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AGENT ORANGE: EXPOSURE OF VIETNAM VETERANS

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HEARING

BEFORE THE

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SUBCOMMITTEE ON

OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON

INTERSTATE AND FOREIGN COMMERCE

HOUSE OF REPRESENTATIVES

NINETY-SIXTH CONGRESS

SECOND SESSION

SEPTEMBER 25, 1980

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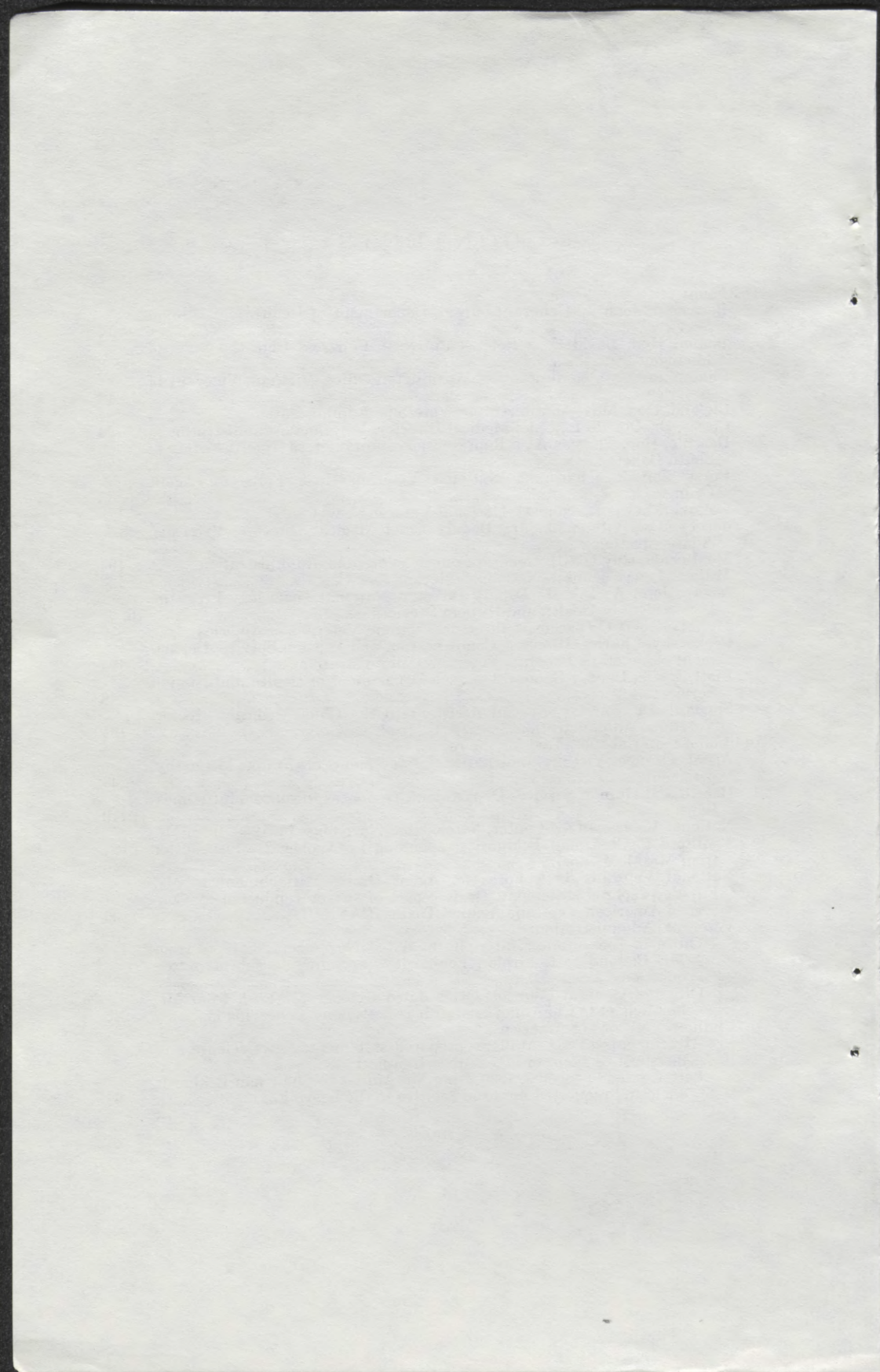
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AGENT ORANGE: EXPOSURE OF VIETNAM VETERANS

THURSDAY, SEPTEMBER 25, 1980

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9 a.m., in room 2322, Rayburn House Office Building, Hon. Bob Eckhardt, chairman, presiding.

Mr. ECKHARDT. The Subcommittee on Oversight and Investigations will commence its hearing.

In the past month, this Congress has begun to awaken to the massive implications of the introduction of toxic chemicals into our human environment.

We are here today to deal with a particularly saddening instance of the damage to human lives that can come from modern man's reliance on dangerous chemicals to achieve all sorts of aims, both peaceful and belligerent.

