, 1918, and whose benefits based on presumptive service-connection were terminated as a result of the Economy Act of 1933).

Although the Economy Act eliminated all benefits based on presumptive service-connection, that statute instead gave the President broad authority to prescribe regulations governing entitlement to service-connected benefits, including regulations governing "the nature and extent of proofs and presumptions for . . . different classes [of veterans]." Economy Act of 1933, ch. 3, § 4, 48 Stat. at 9. Pursuant to the Economy Act's authorization, the President issued Exec. Order 6089, Vet. Reg. No. 1, March 31, 1933. Part I, paragraph 1(c), of this regulation, which had the force of a statute, provided for service connection for purposes of wartime disability pension benefits where a "chronic disease" became manifest to a degree of ten percent or more within one year from the date of separation from active service. The presumption applied to persons who served 90 days or more in the active service and could be rebutted by affirmative evidence to the contrary or evidence of an intercurrent injury or disease which is a recognized cause of the chronic disease. Under Vet. Reg. No. 1 (and its successor Vet. Reg. No. 1(a)), the presumption of service connection was not available to veterans of peacetime service.

Because Vet. Reg. No. 1 was issued by executive order, there is no legislative history which sheds light on its purpose and rationale. However, an opinion of the VA Solicitor, 46 Op. Sol. 140 (9-15-39), indicates that the apparent intent of the regulation was not to authorize the granting of service connection for all chronic diseases, but rather for those chronic diseases which medical information and experience indicated were of "such an insidious nature" that the disease did not become manifest to a ten-percent degree immediately upon inception but required as much as a year from the date of inception to become so manifest.

Vet. Reg. No. 1 did not include a list of chronic diseases to which the presumption of service connection would apply. The Administrator of Veterans Affairs promulgated an approved list of eighteen categories of chronic diseases for purposes of presumptive service connection in Vet. Reg. No. 1, Instruction

No. 2, dated April 12, 1933.⁵ Osteitis deformans (Padget's disease) was added to this list on August 14, 1935, by Vet. Reg. No. 1, Instruction No. 2-A. Internal VA correspondence indicates that the term "constitutional," used to describe diseases in the 1925 list, was dropped from the 1933 list because many of the diseases included on the list were no longer considered "constitutional" diseases. See Memorandum from George E. Brown, Director of Compensation, to O.W. Clark, Assistant Administrator (Mar. 24, 1933).

Instruction No. 2 also provided a special rule for determining whether a "10% degree of active tuberculosis" existed within one year of discharge. Under Instruction No. 2, active pulmonary tuberculosis was deemed to have preexisted the diagnosis by "six months in minimal (incipient) cases; nine months in moderately advanced cases; and twelve months in far advanced cases."

Some diseases on the 1925 list of "chronic constitutional diseases" were not included on the 1933 list of "chronic diseases." Diseases omitted from the 1933 list included rickets, obesity, and acidosis. As noted, supra, doubts had been expressed in the 1925 rating schedule as to whether these diseases should be considered chronic constitutional diseases. Other diseases or disease categories included in the 1925 list but omitted from the 1933 list were beri-beri, chronic cholecystitis, diabetes insipidus, gout, hemophilia, haemochromatosis, hemoglobinuria, nephrolithiasis, ochronosis, pellagra, purpura, scurvy, polycythemia (erythemia), and chronic valvulitis.

New categories of chronic disease added in 1933 which had not been included in the 1925 list were encephalitis lethargica residuals, epilepsies, organic diseases of the nervous system, psychoses, and active tuberculosis. Clearly, encephalitis lethargica and active tuberculosis were not on the 1925 list since they were covered by a statute in effect at the time that list was issued. Paralysis agitans, amoebic dysentery, and spinal meningitis, which had previously been the subject of statutory presumptions, were nonetheless omitted from the 1933 list. Presumably, paralysis agitans and spinal meningitis were considered subsumed under the heading "organic diseases of the

⁵ Diseases listed in Instruction No. 2, Vet. Reg. No. 1, were: anemia, primary; arteriosclerosis; arthritis; cardiovascular-renal disease, including hypertension; diabetes mellitus; encephalitis lethargica residuals; endocarditis; endocrinopathies; epilepsies; Hodgkin's disease; leprosy; leukemia; myocarditis; nephritis; organic diseases of the nervous system; psychoses; tuberculosis, active; and, tumors, malignant, or of the brain.

nervous system," since they were listed under that heading in the 1933 rating schedule. VA, Schedule for Rating Disabilities 35 (1933, 1st ed.). However, encephalitis lethargica, which was also under that heading in the rating schedule, was listed separately as a chronic disease.

Pursuant to Exec. Order No. 6156, issued June 6, 1933, Vet. Reg. No. 1 was superseded by Vet. Reg. No. 1(a). However, no change was made in the provision dealing with presumption of service connection, nor was any change made in the administratively-issued list of diseases.

In Pub. No. 141, 73d Cong., Congress overrode a Presidential veto to restore to veterans who entered service on or before November 11, 1918, the benefit of the presumptive service connection provisions of the World War Veterans' Act of 1924, subject to rebuttal based on clear and unmistakable evidence. In his veto message, President Franklin D. Roosevelt had stated,

Last year it was determined--and I had hoped permanently--that a service-connected disability is a question of fact rather than a question of law. In other words, each individual case should and must be considered on its merits, and there is no justification for legislative dicta which, contrary to fact, provide that thousands of individual cases of sickness which commenced 4, 5, or 6 years after the termination of the war are caused by war services. Veto message, Independent Offices Appropriation Bill (1935), H.R. Doc. No. 291, 73d Cong., 2d Sess. (1934).

However, Congress was apparently persuaded by testimony that, in severing presumptive service connection, the Government had gone back on its word to disabled veterans, Independent Offices Appropriations Bill for 1935: Hearing Before the Subcomm. of the Senate Comm. on Appropriations, 73d Cong., 2d Sess. 163 (statement of Thomas Kirby, National Legislative Chairman, Disabled American Veterans) (1934), and had placed certain disabled veterans in the position of having to develop evidence of direct service connection of their formerly presumptively service-connected disabilities many years after discharge from service. Id. at 121 (statement of Edward Hayes, National Commander, American Legion), 162 (statement of Thomas Kirby, Disabled American Veterans). Mr. Kirby harkened back to the original basis of the presumptions, stating,

In no particular has Congress ever gone deeper into any phase of veterans' relief than on the matter of the system that should be adopted to reach these men. Government authorities, outstanding private medical specialists, and experts of the veterans' organizations combined in an exchange of views on this troublesome question. From all of this evidence Congress

deliberately decided upon the presumptive provision. . . .

.

[T]he presumption clause was not based purely on medicine, but on a combination of the best professional opinion and the necessity of administration. To explain it differently, after giving the matter far more consideration and study than will be possible for this committee to devote to this particular feature, Congress voted overwhelmingly for the presumption, having in view protection of the Government and justice to the men.

Id. at 162-63. In recognition of the fact that the presumptions were based in large part on the hardships of wartime service, the provision was tailored to eliminate from the benefit of the presumptions those who had entered service after the armistice and those whose disabilities were clearly unrelated to service. Id. at 118 (statement of Sen. Reed), 121-22 (statement of Edward Hayes, American Legion).

On January 25, 1936, VA issued several regulations implementing Vet. Reg. No. 1(a) and the restoration of benefits effected through Pub. No. 141, 73d Cong. VA Regulation (VAR) 1086 specified the chronic diseases for purposes of claims of service connection under Vet. Reg. No. 1(a), while other regulations governed presumptive service connection for those veterans who enlisted before November 12, 1918, and for whom presumptive service connection was re-established under Pub. No. 141, 73d Cong. VAR 1086 incorporated as chronic diseases the same nineteen diseases specified in Instruction Nos. 2 and 2-A to Vet. Reg. No. 1, as well as the special rule from Instruction No. 2 for determining when a ten-percent degree of pulmonary tuberculosis was present. However, the group of covered diseases was effectively expanded in VAR 1086 by inclusion of definitions for some diseases which provided a broader scope of coverage. For example, the explanation of nephritis stated that nephrolithiasis (kidney stones) associated with nephritis could be considered a part of the same condition. The explanation of endocarditis indicated that that term was intended to cover all forms of valvular heart disease. The term "organic diseases of the nervous system" was defined by reference to pages 34 and 35 of the 1933 Schedule for Rating Disabilities, which listed twenty-four diseases or disease categories under that term.

Among the regulations implementing Pub. No. 141, 73d Cong., was VAR 1087, which specified that a chronic constitutional disease becoming manifest within one year of separation from service to a degree of ten percent or more would be presumed service-connected. VAR 1088 provided that the one-year presumption of service connection for the chronic constitutional

diseases for those veterans specified in Pub. No. 141, 73d Cong., would include the diseases listed on page 75 of the 1925 Schedule for Rating Disabilities, those diseases listed in Extension 6 of that schedule, and the diseases specified in the second proviso of section 200 of the World War Veterans' Act of 1924, as amended, i.e., tuberculosis, amoebic dysentery, spinal meningitis, paralysis agitans, neuropsychiatric disease, and encephalitis lethargica. VAR 1094 listed more than forty conditions which would be considered neuropsychiatric diseases for purposes of section 200 of the World War Veterans' Act of 1924.

Also on January 25, 1936, VA promulgated VARs 1105 and 1109, which revived with some modification the presumption regarding dental disabilities which had been found in Veterans' Bureau Reg. No. 170, section 9158. VARs 1105 and 1109, which were codified at former 38 C.F.R. §§ 2.1105 and 2.1109 (1938), provided a rebuttable presumption of service connection for dental disabilities incurred by veterans with six months or more wartime service beginning prior to November 11, 1918, where the disability was shown to have existed within one year of the date of service discharge, release from active duty, furlough to the reserves, or July 2, 1921, whichever date was earlier. No specific dental diseases or conditions to which the presumption of service connection would apply were identified in the regulations. Under the authority of the Act of July 13, 1943, ch. 233, § 9, 57 Stat. 554, 556, which extended Vet. Reg. No. 1(a), part I, para. 1(a) to include World War II service, these regulations were amended in November 1943 to include World War II veterans. 8 Fed. Reg. 15,462 (1943). On September 26, 1947, 38 C.F.R. § 2.1109 was revoked. 12 Fed. Reg. 8335 (1947). This had the effect of eliminating reference to release from active duty or furlough to the reserves. Section 2.1105 was recodified as former section 3.105 in 1948. 13 Fed. Reg. 7003 (1948).

B. Tropical Diseases

The list of chronic diseases issued in 1933 under Vet. Reg. No. 1 included only one disease, leprosy, that could be classified as a "tropical" disease. By 1945, it was recognized that veterans had been exposed to other tropical diseases in some geographic areas. On September 19, 1945, Administrator of Veterans Affairs General Omar Bradley issued a service letter which provided in part that statements of a veteran with tropical service as to relapses of malaria within one year after service discharge would be accepted as substantiating a claim for service connection of the disease. Section I of VA Circular No. 8, December 28, 1945, provided clarification of that service letter, indicating that statements submitted within one year of discharge by a veteran with service in a tropical region as to attacks of malaria within one year of discharge would be accepted as establishing service connection for malaria if not inconsistent with other evidence.

Additional guidelines, entitled "Service Connection for Malaria and Chronic Diseases Characteristically Tropical in Origin; Ratings in Malaria Cases," were issued in VA Circular No. 22, January 26, 1946. This circular provided that service connection for malaria "or other chronic disease characteristically tropical in origin" could be established where the disease was diagnosed within one year of service discharge in the absence of evidence of inception prior to or subsequent to service. No chronic diseases other than malaria were specifically identified in the circular.

On January 3, 1947, VA published Technical Bulletin 8-6, "Disability Ratings for Malaria and Chronic Diseases Characteristically Tropical in Origin," which was intended to supplement and clarify VA Circular No. 22. This bulletin specified that amebic dysentery, bacillary dysentery, filariasis (Bancroft's type), leishmaniasis (including kala-azar), schistosomiasis, trypanosomiasis, yaws, and malaria could be considered chronic diseases of tropical origin and that presumptive service connection could be established for these diseases if "shown by proper diagnosis" made within one year from date of service discharge in cases of veterans with service in the tropics or in localities having a high incidence of such diseases. Technical Bulletin 8-6 also made clear that presumptive service connection was only available in cases of wartime service. Technical Bulletin 8-7, dated January 23, 1947, provided additional information clarifying the rating policy in malaria cases. Technical Bulletin 8-43, dated August 19, 1947, modified the terms of Technical Bulletin 8-6, stating that service connection is authorized "when the disease is shown by satisfactory evidence to have been present to 10 percent disabling degree within one year from date of termination of active wartime service, and is subsequently shown by proper diagnosis."

These service letters and technical bulletins were replaced by VAR 1102 (codified in former 38 C.F.R. § 3.102), promulgated September 26, 1947. VAR 1102 incorporated verbatim the original terms of Technical Bulletin 8-6, referred to above, including the eight listed tropical diseases. The following year, Congress enacted a statutory list of chronic and tropical diseases for which service connection could be presumed.

III. Forerunners to Modern Statutory Presumptions of Service Connection: 1941-1948

With the onset of World War II, Congress focused concern on VA's procedures for determination of claims for service connection as applied to veterans who had served under wartime conditions. In the Act of December 20, 1941, ch. 603, 55 Stat. 847, Congress authorized and directed the Administrator of Veterans Affairs to require that "in each case where a veteran is seeking service connection for any disability due consideration shall be given to the places, types, and circumstances of his

service." The statute incorporated VA's policy of resolving every reasonable doubt in favor of the veteran and specified liberal evidentiary rules for proof of service connection in the case of combat veterans. These provisions were similar to those now codified at 38 U.S.C. § 1154 (formerly § 354).

The legislative history of this measure makes clear that it was intended to overcome lack of official records establishing incurrence or aggravation of disease or injury and treatment thereof under wartime conditions. H.R. Rep. No. 1157, 77th Cong., 1st Sess. 2 (1941). Congress recognized that the absence of official records of care or treatment could be readily explained in many cases by the conditions surrounding service by combat veterans. Id. at 2-3. However, Congress emphasized that the question of service connection would remain one of fact, to be determined on the evidence of the particular case. The language of the statute was selected "to make clear that a statutory presumption in connection with determination of service connection is not intended." Id. at 2.

From 1945 to 1947, several bills were introduced in Congress which would have established presumptive service connection, rebuttable only by clear and convincing evidence, for any injury or disease existing at any time within five years after discharge from active service in a veteran of service in World War II. In a report on one such bill, H.R. 2015, 79th Cong., 1st Sess., introduced Feb. 6, 1945, which VA opposed, the Administrator of Veterans Affairs commented:

The bill makes no distinction as to the length, or type of service or as to the various diseases. Certain diseases, particularly cardiovascular-renal disease, endocrinopathies, organic diseases of the central nervous system, and the psychoses, reflect a multitude of etiologies, some of which, when analyzed, are not even remotely affected by any stress or strain of service. Under the terms of this bill, if enacted into law, a veteran with only 1 day active service in World War II and whose disease was first detected 5 years less 1 day from termination of his active service . . . might very well obtain presumptive service connection"

Letter from Frank T. Hines, Administrator of Veterans Affairs, to John E. Rankin, Chairman, House Committee on World War Veterans' Legislation (Aug. 9, 1945). VA opposed this and similar bills on the basis that circumstances had changed since enactment of the presumptive provisions relating to World War I veterans in terms of improvement in organization of the agency, liberalization of criteria governing service connection, and changes in the "principles and practice of medicine." Id. VA asserted that the then-existing provisions of law governing presumptive service connection were "sufficiently liberal to warrant favorable consideration of any meritorious claim." Id.

On May 23, 1947, Edith Nourse Rogers, Chairman, House Committee on Veterans' Affairs, informally requested that VA develop a draft bill amending Vet. Reg. 1(a), part I, to include a conclusive presumption of service connection for tropical diseases diagnosed within one year after separation from active service. According to VA records, Ms. Rogers expressed particular concern with providing relief in claims involving malaria, but wanted the bill to be broad enough to cover all tropical diseases. Memorandum for File, L.A. Lawlor (May 26, 1947). She reportedly indicated that she did not want service connection to depend on any specific degree of disability becoming manifest within one year, as was then the case with regard to chronic diseases. Id.

As a result of this request, VA provided a draft bill, introduced as H.R. 3650, 80th Cong., 1st Sess., which would have provided a conclusive presumption of service connection for tropical diseases diagnosed within one year of service separation. H.R. 3650 was introduced on May 28, 1947. Although VA drafted the bill, as requested by Ms. Rogers, VA opposed establishing a conclusive presumption of service origin for tropical diseases. VA pointed out that VA regulations already provided a rebuttable presumption for certain tropical diseases (amoebic dysentery, bacillary dysentery, filariasis (Bancroft's type), leishmaniasis including kala-azar, schistosomiasis, trypanosomiasis, yaws, malaria, and leprosy), developing to a degree of ten percent within one year of separation from service. Letter from General Omar Bradley, Administrator of Veterans Affairs, to Edith Nourse Rogers, Chairman, House Comm. on Veterans' Affairs (June 5, 1947). The agency felt that Vet. Reg. 1(a) provided sufficient authority to "adjust any errors or injustices" which might occur. Id. Additionally, VA noted that the conclusive presumption provided in H.R. 3650 was applicable even to defects, infirmities, or disorders noted at the time of examination, acceptance, or enrollment for service and that the bill did not require service in the tropics before the presumption could be invoked. Id. Finally, VA stated "[e]xperience has demonstrated that a conclusive presumption works to the advantage of undeserving cases and that a rebuttable presumption, such as is presently provided . . . is adequate for just cases and is in the interests of sound administration." Id.

On July 21, 1947, Ms. Rogers, speaking in favor of H.R. 3889, 80th Cong., 1st Sess., another bill to amend Vet. Reg. 1(a), recognized that VA had regulations in place at that time under which it applied a presumption of service connection to certain diseases, including tropical diseases. She noted, however, that "[o]ne Veterans' Administration office will interpret the regulation in one way and another office will interpret it in another way." 93 Cong. Rec. 9777 (daily ed. July 21, 1947).

Although H.R. 3650 was not enacted, a provision relating to presumption of service connection for tropical diseases was

included in H.R. 3889, 80th Cong., which was enacted in 1948 and which mandated by statute presumptions of service connection as to specified chronic and tropical diseases.

IV. Statutory Codification: 1948

The Act of June 24, 1948, ch. 612, 62 Stat. 581 (hereinafter cited as Pub. L. No. 748, 80th Cong.), amended Vet. Reg. No. 1(a), part I, paragraph I(c), to specify by statute a list of chronic diseases and tropical diseases for which service connection could be presumed in the absence of affirmative evidence to the contrary. The list included twenty-one chronic diseases or categories of chronic disease and sixteen tropical diseases. The list of chronic diseases was similar to the list of diseases for which service connection could be presumed under then-existing VA regulations, with the addition of several diseases.⁶

The Administrator of Veterans Affairs was authorized under Pub. L. No. 748, 80th Cong., to add chronic diseases to the list.⁷ The legislative history of H.R. 3889, 80th Cong., enacted as Pub. L. No. 748, 80th Cong., contains multiple references to VA's long-standing authority to establish presumptions of service connection for chronic diseases for purposes of compensation under Vet. Reg. No. 1(a), part I. Committee reports on H.R. 3889 include the following explanation of the effects of the bill:

The committee realizes that the Administrator [of Veterans' Affairs] has authority under subparagraph (c) of paragraph 1, part I, Veterans Regulation No. 1 (a), as amended, to include by regulation all of the diseases specified in section 1 of the bill as chronic

⁶ Pub. L. No. 748, 80th Cong., largely codified the list of chronic diseases for which a presumption of service connection was available under VA regulations and added several new diseases, i.e., bronchiectasis, calculi of the kidney, bladder, or gallbladder, cirrhosis of the liver, coccidioidomycosis, osteomalacia, ulcers, peptic (gastric or duodenal), and scleroderma. Buerger's disease and Raynaud's disease were included as subcategories of cardiovascular-renal disease. "[T]umors, malignant, or of the brain" was changed to "tumors, malignant." Leprosy was included in the tropical diseases, having been transposed from VA's list of chronic diseases. Psychoses were not included in the statutory list.

⁷ Section 1 of the act authorized presumptive service connection for certain listed chronic diseases "and such other chronic diseases as the Administrator of Veterans' Affairs may add to this list."

diseases which are to be presumed to be service connected under the stated conditions. However, the committee believes it preferable to have the law specifically show that the diseases stated shall be presumed to be service connected when found to exist within a certain period after separation from active service.

H.R. Rep. No. 808, 80th Cong., 1st Sess. 2 (1947); S. Rep. No. 1536, 80th Cong., 2nd Sess. 2, reprinted in 1948 U.S. Code Cong. Serv. 2114, 2115. Thus, Congress recognized VA's authority to create presumptions for chronic diseases under the Veterans Regulations, and, while preferring to specifically identify by statute certain disabling conditions for which presumptive service connection would be provided, did not question or attempt to limit VA's authority to create such presumptions administratively.

The tropical diseases which could be presumed service connected under the statute essentially included seven of the eight diseases for which a presumption was available under VAR 1102 (the exception being trypanosomiasis), plus nine additional tropical diseases.⁸ The tropical disease list was stated in an open-ended manner, apparently permitting the administrative addition of other diseases.⁹ Also, the statute permitted flexibility as to the presumptive period, based on information on incubation periods from "standard and accepted treatises."

In a departure from then-existing laws, Pub. L. No. 748, 80th Cong., extended the availability of presumptive service connection to veterans who had served in peacetime. However, the provisions governing presumption of service connection for those

⁸ The sixteen tropical diseases included in the statute were: leprosy (transposed from the regulatory chronic disease list); black water fever; dysentery; cholera; leishmaniasis; filariasis; loiasis; onchocerciasis; oroya fever; dracontiasis; pinta; plague; schistosomiasis; malaria; yaws; and, yellow fever. The statute also authorized presumptive service connection for resultant diseases or disorders originating because of therapy for, or as a preventive of, the listed diseases.

⁹ While section 1 of Pub. L. No. 748, 80th Cong., specifically provided that the Administrator of Veterans Affairs could add to the list of chronic diseases by regulation, the provisions of sections 1 and 2 relating to tropical diseases did not contain explicit reference to the Administrator. Instead, those provisions merely stated that tropical diseases "such as" those specified "and others" could be service connected on a presumptive basis.

with peacetime service were not as liberal as those applicable to veterans having served in wartime. The presumption of service connection applicable to peacetime service applied only to tropical diseases (not chronic diseases) and applied only to veterans with six months or more of service (rather than 90 days service, as in the case of wartime veterans). The presumption as to tropical diseases for veterans who served during peacetime was rebuttable by "clear and unmistakable evidence" that the tropical disease had its inception prior or subsequent to service.

Veterans' service organizations, dissatisfied with the list of chronic diseases established by VA, had urged Congress to establish "a more comprehensive list by statute." E.g., Chronic and Tropical Diseases: Hearing Before the Senate Committee on Finance, 80th Cong., 2d Sess. 2, 3-4 (May 25, 1948) (statement of T.O. Kraabel, Director, National Rehabilitation Commission, American Legion). The American Legion stated "[w]e are coming to Congress because we are having so much difficulty in getting the Veterans' Administration to add to that chronic disease list those diseases which medical experience shows impel a conclusion of service connection." Id. at 30, 31 (statement of Charles W. Stevens, Assistant Director for Claims, National Rehabilitation Commission, American Legion).

The American Legion took the position that, in certain circumstances, "the chronic nature and extent of the disease affirmatively establishes a conclusion of service origin," id. at 3 (statement of T.O. Kraabel), and that, if a disease develops to a degree of ten percent or more within one year of service, it is in fact directly, not presumptively, service connected. Id. at 31-32 (statement of Charles W. Stevens.)

The American Legion had also expressed dissatisfaction with VA's application of direct and presumptive service connection as to tropical diseases. A VA witness had testified:

With regard to these tropical diseases, the present list is thought to be adequate. Tropical diseases in general, with the exception of malaria, have produced no major problem as yet, and it is thought that malaria has been adequately taken care of.

Service connection is granted for any condition manifested within the known incubation period following the veteran's discharge from service.

Id. at 28 (statement of Henry Q. Brooks, Assistant Director, Veterans' Claims Service, VA). In contrast to this testimony, The American Legion stated, "[w]e have had difficulty in securing recognition of service origin of many chronic and tropical diseases that we feel are the direct result of war service." Id. at 32 (statement of Charles W. Stevens).

The Veterans of Foreign Wars noted that it favored the inclusion of a presumption for peacetime service "because of the unusual circumstances involving our armed services today." Id. at 32 (statement of Omar B. Ketchum, Veterans of Foreign Wars). The Veterans of Foreign Wars expressed the view that the uncertainties of the cold war, "which might erupt into a shooting war," made peacetime service following World War II different from the prior circumstances of peacetime service. Id.

Internal VA memoranda indicate that VA officials believed that presumption of service connection as to the additional diseases proposed to be added to the list of chronic diseases was not warranted on the basis of scientific and medical knowledge. In a memorandum responding to a request from the Assistant Administrator for Legislation for comment on the inclusion in the bill of eight diseases not included in VA's list of chronic diseases, the Assistant Administrator for Claims stated his view that "[o]nly one of the 8 diseases listed presents any likelihood of actual incurrence in service or causal relationship thereto. This is coccidioidosis or coccidioidomycosis, commonly known as San Joaquin Valley fever." Memorandum from the Assistant Administrator for Claims to the Assistant Administrator for Legislation (Oct. 20, 1947). The Assistant Administrator for Claims also stated in the memorandum:

The present list of "chronic" diseases for which service connection is granted . . . is one deeply rooted in the history of the claims program, but one regarding which it would be futile to contend that inclusion of a disease in the list is substantiated by any likelihood of actual incurrence in service or in any way resulting from the circumstances of service. The diseases, when correctly diagnosed, are indeed of chronic type, and their presence within a year after discharge raises a strong probability that part of the course of the disease (not necessarily an early part, unless the service was much longer than the minimum 90 days required) coincided with the period of service, but the likelihood that any of their course was influenced by the facts or circumstances of service is extremely remote.

The Chief Medical Director concurred in the memorandum.

In a November 18, 1947, report to the Senate Committee on Finance on H.R. 3889, 80th Cong., expressing opposition to the bill, Administrator of Veterans Affairs General Omar Bradley stated:

It is believed that extreme care should be exercised in augmenting the list of diseases to be afforded the presumption. It is the view of the Veterans' Administration that this can best be accomplished by continuing the existing Veterans

Regulation No. 1(a), part I, paragraph I(c), and administrative authority to make the medical and adjudicatory determinations.

Determination governing the selection of diseases to be included under the regulation is essentially one of an involved medical and adjudicatory nature. If a list of diseases is provided by statute it is suggested that the consideration of additions . . . would require detailed technical considerations by the Congress which in the opinion of the Veterans' Administration can best be handled administratively. . . . This statement is made in the light of experience under the War Risk Insurance Act, as amended, and the World War Veterans' Act, 1924, as amended

Letter from General Omar Bradley, Administrator of Veterans Affairs, to Eugene D. Millikin, Chairman, Senate Comm. on Finance (Nov. 18, 1947), reprinted in 1948 U.S. Code Cong. Serv. 2116, 2118.

General Bradley also noted that there was no need for presumptions as to peacetime service, because emergency conditions resulting in lack of thorough medical examinations or loss of records, the conditions which justify application of wartime presumptions, do not exist in peacetime. Letter from General Bradley (Nov. 18, 1947), supra, reprinted in 1948 U.S. Code Cong. Serv. at 2117; letter from General Omar Bradley, Administrator of Veterans Affairs, to Edith Nourse Rogers, Chairman, House Comm. on Veterans' Affairs (July 7, 1947).

Congress, while recognizing that VA had the discretion to provide presumptions of service connection by regulation, articulated several bases for providing presumptions of service connection by statute. It was thought that a legislative enactment would promote uniformity of decision making in the area of presumptions. It was observed that VA regulations "are interpreted differently in different offices." 93 Cong. Rec. 9777 (daily ed. July 21, 1947) (statement of Rep. Rogers). Congress also discussed the need to "modernize" VA regulations to "catch up with the things that happened in [World War II]." Id. (statements of Reps. Johnson and Patterson).

Statutory enactment of presumptions as to tropical diseases was felt necessary due to the long incubation periods for some tropical diseases and the fact that suppressive medications could mask the development of symptoms of the disease. Id. (statement of Rep. Patterson). Congress desired to provide for presumptions of service connection for tropical diseases developing after peacetime service and noted that VA had no authority under Vet. Reg. 1(a) to provide presumptions applicable to peacetime service. E.g., H.R. Rep. No. 808, 80th Cong., 1st Sess. 2 (1947). Finally, the "extremely dangerous and very painful"

nature of certain tropical diseases was noted. 93 Cong. Rec. 9777 (daily ed. July 21, 1947) (statement of Rep. Rogers).

The Senate report indicated that the cost of the bill was anticipated to be negligible since the bill generally codified existing regulatory presumptions. S. Rep. No. 1536, 80th Cong., 2nd Sess. 2, reprinted in 1948 U.S. Code Cong. Serv. 2114, 2115; see also 93 Cong. Rec. at 9777 (daily ed. July 21, 1947) (statement of Rep. Rogers).

As originally proposed, H.R. 3889, 80th Cong., would have included "functional diseases of the nervous system" in the list of chronic diseases. The inclusion of functional diseases of the nervous system was urged by the veterans' service organizations. E.g., Chronic and Tropical Diseases: Hearing Before the Senate Comm. on Finance, 80th Cong., 2d Sess. 4, 8-9 (May 25, 1948) (statement of H.D. Shapiro, M.D., Senior Medical Consultant, National Rehabilitation Commission, American Legion). Functional disease of the nervous system was considered as including both psychoses and psychoneuroses. Id. at 8. By regulation, VA had included psychoses as diseases which could be presumptively service connected under Vet. Reg. No. 1(a) since 1933, but had not included psychoneurotic disorders.

Neither functional disorders of the nervous system, nor psychoses, were included in the list of chronic diseases in Pub. L. No. 748, 80th Cong., as enacted. The category "functional disorders of the nervous system" was struck from the bill by the Senate Committee on Finance after receiving the report of the Veterans Administration that inclusion of that category would result in additional cost which could not be estimated. Letter of November 18, 1947, supra, reprinted in 1948 U.S. Code Cong. Serv. at 2119. A VA physician had expressed the opinion at a hearing of the Senate Committee on Finance that there would be a large number of claims under the bill based on nervous disorders. Chronic and Tropical Diseases: Hearing Before the Senate Comm. on Finance on H.R. 3889, 80th Cong., 2d Sess. 27 (May 25, 1948) (statement of J.R. Boswell, M.D., Medical Division, Veterans Administration). Although VA's report to the Committee on Finance was otherwise silent on the issue, VA's enrolled enactment report to the Director, Bureau of the Budget, on the bill indicated that VA's primary objection to the bill as originally introduced was inclusion of functional disorders of the nervous system. Letter from O.W. Clark, Executive Assistant Administrator, Veterans Administration, to James E. Webb, Director, Bureau of the Budget (June 17, 1948). No debate or discussion of the reasons for the change appears to have been recorded.

The Senate Committee on Finance also added without explanation myocarditis and encephalitis lethargica residuals to the list of chronic diseases and deleted fungus diseases and relapsing fever from the list of tropical diseases in H.R. 3889 as originally introduced. In addition, the Committee deleted the

words "amoebic or bacillary" describing dysentery in the tropical disease list. Both Houses of Congress concurred in the amendments without debate or discussion. See 94 Cong. Rec. 8104 (daily ed. June 12, 1948); 94 Cong. Rec. 8254 (daily ed. June 14, 1948).

Following enactment in 1948 of the statutory list of chronic and tropical diseases for which the presumption of service connection was available, VA revised its regulations governing presumptive service connection on February 9, 1949, to implement the statute. 14 Fed. Reg. 571 (1949). The disease leprosy was retained in the revised regulatory list of chronic diseases although the statute had included it only as a tropical disease. Leprosy was one of twelve diseases or disease categories included in VA's 1949 regulatory list of chronic diseases which was not on the 1948 statutory list of chronic diseases. Also included in the VA regulatory list but not in the statutory list were: atrophy, progressive muscular; brain hemorrhage; brain thrombosis; myasthenia gravis; myelitis; palsy, bulbar; paralysis agitans; psychoses; sclerosis, amyotrophic lateral; sclerosis, multiple; and, syringomyelia. Effective October 19, 1949, purpura idiopathic, hemorrhagic was added to the regulatory chronic-disease list, 14 Fed. Reg. 6176 (1949), and on August 31, 1950, sarcoidosis was added by regulation to the list of chronic diseases. 15 Fed. Reg. 5906 (1950).

V. Miscellaneous Liberalizations of Presumptive Provisions: 1950 to 1966

Following the statutory codification in 1948 of the list of chronic and tropical diseases for which service connection could be presumed, legislation was enacted which made specific additions to and modifications of the statutory presumptions. Several of these amendments pertained to the presumptive period for specific disease categories.

Act of June 23, 1950, ch. 352, 64 Stat. 255, amended Vet. Reg. No. 1(a) to extend the presumptive period for active pulmonary tuberculosis from one year to three years after separation from service. The Senate report on the bill stated that extension of the presumption was "fully justified, in view of the nature of this particular chronic disease." S. Rep. No. 1745, 81st Cong., 2d Sess. 2 (1950), reprinted in 1950 U.S. Code Cong. Serv. 2562, 2563. The report went on to state "[t]he entitlement to compensation and preference in hospitalization generally resulting will lessen the need of veterans to engage in labor injurious to their health, encourage them to take proper measures for recovery, and thus result in improving the health of the Nation generally." Id. The Committee also noted that the World War Veterans' Act of 1924 provided a longer presumptive period for active tuberculosis suffered by World War I veterans than the presumptive period mandated in this bill. Id. at 1-2, reprinted in 1950 U.S. Code Cong. Serv. at 2563.

VA, in its report on a similar bill, distinguished the situation of World War I veterans, stating:

[T]he facilities and procedures of the service departments in the examination of recruits prior to their induction into service and their facilities for rendering medical care and treatment, the maintenance of records in individual cases and the furnishing of these records to the Veterans' Administration all represent a great advancement and improvement over comparable situations as they existed during World War I.

. . . [T]he advances in medical science since World War I have facilitated the detection and diagnosis of diseases to such an extent that further extension of statutory presumptions of service connection is not believed to be indicated.

Letter from Carl R. Gray, Jr., Administrator of Veterans Affairs, to John E. Rankin, Chairman, House Committee on Veterans' Affairs (Feb. 23, 1950), reprinted in 1950 U.S. Code Cong. Serv. at 2564-65. VA concluded:

A statutory provision which requires a finding of service connection for a disability which cannot be shown to be due to service is inconsistent with the theory of providing compensation for disability or death resulting from injury or disease incurred in line of duty in active military or naval service, and results in providing compensation for disability or death due to causes which are not in any way connected with military or naval service.

Id., reprinted in 1950 U.S. Code Cong. Serv. at 2565.

The Act of August 8, 1953, ch. 395, 67 Stat. 506, amended Vet. Reg. No. 1(a) to extend from one to three years the presumptive period for all other types of active tuberculosis. The committee reports on the bill indicated that, in establishing the same presumption for both pulmonary and nonpulmonary forms of tuberculosis, Congress relied on a VA report indicating that VA was not aware of any medical or other basis for a distinction between these types of tuberculosis. S. Rep. No. 634, 83d Cong., 1st Sess. 1 (1953), reprinted in 1953 U.S.C.C.A.N. 2278, 2279.

The Act of October 12, 1951, ch. 499, 65 Stat. 421, amended Vet. Reg. No. 1(a) to extend from one to two years the presumptive period for multiple sclerosis. The presumptive period was extended because of "the lack of knowledge as to this disease and the great variance in the amount of time in which the disease manifests itself." S. Rep. No. 750, 82d Cong., 1st Sess. 2 (1951), reprinted in 1951 U.S. Code Cong. Serv. 2340.

Evidence before the Senate indicated that the period necessary to diagnose multiple sclerosis was generally from eight to twenty months after its inception, but was as long as five years in some instances. Id.

VA opposed enactment of this legislation, which, prior to amendment by the Senate Committee on Finance, would have extended the presumptive period to three years. VA stated:

Although the exact cause of the disease is unknown, there is nothing in the circumstances of military service in time of war which from a medical and scientific standpoint would warrant a presumption of fact that a manifestation of the disease 3 years after discharge is in any way related to the fact or circumstances of service. In this connection, it does not appear that the disease is any more prevalent among the veteran population than the nonveteran population.

Letter from Carl R. Gray, Jr., Administrator of Veterans Affairs, to Walter F. George, Chairman, Senate Committee on Finance (June 29, 1951), reprinted in 1951 U.S. Code Cong. Serv. at 2344. VA commented that singling out multiple sclerosis for a longer presumptive period would be discriminatory and could serve as a precedent for extending the presumptive period for other chronic diseases. Id. VA also stated that the amendment would place "cases without merit, from the standpoint of service connection" on a par with cases involving conditions medically proven to be service connected. Id. It was also noted that the symptoms of the disease are such that the victim does not seek treatment until disability arises. 97 Cong. Rec. 6817 (daily ed. June 20, 1951) (statement of Rep. Teague).

Pub. L. No. 86-187, 73 Stat. 418 (1959), extended the presumptive period for multiple sclerosis from two to three years. Again, the rationale for extending the presumptive period was that the disease was difficult to diagnose in the early stages. S. Rep. No. 660, 86th Cong., 1st Sess. (1959), reprinted in 1959 U.S.C.C.A.N. 2159. The Senate report on the measure noted that medical specialists, primarily neurologists, were the only persons likely to diagnose the disease in its early stages and that the average person "would not be inclined to consult a neurologist for the original symptoms." Id. VA opposed the measure on the grounds of lack of a "sound medical basis." Id.

Pub. L. No. 87-645, § 3, 76 Stat. 441, 442 (1962), extended the presumptive period for multiple sclerosis from three years to seven years. This change was based on the opinion of the scientific staff of the National Institutes of Health that seven years was not an unreasonable period to recognize as the interval between onset and diagnosis of multiple sclerosis. S. Rep. No. 1806, 87th Cong., 2d Sess. 5 (1962), reprinted in 1962 U.S.C.C.A.N. 2365, 2369; H.R. Rep. No. 1469, 87th Cong., 2d Sess. 5 (1962) (incorporating letter from Dr. Richard L.

Masland, Director, National Institute of Neurological Diseases and Blindness, to Olin E. Teague, Chairman, House Committee on Veterans' Affairs (May 16, 1961)).

Information was also presented to Congress indicating that the National Multiple Sclerosis Society had reported that the average elapsed time between the onset and diagnosis of multiple sclerosis was considered to be 7.2 years. Miscellaneous Compensation Legislation: Hearings Before the Subcomm. on Compensation and Pensions of the House Comm. on Veterans' Affairs, 87th Cong., 1st Sess. 719-20 (April 26, 1961) (statement of Rep. Hugh J. Addonizio). This information was confirmatory of certain of the information provided to the 85th Congress by Congressman Addonizio, which included reports of studies concerning the average time period between the onset and diagnosis of multiple sclerosis. Service Connected Compensation: Hearings Before the Subcomm. on Compensation and Pension of the House Comm. on Veterans' Affairs, 85th Cong., 2d Sess. 3820-31. VA opposed this extension, stating that existing provisions were considered quite liberal from a medical standpoint and that disease becoming manifest after the presumptive period can nonetheless be service connected on a case-by-case basis. Letter from J.S. Gleason, Administrator of Veterans Affairs, to Harry F. Byrd, Chairman, Senate Committee on Finance (July 10, 1962), reprinted in 1962 U.S.C.C.A.N. at 2369, 2370.

Pub. L. No. 86-188, 73 Stat. 418 (1959), extended the presumptive period for Hansen's disease (leprosy) from one to three years. The Senate report indicated that the minimum incubation period of Hansen's disease was not definitely established, but that it was known to vary from several months to several years. S. Rep. No. 661, 86th Cong., 1st Sess. 2 (1959), reprinted in 1959 U.S.C.C.A.N. 2160, 2161. The report also noted that the Veterans Administration had commented that its records showed only 165 leprosy cases on the compensation and pension roles and that direct service connection was generally granted in leprosy cases where the veteran served in an area where the disease is prevalent. Id. at 1-2, reprinted in 1959 U.S.C.C.A.N. at 2160-61.

The Act of October 30, 1951, ch. 638, 65 Stat. 694, provided a presumption of service connection, only for purposes of hospitalization and medical treatment, for active psychosis developing within two years of separation from service in certain wartime veterans. Benefits other than hospital and medical treatment, e.g., disability compensation, were still available only if psychosis were directly service connected or arose within the one-year presumptive period provided for chronic diseases generally. The Senate report on this measure indicates that the extension of this presumption of service connection was thought necessary in part because of the large number of World War II veterans (estimated at that time to be 9,000) awaiting hospitalization for nonservice-connected psychosis. S. Rep. No. 749, 82d Cong., 2d Sess. (1951), reprinted in

1951 U.S.C.C.A.N. 2563, 2564. These veterans were reportedly having difficulty obtaining necessary treatment from VA or from any other source. Id. Recognizing that psychosis "is not only an individual problem but involves broad social aspects as well," the Senate Committee on Finance felt it was essential to provide priority care at VA facilities to veterans afflicted with this disorder. Id.

Several bills were introduced in the early 1950's which would have extended the presumption of service connection for psychosis beyond one year for purposes of all available benefits. H.R. 5891, 82d Cong., 2d Sess., would have extended the presumption of service connection as to psychosis to two years. H.R. 5892, 82d Cong., 2d Sess., would have extended the presumption for psychosis to three years. At a House subcommittee hearing on these bills, a representative of The American Legion testified that for functional psychoses, those psychoses for which no specific cause can be determined, the presumptive period should be extended because "no one today can tell with certainty the cause or date of onset of such psychosis." Two-Year Presumptive Period for Disease of Psychosis: Hearing Before Subcomm. of the House Comm. on Veterans' Affairs, 82d Cong., 2d Sess. 743-44 (1952) (statement of Dr. H.D. Shapiro, Senior Medical Consultant, National Rehabilitation Commission, American Legion). It was noted that development of psychosis is slow and insidious and it can be present to a disabling degree for months or years before being recognized. Id. at 744. Representatives of other veterans' organizations testified that all psychoses should be covered by a two or three-year presumptive period for compensation purposes. Id. at 751 (statement of A.M. Downer, Assistant Legislative Representative, Veterans of Foreign Wars); id. at 754-58 (statement of Rufus Wilson, Assistant Service Director, AMVETS). Congress' action the prior year establishing a two-year presumption for psychosis for purposes of hospital and medical treatment only was criticized as "a complete breaking away from the historic aspect of service-connecting presumptive disability claims." Id. at 755 (statement of Rufus Wilson).

The Administration opposed extension of the presumptive period for psychosis. VA's report pointed out that the time of onset of a psychiatric disorder is not necessarily indicative of its cause, which may be hereditary or inherent in the individual. VA's report also pointed out that direct service connection may be provided for psychiatric disorders appearing after the presumptive period and that extension of the presumptive period for psychosis could be cited as precedent for extending the period for other chronic diseases. Finally, VA indicated that the costs of the bill, if enacted, would be "very substantial." Letter from Carl R. Gray, Administrator of Veterans Affairs, to Walter F. George, Chairman, Senate Committee on Finance (Mar. 26, 1952). None of these proposals to extend the presumptive period for psychosis to two years for purposes of all veterans' benefits were enacted.

Vet. Reg. No. 7(a), promulgated by Exec. Order 6233 (July 28, 1933), authorized provision of dental services and dental appliances for service-connected dental conditions. Under former 38 C.F.R. § 3.105, dental conditions appearing in certain wartime veterans up to one year following separation from service could be presumed service-connected, even if they did not become manifest to a compensable degree within that period. The large number of veterans seeking dental services strained VA facilities and VA's budget. See, e.g., letter from H.V. Stirling, Deputy Administrator of Veterans Affairs, to Edith N. Rogers, Chairman, House Committee on Veterans' Affairs (July 24, 1953) (indicating a backlog of 306,676 applications for outpatient dental services as of June 30, 1953, and an estimated cost of \$19 million to provide treatment to eligible applicants). Congress imposed limitations on appropriations for treatment of dental conditions in the appropriation acts for the fiscal years ending June 30, 1954, and June 30, 1955, which limited use of appropriations for provision of outpatient dental treatment and dental appliances for veterans with noncompensable service-connected dental conditions to those dental conditions in existence at the time of service discharge. See Second Independent Offices Appropriation Act, 1954, ch. 241, 67 Stat. 187, 191 (1953); Independent Offices Appropriation Act, 1955, ch. 359, 68 Stat. 272, 291 (1954). This limitation had the effect of eliminating most eligibility for dental treatment based on the presumption of service connection, since it was believed that very few dental conditions service connected on a presumptive basis were compensable in degree. Memorandum from the Assistant Administrator for Claims, Veterans Administration, to the Deputy Administrator of Veterans Affairs (Aug. 24, 1953). The Act of July 15, 1954, ch. 506, 68 Stat. 477, enacted three weeks after the Independent Offices Appropriation Act of 1955, exempted veterans of wars prior to World War I, and World War II veterans receiving vocational rehabilitation, from the limitation on dental treatment imposed by the appropriation act.

In 1954, the Veterans Administration amended former 38 C.F.R. § 3.105 to eliminate the presumption of service connection for dental disabilities appearing within one year of service discharge. 19 Fed. Reg. 769 (1954). Among the factors considered in connection with this amendment were Congress' action in limiting the availability of dental treatment and improvements in service department dental records which, it was thought, obviated the need for the presumption. Memorandum from Assistant Administrator for Claims, Veterans Administration, to Deputy Administrator of Veterans Affairs (Aug. 24, 1953). While it was recognized that, unlike Congress' action, amendment of the regulation would affect compensable as well as noncompensable cases, the number of compensable dental conditions was thought to be very small. Id.

In 1955, Congress amended Vet. Reg. No. 7(a) to limit on a permanent basis the provision of outpatient dental treatment and

dental appliances. Act of June 16, 1955, ch. 152, 69 Stat. 161. Under that law, outpatient dental services and treatment, and related dental appliances, could generally be provided only for service-connected conditions or disabilities of a compensable degree, those shown to have been in existence at the time of service discharge, and those due to combat wounds or other service trauma or suffered by former prisoners of war. The exception for pre-World War I veterans was retained to a limited degree. As with the referenced appropriation acts, this measure had the effect of barring outpatient dental treatment for noncompensable dental disabilities service connected on a presumptive basis.

Finally, a major change to the application of presumptions occurred in 1966 with the enactment of legislation authorizing presumption of service connection for chronic diseases incurred by veterans of peacetime service. The Veterans' Readjustment Benefits Act of 1966, Pub. L. No. 89-358, § 7, 80 Stat. 12, 27, referred to at the time as a "Cold War GI Bill," added a new section 337 to title 38, United States Code, providing that, for compensation purposes, the provisions governing presumptive service connection for wartime veterans would be applicable to any veteran with active service after January 31, 1955. The House committee report stated that presumptive service connection should be extended to veterans of peacetime service on the same basis as for veterans of wartime service in light of the "perpetual cold war condition, with its crises, compulsory military service, and expanded overseas commitments." H.R. Rep. No. 1258, 89th Cong., 2d Sess. (1966), reprinted in 1966 U.S.C.C.A.N. 1888, 1889-90.

VI. Recodification of Presumptions During Consolidation and Simplification of Veterans' Benefit Legislation

In 1957, Congress enacted legislation to consolidate into one act all laws administered by VA relating to compensation, pension, hospitalization, burial, and other benefits. Veterans' Benefits Act of 1957, Pub. L. No. 85-56, 71 Stat. 83. As well as consolidating prior enactments in these areas, Congress intended the Veterans' Benefits Act of 1957 to simplify and make more uniform scattered provisions governing veterans' benefits administered by VA and to repeal those provisions of the law which had become obsolete or had been executed. H.R. Rep. No. 279, 85th Cong., 1st Sess. (1957), reprinted in 1957 U.S.C.C.A.N. 1214, 1214-15.

As enacted, the Veterans' Benefits Act of 1957 incorporated then-existing provisions regarding presumptive service connection with little change. As Congressman Teague stated in advocating passage of the legislation, "[t]he bill . . . does not adversely affect the basic entitlement of any veteran or dependent presently on the compensation or pension rolls, nor does it liberalize, except in very minor areas, the provisions of law

which govern the eligibility of veterans and their dependents for such benefits." 103 Cong. Rec. 4384 (daily ed. Apr. 1, 1957).

The Veterans' Benefits Act of 1957 included at section 301(3), 71 Stat. at 95, a list of forty chronic diseases or categories of chronic diseases which could be presumptively service-connected. The act incorporated the previous statutory presumptions of service-connection with little change, while expanding the statutory lists of chronic and tropical diseases and disease categories. The basic statutory list of chronic diseases or disease categories was expanded in the 1957 act to make the statutory list essentially identical to the regulatory list of chronic diseases in effect at that time. See former 38 C.F.R. § 3.86(a) (1956). The disease category "psychoses," which had been added by VA regulation to the 1948 statutory list of chronic diseases, was included in the 1957 statutory list, as were other diseases added by VA regulation in 1949 and 1950.¹⁰ Section 301(4) of the act expanded the statutory list of tropical diseases or disease categories to seventeen by addition of "amebiasis."

In 1958, Congress enacted an even more comprehensive restatement and consolidation of the laws administered by VA. This enactment, Pub. L. No. 85-857, 72 Stat. 1105 (1958), codified in title 38 of the United States Code all provisions consolidated in Pub. L. No. 85-56, as well as other laws relating to education, housing, insurance, and other benefits. H.R. Rep. No. 1298, 85th Cong., 2d Sess. (1958), reprinted in 1958 U.S.C.C.A.N. 4352, 4352-53. Under this act, the provisions relating to presumptive service connection were codified at 38 U.S.C. §§ 301(3) and (4), 312, 313, and 333. No changes were made in the substance of the provisions. Since, with respect to presumptions of service connection, Pub. L. No. 85-857 merely codified the provisions which had already been consolidated the previous year, there was little discussion of issues relating to presumptions during consideration of that legislation.