We are here this morning to continue work begun over a year ago when this subcommittee held 2 days of distressing hearings on the effects of agent orange, a highly toxic herbicide widely used in our conduct of the Vietnam war, on veterans exposed to that defoliant during that war.

It would be good if there were no purpose to our being here this morning. It would be good if the appropriate Federal agencies had been capable of effective response to the findings of those hearings. Unfortunately, that has not been the case.

Today, we seek to question whether the Government has shown an appreciation for the extent of the health problems traceable to the military use of agent orange in Vietnam.

Toward that end, we will hear later this morning from Max Cleland, the Administrator of the Veterans' Administration.

We will also hear testimony this morning from private groups who are attempting to do themselves some of the ground work of finding out which of our citizens have been injured in this way as a result of their service to our country.

The subcommittee will also receive testimony from officials of the Interagency Work Group established last December by President Carter. We have high hopes for this work group. This subcommittee both today and in the future will be closely examining its work to see if it can show some progress in redressing the past failures of the Federal Government in meeting its responsibilities to these injured veterans.

Before hearing from all those witnesses, we will hear from two of our colleagues who have done yeoman service in trying to assist veterans hurt by agent orange exposure.

Representatives Bonior and Daschle have introduced legislation—H.R. 6377—which would shift the burden of proof of exposure to the harmful defoliant from individual veterans to the VA. Here too it is regrettable that such legislation would be necessary to force the agency entrusted with assisting our veterans to do what it should be willing to do under its own authority. But it is to the credit of both Representatives that they are taking this apparently necessary action.

The issues we are discussing this morning are indeed complex. It is true that questions of the precise effects on human beings of agent orange, and related potent herbicides, are not scientifically settled. The element of imprecision in our knowledge of this area is the principal reason cited by the VA for its reluctance to extend readily the benefits sought by these veterans.

Yet the unacceptable element in that reasoning is that it does indeed place the burden of proof, of certainty, on the veteran. Only when veterans demonstrate to the Government's satisfaction that the Government's war caused their illness are they to be assisted.

This might be an appropriate attitude in cases where the private citizens had some substantial role in exposing themselves to a toxic substance. Assumption of risk is a concept familiar to the law, and in some cases might hold the Government free of a true obligation to assist the injured party.

But do not forget that we are talking here today about men and women exposed involuntarily, typically after having been conscripted to serve and generally while being not at all in the command of their own personal movements and activities which led to their exposure. Such citizens surely should not have to shoulder an onerous burden of demonstrating beyond all doubt that their service to their Nation did them harm, when it is at least readily demonstrable that they have suffered harm which might well have come from that service.

The whole premise of veterans' benefits and veterans' programs is the high responsibility of the Government after any major conflict "to bind up the Nation's wounds, to care for him who shall have borne the battle and for his widow and his orphan," as President Lincoln so nobly stated when that other great conflict that divided the Nation neared its term.

This Government has not been meeting that high duty in the case of the Vietnam war. It must begin to do so now.

Mr. Lent?

Mr. LENT. Thank you, Mr. Chairman.

"Frustration" is the word that best describes our initial response to the persistent reports of health damage to the Vietnam veterans who were exposed to the agent orange herbicide.

Veterans are frustrated to the point of desperation at the failure of the Federal Government to confirm or deny with scientific certainty any correlation between agent orange exposure and a variety of adverse health effects ranging from skin rashes to birth defects to a variety of cancers.

This Member of Congress and hundreds of my colleagues are frustrated at their inability to communicate in any helpful way with their constituents who served in the war in Vietnam and may have been exposed to toxic chemicals.

Moreover, we are at a loss to address this problem in any effective way.

No group of servicemen who risked their lives for their country in more ways than we may ever have realized have ever been more rudely treated on their return. Sadly, whole hosts of Vietnam veterans have lost all truth and confidence in the very Federal agency which was established long ago, specifically to provide for their needs.

I can remember how helpful the Veterans' Administration was to me when I was discharged from the Navy in the early 1950's, and I think most veterans then had a good feeling about the VA. Not so for this generation of servicemen. Rightly or wrongly, they believe the VA has let them down and the agent orange controversy brings that negative feeling into sharp focus.

It has always been my hope that this Nation's scientific community would be able promptly to establish, with certitude, whether or not a causal relationship exists between herbicide orange exposure and specific health effects.

Perhaps the most disturbing aspect of the testimony we will hear today is the growing realization that it may never be possible to arrive at the point of scientific certitude.

As framer of legislative policy, Congress is confronted with a dilemma posed by this absence of certainty. Is the circumstantial evidence compelling enough to permit us to arrive at a presumption of causation?

This is a question that we must wrestle with in the very near future. I hope that some of what we hear today will enable us to insure that the next step in our scientific inquiry will provide us with answers that enjoy wide credibility among veterans, scientists, lawmakers, and the public at large.

Mr. Chairman, I would conclude with a commendation to my colleagues, Representatives Bonior and Daschle, who have worked with single-minded determination to see that the agent orange issue is thoroughly aired and that a just conclusion is reached.