¹⁰ Among the diseases and disease categories added to the statutory list of chronic diseases in 1957 were: atrophy, progressive muscular; brain hemorrhage; brain thrombosis; myasthenia gravis; myelitis; palsy, bulbar; paralysis agitans; psychoses; purpura idiopathic, hemorrhagic; sarcoidosis; sclerosis, amyotrophic lateral (Lou Gerhig's disease); and, syringomyelia. In addition, leprosy, which had been listed by statute as a tropical disease only, and multiple sclerosis, which had been addressed by statute but which was not specifically included in the statutory chronic-disease list, were incorporated in that list.

VII. Recommendations for Modification or Elimination of Presumptive Provisions

Prior to the 1957 consolidation of the veterans' benefit laws, the use of presumptions in those laws was extensively studied and discussed. Exec. Order No. 10,588, issued on January 14, 1955, established the President's Commission on Veterans' Pensions. That commission, commonly known as the "Bradley Commission" because it was chaired by General Omar Bradley, conducted a comprehensive study of veterans' benefit programs, including the system of establishing eligibility for disability compensation benefits. The Bradley Commission provided an extensive report (over 400 pages) to the President on April 23, 1956. President's Commission on Veterans' Pensions, Veterans' Benefits in the United States, H.R. Comm. Print No. 236, 84th Cong., 2d Sess. (1956). Among the seventy recommendations of the Commission was Recommendation 13(b), that "[t]he presumption of service connection for chronic diseases, tropical diseases, psychoses, tuberculosis, and multiple sclerosis as now listed should be withdrawn." Id. at 178. The Commission provided this basis for the recommendation:

There is otherwise in the law sufficient protection for the veteran to establish service connection of any and all diseases. Accepted medical principles can reasonably and accurately establish the onset of a disease and the disability process. Where there is reasonable doubt, the law provides for the doubt to be resolved in favor of the veteran.

Id. The report also stated:

With respect to chronic and tropical diseases, psychoses, and multiple sclerosis, the physicians surveyed were in general agreement that service-connection should be determined in accordance with sound medical principles, and not by fiat. As to tuberculosis in particular, modern methods of diagnosis have made rapid strides since the enactment of the original presumption for this disease 35 years ago. The presumptive period of 4 years is not in accord with present-day accepted medical principles.

The recommendation and the basis for the recommendation were apparently based on a report on the disability rating schedule prepared by the Commission staff which included a review of all presumptions, including the presumption of service connection. This report was published as President's Commission on Veterans' Pensions, Staff Report No. VIII, Part B, The Veterans' Administration Disability Rating Schedule: Historical Development and Medical Appraisal, H.R. Comm. Print No. 275, 84th Cong., 2d Sess. (1956). The report included a medical appraisal of the rating schedule and related presumptions, including the presumption of service connection. Id. at 103-272.

The medical appraisal was based on responses to a questionnaire sent to selected physicians by the Commission. ¹¹ Id. at 107.

On the basis of responses concerning the presumption of service connection, the staff report concluded that the "medical nomenclature of the chronic disease list [was] obsolescent and obsolete." Id. at 242. The report went on to state that "[t]he respondents were unable to comprehend and reconcile why a determination of service connection in any disease should be accomplished by fiat. Service connection can be determined in accordance with accepted and sound medical principles." Id. According to the report, respondents singled out the degenerative diseases of old age, such as arteriosclerosis, arthritis, and peptic ulcers, as diseases for which the presumption of service connection should be reconsidered. Id. The report pointed out that many chronic diseases are known to occur irrespective of occupation or military service and concluded, "[t]he basis for singling out the listed chronic diseases is not apparent, except that they are considered as serious." Id.

A substantial majority of the physicians responding to the survey indicated that the presumption of service connection for tropical diseases was based on accepted medical principles. Id. at 136-37. Many respondents stated, however, that the list of tropical diseases included some diseases equally prevalent in non-tropical areas, i.e., amebiasis, leprosy, malaria, and dysentery. Id. at 138. Notwithstanding the respondents' conclusions concerning the medical soundness of the presumptions, the staff report concluded that a list of tropical diseases which can be presumptively service connected is unnecessary since service connection can be established based on sound medical principles, without benefit of a presumption, when a veteran with service in the tropics is later found to have a tropical disease. Id. at 243.

The findings and recommendations of the Bradley Commission were reviewed by the House Committee on Veterans' Affairs. See Findings and Recommendations of the President's Commission on Veterans' Pensions (Bradley Commission): Hearings Before the House Comm. on Veterans' Affairs, 84th Cong., 2d Sess. (1956).

Discussion regarding the recommendation that presumptions of service connection be eliminated included the following:

¹¹ The questionnaire was sent to 169 persons in various medical specialties in different parts of the country. A total of 153 responses were analyzed. Of these responses, 70 were from individuals in private practice, and 83 were from individuals employed in the Federal service, principally in the Veterans Administration and the Departments of the Navy, Army, and Air Force. Id. at 107-09.

The proposal to throw out of the picture the presumption for service connection of certain chronic diseases-tropical diseases-was tried and it did not work. The doctors could not agree about whether the disease discovered 1 year or 2 years after separation from the service had its inception while in the service or not. The Congress became so tired of the subject that it decided they would be given a period of time in which it would be presumed that the disease had its inception while in the service.

Id. at 3626 (statement of O.W. Clark, National Director of Legislation, Disabled American Veterans). The American Legion stated its views regarding presumptions of service connection in this way:

[T]he question is not entirely a medical one. It is also in part a legal one. The purpose of a presumption is to free the veteran from carrying an unconscionable burden of proof in the establishment of the service-connected origin of a disease or a disability. . . . [T]he principle behind the granting of a presumption says to the American veteran that it would be unfair in some cases to require him to prove medically that a given disease or disability did in fact have its inception during the course of his service, or resulted directly from that service. It states in substance that, in those instances in which it would be unfair to impose such a burden upon him, he is entitled to a presumption that the disease or disability did emanate from his service. This is a rebuttable presumption. . . . It enables the Government, if medical knowledge is what the Bradley Commission says that it is, to rebut the presumption

It is the opinion of the American Legion that until American medicine has reached a point where it can determine with more than a reasonable degree of accuracy whether in fact certain types of disease did or did not have their inception during the course of a man's service, the veteran should be entitled, in the areas of doubt . . . to the presumption that his disease or disability, within reasonable periods now or to be specified, was the result of his service.

Id. at 3654-55 (statement of Donald R. Wilson, past National Commander, American Legion).

Discussion of presumptions continued during the debates and hearings that preceded consolidation of the veterans' benefit laws in 1957. In discussing presumptions in a hearing related to veterans' health benefits on March 8, 1957, Olin E. Teague, Chairman, House Committee on Veterans' Affairs, explained the

need for statutory presumptions by stating, "the reason we passed [the presumption statute] was because Congress did not agree with many of the medical findings [of VA doctors]." Construction of New Hospitals-Ability to Pay for Hospitalization-Recruitment and Incentives for VA Medical Personnel: Hearings Before the House Comm. on Veterans' Affairs, 85th Cong., 1st Sess. 942 (1957). Chairman Teague further stated, "[m]any VA doctors have [refused to service connect disabilities] . . . where nearly everyone would agree, [the veteran] should be given the benefit of the doubt." Id. He also stated, "[t]he only way we can force proper administration is by setting up a presumptive right by law Otherwise they could disagree with us." Id. at 943.

In presenting The American Legion's position on presumptions during this same hearing, Dr. H.D. Shapiro, Senior Medical Consultant, National Rehabilitation Commission, American Legion, stated, "I believe it has been the American Legion's sincere effort in asking for any presumptive service connection that it would not do so unless the same was justified on reasonable medical grounds." Id. at 959. Dr. Shapiro went on to state that presumptions are often required due to a lack of knowledge on the part of adjudication personnel or a lack of uniformity in the application of the law. Id.

Despite the Bradley Commission's recommendations, veterans' organizations continued to seek legislation extending the scope of the presumption of service connection. In a hearing before the House Committee on Veterans' Affairs regarding veterans' benefit proposals for 1957, the National Commander of the Disabled American Veterans, Joseph F. Burke, stated, "[t]he position held in some quarters and advocated to your committee that no presumptions should be recognized is downright ridiculous in the present state of medical knowledge." 1957 Legislative Programs of the Disabled American Veterans and Veterans of Foreign Wars: Hearings Before the House Comm. on Veterans' Affairs, 85th Cong., 1st Sess. 1600-01 (1957).

Several bills were introduced in the 85th Congress which would have extended the presumptive period for various chronic diseases or for all listed chronic diseases, added presumptions for certain diseases, or otherwise liberalized the laws governing presumption of service connection. See Service-Connected Compensation: Hearings Before the Subcomm. on Compensation and Pension of the House Comm. on Veterans' Affairs, 85th Cong., 2d Sess. 3777-88 (1958).

VA opposed legislation to extend presumptive periods on the bases that longer presumptive periods were not medically justified, that "ample provision is made for those diseases that have a long incubation period," that cases arising within a reasonable time after the presumptive period can be handled on an individual basis, and that extension of the presumptive period for certain diseases would be cited as precedent with respect to other diseases. Letter from Sumner G. Whittier, Administrator of

Veterans Affairs, to Olin E. Teague, Chairman, House Committee on Veterans' Affairs (June 3, 1958), reprinted in Service-Connected Compensation: Hearings Before the Subcomm. on Compensation and Pension of the House Comm. on Veterans' Affairs, 85th Cong., 2d Sess. 3796, 3797-98 (1958).

The Disabled American Veterans testified in favor of certain extensions of the presumptive periods, stating that, with the passage of time, it becomes more difficult for veterans to prove service-connection of their disabilities and that there is historical precedent for amending the presumptive provisions as a war period becomes more remote. Service-Connected Compensation: Hearings Before the Subcomm. on Compensation and Pension of the House Comm. on Veterans' Affairs, 85th Cong., 2d Sess. 3856 (1958) (statement of O.W. Clark, Director of Legislation, Disabled American Veterans). The Veterans of Foreign Wars supported extension of the presumptive period for all chronic diseases to three years, citing difficulty in obtaining evidence to establish service connection where symptoms of a disease are not recognized for a period of time. Id. at 3870 (statement of Norman Jones, Assistant Director, National Rehabilitation Service, Veterans of Foreign Wars).

Another proposal considered in the 85th Congress would have extended the benefit of the presumption of service connection for chronic and tropical diseases to veterans of World War I who could not meet the requirement of 90 days' service during a period of war. H.R. 11528, 85th Cong., 2d Sess. (1958). VA opposed this liberalization on the basis that it would be unfair to similarly-situated veterans of other wars. Letter from Sumner G. Whittier, Administrator of Veterans Affairs, to Olin E. Teague, Chairman, House Committee on Veterans' Affairs (June 5, 1958), reprinted in Service-Connected Compensation: Hearings Before the Subcomm. on Compensation and Pension of the House Comm. on Veterans' Affairs, 85th Cong., 2d Sess. 3801, 3802 (1958).

None of these proposals was enacted into law by the 85th Congress.

VIII. Presumptions Specific to Former Prisoners of War

Consistent with the direction of the Act of December 20, 1941, (see section III, above) to give due consideration to the places, types, and circumstances of service, VA expressly recognized in the 1945 Schedule for Rating Disabilities that former prisoners of war (POWs) would require special consideration in establishment of service connection. While not providing any specific presumption of service connection applicable to former POWs, the 1945 Schedule for Rating Disabilities included the following instruction relating to adjudication of claims of service-connected disability:

Dysentery and Tropical Service. Great weight must be assigned to tropical service and to imprisonment or

internment under unsanitary conditions, or food deprivation, in the service-connection of dysentery, tropical or bacillary, and other gastro-intestinal diseases with regard to which such service may have been the etiological or aggravating factor.

Schedule for Rating Disabilities 88 (1945). On August 23, 1946, the Administrator of Veterans Affairs issued Instruction No. 2, "Instructions Relating to the Rating of Combat Incurred Disabilities," under the Act of June 27, 1946, ch. 505, 60 Stat. 319 (Public Law No. 458, 79th Cong.). This instruction specified that, in evaluations under the 1945 rating schedule, "[s]ymptomatology consequent upon avitaminosis, malnutrition, metabolic changes and other circumstances of prisoner of war experience requires special consideration." Later that year, Veterans Administration Technical Bulletin 8-3, para. 2, December 4, 1946, identified particular conditions, e.g., intestinal parasites, weakness and fatigability, neuropsychiatric disorders, which should be kept in mind in relation to examination of former POWs. The bulletin also noted that "[r]etinitis is not uncommon following malnutrition." The instructions concluded, "[t]he existence of any chronic disease which may be associated with the circumstances of imprisonment should be carefully checked and reported on." This policy was incorporated in R & PR 1185(c)(3) and reiterated in Claims Information Bulletin 8-6, June 23, 1948.

Concern with the special needs of former POWs, as reflected in referenced instructions, gave impetus to various legislative proposals and eventually resulted in creation of specific presumptions of service connection for former POWs. Special compensation and death benefits for former POWs were proposed in H.R. 5851, 80th Cong., 2d Sess. (1948). Under that bill, any veteran who was held prisoner for a continuous period exceeding two years would have been conclusively presumed to be totally disabled for a period of five years, and death during that period would have been presumed service connected in the absence of clear and convincing evidence to the contrary. A presumption of total disability, rebuttable by clear and convincing evidence, would have been created after that period. VA opposed this legislation on the basis that service connection should not be granted in the absence of a factual showing of disability in the individual. Letter from Carl R. Gray, Jr., Administrator of Veterans Affairs, to Edith Nourse Rogers, Chairman, House Committee on Veterans' Affairs (May 19, 1948), reprinted in Special Compensation Benefits for Prisoners of War: Hearings Before the Subcomm. on Compensation and Pensions of the House Comm. on Veterans' Affairs 58 (1948). VA also provided the House Committee on Veterans' Affairs with a report, Veterans' Administration Procedures in Handling Claims of Former Prisoners of War, reprinted in Special Compensation Benefits Hearings, supra, at 60, which detailed the special consideration VA was giving to POWs without enactment of a special presumption.

Although H.R. 5851 was not enacted, Congress remained interested in the mental and physical sequelae of the conditions of POW imprisonment. Apparently upon the recommendation of the War Claims Commission, a series of bills was introduced to require a study of the mortality rate of former POWs, the mental and physical consequences of hardships suffered by POWs, procedures and standards for the diagnosis of the mental and physical condition of former POWs, the possible evidence to support a conclusive presumption of service connection in favor of former POWs for purposes of VA hospitalization benefits, and the standards which could be applied in the evaluation of disability claims of former POWs.¹² VA opposed these bills on the bases that VA already applied a liberal policy in the adjudication of claims of former POWs and that VA was conducting studies relating to the POW experience. E.g., letter from Carl R. Gray, Jr., Administrator of Veterans Affairs, to Elbert D. Thomas, Chairman, Senate Committee on Labor and Public Welfare (July 27, 1950).

The War Claims Act Amendments of 1954, § 202, 68 Stat. 1033, 1037, incorporated provisions of these bills requiring a study of POW mortality, mental and physical consequences of the hardships suffered by POWs, and procedures and standards for diagnosing the mental and physical condition of former POWs. The act omitted the requirements for standards for the evaluation of claims and for a study of evidence to support a conclusive presumption of service connection for purposes of hospitalization. The results of a study of former POWs, initiated prior to enactment of the War Claims Act of 1954 by the National Research Council at the request of VA, were published on September 21, 1954. Bernard M. Cohen, Ph.D., and Maurice Z. Cooper, M.D., A Follow-up Study of World War II Prisoners of War, VA Medical Monograph (September 21, 1954) [hereinafter NRC-VA Study]. A report by the Department of Health, Education, and Welfare (HEW), required under the War Claims Act Amendments, was submitted to Congress on January 12, 1956. HEW, Effects of Malnutrition and Other Hardships on the Mortality and Morbidity of Former United States Prisoners of War and Civilian Internees of World War II: An Appraisal of Current Information, H.R. Doc. No. 296, 84th Cong., 2d Sess. (1956). Both the NRC-VA Study and the HEW report, which relied heavily on it, indicated that former POWs had exhibited excess mortality and disability as a result of the POW experience. Id. at 42.

Many proposals related to presumptions of service connection for former POWs were introduced following the publication of the NRC-VA and HEW reports in 1954 and 1956. For example, H.R. 1172,

¹² H.R. 8848 and S. 3903, 81st Cong., 2d Sess. (1950); H.R. 304 and S. 513, 82nd Cong., 1st Sess. (1951); and, H.R. 7711 and S. 2901, 83rd Cong., 2d Sess. (1954).

85th Cong., 1st Sess. (1957), would have required that all former POWs held in excess of three years be "officially declared" to be disabled and entitled to full retired pay based on rank and length of service. H.R. 5031 and H.R. 8975, 87th Cong., 1st Sess. (1961), would have required that any disability of a former POW held more than two years by the Japanese government be presumed service connected for VA purposes. H.R. 7952, 88th Cong., 1st Sess. (1963), would have extended the presumption of service connection provided in former 38 U.S.C. § 312 (now § 1112(a)) to cover any disease contracted by a former POW of the Japanese government who suffered malnutrition, avitaminosis, beriberi, or pellagra while in captivity. S. 2756, 88th Cong., 2d Sess. (1964), would have extended the presumptive period for all diseases on the statutory list of chronic and tropical diseases to five years for former POWs.

H.R. 11353, 88th Cong., 2d Sess. (1964), and H.R. 1027, 89th Cong., 1st Sess. (1965), would, in effect, have created an irrebuttable presumption that all former World War II and Korean War POWs held more than thirty-six months had a service connected disability of fifty percent. Later versions of this proposal would have presumed fifty-percent service-connected disability for all former POWs held twelve months or more. E.g., H.R. 5589, 89th Cong., 1st Sess. (1965); H.R. 12386, 90th Cong., 1st Sess. (1967). VA opposed such legislation on the basis that a disability rating should be based on the "extent or severity of the disabling manifestations in the individual case." E.g., letter from W.J. Driver, Administrator of Veterans Affairs, to Olin E. Teague, Chairman, House Committee on Veterans' Affairs (May 29, 1968).

Pub. L. No. 91-376, § 3, 84 Stat. 787, 788 (1970), established a presumption of service connection for seven categories of diseases and conditions ¹³ developing to a ten-percent degree of disability at any time after active service in the case of any veteran held as a POW in World War II, the Korean Conflict, or the Vietnam War who suffered from dietary deficiencies, forced labor, or inhumane treatment in violation of the Geneva Conventions. That law also extended from one year to two years the presumptive period for service connection of psychosis in the case of former POWs held under such conditions. If a POW was held captive for six months or more by the Japanese or German governments during World War II, by the North Korean government during the Korean Conflict, or by the North Korean or North Vietnamese governments or the Viet Cong during the Vietnam

¹³ The seven categories of diseases and conditions listed in Pub. L. No. 91-376 were: avitaminosis; beriberi (including beriberi heart disease); chronic dysentery; helminthiasis; malnutrition (including optic atrophy associated with malnutrition); pellagra; and, any other nutritional deficiency.

era, that individual was deemed to have suffered from dietary deficiencies, forced labor, or inhumane treatment.

As originally introduced in the Senate, S. 3348, 91st Cong., 2d Sess. (1970), the bill which was enacted as Pub. L. No. 91-376 would have applied to any disability suffered by a former POW. It would have limited application of the POW presumptions to veterans held as POWs for 180 days or more, but would not have required a finding that the veteran had suffered deprivations while held prisoner. Also, the bill would have included veterans forcibly detained or interned by a foreign government.

In commenting on this bill, VA stated that the measure would be "discriminatory against those veterans who were prisoners of war for less than 180 days but whose sufferings and deprivations were equal to or greater than those of the veterans coming within [the bill's] purview." Letter from Donald E. Johnson, Administrator of Veterans Affairs, to Russell B. Long, Chairman, Senate Committee on Finance (March 17, 1970), reprinted in S. Rep. No. 784, 91st Cong., 2d Sess. 7, 10 (1970). VA also pointed out that the bill would include a veteran who was interned by a neutral government and had not suffered any deprivation or hardship as a result of that internment. Id. While stating that special consideration should be given to former POWs, VA opposed the presumptive provision of the bill on the basis that "we do not think that the fact that a veteran was a prisoner of war for 180 days or more, standing alone, justifies a presumption that any disability the veteran may acquire at any time during the balance of his life is service connected." Id.

During hearings on S. 3348, The American Legion "questioned whether the 180 days was a valid elapsed time . . . as a measure of whether a disability was or was not incurred" during detention. Veterans' Disability Compensation: Hearing Before the Subcomm. on Veterans' Legislation of the Senate Comm. on Finance, 91st Cong., 2d Sess. 71 (March 18, 1970) (statement of Edward H. Golembieski, Director, National Rehabilitation Commission, American Legion). Senator Jack Miller responded:

On that point, I think we could all understand how a man could be confined . . . under particularly nice conditions for 6 months and the chances of having a disability would be far, far less than somebody confined for only 2 weeks under terrible conditions. This is the problem I have with an arbitrary number of days without any regard to conditions or the possibilities of certain diseases being incurred It would seem that perhaps a refinement, perhaps a presumption if certain diseases or certain symptoms show up later on of a certain category, instead of just whether it is any kind of disability. . . . we might have a fairer approach.

Id. at 72.

As reported out by the Senate Committee on Finance, S. 3348 included a list of POW-specific diseases for which service connection could be presumed. S. Rep. No. 784, supra, at 12-13. The six-month minimum confinement requirement had been deleted and was replaced by a requirement that the veteran have suffered from dietary deficiencies, forced labor, or inhumane treatment. Reference to internment by a foreign government was deleted.

The Senate report commended VA for its policies and procedures for handling claims by former POWs, but indicated that the Committee on Finance felt a statutory presumption was nonetheless desirable. Id. at 4. The report noted that:

Because of the conditions of their captivity and the kinds of long-range harm that may have been caused, it is sometimes difficult for a former prisoner of war to establish, some time after the completion of his military service, that a disability or the aggravation of a previous disability is related to his military service.

Id.; see also H.R. Rep. No. 1166, 91st Cong., 2d Sess. 7 (1970), reprinted in 1970 U.S.C.C.A.N. 3723, 3727.

Despite the modifications made in committee, VA continued to oppose the bill on the basis that it would create a presumption of service connection for former POWs for the listed diseases for the rest of their lives based solely on the fact of internment, which may have lasted only a few hours or days. Letter from Donald E. Johnson, Administrator of Veterans Affairs, to Olin E. Teague, Chairman, House Committee on Veterans' Affairs (May 26, 1970) (incorporated in H.R. Rep. No. 1166), reprinted in 1970 U.S.C.C.A.N. 3732, 3735; see also Bills to Increase Compensation Rates and to Increase Pension Income Limitations and Rates: Hearings Before the Subcomm. on Compensation and Pension of the House Comm. on Veterans' Affairs, 91st Cong., 2d Sess. 2751-52 (May 26, 1970) (statement of Olney B. Owen, Chief Benefits Director, Veterans Administration). Apparently in response to VA's comments about the brief period of confinement as a POW which could give rise to application of the presumption, H.R. 17958, 91st Cong., 2d Sess. (1970), the House version of the measure, required a six-month minimum period of confinement before the provision deeming certain confinement to have involved dietary deficiencies, forced labor, or inhumane treatment could be relied on. The Senate concurred in the House amendment.

To implement Pub. L. No. 91-376, VA amended 38 C.F.R. § 3.307(a) by adding paragraph (5), "Diseases specific as to prisoners of war." See 35 Fed. Reg. 18,280 (1970). Section 3.307(a)(5) stated that "[t]he disease must have become manifest to a degree of 10 percent or more at any time after service, except psychosis which must have become manifest to a degree of 10 percent within 2 years from the date of separation from

service." Reference to use of testimonial evidence concerning the circumstances of service as a POW was included in section 3.307(b). VA also added a new subsection, subsection (c), to 38 C.F.R. § 3.309 listing the specific statutory categories of diseases and conditions covered and specifying the periods of service included, as provided by statute. See also DVB Circular 20-70-73, Appendix C, "Public Law 91-376," section 1, "PL 91-376--Presumption of Service Connection--Prisoners of War," January 7, 1971 (noting existence of "conclusive presumption" of dietary deficiency, forced labor, or inhumane treatment for service under certain circumstances, and evidentiary rules applicable in other POW cases).

Following enactment of Pub. L. No. 91-376, numerous proposals were introduced for expanding the use of presumptions in cases involving former POWs. See, e.g., H.R. 4525, 92d Cong., 1st Sess. (1971) (proposing a five-year presumptive period for chronic diseases for former POWs held ninety days or more); H.R. 2917, 93d Cong., 1st Sess. (1973) (proposing a ten-year presumptive period for chronic diseases for former POWs and the addition of a presumption for chronic bronchitis and chronic bronchial asthma for purposes of claims by former POWs); H.R. 2015, 96th Cong., 1st Sess. (1979) (proposing a seven-year presumptive period for psychotic and psychoneurotic disorders and a five-year presumptive period for other chronic diseases for former POWs). None of these proposals were enacted.

The Veterans' Health Care Amendments of 1979, Pub. L. No. 96-22, 93 Stat. 47, expanded dental-care benefits for former POWs. Section 102(b) of Pub. L. No. 96-22, now codified, as amended, at 38 U.S.C. § 1712(b) (formerly § 612(b)), authorized outpatient dental services without limitation for former POWs of World War I, World War II, Korea, and Vietnam, detained for six months or more.¹⁴ This expansion of dental benefits did not, however, provide benefits on the basis of a presumption of service connection of dental conditions, but rather simply specified that certain POWs would be eligible for dental care.

Although the authorization of dental services for former POWs was not phrased in terms of a presumption, the expressed rationale for this expansion of benefits, as described in S. Rep. No. 100, 96th Cong., 1st Sess. 23 (1979), reprinted in 1979 U.S.C.C.A.N. 169, 177-78, is suggestive of a desire to provide a limited presumption of service connection for purposes of dental care. The Senate report on the measure stated:

¹⁴ This provision was amended by the Former Prisoner of War Benefits Act of 1981, Pub. L. No. 97-37, § 3(b), 95 Stat. 935, 936, to incorporate use of the term "former prisoner of war" as defined in that act. See, infra, at 53.

The Committee notes that many individuals who were prisoners of war developed dental conditions as a result of the prolonged nutritional deprivation they suffered while interned. It is widely recognized by medical and nutritional experts that nutritional and vitamin deficiencies such as beri-beri, scurvy, protein deficiency, and pellagra were common problems of prisoners of war and that these same nutritional deficiencies produce gum diseases which have long-term effects on oral and dental health.

Therefore, to provide assurance that the VA has full authority to meet the dental needs of former prisoners of war resulting from the conditions of their internment, the Committee believes that certain veterans who were prisoners of war should be given comprehensive eligibility for outpatient dental care. However, because such nutritional deficiencies result from a prolonged state of deprivation, the Committee bill would restrict such benefits to those who were incarcerated for 6 months or longer. This approach is consistent with the 6-month incarceration period required for prisoners of war under section 312 of title 38 for the presumption of service connection for certain diseases.

Id.

The Veterans' Benefits and Services Act of 1988, Pub. L. No. 100-322, § 106, 102 Stat. 487, 494, substituted "90 days" for the previous requirement of internment of six months for dental care purposes. During hearings on the measure later enacted as Pub. L. No. 100-322, Dr. Charles S. Prigmore, Legislative Officer, American Ex-Prisoners of War, had testified in favor of changing the internment requirement for dental treatment from six months to 90 days. VA Compensation and Other Service-Connected Benefits: Hearing Before the Senate Comm. on Veterans' Affairs 35 (June 30, 1987). His prepared statement concluded:

[W]e strongly urge the Committee to add to the bill the reduction of the time requirement for dental care ex-POWs from six months to three months. There is little doubt in the mind of any former prisoner of war that broken or cracked teeth, . . . incipient caries, aggravation of existing caries and a host of other dental problems often occurred in less than six months of imprisonment We feel that dental care, while relatively inexpensive, will be particularly helpful to some of the men captured in the Battle of the Bulge.

Id. at 297. The American Defenders of Bataan and Corregidor, Inc., noted that VA had testified in 1986 that "[g]ranting eligibility for full dental benefits to this group of former POWs would bring the scope of dental benefits more in alignment with

existing medical benefits which are currently offered to [former POWs]." Id. at 300. Reduction of the required internment period was described as "a fair, justifiable and reasonable solution." Id. at 301. The committee report on H.R. 2945, 100th Cong., 1st Sess. (1987), which contained the House-approved version of the amendment, indicated that "[t]his change is proposed in recognition of the fact that under some circumstances of incarceration dental/oral pathology could develop and become irreparable within a period of ninety days." H.R. Rep. No. 236, 100th Cong., 1st Sess. 10 (1987).

The Veterans' Disability Compensation and Survivors' Benefits Act of 1978, Pub. L. No. 95-479, § 305, 92 Stat. 1560, 1565, required a comprehensive VA study of the disability compensation awarded to and the health-care needs of former POWs, including review of procedures used with respect to former POWs in repatriation and physical examination and procedures used in determining eligibility for health-care benefits and in adjudicating claims for disability compensation. The law required study of disabilities prevalent among former POWs and review of medical literature on the health-care needs of former POWs. The law also specified that the report should include "recommendations for such administrative and legislative actions as [VA] considers may be necessary to assure that former prisoners of war receive compensation and health-care benefits for all disabilities which may reasonably be attributed to their internment."

The Senate report on the legislation to require the POW study indicates it was prompted by concern with the adequacy of repatriation examinations and concern that health conditions which seemed relatively minor at the time of repatriation, and therefore may not have been reported or recorded, were becoming progressively more debilitating over time. S. Rep. No. 1054, 95th Cong., 2d Sess. 35, reprinted in 1978 U.S.C.C.A.N. 3465, 3493. The Senate report also referred to a National Academy of Sciences study suggesting that former POWs suffered from excess morbidity from certain diseases and a debilitating condition known as "POW syndrome," and that they had higher rates of tuberculosis and certain other conditions. Id. at 35-36, 1978 U.S.C.C.A.N. at 3493-94.

The results of this study were published on June 3, 1980. Veterans Administration, Study of Former Prisoners of War, 96th Cong., 2d Sess., S. Comm. Print No. 25. Among the major findings of this study was that repatriation medical examinations were often inadequate for World War II and Korean War POWs. Id. at 71-72, 161. The study found that medical processing was not an issue among former Vietnam POWs, as they had received the most thorough medical examinations following repatriation of any POW group studied. Id. The study also found that former POWs showed a significantly higher incidence of service-connected disability than other veterans, and that there were differences in disability rates among POWs related to the theater of operations

in which they had been imprisoned. Id. at 94-96, 162. Incidence of disability was found to be highest among World War II Pacific Theater and Korean War POWs. Id. The study noted that long-term effects of the POW experience in Vietnam required further study. Id. at 95, 162. Former POWs showed a high prevalence of neuropsychiatric disability. Id. at 154, 162, 164. The medical evidence also showed that such disability, related to the POW experience, could appear years after service. Id.

Based on these findings, the study report contained one legislative recommendation specifically regarding presumptions, that the two-year limitation on the presumptive period for service connection of psychosis be removed for former POWs, so that psychosis could be service-connected on a presumptive basis whenever it became manifest in a former POW. Id. at 164. The study report also contained the recommendation that, based on the frequent absence of repatriation medical reports and the scientific uncertainty concerning the origins of some disabilities particularly prevalent among former POWs, former POWs should be made eligible for VA hospital care and medical services for any disease or neuropsychiatric disability. Id. at 163-64.

In hearings on benefits and services for former POWs before a subcommittee of the House Committee on Veterans' Affairs, several service organizations commented that the recommendation concerning expansion of the presumptive period for psychosis was not broad enough. The American Ex-Prisoners of War, through the statement of Stanley G. Sommers, National Senior Vice Commander, commented, "[w]e concur with this recommendation but find it so limited in scope as to be totally unresponsive to the facts presented in the . . . report." Benefits and Services for Former Prisoners of War: Hearing Before the Subcomm. on Compensation, Pension, Insurance, and Memorial Affairs of the House Comm. on Veterans' Affairs, 96th Cong., 2d Sess. 12 (June 25, 1980). The Veterans of Foreign Wars and the AMVETS, among other groups, stated that this legislative proposal was inadequate to meet the needs of POWs. Id. at 60-64 (statement of Donald H. Schwab, Director, National Legislative Service, Veterans of Foreign Wars); Id. at 59-60 (statement of Gabriel Brinsky, National Service and Legislative Director, AMVETS). These organizations and others recommended actions significantly expanding the use of presumptions in adjudication of disability compensation claims of former POWs. See, e.g., id. at 60, 63-64.

In response to the 1980 study conducted under Pub. L. No. 95-479, and to address additional concerns raised by former POWs, ¹⁵ the Former Prisoner of War Benefits Act of 1981, Pub. L.

¹⁵ See H.R. Rep. No. 28, 97th Cong., 1st Sess. 3 (1981), reprinted in 1981 U.S.C.C.A.N. 1410, 1411.

No. 97-37, 95 Stat. 935, was enacted. Section 4 of Pub. L. No. 97-37 added "any of the anxiety states" to the list of diseases which could be presumptively service connected on the basis of service as a POW and deleted the two-year presumptive period for service connection of psychosis, adding that disorder to the list of diseases which could be service connected when appearing at any time after confinement as a POW. Pub. L. No. 97-37 also eliminated the requirement that a veteran have suffered dietary deficiencies, forced labor, or inhumane treatment during confinement in order to qualify for the presumption of service connection of the listed POW diseases and eliminated the presumption that a veteran had suffered such deprivations if held by certain governments for a period of six months or more. Pub. L. No. 97-37, § 4, 95 Stat. at 936. In their place, the act substituted a minimum thirty-day period of detention as a POW. Id. The internment requirement for dental services as provided under Pub. L. No. 96-22 remained at six months. Pub. L. No. 97-37, § 3, 95 Stat. at 936.

Pub. L. No. 97-37 also added a generally applicable definition of "former prisoner of war," including within the scope of that term any person who, while in service, was forcibly detained or interned by an enemy government or hostile force during a period of war or by a foreign government or hostile force during peacetime under circumstances comparable to those under which POWs are detained or interned by enemy governments during wartime. Id. Section 5 of the act amended chapter 17 of title 38, United States Code, to provide eligibility for hospital care and medical treatment on the basis of status as a former POW. Pub. L. No. 97-37, § 5, 95 Stat. at 936.

The House report on the legislation which became Pub. L. No. 97-37 explained the rationale for expansion of presumptive service connection for disabilities suffered by former POWs. The report noted the severe conditions experienced by POWs during imprisonment and referred to studies showing higher subsequent incidence of service-related physical and psychological disorders among former POWs than among other veterans. H.R. Rep. No. 28, 97th Cong., 1st Sess. 3, 5, 8 (1981), reprinted in 1981 U.S.C.C.A.N. 1410, 1411, 1413, 1417. The report noted the findings of the 1980 VA study concerning the lack of repatriation medical examinations and the inability of medical science to conclusively determine, on an individual basis, the origins of some disabilities particularly prevalent among former POWs. Id. at 5, 6, reprinted in 1981 U.S.C.C.A.N. at 1413, 1414. The report repeated VA's findings concerning the prevalence of anxiety neurosis and psychosis among former POWs and the potential that psychosis may arise years after service. Id. at 5-6, 8-9, reprinted in 1981 U.S.C.C.A.N. at 1414-15, 1417-18. Finally, the report noted the concerns raised by some persons that medical records for former POWs are inadequate and that certain disabilities originally considered minor have increased in severity since service discharge. Id. at 3, reprinted in 1981 U.S.C.C.A.N. at 1412. The report concluded that, based on these

considerations, the expansion of medical care and compensation eligibility for former POWs "seems not only reasonable but necessary." Id. at 9, reprinted in 1981 U.S.C.C.A.N. at 1418.

Accordingly, Congress essentially adopted the 1980 study recommendations concerning expanded health-care eligibility and liberalization of the presumptive period for psychosis. As to health-care eligibility, the House committee report noted that delays in receipt of medical care due to difficulty in establishing service connection can be prejudicial to an individual's health. Id. at 10, reprinted in 1981 U.S.C.C.A.N. at 1419; see also S. Rep. No. 88, 97th Cong., 1st Sess. 29 (1981) (noting the trying circumstances of confinement as a POW, the inability of certain POWs to establish service connection for disabilities which may be related to service and the higher incidence of disability and resulting greater need for medical services among former POWs).

Congress also went farther in creating a presumption for anxiety neurosis and liberalizing the provisions governing length and circumstances of confinement. The latter change was justified on the basis that "[t]hough dietary deficiencies are clearly a function of time and malnourishment, medical evidence reveals that a person can suffer from malnutrition in less than 6 months." Id. Elimination of the so-called "two-step presumption" regarding proof that a former POW had suffered specified deprivations while in captivity was intended "to relieve to a certain extent the burden on the former POW to submit evidence . . . that certain disabilities are service-connected." S. Rep. No. 88 at 29.

Finally, the adoption of a general definition of "former prisoner of war" had:

the effect of no longer excluding veterans who were interned during World War I . . . as well as including POW's of future hostilities and giving the Administrator [of Veterans Affairs] the discretion to determine if an internment in a period other than a period of war would be comparable for all purposes of title 38.

Id. at 19. The Senate committee report noted, in this regard, that, if the "Pueblo incident" had not occurred during the Vietnam era, individuals taken captive by North Korea in that incident could not have qualified for the special consideration given former POWs under then-existing law. Id.

To implement Pub. L. No. 97-37, VA revised 38 C.F.R. §§ 3.307 and 3.309. 47 Fed. Reg. 11,655 (1982). The revised regulations conformed with Pub. L. No. 97-37, providing that, in the case of a veteran who was detained or interned as a POW for not less than thirty days, any condition on the statutorily prescribed list which becomes manifest to a degree of ten percent or more at any

time after service will be considered service connected, notwithstanding that there is no record of the condition during service. See also 47 Fed. Reg. 54,435 (1982) (amending presumptive provision to emphasize that establishment of service connection is not discretionary when all prerequisites are met).

The Veterans' Compensation and Program Improvements Amendments of 1984, Pub. L. No. 98-223, § 111, 98 Stat. 37, 40, added dysthymic disorder (depressive neurosis) to the list of disabilities developing anytime after service for which presumptive service connection may be granted for former POWs. (VA then amended 38 C.F.R. § 3.309(c) to add dysthymic disorders to the regulatory list of POW diseases. 49 Fed. Reg. 47,002 (1984).)

Senator Alan K. Simpson, in his remarks in favor of final passage of S. 1388, 98th Cong., 1st Sess. (1983), the bill he sponsored which was enacted as Pub. L. No. 98-223, stated, "the compromise version of the bill includes a clarification of a presumption concerning dysthymic disorder--or depressive neurosis--for veterans who are former prisoners of war. It . . . will clarify the original intent of Public Law 97-37, the Former Prisoners of War Benefits Act of 1981." 130 Cong. Rec. S1324 (daily ed. Feb. 9, 1984). Senator Simpson explained that the clarification was necessary because "[t]he complexity of anxiety states, anxiety neuroses, posttraumatic stress disorder, and dysthymic disorders and their associated and sometimes interrelated diagnoses inadvertently resulted in a lack of clarity regarding the granting of service connection for depression." Id.

The Senate Committee on Veterans' Affairs report on the bill noted that the explanation of and justification for inclusion of dysthymic disorder was discussed in S. Rep. No. 145, 98th Cong., 1st Sess. (1983), and the Committee incorporated a portion of that report by reference. S. Rep. No. 249, 98th Cong., 1st Sess. 26 (1983), reprinted in 1984 U.S.C.C.A.N. 58, 74. S. Rep. No. 145 noted that, in enactment of Pub. L. No. 97-37, the term "anxiety states" was added to the list of diseases which may be presumed service-connected for former POWs rather than the terms "psychoneurosis" and "psychophysiologic disorders" because the latter terms included a variety of mental disorders not often associated with internment. S. Rep. No. 145 at 59-60. The report included an overview of the medical literature documenting depression as a response to internment, id. at 60, and noted that:

at the time of the agreement with the House Committee on Public Law 97-37, the [Senate Veterans' Affairs] Committee was not aware that there would be cases in which former POW's suffering from nonpsychotic depressive disorders would not be diagnosed as suffering from Post-Traumatic Stress Disorder and,

therefore, not adjudged under the VA guidelines to be service-connected disabled.

Id. at 61.

S. Rep. No. 145 further stated that "in reviewing the disposition of claims for benefits . . . submitted by former POW's during the first 18 months after Public Law 97-37 was enacted, the Committee found an apparent inconsistency in the resolutions of claims which were decided solely on the issue of depression or a depression-related diagnosis." Id. In correspondence with the Veterans Administration, Senate Committee on Veterans' Affairs Chairman Alan K. Simpson had referred to review by Committee staff of nineteen claims decided solely on the issue of service connection for depression. Id. at 64 (letter from Alan K. Simpson, Chairman, Senate Committee on Veterans' Affairs, to Dorothy Starbuck, Chief Benefits Director, Veterans Administration (Feb. 2, 1983)). Senator Simpson reported that eleven of these claims had been denied and eight had been granted. Id. Of the eleven cases diagnosed as depression in which benefits were denied, five of the cases were decided based on the lack of a specific presumption for depression in Pub. L. No. 97-37. Id. Chief Benefits Director Starbuck responded:

With regard to "depression", the word itself is more accurately a symptom than a diagnosis. . . . Rating boards are not, however, permitted to establish service-connection for a veteran's symptoms. . . . If an examining physician makes a diagnosis of depressive neurosis or dysthymic disorder instead of post-traumatic stress disorder with associated features of depression, the rating board is bound by that diagnosis"

Id. at 65-66 (letter from Dorothy Starbuck, Chief Benefits Director, Veterans Administration, to Alan K. Simpson, Chairman, Senate Committee on Veterans' Affairs (Feb. 24, 1983)). S. Rep. No. 145 concluded, "[t]he Committee intends that this addition would correct the inadvertent oversight in the original legislation and establish a presumption for a mental disorder which is linked in scientific literature to the POW experience." Id. at 61.

The Veterans' Benefits Improvement and Health-Care Authorization Act of 1986, Pub. L. No. 99-576, § 108, 100 Stat. 3248, 3252, added two conditions, post-traumatic osteoarthritis and organic residuals of frostbite (if consistent with climatic conditions of internment), to the list of disabilities developing any time after service which may be presumed to be service connected for former POWs. (Following enactment of Pub. L. No. 99-576, VA amended 38 C.F.R. § 3.309(c) to conform with the addition of organic residuals of frostbite and traumatic

osteoarthritis to the list of presumptive diseases for POWs. 53 Fed. Reg. 23,234 (1988).)

The Senate Committee on Veterans' Affairs report on this measure noted that "the circumstances surrounding the capture and internment of prisoners of war are such that unrecorded frostbite could occur in a significant number of instances." S. Rep. No. 444, 99th Cong., 2d Sess. 30 (1986), reprinted in 1986 U.S.C.C.A.N. 5469, 5480. The Committee intended the presumption to be available only to veterans captured or held in a climate in which frostbite might occur and to exclude veterans held only in tropical climates or during warm weather. Id. The report stated that, where a veteran was held in a climate in which frostbite might occur, "[t]he Committee expects the VA to give great weight to the veteran's description of the circumstances of frostbite injury and to accept that description if it is possible that these circumstances occurred and the veteran suffers from residuals of frostbite." Id.

As to traumatic arthritis, the Senate Committee on Veterans' Affairs had initially noted in its report that "there is disagreement as to the adequacy of current medical science to distinguish between arthritis resulting from earlier trauma and arthritis which is the result of other causes or which normally occurs during the aging process." Id. Accordingly, the Committee merely directed VA to provide a report of the effectiveness of procedures for evaluating claims for service connection for traumatic arthritis. Id. A presumption relating to post-traumatic osteoarthritis was added as a floor amendment on the basis of unspecified "additional information" received by the Committee of Veterans' Affairs since submission of its report. 132 Cong. Rec. S14,354 (daily ed. Sept. 30, 1986) (statement of Sen. Murkowski). The House Committee on Veterans' Affairs indicated that a House-approved presumption provision was intended to address "a few cases" where former POWs did not assert their claims until several years after service separation. H.R. Rep. No. 728, 99th Cong., 2d Sess. 2 (1986).

VA did not oppose establishment of presumptions for frostbite and post-traumatic arthritis, but questioned the need for such legislation on the basis that, if a POW developed either of these conditions, "the condition ordinarily would have manifested itself and required treatment upon repatriation or shortly thereafter." Letter of Thomas K. Turnage, Administrator of Veterans Affairs, to Frank H. Murkowski, Chairman, Senate Committee on Veterans' Affairs (July 23, 1986), reprinted in 1986 U.S.C.C.A.N. 5569. VA did recognize that the presumptions would serve as a "safety net" for some veterans given the circumstances of the repatriation process and the tendency of some former POWs to initially put aside traumatic experiences associated with captivity. Id.

The next legislative change affecting presumptions applicable to former POWs was enactment of the Veterans' Benefits and

Services Act of 1988, Pub. L. No. 100-322, § 312, 102 Stat. 487, 534 (1988), which, in addition to changing eligibility requirements for dental treatment of former POWs, as noted above, also added three diseases, peripheral neuropathy (except where directly related to infectious causes), irritable bowel syndrome, and peptic ulcer disease, to the list of diseases which could be presumed service connected for former POWs. Legislation approved by the House, H.R. 2945, 100th Cong., 1st Sess. § 202 (1987), would have added peripheral neuropathy due to trauma, spastic colon, and peptic or duodenal ulcers to the list of diseases presumed to be service connected for former POWs. The bill approved by the Senate, S. 9, 100th Cong., 1st Sess. § 111(b) (1987), as amended in committee, contemplated addition of peripheral neuropathy, irritable bowel syndrome, and peptic ulcer disease. By conference agreement, Congress adopted the list of diseases to be presumed service connected under the Senate bill, with the addition of the qualifying phrase pertaining to peripheral neuropathy. H.R. Conf. Rep. No. 578, 100th Cong., 2d Sess. 112 (1988), reprinted in 1988 U.S.C.C.A.N. 477, 516.

Senator Alan Cranston, in a prepared statement to the Senate Committee on Veterans' Affairs, stated that "[r]ecent studies of both ex-POWs and the general population indicate that the conditions experienced by ex-POWs during internment--including severe malnutrition, extreme stress, and exhausting physical exertion--are significant risk factors for peripheral neuropathy, peptic ulcer disease, and irritable bowel syndrome." VA Compensation and Other Service-Connected Benefits: Hearing Before the Senate Comm. on Veterans' Affairs, 100th Cong., 1st Sess. 115, 124 (June 30, 1987). Senator Cranston referenced a 1986 study of VA patients which found evidence of persisting peripheral neuropathy in twenty-five of thirty-two former POWs held in Japanese camps and nine of twenty former POWs held in German camps. Id. He also referred to a 1985 Australian study which found that nearly fifty percent of the ex-POWs examined showed symptoms of peripheral neuropathy, and that these ex-POWs also exhibited a higher incidence of duodenal ulcers than did a control group. Id. He also noted a study of VA patients in which over thirty of the forty-one ex-POWs studied reported symptoms of peripheral neuropathy and that thirty-five of forty-one ex-POWs continued to suffer from gastrointestinal disorders. Id. During debate on S. 9, Senator Cranston noted that the diagnosis of and research on the diseases proposed to be added to the presumptive provisions is difficult because their symptoms, particularly in the case of peptic ulcer and irritable bowel syndrome, can vary greatly from one individual to the next and require reliance on evaluation of subjective factors, such as pain. 133 Cong. Rec. S17,084 (daily ed. Dec. 3, 1987); see also S. Rep. No. 215, 100th Cong., 1st Sess. 70 (1987).

In its report, the Senate Committee on Veterans' Affairs accepted Senator Cranston's view that conditions experienced by POWs are significant risk factors for the diseases covered by S. 9. S. Rep. No. 215 at 71. In particular, the Committee found

that peripheral neuropathy is causally related to exposure to cold temperatures, exhausting physical activity, and vitamin deficiency resulting from extreme malnutrition. Id. at 71-72. The Committee also found that stress and malnutrition are probable risk factors for irritable bowel syndrome and peptic and duodenal ulcers. Id. at 72; see also 133 Cong. Rec. S8156-57 (daily ed. June 16, 1987) (statement of Sen. Cranston).

VA did not support adding to the list of diseases presumed service connected if suffered by former POWs. VA Compensation and Other Service-Connected Benefits: Hearing Before the Senate Comm. on Veterans' Affairs, 100th Cong., 1st Sess. at 153 (statement of R.J. Vogel, Chief Benefits Director, Veterans Administration). VA took the position that the conditions in question ordinarily would become manifest and require treatment upon repatriation or shortly thereafter, thus entitling the ex-POW to direct rather than presumptive service connection. Id. at 9, 153. VA stated that the conditions at issue do not lend themselves to a presumption, pointing out, for example, that irritable bowel syndrome is a functional disorder of unknown etiology and pathogenesis. Id. at 153. (Following enactment of Pub. L. No. 100-322, VA amended 38 C.F.R. § 3.309(c) to add the three diseases included in that act to the regulatory list of former-POW diseases for which presumptive service connection is available. 54 Fed. Reg. 26,027 (1989).)