Thank you, Mr. Chairman.

Mr. ECKHARDT. First we have Congressman Bonior.

Mr. BONIOR. Thank you.

Mr. ECKHARDT. We are awfully glad to have you here this morning.

We always swear our witnesses, even congressional witnesses.
[Congressman Bonior was sworn.]

TESTIMONY OF HON. DAVID E. BONIOR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. BONIOR. Thank you, Mr. Chairman.

Mr. Chairman, members of this subcommittee, I would like to commend you for holding these hearings today on agent orange and would like to thank you for the opportunity to appear before you.

An ex-Senator from Michigan once noted that the chemicals which make up agent orange:

* * * may in the end appear to be much ado about very little indeed. On the other hand, they may ultimately be regarded as portending the most horrible tragedy ever known to mankind. What does emerge clearly from this uncertainty is that we must take steps to eliminate it * * * absolutely no delay is tolerable in the search for answers to the questions posed.

Mr. Chairman, members of this committee, we do not travel new ground today. We do not consider new questions. Today's hearings follow on 10 years of governmental concern. Over a decade ago the evidence on the health impact of agent orange was serious enough to lead the Air Force to discontinue its use.

Over 10 years ago, the late Senator Philip Hart held hearings that aired and discussed the health impact from exposure. It was from those hearings of April 1970 that I took my opening paragraph.

We do not turn to a new issue, an issue without a past. We turn to a well-known issue with a disappointing past, a past made up of VA neglect, a past made up of the suffering of Vietnam veterans and their families while they wait, finally for a proper Veterans' Administration response.

It was only 5 months ago that the Administrator of the Veterans' Administration proclaimed that all was well on the agent orange front. The VA was handling its job in a comprehensive and effective manner.

The Administrator also confidently noted that: "I want to assure you that no one is currently suffering from a lack of treatment because of a lack of knowledge" regarding agent orange.

What this Congress was not told, however, was that only 1 month earlier the Environmental Protection Agency had made public four independently conducted epidemiological studies documenting the carcinogenicity of 2,4,5-T.

What this Congress was not told was that the EPA had received a fifth study, then undergoing translation. What this Congress was not told was that other studies existed, and although not published were widely known enough that the Congressional Research Service cited them in their most recent agent orange issue brief.

But perhaps equally disturbing, not only was Congress deceived, but so were tens of thousands of Vietnam veterans across this land. For only 1 short month after the Veterans' Administration testimony before this committee, a package was sent to all the readjustment counseling centers that contained the same perspectives and limited views as the material contained in the VA testimony of February 25, 1980.

Not surprisingly, today, more than 6 months after the studies were brought to the attention of the VA, not only you and I, but all the Vietnam vets of America have yet to receive an adequate response from the VA explaining their earlier position and analyzing the significance of these studies.

Of course, the VA has responded. Administrator Cleland told the San Francisco Chronicle that the studies had limited use because they were not done on a Vietnam veteran population. While I am certainly unaware of any biological differences between Vietnam veterans and the rest of the population, it is just this type of illogic which has symbolized VA's approach to the agent orange issue.

The Veterans' Administration's handling of the scientific evidence is indicative of a wider attitude that I find continually baffling. Today, more than 3 years after the first agent orange cases came to the attention of the VA, the VA has yet to pay any compensation claims on the grounds of exposure to agent orange.

There are, of course, legitimate health questions remaining about the effect of exposure to agent orange. But there are equally clear areas where there is no room for responsible medical doubt.

Study after study have documented that individuals exposed to 2,4,5-T and its contaminant, TCDD, break out in a distinctive rash called chloracne. Yet, the Veterans Administration continues to refuse to pay compensation for chloracne unless they can establish evidence of the rash on the veteran's medical records.

Again, despite efforts to elicit from the VA an explanation for their policies, their change in policies, we as well as the Vietnam veterans have yet to receive a response.

Accordingly, it is not surprising that a private organization, the Vietnam Veterans of America, has had to step forward and perform the VA's responsibility for them and conduct, at considerable expense, a national outreach program.

Similarly, it is not surprising that the Vietnam veterans from across the country through their Representatives and the National Veterans Law Center, have had to sue the VA to insure that an adequate study was undertaken.

Mr. Chairman, what we must constantly keep in mind is that delay in this issue, delay since 1970, is not a neutral position. Agent orange is not a problem which can wait harmlessly on the sidelines for a change in VA policy. For delay must be calculated in not only the suffering of Vietnam vets and their families while they singularly deal with this problem but, finally, in lost lives.

What is perhaps the most disturbing element in VA policy is that this bureaucracy has not worked aggressively to help vets in the interim period of wait and anxiety. The VA has not created some sort of halfway position to help people or even to insure that medical assistance will be available if the VA ever changes its intransigent position.

Mr. Chairman, as past president of Vietnam Veterans in Congress, my office has been deluged with complaints and requests from veterans who have gone forth to VA facilities with agent orange related problems and have been brushed aside, ignored, and insulted by medical personnel unaware of what agent orange is. I am sure all of our offices have received similar correspondence.