Thus, after enactment of Pub. L. No. 100-322 in 1988, former POWs had the benefit of a presumption of service connection for fifteen categories of diseases or conditions ¹⁶ becoming manifest to a degree of ten percent at any time after active service. No additional diseases have been added to the list of former-POW diseases since enactment of Pub. L. No. 100-322. ¹⁷

¹⁶ The categories of diseases or conditions, which are listed in 38 C.F.R. § 3.309(c), are: avitaminosis, beriberi (including beriberi heart disease), chronic dysentery, helminthiasis, malnutrition (including optic atrophy associated with malnutrition), pellagra, any other nutritional deficiency, psychosis, any of the anxiety states, dysthymic disorder (or depressive neurosis), organic residuals of frostbite (if it is determined that the veteran was interned in climatic conditions consistent with the occurrence of frostbite), post-traumatic osteoarthritis, irritable bowel syndrome, peptic ulcer disease, and peripheral neuropathy (except where directly related to infectious causes).

¹⁷ On June 30, 1992, legislation was introduced in Congress to grant all veterans who are former POWs, regardless of length of internment, a non-rebuttable presumption of total disability. See 138 Cong. Rec. S9296-97 (daily ed. June 30, 1992) (statement of Sen. D'Amato referring to S. 2916, 102d Cong., 2d Sess. (1992) and H.R. 4909, 102d Cong., 2d Sess. (1992)).

IX. Recent Developments Regarding Presumptions: 1976-Present

More recent changes in law concerning presumptions have resulted from both regulatory and legislative action. VA regulations issued since 1976 have created presumptions of service connection for cardiovascular disorders and non-Hodgkin's lymphoma under certain circumstances and for certain conditions associated with exposure to mustard gas. Legislation since 1976, in addition to that affecting presumptions for former prisoners of war, has addressed presumptive service connection for systemic lupus erythematosus and for conditions related to exposure to ionizing radiation and dioxin.

A. Regulations

1. Amputation and Cardiovascular Disorders

The Veterans Disability Compensation and Survivor Benefits Act of 1976, Pub. L. No. 94-433, § 403, 90 Stat. 1374, 1378 (1976), directed the Administrator of Veterans Affairs to "conduct a scientific study to determine if there is a causal relationship between the amputation of an extremity and the subsequent development of cardiovascular disorders." The study mandated by the statute consisted of two parts, a literature review and a statistical analysis. The literature review, entitled "Amputations of Extremities and Cardiovascular Disease," H.R. Comm. Print No. 7, House Committee on Veterans' Affairs, "Relationship Between the Amputation of an Extremity and the Subsequent Development of Cardiovascular Disorders," 96th Cong., 1st Sess. 1 (1979) [hereinafter Comm. Print No. 7], was submitted to Congress on June 30, 1977. It concluded that the available evidence did not support a statistically significant link between atherosclerotic cardiovascular disease and amputation. Comm. Print No. 7 at 5. The results of the statistical analysis, conducted for VA by the Medical Follow-up Agency of the National Academy of Sciences, were described in "Report to the Veterans' Administration Department of Medicine and Surgery on Service-Connected Traumatic Limb Amputations and Subsequent Mortality from Cardiovascular Disease and Other Causes of Death," Comm. Print No. 7 at 7, which was submitted to Congress on February 15, 1979.

The statistical analysis involved comparison of data on amputee and nonamputee veterans matched by age, sex, and war period. The analysis contrasted mortality of veterans with proximal amputations, defined as knee or above or elbow and above, with that of veterans having distal amputations, defined as loss of part of a hand or loss of part of a foot, and with that of veterans having disfigurement, including painful and adherent scars and disfigurement of other than the head, face, or skull. Comm. Print No. 7 at 9. The report concluded that veterans with a proximal limb amputation had a mortality rate, standardized for age and calendar time, 1.4 times that of

veterans with disfigurement without loss of body part and 1.3 times that of veterans with distal amputation. Comm. Print No. 7 at 8. When contrasted with the United States male population as a whole, excess mortality from ischemic heart disease and other diseases of the cardiovascular system was statistically significant for the proximal limb amputation group. Comm. Print No. 7 at 8 and 26, Figure 1. The results also indicated that bilateral lower-limb amputees had the highest relative risk of cardiovascular disease and that relative risks were greater for lower-limb unilateral amputees than for arm amputees. Comm. Print No. 7 at 15 and 23, Table 9. The study identified a variety of possible causes of the increased risk of cardiovascular disease among proximal amputees, but noted that the study was not designed to test specific hypotheses regarding the causes of the increased risk. Comm. Print No. 7 at 16-18.

In contrast to the increased risk of cardiovascular disease found among the proximal amputees, the group of veterans with distal amputations had a mortality from cardiovascular disease slightly above that expected for the male United States population as a whole initially, but that rate dropped to the expected mortality for the general male population after about twenty years postamputation. Comm. Print No. 7 at 14 and 26, Figure 1. The group of veterans with disfigurement had mortality rates from cardiovascular disease below that expected for men in the United States throughout the follow-up period of thirty-two years. Comm. Print No. 7 at 14 and 26, Figure 1.

Following receipt of these findings, VA published a notice of proposed rulemaking (NPRM) on May 7, 1979, proposing to amend 38 C.F.R. § 3.310 to add a subsection establishing service connection for ischemic heart disease or other cardiovascular disease developing in a veteran who has a service-connected amputation of one lower extremity at or above the knee or service-connected amputation of both lower extremities at or above the ankles. 44 Fed. Reg. 26,762 (1979). The preamble to the NPRM stated, in part, "[t]his amendment results from a report made by the National Academy of Sciences." Id. The preamble further explained, "[t]he [National Academy of Sciences] report indicates that veterans who have suffered an amputation of both legs or of one leg at or above the knee, have a significantly higher risk of dying from diseases of the cardiovascular system," and specifically stated that section 3.310 was being amended "[a]s a result of these findings." Id.

In response to publication of the NPRM, VA received comments suggesting expansion of the presumption to include veterans suffering from other types of disabilities, such as single below-the-knee amputations. One commenter suggested that service connection should be presumed for cardiovascular disease developing in a veteran who had suffered unilateral amputation below the knee and who had been hospitalized for a prolonged period while in service to treat other disabilities or who has a thirty-percent or more disabling condition involving the other

leg. The preamble to the final rule noted that "[s]ince these situations were not dealt with in the NAS report we are unable to favorably consider these suggestions." 44 Fed. Reg. 50,339, 50,340 (1979). The preamble went on to state that "[t]he NAS report shows that only unilateral above-the-knee amputations and amputations of both lower extremities result in a significant increase in the incidence of cardiovascular disease." Id. Accordingly, the amendment was adopted without change.

2. Mustard Gas

In 1992, VA recognized that some naval personnel were experimentally exposed to mustard gas during full-body, field, or chamber tests of protective equipment and clothing conducted at the Naval Research Laboratory, located at Edgewood Arsenal, between 1943 and 1945. 57 Fed. Reg. 1699 (1992). VA noted that similar testing may have been conducted at other locations during World War II. Id. VA observed that these tests were classified, participants were instructed not to discuss their involvement, medical records associated with the tests are generally unavailable, and no long-term follow-up examinations of test participants were conducted. Id. VA concluded that, for these reasons, some test participants may not have filed claims with VA for disabilities resulting from mustard-gas poisoning, or, if they did file claims, may have experienced difficulty in establishing entitlement to benefits. Id.

VA recognized that the special circumstances surrounding these World War II testing programs placed veterans who participated in them at a disadvantage with respect to establishment of entitlement to compensation for disability or death resulting from experimental exposure. Id. Consequently, VA proposed a new regulation, to be codified at 38 C.F.R. § 3.316, providing that, if exposure to mustard gas occurred under specified circumstances, the development of a chronic form of certain specified conditions will be sufficient to establish service connection for the conditions. 57 Fed. Reg. 1699 (1992). VA noted in the preamble to the NPRM that a review of the available medical literature by the Veterans Health Administration indicated that the chronic, long-term effects of acute mustard-gas poisoning may include laryngitis, bronchitis, emphysema, asthma, conjunctivitis, keratitis, and corneal opacities. Id. Accordingly, VA proposed incorporating these conditions in the regulation as providing a basis for service connection on a presumptive basis when developing in a chronic form in a veteran exposed to mustard gas while participating in full-body, field or chamber experiments to test protective clothing or equipment during World War II.

Among the public comments received concerning the proposed rule was one suggesting that it would discriminate against World War I veterans exposed to mustard gas under combat conditions. In the preamble to the notice announcing the final rule, VA responded that, in contrast to the case of the World War II test

participants, there was no government-imposed condition which would have prevented or discouraged World War I veterans from filing claims based on mustard-gas exposure. 57 Fed. Reg. 33,875, 33,876 (1992). VA went on to note that, because the service medical records of World War I veterans should show evidence of acute effects of any exposure, these veterans would not need the benefit of a presumption to establish service connection for the residuals of mustard-gas exposure. Id. Two commenters suggested inclusion of additional conditions in the list of conditions for which service connection could be presumed. VA responded that its literature review of English language sources did not provide a scientific basis for expanding the list of conditions. Id. The regulation was thus adopted without change.

To supplement its own literature review, VA contracted with the National Academy of Sciences to conduct a review of the world medical and scientific literature, including non-English-language literature, to determine the long-term health effects of exposure to mustard gas. The results of that review, conducted by the Institute of Medicine, indicated a causal relationship between significant exposure to mustard gas and a variety of health conditions. In January 1993, the Acting Secretary of Veterans Affairs, Anthony J. Principi, announced VA's intention to amend its regulation to expand the list of conditions which may be presumed service connected based on mustard-gas exposure. At that time, VA announced that it would propose recognizing the following additional conditions as associated with mustard-gas exposure: respiratory cancers (nasopharyngeal, laryngeal, and lung cancer, except mesothelioma); skin cancer; chronic obstructive pulmonary disease; and, leukemia (acute nonlymphocytic type resulting from nitrogen mustard).

In a March 10, 1993, statement to the Subcommittee on Compensation, Pension, and Insurance, House Committee on Veterans' Affairs, VA's Deputy Under Secretary for Benefits, R. J. Vogel, indicated that, based on the Institute of Medicine findings, VA would propose amending its regulation to extend the presumption to veterans exposed to mustard gas in battle during World War I, involved in the Bari, Italy incident in World War II, or exposed to mustard gas while manufacturing or transporting chemical warfare agents during service. In addition, Mr. Vogel indicated that VA would address by regulation service connection for chronic forms of laryngitis, bronchitis, emphysema, asthma, and chronic obstructive pulmonary diseases resulting from full-body exposure to Lewisite, a compound sharing some properties with mustard gas.

B. Legislation

1. Legislative and Regulatory Presumptions Related to Exposure to Dioxin

The herbicide Agent Orange was used in Vietnam during the Vietnam era, primarily to decrease jungle-foliage cover available to enemy troops. That defoliant contained dioxin as a contaminant. H.R. Rep. No. 592, 98th Cong., 2d Sess. 4 (1984), reprinted in 1984 U.S.C.C.A.N. 4449, 4450. The majority of the herbicides used in Vietnam were disseminated by aerial spraying through an Air Force project, code-named "Operation Ranch Hand." S. Rep. No. 82, 101st Cong., 1st Sess. 25 (1989). Dioxin was known to be highly toxic to certain animal species; however, its toxicity and health effects in humans were not known and were a matter of considerable controversy. H.R. Rep. No. 592 at 4, reprinted in 1984 U.S.C.C.A.N. at 4450-51.

Because of the "concern and apprehension" in the veteran community regarding the health effects of dioxin, an epidemiologic study of the effects of exposure to dioxin was mandated by Congress in the Veterans Health Programs Extension and Improvement Act of 1979, Pub. L. No. 96-151, § 307, 93 Stat. 1092, 1097. H.R. Rep. No. 592 at 5, reprinted in 1984 U.S.C.C.A.N. at 4451. This measure required that the Administrator of Veterans Affairs design and conduct an epidemiologic study of veterans exposed to dioxin during the Vietnam conflict to determine if long-term health effects may have resulted from such exposure. In addition, VA was required to conduct a review and scientific analysis of literature relating to possible long-term health effects of human exposure to dioxin. The study requirements mandated by Pub. L. No. 96-151 were amended by Pub. L. No. 97-72, § 401, 95 Stat. 1047, 1061 (1981), to authorize expansion of the study and literature review to include the impact of aspects of the Vietnam experience other than dioxin exposure.

Responsibility for the epidemiologic study mandated by Pub. L. Nos. 96-151 and 97-72 was transferred to the Centers for Disease Control in 1982. The study was ultimately structured as three studies, including: (1) a Vietnam experience study, designed to evaluate the overall impact of military service in Vietnam on those who served there; (2) an Agent Orange exposure study, intended to assess the possible adverse health effects on Vietnam veterans of herbicide exposure; and (3), a selected cancers study, designed to determine the risks of Vietnam veterans developing specific types of cancer. See 137 Cong. Rec. H723-24 (daily ed. Jan. 29, 1991) (statement of Rep. Montgomery). The Vietnam experience portion of the study, released in parts from 1987 through 1989, found excess mortality among Vietnam veterans, mainly in the first five years post-discharge, primarily due to suicide, homicide, and accidents, including vehicular accidents. Id. at H724. Higher morbidity, particularly due to depression, anxiety, and substance abuse was

also found. Id. The Agent Orange exposure study was found not to be feasible because of problems related to exposure assessment, and that study was canceled. Id. Findings of the study of selected cancers, released in March 1990, indicated that Vietnam veterans had a roughly fifty-percent greater relative risk of developing non-Hodgkin's lymphoma (NHL). Id.

Pub. L. No. 97-72 also authorized VA to provide hospital and nursing home care to certain veterans exposed during service to dioxin or ionizing radiation for conditions which, although not shown to have resulted from such exposure, are not found to have resulted from a cause other than such exposure. Pub. L. No. 97-72, § 102, 95 Stat. 1047. Congress' rationale in enacting this legislation, as it related to dioxin, was that:

[U]ntil the scientific community [is] able to make a determination as to the possible cause and effect relationship of the toxic herbicides utilized as defoliants in the Republic of Vietnam during the Vietnam conflict, the Veterans' Administration should do everything possible to provide the care to such veterans. When a doubt exists, the doubt should be resolved in favor of the veteran.

H.R. Rep. No. 79, 97th Cong., 1st Sess. 3, reprinted in 1981 U.S.C.C.A.N. 1685, 1688. The congressional committees involved in the development of this legislation stated their intent that,

in light of the current difficulties that have arisen with respect to determining definitively the actual usage patterns of Agent Orange and other dioxin-contaminated defoliants and herbicides and troop movements during the Vietnam conflict, . . . with respect to any claim based on exposure to dioxin, the Administrator concedes that such exposure occurred if the Administrator finds that the military records of the veteran claiming such exposure indicate that the veteran served in the Republic of Vietnam during the Vietnam era.

Explanatory Statement of Compromise Agreement, 127 Cong. Rec. S11,573 (daily ed. Oct. 16, 1981), reprinted in 1981 U.S.C.C.A.N. 1718, 1719-20.

The authority of Pub. L. No. 97-72 was to expire one year after VA submitted to Congress the first epidemiologic report mandated by Pub. L. No. 96-151. However, this authority was later extended. Currently, under the Agent Orange Act of 1991, Pub. L. No. 102-4, § 5, 105 Stat. 11, 15, it is set to expire on December 31, 1993.

VA has issued regulations at 38 C.F.R. § 17.47(a)(5) governing eligibility for inpatient hospital care and nursing home care for veterans exposed to "a toxic substance or

radiation." Regulations at 38 C.F.R. § 17.60g(d) authorize provision of outpatient medical care on a priority basis "to any veteran eligible for treatment for conditions which may have resulted from exposure to dioxin or toxic substances or ionizing radiation."

Independent of the study mandated in Pub. L. No. 96-151, the Air Force was conducting a study of Air Force personnel exposed to dioxin during "Operation Ranch Hand." The Air Force's "Ranch Hand" study is a long-term study expected to continue into the 21st century. Interim mortality reports and morbidity assessments have been released from time to time under this project, beginning in 1983. 137 Cong. Rec. at H724.

In 1983, Congress took up the issue of whether some action should be taken to provide compensation to veterans exposed to dioxin in Vietnam, notwithstanding the ongoing research efforts. Several bills dealing with compensation for exposure to herbicides in Southeast Asia during the Vietnam era were introduced early in the 98th Congress, including S. 374, 98th Cong., 1st Sess. (1983), S. 786, 98th Cong., 1st Sess. (1983), S. 991, 98th Cong., 1st Sess. (1983), and H.R. 1961, 98th Cong., 1st Sess. (1983). These bills would have variously created presumptions of service connection for particular diseases and/or directed VA to conduct rulemaking on the subject of presumptions. Hearings on these bills were held in the Senate and House in April, June, and July 1983, at which numerous persons provided oral or written testimony and many scientific studies and analyses were presented to Congress. See H.R. 1961-Vietnam Veterans Agent Orange Relief Act: Hearings Before the Subcomm. on Compensation, Pension and Insurance of the House Comm. on Veterans' Affairs, 98th Cong., 1st Sess. (April 26 and 27, 1983); Hearings Before the Senate Comm. on Veterans' Affairs, 98th Cong., 1st Sess. (June 15 and 22, 1983); H.R. 1961-Vietnam Veterans Agent Orange Relief Act: Hearing Before the Subcomm. on Compensation, Pension and Insurance of the House Comm. on Veterans' Affairs, 98th Cong., 1st Sess. (July 12, 1983). One of the scientific reports submitted was the initial mortality report from the Air Force Ranch Hand study. H.R. 1961-Vietnam Veterans Agent Orange Relief Act: Hearing Before the Subcomm. on Compensation, Pension and Insurance of the House Comm. on Veterans' Affairs, 98th Cong., 1st Sess. 75, 82 (July 12, 1983). The Ranch Hand data showed that, as of June 30, 1983, "the mortality experience of the Ranch Hand group is nearly identical to that of the comparison group." Id. at 84.

Witnesses differed as to the merits of creation of presumptions based on exposure to herbicides containing dioxin. Compare, e.g., H.R. 1961-Vietnam Veterans Agent Orange Relief Act: Hearings Before the Subcomm. on Compensation, Pension and Insurance of the House Comm. on Veterans' Affairs, 98th Cong., 1st Sess. 14-17 (April 26, 1983) (testimony of James R. Currieo, Commander in Chief, Veterans of Foreign Wars, supporting H.R. 1961 as a compassionate and responsible response to the

needs of Vietnam veterans), with, id. at 58-62 (testimony of R. Jack Powell, Executive Director, Paralyzed Veterans of America, opposing H.R. 1961 on the basis that legislation would be premature until completion of scientific studies to provide a sound basis for the presumptions). VA opposed the various bills on several bases, including that certain diseases for which presumptions were contemplated, i.e., chloracne and porphyria cutanea tarda, would become manifest very near in time to the exposure, thus obviating the need for a presumption, and that there was no consensus on whether herbicides could induce soft-tissue sarcoma or other delayed health effects. E.g., Veterans' Exposure to Agent Orange: Hearings Before the Senate Comm. on Veterans' Affairs, 98th Cong., 1st Sess. 437-60 (June 22, 1983) (statement of Dorothy L. Starbuck, Chief Benefits Director, Veterans Administration).

Two bills emerged from this process. The House bill, H.R. 1961, would have provided a presumption of service connection for soft-tissue sarcoma, porphyria cutanea tarda, and active and residual chloracne and chloracneiform lesions for veterans who served in Southeast Asia during the Vietnam era. The proposed legislation also would have authorized VA to prescribe by regulation presumptive service connection for additional diseases which medical research showed may be due to exposure to herbicides, chemicals, medications, or environmental hazards. The statutory presumptions were to terminate one year after the first report on the epidemiologic study mandated by Pub. L. No. 96-151 was submitted to Congress.

The comparable Senate bill, S. 1651, 98th Cong., 1st. Sess. (1983), was introduced in the Senate on July 20, 1983. S. 1651 included specific presumptions of service connection for veterans who served in Vietnam during the Vietnam era and who were exposed to a herbicide containing dioxin. The diseases for which service connection could be presumed, if developed to a degree of disability of ten percent or more, were soft-tissue sarcoma developing within thirty years after departure from Vietnam, porphyria cutanea tarda developing within one year after departure, and chloracne developing within one year after departure. Availability of the presumptions was conditioned, however, on rulemaking action by VA with respect to the specified diseases. 129 Cong. Rec. S10,478 (daily ed. July 20, 1983) (statement of Sen. Cranston). S. 1651 also would have authorized VA to establish, through rulemaking, presumptions of service connection for other diseases found to be connected to exposure to herbicides containing dioxin. The bill specified that the rulemaking process used to establish the presumptions and standards for using the presumptions would include public participation, both through public review and comment and through public hearings, and consultation with an advisory committee. Unlike H.R. 1961, S. 1651 also included specific presumptions of service connection for certain veterans exposed to ionizing radiation.

VA opposed this proposal partly on the basis that legislative action to create presumptions could not be supported on the basis of available evidence and that it would therefore be inappropriate to refer the matter for rulemaking. Letter to Alan K. Simpson, Chairman, Senate Committee on Veterans' Affairs, from Harry N. Walters, Administrator of Veterans Affairs (April 10, 1984). VA also noted that the procedural process imposed by the bill would impede resolution of the issues involved and that the legislation would create false expectations on the part of affected veterans and their families. Id.

After considerable debate and amendment, consideration of these proposals ultimately culminated in enactment on October 24, 1984, of the Veterans' Dioxin and Radiation Exposure Compensation Standards Act, Pub. L. No. 98-542, 98 Stat. 2725. As enacted, Pub. L. No. 98-542 did not provide a presumption of service connection for any specific disease based on exposure to dioxin. Section 5 of the act, 98 Stat. at 2727, did, however, direct VA to issue regulations to establish guidelines and, where appropriate, standards and criteria for the resolution of benefit claims based on exposure in service to herbicides containing dioxin in the Republic of Vietnam during the Vietnam era or to ionizing radiation from participation in atmospheric nuclear tests or the occupation of Hiroshima and Nagasaki, Japan, prior to July 1, 1946. These regulations were to ensure continuation of VA's policy of granting claimants the benefit of the doubt when there is an approximate balance of positive and negative evidence regarding any issue material to resolution of a claim. The regulations were to provide that service connection will not be established where the evidence establishes that disability or death resulted from some intercurrent cause or from the veteran's own willful misconduct.

The rules were to specify whether, and, if so, under what circumstances, diseases will be recognized as connected to a veteran's exposure in service to herbicides containing dioxin or to ionizing radiation. With respect to Vietnam veterans exposed to herbicides containing dioxin, the act required specific findings, either positive or negative, regarding service connection as to three diseases, chloracne, porphyria cutanea tarda, and soft-tissue sarcoma. The rules were to be grounded in "sound scientific and medical evidence." Id. § 5(b)(2)(A)(i) and (B), 98 Stat. at 2728. In addition, VA was to publish guidelines governing its evaluation of scientific studies of the possible adverse health effects of exposure to ionizing radiation or herbicides containing dioxin. The contemplated requirement that rulemaking include public hearings was not included in the bill as approved.

Pub. L. No. 98-542 also authorized, at section 6, 98 Stat. at 2729, a new Veterans' Advisory Committee on Environmental Hazards (VACEH) to advise VA as to possible service connection of specific diseases and with respect to its findings and evaluations concerning scientific studies. Finally, interim

benefits, payable like compensation, were provided for Vietnam veterans disabled by chloracne or porphyria cutanea tarda which became manifest within one year after departure from the Republic of Vietnam. Id. § 9, 98 Stat. at 2732. Payment of interim benefits to this group of veterans was limited to the period October 1, 1984, through September 30, 1986.

In enacting Pub. L. No. 98-542, Congress specifically found that "[t]here is some evidence that chloracne, porphyria cutanea tarda, and soft tissue sarcoma are associated with exposure to certain levels of dioxin as found in some herbicides." Id. § 2(5), 98 Stat. at 2725. The House committee report on the legislation explained that "[m]embers of the Committee have demonstrated their strong desire to respond to the apprehension and concern among some Vietnam veterans and their families about possible long-term health effects that may have been caused by their exposure to the herbicide Agent Orange while serving in South Vietnam." H.R. Rep. No. 592 at 7, reprinted in 1984 U.S.C.C.A.N. at 4453. The report went on to state:

[T]here is insufficient credible scientific evidence that this group of veterans has demonstrated they are experiencing any higher incidence or frequency of medical problems related to their possible exposure to dioxin while in service as to warrant a statutory presumption that such medical problems are related to military service. Notwithstanding this fact, the Committee is proposing the temporary payment of benefits for certain disabilities until the Agent Orange Epidemiological Study has been completed and the results of such study are submitted to the Congress.

Id.

The Senate approach of requiring rulemaking by VA was justified on the basis that:

Unless and until the executive branch has focused more intensively than it has thus far on the issues related to agent orange and radiation compensation, the Congress should not attempt to enact answers to the highly technical questions that are involved.

The VA must address questions of the degree and type of exposure and the likely or possible health effects of such exposure and do so in a fact-finding and policy-making process in which it is forced to consider all relevant information and viewpoints and make firm reasoned decisions on the record. . . . [t]he agency with the responsibility and resources to make the scientific, medical, and policy judgments involved should first be required to come to grips with and resolve the key issues

130 Cong. Rec. S6147 (daily ed. May 22, 1984) (statement of Sen. Cranston). The House approach of providing interim benefits was explained as being based on "some speculation" and as reflecting "a desire to go the extra mile for these veterans even though actual scientific evidence did not exist as to a real relationship between exposure and the disabling conditions." 130 Cong. Rec. H11,160 (daily ed. Oct. 3, 1984) (statement of Rep. Hammerschmidt). The final bill was a compromise measure which included provisions drawn from both bills. Id.

After enactment of Pub. L. No. 98-542, sections 1.17 (study evaluation), 3.311a (service connection), and 3.813 (interim benefits) were added to title 38, Code of Federal Regulations, to implement that law and to govern the adjudication of claims for benefits related to exposure to dioxin. 50 Fed. Reg. 34,452 (1985). Under 38 C.F.R. § 3.311a, as promulgated in 1985, service connection of one disease, chloracne, could be established if that condition became manifest within three months of exposure to dioxin. Dioxin exposure was presumed for any veteran who served in the Republic of Vietnam during the Vietnam era, and, for purposes of the latency period established by the regulation, exposure was presumed to continue until the veteran's date of departure from Vietnam. The regulation also provided that "[s]ound scientific and medical evidence does not establish a cause and effect relationship between dioxin exposure" and porphyria cutanea tarda, soft-tissue sarcoma, or any other disease with the exception of chloracne. 38 C.F.R. § 3.311a(d).

On May 3, 1989, the United States District Court for the Northern District of California issued an order in the case of Nehmer v. United States Veterans' Administration, 712 F. Supp. 1404 (N.D. Cal. 1989), interpreting the rulemaking requirements of Pub. L. No. 98-542. The court invalidated 38 C.F.R. § 3.311a(d), finding that Congress intended that VA predicate service connection upon a finding of a significant statistical association between exposure to a hazardous substance and disease and that the policy of resolving reasonable doubt in favor of the claimant should be applied in rulemaking under Pub. L. No. 98-542. 712 F. Supp. at 1420, 1422. The Government decided not to appeal this ruling.

As a result, VA amended 38 C.F.R. § 1.17 on October 2, 1989. 54 Fed. Reg. 40,388-92 (1989). Under the revised 38 C.F.R. § 1.17(c), when VA determines that a significant statistical association exists between any disease and exposure to a herbicide containing dioxin (or to ionizing radiation), 38 C.F.R. § 3.311a (or 3.311b) will be amended to provide guidelines for the establishment of service connection for the disease.

Using these new standards, the VACEH provided advice to VA on whether a statistically significant association exists between dioxin exposure and various diseases. After consideration of that advice, VA initiated rulemaking proceedings to amend 38 C.F.R. § 3.311a to reflect the Secretary's findings under the

new standards. On February 25, 1991, VA published a notice of proposed rulemaking to amend 38 C.F.R. § 3.311a(c) to establish a presumption of service connection for soft-tissue sarcoma manifested at any time after service in a veteran exposed during service to herbicides containing dioxin. 56 Fed. Reg. 7632 (1991). VA explained that, in making a determination on this issue, VA had considered the conflicting results among the scientific and medical studies on the subject and the advice of the VACEH that the relative weights of the valid positive and negative studies permitted the conclusion that it is at least as likely as not that there is a significant statistical association between exposure to a herbicide containing dioxin and soft-tissue sarcoma. Id. VA also noted that in order "to insure equitable treatment of veterans who may have been exposed to herbicides containing dioxin during service other than in Vietnam during the Vietnam era, e.g., in activities related to testing, storage or shipping of herbicides," VA was proposing that the presumptions established by section 3.311a not be limited to veterans who served in Vietnam during the Vietnam era. Id. The proposed regulation included a definition of "soft-tissue sarcoma" which excluded tumors of infancy and childhood and those having a strong, known causal association with a specific etiology, e.g., HIV infection or asbestos exposure, on the basis that it is unlikely there is a reasonable probability of a significant statistical association between such tumors and exposure to herbicides containing dioxin. 56 Fed. Reg. at 7633. A final rule incorporating minor technical amendments to the proposed rule was published on October 15, 1991. 56 Fed. Reg. 51,651 (1991).

On March 19, 1991, VA, citing the advice of the VACEH and the results of studies of a population exposed to dioxin in an industrial accident in Seveso, Italy, published a notice of proposed rulemaking to amend 38 C.F.R. § 3.311a(c) to extend from three months to nine months the presumptive period for chloracne. 56 Fed. Reg. 11,536 (1991). In that notice, VA also proposed to include in 38 C.F.R. § 3.311a(d) a finding that sound scientific and medical evidence does not establish a significant statistical association between exposure to herbicides containing dioxin and porphyria cutanea tarda. Id. With regard to porphyria cutanea tarda, VA noted the negative recommendation of the VACEH and the presence of confounding factors in those instances in which that condition appeared in individuals exposed to dioxin in industrial settings. Id. In adopting the proposed amendments without change, VA found the scientific evidence concerning porphyria cutanea tarda submitted by the one commenter on the proposed rule to be unconvincing. 56 Fed. Reg. 52,473 (1991).

On March 29, 1990, the Centers for Disease Control released a study entitled "The Association of Selected Cancers with Service in the U.S. Military in Vietnam." That study found that Vietnam veterans have roughly a fifty-percent increased risk of developing NHL after service in Vietnam. See 55 Fed. Reg. 25,339

(1990).¹⁸ A similar increased risk was not shown among veterans who served in other locations during the Vietnam era. Id.

Shortly thereafter, citing the Centers for Disease Control study, the Secretary of Veterans Affairs determined that "there is a relationship between Vietnam service and NHL" and proposed regulations to add a new 38 C.F.R. § 3.313 providing that service in Vietnam during the Vietnam era, together with the development of NHL manifested subsequent to that service, is sufficient to establish service connection for that disease. See 55 Fed. Reg. 25,339 (1990). A final regulation to that effect was published in October 1990. 55 Fed. Reg. 43,123 (1990).

Congress essentially codified VA's regulatory presumptions of service connection for Vietnam veterans in the Agent Orange Act of 1991. Pub. L. No. 102-4, § 2, 105 Stat. at 11; see Explanatory Statement on the Agent Orange Act of 1991, 137 Cong. Rec. H726 (daily ed. Jan. 29, 1991). That act added a new section 316 (now section 1116) to title 38, United States Code, establishing a presumption of service connection, applicable to veterans who served in the Republic of Vietnam during the Vietnam era, for: NHL becoming manifest to a degree of disability of ten percent or more at any time after service; soft-tissue sarcoma,¹⁹ other than osteosarcoma, chondrosarcoma, Kaposi's sarcoma, and mesothelioma, becoming manifest to a degree of disability of ten percent or more; and, chloracne or other

¹⁸ A 1986 study of agricultural exposure to herbicides among farmers in Kansas had found a six-fold to eight-fold increase in NHL among those with heavy exposure to 2,4-D, an Agent Orange component. S. Rep. No. 82, 101st Cong., 1st Sess. 36 (1989). A VA study of proportionate mortality of Army and Marine Corps Vietnam veterans, released in 1987, found a statistically significant two-fold increase in NHL among the subgroup of Marines studied, but not among all Vietnam veterans in the study or among the subgroup of Army veterans. Id. at 31, 32, 36, 54.

¹⁹ On May 19, 1993, VA published a final rule defining soft-tissue sarcoma for purposes of regulations implementing Pub. L. No. 102-4. 58 Fed. Reg. 29,107 (1993). That rule added a note following new 38 C.F.R. § 3.303(e) explaining that soft-tissue sarcoma which may be presumed service connected based on service in the Republic of Vietnam includes those tumors listed at 38 C.F.R. § 3.311a(c)(2), as well as extraskeletal Ewing's sarcoma, congenital and infantile fibrosarcoma, and malignant ganglioneuroma. In adding the three additional tumor categories, VA noted that, while these sarcomas are generally considered tumors of infancy and childhood which rarely, if ever, appear in individuals old enough for military service, they were included to satisfy the statutory requirements of Pub. L. No. 102-4. 58 Fed. Reg. at 29, 108.

acneiform disease consistent with chloracne becoming manifest to a degree of disability of ten percent or more within one year (in contrast to the regulatory period of three months) after service in Vietnam. ²⁰

Section 3 of Pub. L. No. 102-4, 105 Stat. at 13, called for VA to contract with the National Academy of Sciences, or another appropriate non-governmental, not-for-profit, scientific organization with expertise and objectivity comparable to that of the National Academy of Sciences, to perform a review and evaluation of the scientific evidence regarding the association between disease and exposure to herbicides used in connection with the Vietnam War and each disease suspected of association with such exposure. ²¹ Review and evaluation by the National Academy of Sciences took the place of review by the VACEH, the dioxin-related functions of which were eliminated by section 10 of Pub. L. No. 102-4, 105 Stat. at 13.

Section 10 of Pub. L. No. 102-4 also repealed the dioxin-related rulemaking provisions of Pub. L. No. 98-542. In their place, the act established standards and procedures which VA is to use in determining whether a presumption of service connection should be established for a particular disease based on herbicide exposure. Pub. L. No. 102-4, § 2, 105 Stat. at 11, 12. The act requires VA to prescribe regulations providing a presumption of service connection for a disease where the Secretary determines, "on the basis of sound medical and scientific evidence, that a positive association exists between . . . exposure of humans to an herbicide agent, and . . . the occurrence of a disease in humans." Id. at 12. In making such determinations, VA is to

²⁰ Unlike VA's regulations, these presumptions were only made applicable to veterans who served in Vietnam during the Vietnam era, not to veterans who may have been otherwise exposed to dioxin in service. However, the Explanatory Statement on the Agent Orange Act of 1991 contained the observation that VA already has the authority to apply any of the presumptions to veterans exposed outside Vietnam to the same herbicide agents on which the presumptions were based. 137 Cong. Rec. at H726-27.

²¹ After protracted negotiations, an agreement was signed with the National Academy of Sciences on January 31, 1992. To facilitate this agreement, the Agent Orange Act of 1991 was amended by the Veterans' Benefits Programs Improvement Act of 1991, Pub. L. No. 102-86, § 503, 105 Stat. 414, 424, to allow the Secretary of Veterans Affairs to provide the National Academy of Sciences with liability insurance for performing the review and evaluation required in the Agent Orange Act. See Joint Explanatory Statement on H.R. 1047, 137 Cong. Rec. H5931, H5934 (daily ed. July 29, 1991), reprinted in 1991 U.S.C.C.A.N. 181, 192.

take into account reports received from the National Academy of Sciences and all other available "sound medical and scientific information and analyses" and find a positive association between a disease and exposure to a herbicide agent "if the credible evidence for the association is equal to or outweighs the credible evidence against the association." Id.

The congressional debates on Pub. L. No. 102-4 reflect a substantial difference of opinion in Congress at the time of enactment of the legislation concerning the human health effects of dioxin exposure. Compare 137 Cong. Rec. S1267 (daily ed. Jan. 30, 1991) (statement of Sen. Daschle referring to the "sizable and growing body of scientific evidence suggest[ing] that exposure to agent orange is associated with the development of various diseases in Vietnam veterans"), with 137 Cong. Rec. H725 (daily ed. Jan. 29, 1991) (statement of Rep. Montgomery noting the consistent and reputable evidence that "exposure to herbicides in Vietnam is not responsible for the health effects now experienced by Vietnam veterans"). The legislation was described as "an historic compromise" between these competing viewpoints. 137 Cong. Rec. S1263 (daily ed. Jan. 30, 1991) (statement of Sen. Cranston).

The approach chosen was intended to ensure that an "independent scientific organization will make independent scientific judgments and recommendations, while the policymaker--the Secretary--will make the policy decision that determines whether VA must establish a presumption of service connection." Id. Regarding the level of scientific evidence necessary to support a presumption of service connection, the debates contain the following statement:

Congress clearly does not--and I strongly believe should not--use the high standard of proof required for a scientific conclusion of causation in deciding whether to establish presumptions of service connection. To do so would place the heavy burden of scientific uncertainty totally upon the veteran and that would be inconsistent with the approach that Congress has followed in creating presumptions of service connection and providing for the creation of presumptions.

137 Cong. Rec. S1270-71 (daily ed. Jan. 30, 1991) (statement of Sen. DeConcini). ²²

²² It had been noted during debates that "scientific investigative efforts . . . have not established a causal link between exposure to agent orange in Vietnam and any disease in humans other than chloracne." 137 Cong. Rec. H725 (daily ed. Jan. 29, 1991) (statement of Rep. Montgomery).

On July 27, 1993, the National Academy of Sciences' Institute of Medicine issued its initial report pursuant to its contract with VA under Pub. L. No. 102-4. In its report, entitled "Veterans and Agent Orange: Health Effects of Herbicides Used in Vietnam," the Institute of Medicine found "sufficient evidence" of an association between exposure to herbicides and occurrence in humans of five diseases, chloracne, Hodgkin's disease, non-Hodgkin's lymphoma, porphyria cutanea tarda, and soft-tissue sarcoma.

On September 27, 1993, Secretary of Veterans Affairs Jesse Brown, in letters to the Chairmen and Ranking Minority Members of the Senate and House Committees on Veterans' Affairs, reported that VA would propose rules to provide presumptions of service connection for the two diseases included by the Institute of Medicine in the "sufficient evidence" category, Hodgkin's disease and porphyria cutanea tarda, for which no presumption of service connection was currently available under VA regulations. In those letters, Secretary Brown also stated that VA would propose establishment of service connection for two diseases, respiratory cancers and multiple myeloma, for which the Institute of Medicine found "limited/suggestive evidence" of an association. Secretary Brown further indicated that he had determined that a positive association had not been established with respect to the other diseases covered by the Institute of Medicine report.²³

2. Presumptions Related to Exposure to Ionizing Radiation

The health risks of veterans exposed to ionizing radiation during military service have also been a matter of considerable concern and controversy. Between 1945 and 1963, the United States exploded approximately 235 nuclear devices in the American Southwest and in the Pacific Ocean. H.R. Rep. No. 592 at 7, reprinted in 1984 U.S.C.C.A.N. at 4453. Approximately 220,000 American service personnel participated in these tests. Id. Many servicemembers were exposed to low-level ionizing radiation during that testing or during the occupation of Japan at the

²³ One such disease was peripheral neuropathy, which, on January 21, 1992, following receipt of a positive recommendation from the VACEH, VA had proposed to add to the list of diseases which could be presumed service connected under 38 C.F.R. § 3.311a(c) (subject to the qualification that the disease become manifest within ten years of exposure to herbicides containing dioxin). 57 Fed. Reg. 2236 (1992). In that notice, VA had also proposed amending 38 C.F.R. § 3.311a(d) to include a finding that sound scientific and medical evidence does not establish a significant statistical association between exposure to herbicides containing dioxin and lung cancer. Id.

conclusion of World War II. Id. The accuracy of documentation of exposure levels of these personnel has been questioned. Id.

Proposals to presume service connection for diseases developing in veterans exposed to radiation in service were introduced in Congress as early as 1980. See, e.g., H.R. 8380, 96th Cong., 2d Sess. (1980). Congressional concern for the needs of radiation-exposed veterans was reflected in the enactment of the Veterans' Health Care, Training, and Small Business Loan Act of 1981, Pub. L. No. 97-72, 95 Stat. 1047. Pub. L. No. 97-72 authorized VA to provide hospital and nursing-home care to veterans exposed on active duty to ionizing radiation from the detonation of a nuclear device during testing or in connection with the occupation of Hiroshima and Nagasaki, Japan, for any disability which, although not shown to have resulted from such exposure, is not found, under guidelines to be issued by VA's Chief Medical Director, to have resulted from a cause other than such exposure. Id. § 102(a), 95 Stat. at 1047. This authority was to expire at the end of the one-year period beginning on the date on which VA submitted its first report to Congress on the epidemiological study pertaining to dioxin mandated by Pub. L. No. 96-151, § 307(b)(2), 93 Stat. 1092, 1098 (1979). ²⁴

In explaining the basis for this provision, Senator Alan Cranston stated:

[T]here still are many questions that must be answered before the VA will be able to develop a uniform practice for resolving radiation-related claims that will be accepted as adequate and appropriate by veterans exposed to radiation during their service, survivors of those veterans, and others concerned with this issue.

In the interim, I believe it is fully appropriate . . . to provide basic health care for disabilities that might be associated with exposure to radiation.

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. . . [T]he support for this new eligibility is founded on the view that some of the disabilities for which care is being sought may, in time, be determined to be service-connected disabilities but, in the interim, veterans suffering current health problems should be provided access to VA health care without

²⁴ The expiration date for this authority for health-care eligibility for radiation-exposed veterans has been extended through December 31, 1993. Pub. L. No. 102-4, § 5, 105 Stat. 11, 15 (1991).

reference to whether they can afford the cost of the care--the criterion that they would have to meet under current law.

127 Cong. Rec. S11,587-88 (daily ed. Oct. 16, 1981) (statement of Sen. Cranston).

In 1983, Congress held a hearing to review the activities of Federal agencies conducting scientific studies and investigations into the health effects of low-level radiation exposure experienced by certain veterans, reconstruction of exposure levels of nuclear-test participants, and VA's implementation of Pub. L. No. 97-72. Review of Federal Studies on Health Effects of Low-Level Radiation Exposure and Implementation of Public Law 97-72: Hearing Before the Subcomm. on Oversight and Investigations of the House Comm. on Veterans' Affairs, 98th Cong., 1st Sess. 1 (1983) [hereinafter Low-Level Radiation Exposure Hearing]. During that hearing, Dr. D. Earl Brown, VA's Associate Deputy Chief Medical Director, testified that initial guidelines issued by VA to implement Pub. L. No. 97-72 limited the provision of hospital and nursing-home care to veterans suffering from cancer and thyroid nodules. Id. at 25. Those guidelines provided that all other conditions are not ordinarily attributable to exposure to ionizing radiation. Id.

Dr. Brown went on to testify that, following complaints that the eligibility guidelines were too restrictive, particularly when compared with guidelines related to Agent Orange, VA reviewed the radiation guidelines. Id. VA determined that it could, consistent with the intent of Pub. L. No. 97-72, revise its guidelines to allow treatment for all conditions except those which are known to have causes other than exposure to ionizing radiation. Id. Revised guidelines, issued April 5, 1983, provided that authorization for treatment under Pub. L. No. 97-72 excluded only conditions found to have resulted from a cause other than exposure to ionizing radiation under the specified circumstances. Department of Medicine and Surgery, Veterans Administration, "Guidelines for Implementation of Legislation Related to the Provision of Health Services to Veterans Exposed to Ionizing Radiation as a Result of Detonation of Nuclear Devices," VA Circular 10-83-61, April 5, 1983, reprinted in Low-Level Radiation Exposure Hearing at 268. Physicians were advised that, in making this determination, the following types of conditions are not ordinarily considered to be due to radiation exposure: congenital or developmental conditions (e.g., spina bifida, scoliosis); conditions known to have pre-existed military service; conditions resulting from trauma; conditions having a specific and well-established etiology (e.g., tuberculosis, gout); and, common conditions having a well-recognized clinical course (e.g., inguinal hernia, acute appendicitis). Id., reprinted in Low-Level Radiation Exposure Hearing at 269.

Later that year, Congress enacted Pub. L. No. 98-160, § 601, 97 Stat. 993, 1006 (1983), which required VA to contract for an

epidemiological study of the long-term adverse health effects of exposure to ionizing radiation on veterans exposed to such radiation from the testing of nuclear devices or in connection with the occupation of Hiroshima and Nagasaki, Japan, if VA determined, in consultation with the Director of the Office of Technology Assessment, that such a study was feasible. This study was intended to assess the health status of radiation-exposed veterans in light of reports of excess leukemia in a certain group of nuclear-test participants, uncertainties regarding exposure levels, recently reported information on excess incidence of cancer among survivors of the Nagasaki nuclear detonation, and uncertainties regarding dose-response relationships. See S. Rep. No. 145, 98th Cong., 1st Sess. 71 (1983), reprinted in 1983 U.S.C.C.A.N. 1344, 1397.

Also in 1983, the House Committee on Veterans' Affairs adopted an amendment to H.R. 1961, 98th Cong., 1st Sess. (1983), to provide interim benefits to veterans exposed to ionizing radiation during nuclear testing or during occupation of Hiroshima and Nagasaki during World War II. See H.R. Rep. No. 592 at 3-4, reprinted in 1984 U.S.C.C.A.N. at 4450. As amended, the bill would have created temporary disability and death allowances for veterans suffering from leukemia, polycythemia vera, or carcinoma of the thyroid appearing within twenty years after participation in nuclear-weapons testing or the occupation of certain areas in Japan. In reporting the amended bill, the House committee noted, "[a]lthough current evidence indicates that some veterans exposed to ionizing radiation are experiencing serious medical problems, available data falls far short of meeting the test that the exercise of sound medical judgment reflects that these disabilities are related to military service." Id. at 9, reprinted in 1984 U.S.C.C.A.N. at 4455. The amended bill was passed by the House on January 30, 1984.

The Senate also had before it in 1983 a proposal to authorize benefits for radiation-exposed veterans. S. 1651, 98th Cong., 1st Sess. (1983), would have amended 38 U.S.C. § 312 (now § 1112) to authorize VA to create by regulation, based on medical and scientific evidence, presumptions of service connection for "a malignancy," polycythemia vera, hypothyroidism or a thyroid nodule, and any other disease specified by VA by regulation, developing to a degree of disability of ten percent or more in a veteran exposed to ionizing radiation from detonation of a nuclear device during participation in nuclear testing or the occupation of Hiroshima and Nagasaki. VA had opposed this measure on the bases that rulemaking was an inappropriate approach in view of the substantial, unresolved questions concerning the long-term impact of low-level radiation exposure and that public support for the disability compensation program would be undermined if presumptions were not scientifically supported. Letter to Alan K. Simpson, Chairman, Senate Committee on Veterans' Affairs, from Harry N. Walters, Administrator of Veterans Affairs (April 10, 1984). VA also noted that the

exposure levels of members of the occupation forces were so low that "[a]ny scientific basis for presumption of service connection for radiation-related diseases based on such exposure is totally lacking." Id.

An amended bill requiring rulemaking concerning additional diseases was passed by the Senate on May 22, 1984. Compromise legislation resolving the differences between the House and Senate bills was enacted as Pub. L. No. 98-542, 98 Stat. 2725, on October 24, 1984. The legislation as enacted contained no provision for interim benefits based on exposure to ionizing radiation. Section 5 of the act, 98 Stat. at 2727, did include a requirement that VA, after receiving the advice of the VACEH, prescribe regulations based on sound scientific and medical evidence regarding whether service connection of certain disabilities will be granted in the case of veterans exposed to ionizing radiation in connection with participation in atmospheric nuclear testing or the occupation of Hiroshima and Nagasaki before July 1, 1946. The act required that VA make specific findings regarding service connection of leukemia, polycythemia vera, and malignancies of the thyroid, female breast, lung, bone, liver, and skin. Pub. L. No. 98-542, §§ 2(5) and 5(b)(2), 98 Stat. at 2725, 2728. Inclusion of these diseases was based on Congress' finding that they "are associated with exposure to certain levels of ionizing radiation." Id. § 2(5), 98 Stat. at 2725.

Rejection in the final bill of benefits based on exposure to ionizing radiation reflected concern on the part of the Senate that, in light of the available scientific evidence, payment of such benefits would have undermined the principle of service connection. 130 Cong. Rec. S13,590, S13,592 (daily ed. Oct. 4, 1984) (statement of Sen. Simpson). House supporters of the legislation had conceded that the disabilities which would have been compensated for under the House bill "involved some speculation" and that "actual scientific evidence did not exist as to a real relationship between exposure and the disabling conditions." 130 Cong. Rec. H11,160 (daily ed. Oct. 3, 1984) (statement of Rep. Hammerschmidt). Senator Alan Cranston expressed his view that:

[I]t was not appropriate for the Congress to make decisions to include or not include in a list of presumptively service-connected disabilities for purposes of VA compensation various disabilities as to which there are fundamental differences of opinion among informed scientists as to whether the exposures that veterans experienced were likely to have caused various disabilities.