When Administrator Cleland gave his infamous "no one is currently suffering from a lack of treatment due to a lack of knowledge" statement about agent orange, many persons cast a dubious eye toward the accuracy of such a remark.

However, it was not long ago until our position had been substantiated by the Administrator himself when only several weeks later he called random VA hospitals, identifying himself as only a Vietnam veteran, and could not find anyone willing or able to discuss his predicament.

The result was the now famous conference call to VA hospitals telling the regional personnel to get their act together.

Mr. Chairman, I hope this subcommittee will not allow the regional offices to be the fall guys for the failures of the VA central office policies.

I would suggest that one might question the Administrator when he appears later this morning to see if there has been a change in direction in terms of what is being disseminated from the central office to the regional offices and their willingness and knowledge on the agent orange problem to make the general public and veterans aware of the problems that lie ahead in this area.

The problem does not lie principally at the local level. It lies with the central office that has been too slow in distributing information, that has been unwilling to distribute the state of the science information, that has been unwilling to distribute information which runs contrary to their positions. What must be required is forceful administration of a national medical program. What is required is leadership.

When confronted with their record, the VA response has been to point toward the gaps in our scientific information.

Gaps there are; gaps there certainly will be. But the VA cannot continue to hide behind a facade of scientific prudence, for the question no longer remains whether or not there is some uncertainty, the question now is, how much science will the VA require, how much certainly will they hold out for until they make a humane decision to resolve this pressing health problem?

As a raft of recent court opinions have noted, in the complex area of toxicology, absolute certainty is impossible. As the Supreme Court itself noted in a recent decision overturning OSHA's benzene rule, certainty is elusive. But even the Justices in the majority to overrule the benzene rule were careful to note that they were not requiring absolute certainty, only that OSHA be prepared to act with the best available evidence, and evidence there surely is, as reflected in the recently released European and Scandinavian epidemiological studies, as reflected in the National Cancer Institute's recently released animal studies, as reflected, indeed, in over a decade of research.

I can go on and talk about Dr. Allen's studies at the University of Wisconsin, and the studies done at Oregon Primate Institute, Mendelsohn's studies at Harvard, and some of the other European studies that I think point to an abundance of knowledge that has been assimilated on this issue over a period of time.

The measure of leadership in this, and in all toxic chemical questions, is the ability to accept the final margin of uncertainty and to act. It is this final step which the VA has failed to take. Instead, they have simplistically pursued the final elusive certainty, a pursuit which condemns them to sit back silently while young Vietnam veterans and their families suffer.

Another question remains. That is, is the VA pursuit of certainty grounded in a responsible quest for additional science or is it a deliberate measure designed to produce delay?

Are we left again, as we have been so in the past on this issue, with the feeling that the VA is motivated principally by the fear of litigation and concerns about paying the final costs of compensation?

That question, while it may not be one which I would be willing to suggest to this subcommittee or to condemn the VA is one certainly that is being asked by many Vietnam veterans and their families today and one which they are giving more and more credence to day by day as time goes by?

Delay is inherent in any major bureaucracy, but when institutionalized delays multiplied by uncertainty and deliberate delay, the price is too high. It must be repeated that we cannot forget the obvious, for the Vietnam veteran the price is now being paid.

Tell Charlie Owens, one of the first agent orange claimants, now dead of cancer, that we need more science. You can tell Frank Moore, now dead of cancer, whose family is still staggering under the weight of medical and funeral bills, that the Administrator was not completely certain.

Mr. Chairman, I can no longer tell Vietnam veterans that they must wait with no good reason. What will it take?

Will you and I, 10 or 15 years down the road, have to secure passage of another Vietnam veterans' memorial, this time a memorial dedicated for those who died in the final battle for medical care, compensation and respect?

Mr. Chairman, there is an alternative.

This Congress can move to enact H.R. 6377, the Vietnam Veterans' Agent Orange Act. It is a responsible approach, well established in precedent. It does not require the payment of frivolous claims. It does not set up a presumption for disabilities, whether or not they are related to exposure.

Instead, it merely mandates that a decision be made, not 6, 10, 15 years from now, but now. It then requires that a responsible presumption be established in individual cases, insuring that no veteran must individually carry the impossible burden of reconstructing the last 15 years of his life showing the individual genesis of his disability.

The presumption established by H.R. 6377 is not unique. It follows upon the more than 40 presumptions already existing in title 38. It follows the precedent of the black lung program.

Mr. Chairman, it is my strong hope that these hearings will result in answers for the Vietnam veteran, answers which are long overdue.

I commend you again and thank you for the opportunity to appear and to state my position and the position I believe of many Vietnam veterans on this most important issue.

I would yield to add one postscript. It relates to the confidence question that Mr. Lent raised in his opening statement, that Vietnam veterans are losing confidence in the VA system.

There was a great diminution of confidence lost in the VA system, and it was through an act that was passed by this Congress after a struggle of four Congresses, I might add, that I think lent some hope to restoring the faith of the Vietnam veterans.