130 Cong. Rec. S13,597 (daily ed. Oct. 4, 1984) (statement of Sen. Cranston).

VA regulations governing adjudication of claims based on exposure to ionizing radiation, issued to implement Pub. L. No. 98-542, were codified at 38 C.F.R. § 3.311b. These regulations did not specify that any disease could be presumed service connected on the basis of exposure to ionizing radiation. See 50 Fed. Reg. 34,452 (1985). Rather, relying heavily on Committee on the Biological Effects of Ionizing Radiation, National Research Council, The Effects on Populations of Exposure to Low Levels of Ionizing Radiation: 1980 (BEIR III report), VA stated the factors to be considered in adjudication of claims for compensation based on exposure to ionizing radiation. See 50 Fed. Reg. at 15,848, 15,851 (1985). Again relying heavily on the BEIR III report, see id. at 15,851-52, as well as the advice of the VACEH, see 50 Fed. Reg. at 34,456, VA included in 38 C.F.R. § 3.311b(b)(2) a list of "radiogenic diseases" for which service connection could be established under appropriate circumstances based on radiation exposure.²⁵

The 100th Congress considered several proposals to create presumptions of service connection based on exposure to ionizing radiation. S. 453, 100th Cong., 1st Sess. (1987), would have created a rebuttable presumption of service connection for leukemia, liver cancer, multiple myeloma, and cancer of the bone marrow becoming manifest within specified periods after participation in the atmospheric detonation of a nuclear device or the occupation of Hiroshima and Nagasaki. S. 1002, 100th Cong., 1st Sess. (1987), would have provided a rebuttable presumption of service connection for certain radiation-exposed veterans developing specified diseases within particular time

²⁵ The fifteen diseases or categories of diseases listed as "radiogenic" in 38 U.S.C. § 3.311b(b)(2), as originally promulgated, were: all forms of leukemia except chronic lymphatic leukemia; bone cancer; colon cancer; esophageal cancer; female breast cancer; kidney cancer; liver cancer; lung cancer; multiple myeloma; pancreatic cancer; salivary gland cancer; skin cancer; stomach cancer; thyroid cancer; and, urinary bladder cancer. VA's list included several diseases not included in section 2(5) of Pub. L. No. 98-542, but excluded polycythemia vera based on an absence of sound scientific and medical evidence establishing a connection between that disease and radiation exposure. 50 Fed. Reg. at 15,851. The list of radiogenic diseases in 38 C.F.R. § 3.311b(b)(2) was amended in 1989 to include posterior subcapsular cataracts and non-malignant thyroid nodular disease and to eliminate the gender restriction on breast cancer. 54 Fed. Reg. 42,802 (1989). Based on advice from VACEH, ovarian cancer and parathyroid adenoma were added to the list of radiogenic diseases in 1993. 58 Fed. Reg. 16,358 (1993) (final rule); 57 Fed. Reg. 10,449 (1992) (proposed rule on ovarian cancer); 57 Fed. Reg. 10,853 (1992) (proposed rule on parathyroid adenoma).

periods, but would have provided full compensation only for diseases, i.e., leukemia and cancer of the thyroid, "strongly associated with radiation and . . . not . . . strongly associated with any other risk factors." Fifty percent of the compensation rate otherwise payable would have been provided for several other specified diseases "moderately associated with radiation," where a veteran's estimated service-related radiation exposure exceeded a certain level.

During hearings on these and other bills, Senator Alan Cranston, Chairman, Senate Committee on Veterans' Affairs, described his view of the rationale for providing presumptions of service connection for certain diseases occurring in radiation-exposed veterans:

Officials of the United States Government were aware as early as 1945 of the risks of long-term, adverse health effects from exposure to ionizing radiation. Nevertheless, military personnel continued to be exposed to ionizing radiation in connection with the nuclear weapons testing program. These military personnel were not informed of the risks associated with their participation in the program, nor was their health status systematically monitored thereafter. These factors place an even greater than usual responsibility on the Government to ensure that these veterans receive appropriate compensation as well as necessary health care through the VA for any disabilities that could reasonably have resulted from such exposure.

VA Compensation and Other Service-Connected Benefits: Hearing Before the Senate Comm. on Veterans' Affairs 119 (1987). In 1988, Congress enacted the Radiation-Exposed Veterans Compensation Act of 1988, Pub. L. No. 100-321, 102 Stat. 485, which amended 38 U.S.C. § 312 (now § 1112) to establish presumptions of service connection for specified diseases becoming manifest to a degree of ten percent or more within forty years (thirty years in the case of leukemia) of a veteran's participation on active duty in a radiation-risk activity. The term "radiation-risk activity" was defined as onsite participation in atmospheric nuclear testing, occupation of Hiroshima and Nagasaki during the period August 6, 1945, to July 1, 1946, and internment as a POW in Japan which resulted in opportunity for radiation exposure comparable to that experienced by the Hiroshima and Nagasaki occupation forces.²⁶

²⁶ The diseases to be presumed service connected under Pub. L. No. 100-321 were: cancer of the bile ducts, breast, esophagus, gall bladder, pancreas, pharynx, small intestine, stomach, and, thyroid; leukemia (other than chronic lymphocytic leukemia); lymphomas (except Hodgkin's disease); multiple myeloma; and,

Pub. L. No. 100-321 was based in part on H.R. 1811, 100th Cong., 1st Sess. (1987), which, as initially introduced, would have provided a presumption of service connection for five diseases (leukemia other than chronic lymphatic leukemia, thyroid cancer, female breast cancer, polycythemia vera, and bronchogenic cancer). VA had strongly opposed this measure, stating:

Our primary objections to the bill may be summarized as follows: existing law already provides entitlement to service connection for radiogenic diseases; a presumption of law in the case of low-level radiation exposure would substantially weaken the legitimacy of the service-connected disability benefit programs; and, the eligibility criteria embodied in the bill are over inclusive and inequitable.

Letter to G.V. (Sonny) Montgomery, Chairman, House Committee on Veterans' Affairs, from Thomas K. Turnage, Administrator of Veterans' Affairs 1 (June 25, 1987), reprinted in 1988 U.S.C.C.A.N. 418. The Administrator noted the "very low doses of radiation" received by most nuclear test participants and the "even more negligible" doses received by occupation forces and argued that establishing blanket entitlement based on such exposures dilutes the concept of service connection of disability. Id. at 3-4, reprinted in 1988 U.S.C.C.A.N. at 420-21. He also observed that since all veterans have been exposed to radiation to some degree from sources such as natural background, fallout, and medical and dental x-rays, it would be discriminatory to provide presumptions only for the classes of

primary liver cancer (except if cirrhosis or hepatitis B is indicated).

A comparison of the seventeen "radiogenic" diseases in 38 U.S.C. § 3.311b(b)(2) with the diseases which may be presumed service connected under Pub. L. No. 100-321 shows that the regulatory list of radiogenic diseases does not include five of the diseases included in Pub. L. No. 100-321--cancer of the pharynx, cancer of the small intestine, lymphomas, cancer of the bile ducts, and cancer of the gall bladder. Until recently, nine diseases identified as radiogenic in 38 C.F.R. § 3.311b(b)(2)--lung cancer, bone cancer, skin cancer, colon cancer, kidney cancer, urinary bladder cancer, salivary gland cancer, posterior subcapsular cataracts, and non-malignant thyroid nodular disease--were not included in the statutory list of diseases which could be presumed service connected following exposure to ionizing radiation. However, as discussed below, cancer of the salivary gland, and cancer of the urinary tract (including kidney cancer and urinary bladder cancer, along with other cancers of the urinary tract) were added to the statutory list by Pub. L. No. 102-578, § 2, 106 Stat. 4774 (1992).

veterans covered by the proposed legislation. Id. at 4, reprinted in 1988 U.S.C.C.A.N. at 421.

Finally, the Administrator questioned on scientific grounds the rationality of including bronchogenic carcinoma and polycythemia vera in the bill while excluding various radiogenic forms of cancer. Id. The VACEH, in a separate letter, also noted that scientific evidence does not support inclusion in the bill of polycythemia vera as a radiogenic disease and that the committee did "not believe that an absolute distinction should be made between female breast cancer and male breast cancer as concerns the probability of causation by radiation." Letter to G.V. (Sonny) Montgomery, Chairman, House Committee on Veterans' Affairs, from Oliver H. Meadows, Chairman, VACEH 4 (May 19, 1987), reprinted in 1988 U.S.C.C.A.N. 423, 426. The proposed bill was subsequently amended to eliminate polycythemia vera, to delete the word "female" in the phrase "cancer of the female breast," and to include several additional types of cancer.

The House Committee on Veterans' Affairs, in explaining the basis for the establishment of presumptions in Pub. L. No. 100-321, acknowledged the lack of clear scientific evidence at that time for service connection of the listed diseases, stating:

While much has been learned about the carcinogenic effects of high doses of radiation exposure, scientists still are uncertain how low-level ionizing radiation exposure causes cancer, and how to predict the effects of exposure to low doses of ionizing radiation.

Medical and scientific information available to the Committee has identified a number of disabilities that appear to bear some relationship to exposure to ionizing radiation.

H.R. Rep. No. 235, 100th Cong., 1st Sess. 4, reprinted in 1988 U.S.C.C.A.N. 412, 414.

The Committee further noted the dilemma presented by the uncertainty regarding radiation doses actually received by veterans exposed to radiation during service, stating:

Some feel that Congress should abide by its long-standing tradition that benefits should be paid only where substantive evidence is clearly available to establish that the disabling conditions existed while on active duty or are clearly related to such period of service. It has become apparent that such evidence will never be available in the cases of veterans covered under the provisions of the reported bill because the level of exposure cannot be verified.

Id.

The Committee addressed this uncertainty as follows:

Since the amount of exposure of the "radiation-exposed veteran", as defined in the reported bill, is less than certain, the Committee has deliberately ignored the issue of level of exposure and has concentrated instead on the likelihood of relationship of disease entities to radiation exposure. The proposed legislation includes those malignancies considered most likely to be related to ionizing radiation exposure.

Id., reprinted in 1988 U.S.C.C.A.N. at 414-15.

To implement Pub. L. No. 100-321, VA amended 38 C.F.R. § 3.309 to add a new paragraph (d). 54 Fed. Reg. 26,027 (1989). This regulation essentially restated the provisions of the statute and added definitions to further specify the groups which would be considered to have participated in radiation-risk activities within the meaning of the statute. 53 Fed. Reg. 50,547, 50,548 (1988) (proposed-rule notice).

In December 1989, the National Research Council Committee on the Biological Effects of Ionizing Radiation issued a report (BEIR V report), containing new analysis of the health effects of radiation exposure employing research results and analytical techniques not available at the time the BEIR III report was issued. S. Rep. No. 379, 101st Cong., 2d Sess. 100 (1990). This report suggested that lifetime excess cancer risks from low-level radiation exposure are greater than previously thought. Id. at 101. The report also contained new information based on analysis of data on Japanese atomic-bomb survivors indicating that, although the mortality rate for leukemia peaked within the first ten years after radiation exposure, the increased risk of death persists much longer than previously suspected. Id.

Based on the BEIR V report and the recommendation of the VACEH, Congress enacted the Veterans' Benefits Programs Improvement Act of 1991, Pub. L. No. 102-86, § 104, 105 Stat. 414, 415, which extended the presumptive period for service connection of leukemia based on radiation exposure from 30 years to 40 years. 137 Cong. Rec. H5928 (daily ed. July 29, 1991) (statement of Rep. Montgomery). This legislation also extended the radiation presumptions to include reservists and National Guard members who participated in radiation-risk activities during active duty for training or inactive duty training. Pub. L. No. 102-86, § 105, 105 Stat. at 415.

In thus expanding the scope of coverage of the radiation presumptions, Congress relied on information that as many as 1,500 reservists and National Guard personnel may have participated in atmospheric nuclear tests and that VA's General Counsel had determined that such individuals were not covered by the existing presumptions since they were not on active duty

during the testing. 137 Cong. Rec. H5929 (daily ed. July 29, 1991) (statement of Rep. Montgomery). The legislation was apparently reflective of Congress' judgment that the rationales for creation of the radiation presumptions, i.e., the deliberate exposure of service personnel to radiation, the failure to warn, to provide adequate protection, and to follow up on the health status of test participants, and the "impossible" burden of proving a relationship between exposure and disease occurring years later, "apply with equal force" to reservists who participated in the testing program. S. Rep. No. 379, 101st Cong., 2d Sess. 99-100 (1990) (on predecessor legislation considered in the 101st Congress).

Most recently Congress enacted the Veterans' Radiation Exposure Amendments of 1992, Pub. L. No. 102-578, 106 Stat. 4774, section 2 of which eliminated the requirement that, in order to be service connected on the basis of radiation exposure, a disease must become manifest to a degree of ten percent or more within forty years of participation in a radiation-risk activity. Section 2 of this act also added two additional diseases, cancer of the salivary gland and cancer of the urinary tract, to the list of diseases in 38 U.S.C. § 1112(c) that may be presumed service connected in the case of radiation-exposed veterans. With the addition of these diseases, there are now fifteen diseases which may be presumptively service connected for radiation-exposed veterans, and there are no limitations as to the time period in which the disease must appear or the degree of disability needed to give rise to application of the presumption.

With regard to elimination of the latency-period restriction, the Senate report indicated "BEIR V shows that the current latency-period limitations . . . no longer are supportable" because existing data do not define the period of increased cancer risk following radiation exposure. S. Rep. No. 139, 102d Cong., 1st Sess. 16 (1991), reprinted in 1992 U.S.C.C.A.N. 4057, 4070. As to the addition of diseases to the presumptive list, the report relied on BEIR V data demonstrating a "'relatively high' susceptibility of salivary glands to radiation-induced carcinogenesis" and "an especially strong, dose-dependent connection between radiation and bladder cancer." Id. The report went on to state:

The standard the Committee has applied in making the distinctions reflected in the Committee bill is to include presumptions of service connection for any disease shown to be strongly associated with radiation that has not been shown to be strongly associated with other risk factors. This is the same standard applied in drafting the Senate provisions that were enacted in Public Law 100-321.

Id. at 17, reprinted in 1992 U.S.C.C.A.N. at 4071.

3. Addition of Systemic Lupus Erythematosus to List of Chronic Diseases Which May Be Presumed Service Connected

The Veterans' Benefits and Services Act of 1988, Pub. L. No. 100-322, § 313, 102 Stat. 487, 535, amended what is now 38 U.S.C. § 1101(3) (formerly § 301(3)) by adding "lupus erythematosus, systemic," to the list of chronic diseases which may be presumed service connected if becoming manifest to a degree ten percent or more within one year from the date of separation from service. The report of the Senate Committee on Veterans' Affairs included this explanation for the addition of systemic lupus erythematosus (SLE) to the list of chronic diseases:

[P]resumptions are based on the need to ensure that diseases and disabilities incurred in or aggravated during service are, in fact, determined to be service connected. This need arises most clearly in the cases of diseases that have a latency period of varying length causing early manifestations to be easily overlooked or misdiagnosed or diseases that are otherwise difficult to diagnose.

SLE is such a disease. . . . Although the disease may start acutely, the course is usually chronic and irregular with periods of activity alternating with periods of remission, thereby making diagnosis very difficult and the manifestations quite diverse. . . . SLE is instigated by a combination of genetic predisposition and environmental factors. Current data stress the importance of various environmental factors as accelerating or causal elements to a greater degree than previously had been assumed. Accordingly, factors present during the veteran's service may trigger onset of the disease and yet not appear on the veteran's service record. . . .

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Based on the significant likelihood that SLE had its onset during service in the case of a veteran who develops the disease to the extent of being 10-percent-or-more disabling within one year after service even though it was undetected during service, section 112 of the Committee bill would add SLE to the one-year chronic disease presumptive list.

S. Rep. No. 215, 100th Cong., 1st Sess. 73 (1987). With the inclusion of SLE, there are forty-one chronic diseases, conditions, or disease categories to which a presumption of service connection may apply under 38 U.S.C. § 1112(a)(1) (formerly § 312(a)(1)).

4. Recent Legislative Initiatives to Modify Presumptions

Numerous legislative proposals have been introduced in recent years to expand the list of diseases which qualify for a presumption of service connection, extend the presumptive period for particular diseases, or otherwise alter the requirements for presumptive service connection. Several bills have been introduced to eliminate the requirement that a chronic disease becoming manifest in a veteran within one year after separation from service must develop to a degree of disability of ten percent or more within that period in order to be presumed service connected. E.g., H.R. 2824, 101st Cong., 1st Sess. (1989); H.R. 2349, 100th Cong., 1st Sess. (1987); H.R. 1487, 99th Cong., 1st Sess. (1985). The congressional committees of jurisdiction have not requested VA's views on these proposals.

A series of bills have been introduced to provide a presumption of service connection for post-traumatic stress disorder (PTSD) developing at any time after service in a veteran who served in Southeast Asia during the Vietnam era. E.g., H.R. 794, 101st Cong., 1st Sess. (1989). Proponents have asserted that extension of an open-ended presumption of service connection for this disease is justified on the basis of the unusual stresses of the Vietnam War, difficulties in repatriation and in obtaining treatment for psychological disorders, and studies showing excess traumatic deaths in Vietnam veterans. 135 Cong. Rec. E278 (daily ed. Feb. 2, 1989) (statement of Cong. Kastenmeier). However, despite approving a series of measures requiring studies and reports concerning PTSD, ²⁷ legislation establishing an open ended presumption of service connection for PTSD developing in veterans other than former POWs has not been enacted.

Other conditions which have been the subject of recent proposed but unenacted legislation regarding presumptions include amyotrophic lateral sclerosis, transverse myelitis, and syringomyelia. A long-standing proposal to add a presumption of service connection for transverse myelitis caused by disease, if developing to a ten-percent degree of disability within seven years of service was introduced most recently as H.R. 340, 102d Cong., 1st Sess. (1991). VA has opposed creation of a presumption of service connection for transverse myelitis on the

²⁷ Veterans' Health Care Amendments of 1983, Pub. L. No. 98-160, § 102, 97 Stat. 993, 994; Veterans' Health Care Act of 1984, Pub. L. No. 98-528, § 110, 98 Stat. 2686, 2691; Veterans' Benefits Amendments of 1989, Pub. L. No. 101-237, § 201(e), 103 Stat. 2062, 2066; Department of Veterans Affairs Nurse Pay Act of 1990, Pub. L. No. 101-366, § 204, 104 Stat. 430, 439; Veterans' Medical Program Amendments of 1992, § 122, 106 Stat. 1972, 1981.

bases that the disease is not insidious in onset, the existing presumption for organic diseases of the nervous system, which includes transverse myelitis developing to a degree of ten percent or more within one year of service, affords adequate protection, and enlargement of the presumptive period for this disease would not be justified from a medical standpoint. Letter to G.V. (Sonny) Montgomery, Chairman, House Committee on Veterans' Affairs, from Edward J. Derwinski, Secretary of Veterans Affairs (Jan. 29, 1992). VA also noted that transverse myelitis resulting from some other disease, such as multiple sclerosis, can be service connected as secondary to the primary disease, through application of the presumption applicable to the primary disease. Id.

Several bills have been introduced to establish a presumption of service connection for syringomyelia becoming manifest to a degree of disability of ten percent or more within seven years of service. E.g., S. 1212, 96th Cong., 1st Sess. (1979); H.R. 1502, 99th Cong., 1st Sess. (1985). Syringomyelia is a disorder of the spine which falls within the scope of the current one-year chronic-disease presumption applicable to organic diseases of the nervous system. Speaking in support of S. 1212, Senator Gary Hart expressed his view that the presumptive period for syringomyelia should be extended to seven years because, like multiple sclerosis, syringomyelia is difficult to diagnose and of insidious onset. 125 Cong. Rec. S7416 (daily ed. June 12, 1979) (statement of Sen. Hart). VA opposed extending the presumptive period for syringomyelia to seven years on the basis that the consensus of medical opinion is that the condition results from a congenital or developmental anomaly which emerges gradually, usually being diagnosed after age thirty. Letter to Senator Alan Cranston, Chairman, Senate Committee on Veterans' Affairs, from Max Cleland, Administrator of Veterans Affairs (July 10, 1980).

Similarly, there have been several proposals to extend from one year to seven years the presumptive period for progressive muscular atrophy or amyotrophic lateral sclerosis (ALS) (also known as Lou Gerhig's disease). E.g., H.R. 4308, 97th Cong., 1st Sess. (1981). VA opposed these proposed extensions of the presumptive period, noting that ALS is not of an insidious nature and is usually diagnosed within three to six months of manifestation of initial symptoms. Letter to G.V. (Sonny) Montgomery, Chairman, House Committee on Veterans' Affairs, from Robert P. Nimmo, Administrator of Veterans Affairs (March 18, 1982). VA also noted that individuals who are diagnosed with the condition have a life expectancy of much less than seven years. Id. For these reasons, VA concluded extension of the presumptive period to seven years is not scientifically justified. Id.

MEDICAL VIEWPOINT ON PRESUMPTIONS OF SERVICE CONNECTION

I. Presumptions in Relation to Medical Practice Generally

Medicine is viewed as a science, dealing in facts and proofs. However, science may rely on hypotheses in the absence of proofs. In this regard, medicine is a science, but it must be recognized that medicine is an art as well as a science. The concept of presumptions is not entirely foreign in the medical tradition, where an "impression" in a clinical work-up may be another name for a presumption, or a presumptive diagnosis. For example, the diagnosis of "influenza" is usually a presumption since it is rarely based on definitive viral studies required for proof, but instead results from a physician's knowledge of common symptoms and prevailing conditions in the community. Since there is no specific therapy for flu, a more specific diagnosis is rarely needed, if other treatable causes for the symptoms can be ruled out. Local standards, medical economics, patient preferences, and the state-of-the-art for any given medical condition, all impact on whether a proven diagnosis is necessary or a clinical impression will suffice. More specific diagnoses may result as simple, inexpensive tests (hepatitis B or HIV antibody tests) become available, even when specific therapy is not available. A positive response to available treatments may further reinforce the clinical impression. When treatment is not available or not possible, as in the case of a metastatic lung cancer, extensive diagnostic tests may not be warranted even if the diagnosis could be proven. This is where the art of medicine as well as the science of medicine come in to play.

As medical advances are made they tend to be incorporated into practice gradually, first in academic centers where new tests and therapies are often available on an investigational or research basis, such as was the case with viral markers for hepatitis B or HIV, then, in community hospitals, often promoted by manufacturers; and finally in the most remote areas. Most physicians are comfortable with this fluid situation, recognizing limitations in their ability to diagnose while almost unconsciously adapting to advances in medical technology that improve both diagnosis and treatment. Less ambiguity is tolerated in the arena of reimbursement for insurance purposes and for establishment of disability. It is in the latter area that presumptions take on a somewhat different meaning, one more in keeping with the legal definition.

II. Presumptions in Relation to Medical Aspects of Disability Determinations

For disability determinations, presumptions address two areas of medical uncertainty: (1) diseases of unknown etiology, particularly where the early manifestations may be vague or nonspecific, and (2) diseases of known etiology where the incubation period is uncertain or lengthy and/or where the early manifestations may be ignored or misinterpreted, often because

physicians lack practical experience with the disease. Early presumptions in law resulted from difficulties veterans had in "proving" onset during their service despite evidence that a condition, such as tuberculosis, could have been present then. Recently presumptions for service connection have been based on studies linking specific exposures with specific disease states. The mechanism of a presumption in such cases assures some uniformity of both knowledge and interpretation of relevant studies on the part of physicians.

It is not inappropriate that the decision on what to include in the list was made by Congress, with varying degrees of medical input, in response to difficulties veterans experienced in trying to service connect various medical conditions. The entire disability system is an appropriate response to impairments suffered by participants in the armed forces. While medically based, it involves other factors such as functionality, employability, compensation and access to medical and rehabilitative services. The last extensive study of the use of presumptions was done in the 1950's by the "Bradley Commission" (The President's Commission on Veterans Pensions).

The Commission recommended that the existing presumptions for service connection should be withdrawn. They felt that "there is otherwise in the law sufficient protection for the veteran to establish service connection of any and all diseases," a view with which Congress clearly disagreed. They further stated that ". . . service connection should be determined in accordance with sound medical principles, and not by fiat." No one would disagree with that as a general principle. However, existing "sound medical principles" do not always pinpoint the exact cause, the time of onset, or aggravating circumstances because sound scientific studies either have not, cannot or would not be done because of expense or because they are of little interest to the medical community at large. Furthermore, equally learned physicians can disagree on when a condition actually started and/or the role military service played in its subsequent course.

After considering both the history and legal basis for presumptions as well as the current state of both medical knowledge and medical uncertainty, we conclude that presumptions for service connection have stood the test of time. They have a long, well established tradition in veterans' benefits. Furthermore, they work by removing an unfair burden of proof for veterans. To eliminate presumptions would do more harm than good. Likewise, expansion of presumptions should only be done for the most compelling medical, and perhaps social, reasons, as has been done for certain military occupational exposures in recent years.

III. Analysis of Presumptions in Light of Medical Knowledge

In order to examine the list of diseases for which presumptive service connection is available in an orderly fashion, a series of questions was developed by the Veterans Health Administration:

1. Does this terminology define a discrete disease entity or entities?

2. If not, what is the current medical terminology which most accurately describes the disease entities referred to by this terminology?

3. A.) Does current medical science provide incontrovertible evidence that physical, mental, or emotional rigors or environmental aspects of military service could not precipitate the onset of , or aggravate, these diseases?

B.) If such evidence currently exists, does it apply equally to all of the disease entities referred to by this terminology?

C.) If not, which of these disease entities are affected by this medical evidence?

An examination of the list and a general review of the literature provides no incontrovertible evidence that any of the conditions on the list could not be aggravated or have the onset precipitated by military service. Thus, questions 3, 4, and 5 cannot be answered given the currently available state of medical knowledge.