As to the Administrator, Mr. Cleland, I have been rather harsh on his performance this morning and in the past, but I must admit he has taken that issue firmly and provided outreach centers, psychological readjustment outreach centers to the Vietnam veteran.

I can't tell this subcommittee or the VA how much that has helped in restoring the confidence of the Vietnam veteran in this Government and to the Administration.

I would like to point out all the good work the Administrator did, the Congress did, the Government did to restore some confidence which was being eroded quickly by its failures to act on this important question of agent orange and the defoliants sprayed on Vietnam veterans.

It's my hope that delay we will no longer have and we will have a strong, affirmative voice coming out of the VA to resolve this issue and at least show more concern in terms of the burdens the Vietnam veterans and their families are now suffering.

Thank you very much.

Mr. ECKHARDT. Thank you.

Mr. Gore?

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

I would like to express my thanks to our colleague, Congressman Bonior.

As a Vietnam veteran myself, I would like to thank you, not only for taking the leadership on this issue, but for taking the leadership in the last Congress and establishing the Vietnam Era Veterans Group Caucus in the Congress and for taking the leadership on a wide range of issues of concern to Vietnam veterans.

I have had the same experiences that you have had with constituents coming to open meetings or coming to my district office and saying, "I dealt with agent orange in Vietnam; look at my hands, look at my skin," and then reciting a litany of other health problems that all fit into the same pattern.

They have contacted the VA and have found that no response was forthcoming. I have told such veterans, and I guess not to exaggerate the extent of the problem from my own particular perspective, but in the last 3½ years I have encountered I guess almost a dozen such veterans in the one congressional district that I represent, I have told them we are going to try to get some help for you. We understand some of those new substances that were created in recent decades pose puzzles for science; the scientists don't fully understand their effects.

Yet we asked you to serve in this war and deal with this substance and fight in close proximity to this substance, so we ought to be able to answer your questions and get you some help when it's appropriate.

But it has been very frustrating. As you know, and as you have so eloquently said in your statement here, the VA has not as yet compiled the scientific data that we need to proceed in a traditional manner. So the open question remains, should we proceed in some other way?

Let me just ask you the question: What, in your judgment, should the VA be doing right now that it is not doing?

Mr. BONIOR. Well, I think one of the things I alluded to in my statement is that they should be doing the work that the Vietnam Veterans of America are doing in terms of outreach, in terms of people being available to notify an agency that they have a problem and can get some advice and medical help.

I think that is something that they can deal with.

Let me mention another thing.

Senator Heinz adopted an amendment to the Senate bill—the vocational rehabilitation bill that we sent over there, which requires the Veterans' Administration to promulgate rules in terms of when it will proceed to deal with the claims on agent orange.

It's the first legislative action that has passed either body or gotten out of committee that specifically deals with this issue. It's coming back to the House, presumably today.

That is another step that can be taken by this Congress or by the Veterans' Administration to start to move toward some type of legislative remedy to put into effect the rules and guidelines to process those people along the way as the evidence becomes available.

So those are a couple of things that I think can be done. I would hope that they would speed up their studies in terms of not only the ranch hand people, the people who sprayed the defoliant in Vietnam, but those who were sprayed.

There is no reason I can think of why the VA cannot notify everyone who served in Vietnam and possibly were exposed to agent orange without unduly alarming those people, but letting them know there may be some possibility of a health defect.

Someone mentioned to me the other day that when Ford or Chrysler or GM has a problem with a car, there's a recall notice to everybody; and it seems to me when you are dealing with human lives and human and health effects, the least you can do is notify the people.

Another thing I would suggest is that we do have some troop movement records and tapes identifying the areas which were sprayed. I think you can match those things up and have some idea of where the possibilities are that people have been heavily exposed to some type of agent orange or agent blue or some type of defoliant exposure.

We have one GAO report¹ which came out—Senator Percy released it about a year ago—that indicated we have identified Marine troop movement which shows they were specifically sprayed. There is some difficulty with tracing the movement of all Army personnel because I understand some of those records were lost in the fall of Saigon.

There are a number of actions that could be taken that I hope will be done. I think it's incumbent upon us to press the Administrator and the Veterans' Administration to move in these directions.

Mr. GORE. Thank you again for your leadership on this issue. Thank you, Mr. Chairman.

Mr. LENT. I want to thank the witness.

I have no questions.

Mr. ECKHARDT. We certainly do appreciate your efforts in this respect, Mr. Bonior.

Thank you for your testimony.

Mr. BONIOR. Thank you for your attention, Mr. Chairman.

¹ Report by the Comptroller General of the United States entitled: "U.S. Ground Troops in South Vietnam Were in Areas Sprayed With Herbicide Orange," Nov. 16, 1979, FPCD-80-23.

Mr. ECKHARDT. Mr. Robert Muller, director of the Vietnam Veterans of America, and Mr. Jon R. Furst, chairman of the National Veterans Task Force on Agent Orange.

Mr. MOTT. Before Mr. Bonior leaves us, I would like to say that he is a real champion for this cause and doing something for our veterans with this agent orange.

I think he should be commended for all his efforts as being a champion for the Vietnam veteran and also he should be commended for the great job he did at shortstop for the Democratic baseball game last night.

TESTIMONY OF ROBERT O. MULLER, EXECUTIVE DIRECTOR, VIETNAM VETERANS OF AMERICA, ACCOMPANIED BY STEVE CHAMPLIN, ADMINISTRATOR, WASHINGTON OFFICE; AND JON R. FURST, CHAIRMAN, NATIONAL VETERANS TASK FORCE ON AGENT ORANGE

Mr. MULLER. I have with me Steve Champlin who administers our Washington office.

Mr. ECKHARDT. You are under oath too, Mr. Champlin.

Mr. MULLER. At this point, because our prepared testimony is 18 pages legal sized, I would like to submit it for the record and basically summarize the key points we would like to stress today.

Mr. ECKHARDT. Without objection, that will be permitted. [See p. 14.]

Mr. MULLER. I would like to start by noting this subcommittee's leadership role over one year ago in holding the first serious hearings on this issue since Senator Hart back in 1970. You succeeded in galvanizing public interest by beginning a serious process of advancement which admittedly it has been a long time, but recently we have started to see some signs of hope and encouragement that a resolution of this issue is at least beginning to be undertaken.

You are aware, perhaps more than most of the other Members of the Congress because of your interest and involvement, of the extraordinary level of concern that exists in the Vietnam veteran community. I tell you as a veteran's activist of almost 12 years that there has not been, in that entire 12-year period, any issue that approaches the issue of agent orange in affecting the Vietnam veterans, affecting them in ways of creating a sense of anxiety, fear, not knowing what the answers are, not knowing what the problems are that they might be facing.

As you know, Vietnam was basically a bad experience for most of the guys that served there. It is something that most people simply said, "Let it be part of my past; let it be part of my history; and let me get on with life." With agent orange, we finally have an issue that no veteran who served in Vietnam can afford not to at least listen to what we are saying, to listen to the views of the potential risk that he may have been exposed to. It is in that sense a hook that this Nation has, this Congress has, and the national leadership has of effecting a communications process with the Vietnam veteran, and use that hook where you know you have his interest and you know you have an issue that he is going to listen to, to demonstrate some responsiveness, demonstrate some caring, some compassion, sensitivity, and ability to address his needs and by

that, hopefully, rehabilitate what is now recognized for all too many Vietnam veterans their sense of betrayal by the Government in recognizing their needs that are directly related to their military service.

I think I would like to follow up and emphasize what Congressman Bonior just said about our 800 number. I think it is a shame that a small, struggling, not-for-profit organization has undertaken the initiative to get the word out to try and let Vietnam veterans know that there are problems. We have done that. The Veterans' Administration has failed to undertake any notice or any outreach to Vietnam veterans to tell them that there might be a problem as a result of their service in Vietnam.

We have had minimum funding, and yet our results, I think, are truly impressive. When we announced the 800 number, we could only afford to have two incoming lines. There were days on end where as soon as we would put the phone down, the phone would ring again. How many thousands, probably tens of thousands, of people we lost because of the frustration of getting through the busy signal I do not know. I can tell you now that we have had over 10,000 veterans call and we serviced them with the response package.

I would like to show you on that map the basic numbers on a regional breakdown, and it is part of our testimony included in the packages we presented to you, how across the country the concern has been there in every region. It is not as though it is one particular State, it is not as though it is one particular region. It is broad based.

What we also have on this map is, as we were here last year testifying, the VA hospitals that are marked in orange were where we have presented in the packages submitted to you the testimony of veterans about the negligence and the treatment they received in going there, other complaints about the lack of ability to get their military records, to get the results of exams, et cetera.

There is one note of encouragement. The black dots are where we have had very positive reports from how the VA is handling the agent orange intake system.

The problems that we are having in the hospitals are extensive and varied. The long lines, the delays, the lack of a thorough exam, the lack of followup on the exams are the lingering problems that we are still facing; the hostility and the lack of belief and credibility that we testified to last year has started to taper off noticeably. We are getting much fewer complaints about the negative attitude of the VA in at least being able to listen to the veterans coming in on an agent orange allegation.

We are announcing today with the support of the Paralyzed Veterans of America, a continuation of our 800 number. [See p. 32.] Who knows how many thousands more we will receive, but I think one point of comparison here is interesting. With our \$25,000 Ford Foundation grant, we got over 10,000 names and addresses of veterans. The VA with its \$21 billion a year budget has only been able to get to 30,000 guys. If a \$25,000 grant can almost match a third of the outreach effort of the VA, I think that says something.

The frustration that we have had with the VA has been fairly total. The best way to make the point without getting involved in

the rhetoric and just venting of the frustration we have had is to point to the minimum agenda which even today, the absolute minimum that we expected the Veterans' Administration to undertake. It is something that I fail to see how a reasonable person can argue with and it has four components.