4. A.) If such evidence does not exist, is it likely and reasonable that physical, mental, or emotional aspects of military service could precipitate the onset, or aggravate these diseases without the presence of clinically evident manifestations for a period in excess of one year following military service?

B.) If it is likely and reasonable, what number of years might elapse following military service prior to the development of clinically evident manifestations of these diseases?

Further analysis of the literature reveals no evidence specifically addressing the question of latency for most of the chronic diseases for which there is a one-year presumption of service connection. Thus the answers to questions 6 and 7 must be based in policy considerations, rather than currently-available scientific information. The generally brief presumptive period, which is one year for most conditions, addresses more the difficulty veterans have in providing proof

that their symptoms began in the military than any expectation that there was a specific latency period that could be described.

Therefore, since the other questions cannot be answered more fully given the current state of medical knowledge, the first two questions are the relevant ones to the current discussion.

IV. Analysis of Terminology

A. Current List of Diseases and Conditions for Which a Presumption Is Available

The current list of forty-one "chronic" diseases for which presumptions exist is as follows:

- Anemia, primary
- Arteriosclerosis
- Arthritis
- Atrophy, progressive muscular
- Brain hemorrhage
- Brain thrombosis
- Bronchiectasis
- Calculi of the kidney, bladder, or gallbladder
- Cardiovascular-renal disease, including hypertension
- Cirrhosis of the liver
- Coccidioidomycosis
- Diabetes mellitus
- Encephalitis lethargica residuals
- Endocarditis
- Endocrinopathies
- Epilepsies
- Hansen's disease
- Hodgkin's disease
- Leukemia
- Lupus erythematosus, systemic
- Myasthenia gravis
- Myelitis
- Myocarditis
- Nephritis
- Other organic diseases of the nervous system
- Osteitis deformans (Paget's disease)
- Osteomalacia
- Palsy, bulbar
- Paralysis agitans
- Psychoses
- Purpura idiopathic, hemorrhagic
- Raynaud's disease
- Sarcoidosis
- Scleroderma
- Sclerosis, amyotrophic lateral
- Sclerosis, multiple
- Syringomyelia
- Thromboangiitis obliterans (Buerger's disease)
- Tuberculosis, active

Tumors, malignant, or of the brain or spinal cord or
peripheral nerves
Ulcers, peptic (gastric or duodenal)

B. Archaic Terms Compared to Modern Terms

Unfortunately, the current list of presumptive conditions, set forth above, is a hodgepodge of terms, some of which are specific diseases, others are general disease categories, and still others are simply archaic usages. The following is an analysis of the terminology:

<u>"Archaic" Term</u>	<u>Modern Term</u>
Anemia, primary	Pernicious anemia (now completely treatable by Vitamin B-12)
Brain hemorrhage	Stroke (cerebral hemorrhage)
Brain thrombosis	Stroke (cerebral embolism)
Paralysis agitans	Parkinson's Disease
Encephalitis lethargica residuals (seen following Influenza A epidemic 1919-1926)	No modern equivalent because it applied to a very specific, isolated population
Atrophy, progressive muscular	No modern equivalent
Osteomalacia	Not an archaic term but rarely if ever seen as a primary condition due to vitamin D deficiency. It may be seen occasionally secondary to conditions such as liver disease.

C. General Categories and Specific Diseases Compared to Modern Terminology for Such Conditions

General Category

Arteriosclerosis
Arthritis
Cardiovascular - renal disease, including hypertension (would include arteriosclerosis)
Endocrinopathies
Epilepsies
Myelitis
Myocarditis
Nephritis

Organic diseases of the nervous system (would include stroke, Parkinson's Disease, and encephalitis lethargica, if encountered)

Psychoses

Tumors, malignant, or of the brain or spinal cord or peripheral nerves

Specific Diseases

Bronchiectasis

Calculi of the kidney, bladder or gallbladder

Cirrhosis of the liver

Coccidioidomycosis

Diabetes mellitus (would be included under endocrinopathies)

Endocarditis

Hansen's Disease

Hodgkin's Disease

Leukemia (includes several types)

Lupus erythematosus, systemic

Myasthenia gravis

Osteitis deformans (Paget's Disease)

Palsy, bulbar

Purpura idiopathic, hemorrhagic

Raynaud's disease (to be consistent with Buerger's disease, should be listed as idiopathic arteriolar spasm)

Sarcoidosis

Scleroderma

Sclerosis, amyotrophic lateral

Sclerosis, multiple

Syringomyelia

Thromboangiitis obliterans (Buerger's disease)

Tuberculosis, active

Ulcers, peptic (gastric or duodenal)

A list which would reflect modern terminology and include both the categories of illnesses and the specific illnesses currently covered while eliminating unnecessary redundancies would include the following:

Arteriolar spasm, idiopathic (Raynaud's disease)

Arthritis

Bronchiectasis

Calculi of the kidney, bladder or gallbladder

Cardiovascular disease (including hypertension and arteriosclerosis)

Cirrhosis of the liver

Coccidioidomycosis

Endocarditis

Endocrinopathies (including diabetes mellitus)

Epilepsies

Hansen's Disease

Hodgkin's Disease

Leukemia

Lupus erythematosus, systemic

Myasthenia gravis
Myelitis
Myocarditis
Nephritis
Organic diseases of the nervous system (including
stroke, Parkinson's Disease, and encephalitis
lethargica, if encountered)
Osteitis deformans (Paget's disease)
Palsy, bulbar
Purpura idiopathic, hemorrhagic
Psychoses
Sarcoidosis
Scleroderma
Sclerosis, amyotrophic lateral
Sclerosis, multiple
Syringomyelia
Thromboangiitis obliterans (Buerger's disease)
Tuberculosis, active
Tumors, malignant, or of the brain or spinal cord
or peripheral nerves
Ulcers, gastric (peptic or duodenal)

This would consolidate the list of conditions into thirty-two categories and "clean up" the language. However it is unlikely to change the outcome for any specific case under consideration at this time or in the future. This is in keeping with the conclusion that presumptions, as they are currently used in practice serve a useful purpose in fairly adjudicating veterans' claims for service connection.

CONCLUSION

Presumptions play an important current role in both the philosophical basis for service connection and in the actual administration of the compensation program. Presumptions serve to fill in holes in scientific and medical knowledge. They also provide a lubricant to alleviate perplexing frictions between claims from veterans, sparse evidence and incomplete medical knowledge. The practical advantages of presumptions should not be overlooked or underestimated in a search for philosophical or scientific bases for presumptions. Presumptions are very useful to Congress and the Executive Branch in resolving complex policy questions, to VA in simplifying determinations regarding service connection and to veterans in pursuit of their claims. Viewed thusly, the use of presumptions is a beneficial policy for all concerned.

It has been suggested in the past that presumptions are not necessary and that they can be eliminated, basing service connection strictly on "sound medical principles." This is an attractive concept, one that would seem to avoid designating as service connected conditions which are not, in fact, related to service. The problem is, however, that the impressive term, "sound medical principles," becomes less impressive upon

examination. As pointed out in the medical portion of the study, medicine actually operates on a day-to-day basis with sets of working assumptions in a highly pragmatic fashion. Medical science often does not know, nor does it always need to know, exactly when a condition first arose, its latency period, the effect of working or living conditions on the course of the condition, or its exact cause. As a result, studies do not necessarily exist which definitively pinpoint the inception or even the cause of the chronic conditions for which presumptive service connection is established.

Cardiovascular disease is a good example of this situation. Many studies are being conducted on the subject of the cause of cardiovascular disease. A very basic fact shown by all these studies is that there are many contributing factors in cardiovascular disease and these factors are at work over a considerable period of time before a diagnosis is made. Not all conditions on the chronic list are subject to such scientific interest and not as much is known about their cause or course. As stated in the medical portion, science does not have an interest in pinning down the exact temporal beginning date for a condition.

As medical science learns more about various diseases, the role of genetics has been receiving more and more consideration and more and more publicity. With most conditions, however, the degree to which the genetic factor contributes to a disease is subject to debate, and, the relationship between the genetic factor and other factors is largely unknown. There is simply not enough knowledge on the subject of causation to state that "sound medical principles" can be used as the sole basis for determining service connection.

If the presumptions for the chronic diseases did not exist, veterans, their advocates and VA would surely resort to the extent possible to expert medical opinion. Expert medical opinion has been and is being used by both VA and claimants in connection with some of the most perplexing and difficult medical conditions, conditions which do not develop for many years following exposure to suspected causative agents. To require veterans, and VA, to employ the same procedure for all of the conditions on the chronic list would be an intolerable burden. The VA expense involved in expert medical opinions (currently approximately \$300 each) would add considerably to the cost of adjudicating claims in which the claimant submits his or her own expert medical opinions. The presumptive period for chronic conditions eliminates much of the need for such "dueling experts." In addition, as stated above, there are numerous conditions where medical knowledge is in a state of flux with more unanswered questions than solid facts and a great deal of opportunity for opposing opinions. Use of presumptions in these situations is a way of admitting uncertainty and admitting that more opinions do not necessarily shed more light on the question.

Under current law, service connection is established for all conditions incurred or aggravated coincident with military service. The fact that military personnel are on duty 24 hours a day and serve all over the world undergirds both that policy and the existence of presumptions of service connection. In fact, these circumstances of military service are much more relevant to the basic definition of service connection itself than to presumptions in particular. Once the policy has been established that service connection is warranted if the condition is noted during active duty, the presumptions flow naturally from this original decision for the practical reasons cited above.

Finally, Senator Cranston asked for views on the conduct of the federal government with respect to the veterans to whom a presumption might apply. However, we do not believe we are in a position either to pass judgment on the past activities of other agencies or to speculate on their conduct in future situations.

TABLE

ORIGINS OF PRESUMPTIONS OF SERVICE CONNECTION -- DISEASES FOR WHICH A PRESUMPTION OF SERVICE CONNECTION IS CURRENTLY AVAILABLE

	<u>LEGISLATION OR REGULATION</u>	<u>DATE</u>
<u>CHRONIC DISEASES</u>		
Anemia, primary	Internal memorandum implementing Veterans' Bureau Regulation No. 11	Dec. 1921
Arteriosclerosis	Internal memorandum implementing Veterans' Bureau Regulation No. 11	Dec. 1921
Arthritis	Veterans' Bureau Schedule for Rating Disabilities (1925)	1925
Atrophy, progressive muscular	Former 38 C.F.R. § 3.86(a) 14 Fed. Reg. 571	Feb. 9, 1949
Brain hemorrhage	Former 38 C.F.R. § 3.86(a) 14 Fed. Reg. 571	Feb. 9, 1949
Brain thrombosis	Former 38 C.F.R. § 3.86(a) 14 Fed. Reg. 571	Feb. 9, 1949
Bronchiectasis	Act of June 24, 1948, ch. 612, § 1, 62 Stat. 581 (Pub. L. No. 748, 80th Cong.)	June 24, 1948
Calculi of the kidney, bladder, or gallbladder	Act of June 24, 1948, ch. 612, § 1, 62 Stat. 581 (Pub. L. No. 748, 80th Cong.)	June 24, 1948
Cardiovascular-renal disease, including hypertension	Veterans' Bureau Schedule for Rating Disabilities (1925)	1925
Cirrhosis of the liver	Act of June 24, 1948, ch. 612, § 1, 62 Stat. 581 (Pub. L. No. 748, 80th Cong.)	June 24, 1948
Coccidioidomycosis	Act of June 24, 1948, ch. 612, § 1, 62 Stat. 581 (Pub. L. No. 748, 80th Cong.)	June 24, 1948
Diabetes mellitus	Internal memorandum implementing Veterans' Bureau Regulation No. 11	Dec. 1921

Encephalitis lethargica residuals	World War Veterans Act of 1924, ch. 320, § 200, 43 Stat. 607, 615	June 7, 1924
Endocarditis	Veterans' Bureau Schedule for Rating Disabilities (1925)	1925
Endocrinopathies	Internal memorandum implementing Veterans' Bureau Regulation No. 11	Dec. 1921
Epilepsies	Instruction No. 2, implementing Vet. Reg. No. 1, Exec. Order 6089, March 31, 1933	Apr. 12, 1933
Hansen's disease	Veterans' Bureau Schedule for Rating Disabilities (1925)	1925
Hodgkin's disease	Internal memorandum implementing Veterans' Bureau Regulation No. 11	Dec. 1921
Leukemia	Internal memorandum implementing Veterans' Bureau Regulation No. 11	Dec. 1921
Lupus erythematosus, systemic	Veterans' Benefits and Services Act of 1988, Pub. L. No. 100-322, § 313, 102 Stat. 487, 535	May 20, 1988
Myasthenia gravis	Former 38 C.F.R. § 3.86(a) 14 Fed. Reg. 571	Feb. 9, 1949
Myelitis	Former 38 C.F.R. § 3.86(a) 14 Fed. Reg. 571	Feb. 9, 1949
Myocarditis	Veterans' Bureau Schedule for Rating of Disabilities (1925)	1925
Nephritis	Veterans' Bureau Schedule for Rating of Disabilities (1925)	1925
Organic diseases of the nervous system	Instruction No. 2 implementing Vet. Reg. No. 1, Exec. Order 6089, March 31, 1933; <u>see also</u> Act of August 9, 1921, ch. 57, § 18, 42 Stat. 147, 153 (neuro- psychiatric disease)	Apr. 12, 1933

Osteitis deformans (Padgett's disease)	Instruction No. 2-A implement- ing Vet. Reg. No. 1, Exec. Order 6089, March 31, 1933	Aug. 14, 1935
Osteomalacia	Act of June 24, 1948, ch. 612, § 1, 62 Stat. 581. (Pub. L. No. 748, 80th Cong.)	June 24, 1948
Palsy, bulbar	Former 38 C.F.R. § 3.86(a) 14 Fed. Reg. 571	Feb. 9, 1949
Paralysis agitans	World War Veterans Act of 1924, ch. 320, § 200, 43 Stat. 607, 615	June 7, 1924
Psychoses	Act of August 9, 1921, ch. 57, § 18, 42 Stat. 147, 153 (neuropsychiatric disease)	Aug. 9, 1921
Purpura idiopathic, hemorrhagic	Former 38 C.F.R. § 3.86(a) 14 Fed. Reg. 6176; <u>see also</u> Internal memorandum implement- ing Veterans' Bureau Regulation No. 11 (Dec. 1921) (prior presumption not carried forward in 1933 regulations)	Oct. 19, 1949
Raynaud's disease	Act of June 24, 1948, ch. 612, § 1, 62 Stat. 581 (Pub. L. No. 748, 80th Cong.)	June 24, 1948
Sarcoidosis	Former 38 C.F.R. § 3.86(a) 15 Fed. Reg. 5906	Aug. 31, 1950
Scleroderma	Act of June 24, 1948, ch. 612, § 1, 62 Stat. 581 (Pub. L. No. 748, 80th Cong.)	June 24, 1948
Sclerosis, amyotrophic lateral	Former 38 C.F.R. § 3.86(a) 14 Fed. Reg. 571	Feb. 9, 1949
Sclerosis, multiple	Former 38 C.F.R. § 3.86(a) 14 Fed. Reg. 571	Feb. 9, 1949
Syringomyelia	Former 38 C.F.R. § 3.86(a) 14 Fed. Reg. 571	Feb. 9, 1949
Thromboangiitis obliterans (Buerger's disease)	Act of June 24, 1948, ch. 612, § 1, 62 Stat. 581 (Pub. L. No. 748, 80th Cong.)	June 24, 1948

Tuberculosis, active	Act of August 9, 1921, ch. 57, § 18, 42 Stat. 147, 153	Aug. 9, 1921
Tumors, malignant, or of the brain or spinal cord or peripheral nerves	Veterans' Bureau Schedule for Rating Disabilities (1925) (carcinoma, sarcoma, and other tumors)	1925
Ulcers, peptic (gastric or duodenal)	Act of June 24, 1948, ch. 612, § 1, 62 Stat. 581 (Pub. L. No. 748, 80th Cong.); <u>see also</u> Veterans' Bureau Schedule of Disability Ratings, Extension 6, (Nov. 2, 1928) (prior presumption not carried forward in 1933 regulations)	June 24, 1948

TROPICAL DISEASES

Amebiasis	Veterans' Benefits Act of 1957, Pub. L. No. 85-56, § 301(4), 71 Stat. 83, 95	June 17, 1957
Blackwater fever	Act of June 24, 1948, ch. 612, §§ 1, 2, 62 Stat. 581, 582 (Pub. L. No. 748, 80th Cong.)	June 24, 1948
Cholera	Act of June 24, 1948, ch. 612, §§ 1, 2, 62 Stat. 581, 582 (Pub. L. No. 748, 80th Cong.):	June 24, 1948
Dracontiasis	Act of June 24, 1948, ch. 612, §§ 1, 2, 62 Stat. 581, 582 (Pub. L. No. 748, 80th Cong.)	June 24, 1948
Dysentery	World War Veterans Act of 1924, ch. 320, § 200, 43 Stat. 607, 615 (as a chronic disease)	June 7, 1924
Filiariasis	VA Technical Bulletin 8-6	Jan. 3, 1947
Hansen's disease	Veterans' Bureau Schedule for Rating Disabilities (1925) (as a chronic disease)	1925
Leishmaniasis (including kala-azar)	VA Technical Bulletin 8-6	Jan. 3, 1947

Loiasis	Act of June 24, 1948, ch. 612, §§ 1, 2, 62 Stat. 581, 582 (Pub. L. No. 748, 80th Cong.)	June 24, 1948
Malaria	VA Circular No. 8, section I	Dec. 28, 1945
Onchocerciasis	Act of June 24, 1948, ch. 612, §§ 1, 2, 62 Stat. 581, 582 (Pub. L. No. 748, 80th Cong.)	June 24, 1948
Oroya fever	Act of June 24, 1948, ch. 612, §§ 1, 2, 62 Stat. 581, 582 (Pub. L. No. 748, 80th Cong.)	June 24, 1948
Pinta	Act of June 24, 1948, ch. 612, §§ 1, 2, 62 Stat. 581, 582 (Pub. L. No. 748, 80th Cong.)	June 24, 1948
Plague	Act of June 24, 1948, ch. 612, §§ 1, 2, 62 Stat. 581, 582 (Pub. L. No. 748, 80th Cong.)	June 24, 1948
Schistosomiasis	VA Technical Bulletin 8-6	Jan. 3, 1947
Scars	VA Technical Bulletin 8-6	Jan. 3, 1947
Yellow fever	Act of June 24, 1948, ch. 612, §§ 1, 2, 62 Stat. 581, 582 (Pub. L. No. 748, 80th Cong.)	June 24, 1948

PRISONER OF WAR DISEASES

Anxiety states	Former Prisoner of War Benefits Act of 1981, Pub. L. No. 97-37, § 4, 95 Stat. 935, 936	Aug. 14, 1981
Avitaminosis	Pub. L. No. 91-376, § 3, 84 Stat. 787, 788	Aug. 12, 1970
Beriberi (including beriberi heart disease)	Pub. L. No. 91-376, § 3, 84 Stat. 787, 788	Aug. 12, 1970
Chronic dysentery	Pub. L. No. 91-376, § 3, 84 Stat. 787, 788	Aug. 12, 1970

Dysthymic disorder (or depressive neurosis)	Veterans' Compensation and Program Improvements Amendments of 1984, Pub. L. No. 98-223, § 111, 98 Stat. 37, 40	Mar. 2, 1984
Helminthiasis	Pub. L. No. 91-376, § 3, 84 Stat. 787, 788	Aug. 12, 1970
Irritable bowel syndrome	Veterans' Benefits and Services Act of 1988, Pub. L. No. 100-322, § 312, 102 Stat. 487, 534	May 20, 1988
Malnutrition (including optic atrophy associated with malnutrition)	Pub. L. No. 91-376, § 3, 84 Stat. 787, 788	Aug. 12, 1970
Nutritional deficiency (other than pellagra)	Pub. L. No. 91-376, § 3, 84 Stat. 787, 788	Aug. 12, 1970
Organic residuals of frostbite	Veterans' Benefits Improvement and Health-Care Authorization Act of 1986, Pub. L. No. 99-576, § 108, 100 Stat. 3248, 3252	Oct. 28, 1986
Pellagra	Pub. L. No. 91-376, § 3, 84 Stat. 787, 788	Aug. 12, 1970
Peptic ulcer disease	Veterans' Benefits and Services Act of 1988, Pub. L. No. 100-322, § 312, 102 Stat. 487, 534	May 20, 1988
Peripheral neuropathy	Veterans' Benefits and Services Act of 1988, Pub. L. No. 100-322, § 312, 102 Stat. 487, 534	May 20, 1988
Post-traumatic osteoarthritis	Veterans' Benefits Improvement and Health-Care Authorization Act of 1986, Pub. L. No. 99-576, § 108, 100 Stat. 3248, 3252	Oct. 28, 1986
Psychosis	Pub. L. No. 91-376, § 3, 84 Stat. 787, 788	Aug. 12, 1970

DISEASES ASSOCIATED WITH HERBICIDE EXPOSURE OR VIETNAM SERVICE

Chloracne	38 C.F.R. § 3.311a(c) 50 Fed. Reg. 34,452	Aug. 26, 1985
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Non-Hodgkin's lymphoma	38 C.F.R. § 3.313(b) 55 Fed. Reg. 43,123	Oct. 26, 1990
Peripheral neuropathy	(proposed) 38 C.F.R. § 3.311a(c) 57 Fed. Reg. 2236	Jan. 21, 1992
Soft-tissue sarcoma	38 C.F.R. § 3.311a(c) 56 Fed. Reg. 51,651	Oct. 15, 1991

DISEASES ASSOCIATED WITH RADIATION EXPOSURE

Cancer of the bile ducts	Radiation-Exposed Veterans Compensation Act of 1988, Pub. L. No. 100-321, § 2, 102 Stat. 485	May 20, 1988
Cancer of the breast	Radiation-Exposed Veterans Compensation Act of 1988, Pub. L. No. 100-321, § 2, 102 Stat. 485	May 20, 1988
Cancer of the esophagus	Radiation-Exposed Veterans Compensation Act of 1988, Pub. L. No. 100-321, § 2, 102 Stat. 485	May 20, 1988
Cancer of the gall bladder	Radiation-Exposed Veterans Compensation Act of 1988, Pub. L. No. 100-321, § 2, 102 Stat. 485	May 20, 1988
Cancer of the pancreas	Radiation-Exposed Veterans Compensation Act of 1988, Pub. L. No. 100-321, § 2, 102 Stat. 485	May 20, 1988
Cancer of the pharynx	Radiation-Exposed Veterans Compensation Act of 1988, Pub. L. No. 100-321, § 2, 102 Stat. 485	May 20, 1988
Cancer of the salivary gland	Veterans' Radiation Exposure Amendments of 1992, Pub. L. No. 102-578, § 2, 106 Stat. 4774	Oct. 30, 1992

Cancer of the small intestine	Radiation-Exposed Veterans Compensation Act of 1988, Pub. L. No. 100-321, § 2, 102 Stat. 485	May 20, 1988
Cancer of the stomach	Radiation-Exposed Veterans Compensation Act of 1988, Pub. L. No. 100-321, § 2, 102 Stat. 485	May 20, 1988
Cancer of the thyroid	Radiation-Exposed Veterans Compensation Act of 1988, Pub. L. No. 100-321, § 2, 102 Stat. 485	May 20, 1988
Cancer of the urinary tract	Veterans' Radiation Exposure Amendments of 1992, Pub. L. No. 102-578, § 2, 106 Stat. 4774	Oct. 30, 1992
Leukemia	Radiation-Exposed Veterans Compensation Act of 1988, Pub. L. No. 100-321, § 2, 102 Stat. 485	May 20, 1988
Lymphomas	Radiation-Exposed Veterans Compensation Act of 1988, Pub. L. No. 100-321, § 2, 102 Stat. 485	May 20, 1988
Multiple myeloma	Radiation-Exposed Veterans Compensation Act of 1988, Pub. L. No. 100-321, § 2, 102 Stat. 485	May 20, 1988
Primary liver cancer	Radiation-Exposed Veterans Compensation Act of 1988, Pub. L. No. 100-321, § 2, 102 Stat. 485	May 20, 1988

DISEASES ASSOCIATED WITH AMPUTATION

Ischemic heart disease or other cardiovascular disease	38 C.F.R. § 3.310 44 Fed. Reg. 50,339	Aug. 28, 1979
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DISEASES ASSOCIATED WITH MUSTARD GAS EXPOSURE

Asthma	38 C.F.R. § 3.316 57 Fed. Reg. 33,875	July 31, 1992
Bronchitis	38 C.F.R. § 3.316 57 Fed. Reg. 33,875	July 31, 1992
Conjunctivitis	38 C.F.R. § 3.316 57 Fed. Reg. 33,875	July 31, 1992
Corneal opacity	38 C.F.R. § 3.316 57 Fed. Reg. 33,875	July 31, 1992
Emphysema	38 C.F.R. § 3.316 57 Fed. Reg. 33,875	July 31, 1992
Keratitis	38 C.F.R. § 3.316 57 Fed. Reg. 33,875	July 31, 1992
Laryngitis	38 C.F.R. § 3.316 57 Fed. Reg. 33,875	July 31, 1992