One, effect an outreach program, at least advise people of the risk that a lot of people feel they are running if they were in contact with agent orange in Vietnam. Notice, outreach. That is No. 1.

No. 2, given the consensus of the medical evidence that is in, grant your service connection for your chloracne rash. It is the recognized marker of exposure to agent orange. There is enough evidence that is in to support it. It is an administrative action the VA could take without a legislative mandate and it should have been done a long time ago.

The third thing is also an administrative action that does not require legislation. It is establish the policy of when veterans come in for an agent orange examination, that they be given service-connected priority status. All too often when we can get the Vietnam veteran to come in, there has been that delay, a scheduling process of weeks down the road, you come in, and you might be delayed and come back another day to complete the exam. Establish the same priority for that agent orange exam as you would for a service-connected veteran coming in.

Mr. ECKHARDT. You just mean equal treatment, do you not? Rather than priority? Prompt treatment?

Mr. MULLER. Yes, equal treatment with that granted a service-connected disability.

The fourth element is what all the other agencies in Government have to abide by, an open rulemaking process. We want to have a hearing examiner appointed. We want to have the ability to participate in the development of the regulations on the criteria for disability and exposure. We want to have full, open public participation. We cannot get that. We do not know what the VA's policy is.

I could go on and just continue with the sense of frustration, but I would rather get away from that and just come back to the fact that this agenda is doable, it is reasonable, it shows forward action, and it should be undertaken now. There are some hopeful signs. What is for us the most refreshing experience is the dealings we have had with the interagency work group. It is headed, as you know, by Joan Bernstein, the general counsel of HHS. She is a woman whose reputation is extraordinary, whose ability in our relations to produce, to hold the open hearings, to set forth an aggressive research agenda are laudible, commendable, well received and greatly appreciated.

We have hopes that with some new personnel coming into the VA, Dr. Shepard perhaps, that we might see a change in the VA's policy.

We would like to see it happen now and not down the road. I would like to close perhaps with a study that you are probably familiar with, which was the VA study that was commissioned by Lou Harris to survey the Nation's attitude about the Vietnam veteran and the Vietnam war. The most significant finding of that

half-million dollar, 2-year survey for us was that the principle finding was not one unique to the Vietnam veteran. It showed how all Americans shared the experience of Vietnam along with the Vietnam veteran in that there was a noticeable erosion of the public trust and confidence in our institutions of government and in our political leaders. The only way you are going to rehabilitate the public sense of trust and confidence in our institutions of government and in our political leadership is by dealing honestly and effectively with the problems that are there, starting perhaps with the legacy of Vietnam, the Vietnam veterans, and their problems.

Thank you.

[Testimony resumes on p. 35.]

[Mr. Muller's prepared statement and attachments follows:]

Statement of
Robert O. Muller
Executive Director
Vietnam Veterans of America

Mr. Chairman, members of the subcommittee, I am honored to appear today, before the Subcommittee on Oversight and Investigation of the Interstate and Foreign Commerce Committee, to discuss aspects of the federal government's Agent Orange policy.

Today's hearings mark an important anniversary in the life of the Agent Orange issue. A little over a year ago, in June 1979, this Committee held the first serious hearings on the health impact on Vietnam veterans exposure to Agent Orange. Not since Senator Hart's hearings of a decade ago had Congress turned its attention to the impact of 2,4,5-T use in South Vietnam, never had it given serious consideration to its impact specifically on Vietnam veterans.

The June 1979 hearings marked a milestone. Once Congressional attention was focused on the serious questions raised it remained focused. The last year has seen a series of hearings.

But, Mr. Chairman, as I appear today--one year later--I have to report that there has been little progress. Despite the sound and the fury, we appear today to mark an anniversary of inaction.

There is one, important exception. A year ago, there was not even a coherent federal research agenda to address the health questions raised by exposure to Agent Orange. As documented in the June hearings, the Veterans Administration (VA) had pursued a policy of public promise and private inaction which had resulted in no serious studies, nor even any formal commitments to serious future studies.

Today, under the auspices of the Interagency Work Group, (IWG) the federal government is pursuing a forceful research agenda. Equally important, that research agenda is being

openly defined in a process that allows public participation. The result is that while some questions remain, the IWG agenda has received a fairly full articulation and has earned at least our confidence.

The breakthroughs on the research front will allow us, I hope, to turn our attention from details of research to the service and policy problems. In the past, the concentration on research, with its focus on the serious, unanswered medical questions, has too often left the impression that we know nothing; and, knowing nothing, are incapable of acting. There are great gaps in our knowledge. But, there also are things we do know. And, there are reasonable intermediate steps that can be taken while we wait for further information.

Mr. Chairman, today I, at least, would like to stop, for a moment, the paper chase of federal studies and take stock of the federal government's range of service programs for veterans exposed to Agent Orange.

To do that, Mr. Chairman, we have to turn, regrettably, to the VA. Regrettably, I say, because the VA's policy is a source of almost interminable frustration.

There are a variety of ways to approach the problems in VA policy. The VA, inexperienced with toxicological questions, has pursued a policy that appears to be grossly inconsistent with the federal government's general guidelines on toxicological questions. So, for example, there is a great deal of animal evidence on the health impact of exposure to Agent Orange. The use of the animal data becomes, accordingly, one of the touchstones of Agent Orange policy. The VA generally, in contrast to general federal policy, has not been prepared to infer human health risks from the ani-

mal data. Similarly, the VA has often discussed the need to wait for further data, as if the scientists can reasonably be expected to answer, in time, all our questions. The VA acts as if the fundamental policy problems can be avoided. They cannot. Hiding behind the science will be of no avail.

But, Mr. Chairman, I do not want to present today merely a list of VA mistakes. The list would be too long, and besides, the fundamental failure of leadership would be lost in the details.

But, more important, I do not want to suggest today that the Agent Orange problem is interminable--that behind every problem lies another problem--that there is no place to begin and no limited agenda of action that would meet the need. That is wrong. It is possible to respond to the Agent Orange problem.

Accordingly, I will begin by outlining four steps which constitute, I think, the basic program that any agency would have to take in the face of the Agent Orange issue. These four specific, and simple steps give us a yardstick we can then apply to VA action.

THE YARDSTICK: AN AGENT ORANGE BILL OF RIGHTS

The centerpiece of the VA's Agent Orange program is an examination for the health impact of exposure. Any veteran concerned about Agent Orange can go to one of the more than 170 local VA hospitals to receive the exam which should assist him in locating any immediate health problems. In addition to health care, however, veterans with disabilities resulting from exposure to Agent Orange should be eligible for VA compensation.

Vietnam veterans and their families have a right to be

informed about the health risks they face as a result of exposure to Agent Orange. That information should contain the best possible description of what we know and don't know.

But, the information should not be simply limited to alerting Vietnam veterans to the risks. It should also alert them to the steps they can take to address those risks. Vietnam veterans should be informed, first, that the VA presently makes available a clinical exam to screen, to the degree possible, for the adverse health impact of exposure; and secondly, that they can apply for compensation. Outreach then, is a first step.

1. The VA should commit to a national outreach program, including a mailing to available lists, such as service connected disabled Vietnam-era veterans, and the establishment of an "800" number linked to media outreach.

To the extent that exposure results in chronic health hazard that show a latency period, such as cancer, outreach serves a second function. It provides the VA with a list of veterans at risk which the VA can then use to direct follow up at a later date. The list would allow the VA to engage in an ongoing monitoring program that could result in important early detection.

But, a third purpose is also served. While the group of Vietnam veterans who report for an exam do not constitute a methodologically adequate cohort for epidemiological study, they do provide an invaluable pool of information about the patterns of disabilities emerging among Vietnam veterans.

2. The VA should ensure that the examination for the possible long term impact of Agent Orange

exposure is both reasonably available and reasonably thorough.

The VA does not provide an open-ended program of health care for any needs faced by any veterans. Instead it provides a health care system defined by statute and administered through a system of eligibility and priority categories.

Veterans with service connected disabilities have priority access to the system. Veterans with nonservice-connected disabilities may have access to the system only on a space-available basis, although they fall into further groups of ordered categories.

Within the VA priority⁴ schema, Vietnam veterans who call VA facilities for an Agent Orange exam fall into a kind of neither world. Since the VA has never recognized the adverse health impact of Agent Orange they are not. Accordingly, they can receive their exams only on a space-available basis. Yet they are inquiring about health risks that are clearly and specifically related to their service.

This legal limbo should be addressed head on. The Agent Orange exam should be deemed as constituting a service-connected health need for purposes of the VA's in-house priority schema.

But immediate access to an inadequate examination serves no needs. Vietnam veterans concerned about the adverse health impact of exposure need an examination that is both reasonably thorough and tailored, to the degree our knowledge allows, to the specific hazards posed by toxic chemical exposure.

3. The VA should establish a presumption of service connection for veterans who served in South Vietnam and have chloracne.

Although Vietnam veterans with Agent Orange disabilities are eligible for compensation, in reality the VA has never paid a claim on the basis of Agent Orange exposure. Despite the record, the VA has repeatedly stated that they will pay compensation claims for Agent Orange-related disabilities when the evidence is in. The only problem, according to the VA, is that the evidence is not yet in.

That is true to a degree. The evidence is not in on the birth defects, for example, and while extensive evidence is in on the carcinogenicity of TCDD, there are, perhaps, remaining questions that must be answered before the VA could create a responsible compensation policy for cancer. The cancer question is the proverbial "hard case."

But, the Agent Orange issue is not a seamless web. Difficulties in the data on birth defects, for example, are of a different order than the difficulties in the liver dysfunction data. It is not all or nothing at all. Instead, we should be able to proceed to address those disabilities about which we have reached an appropriate degree of certainty.

From the very beginning, the VA has repeatedly acknowledged that exposure to Agent Orange will cause chloracne. The implication of their position is clear. They should pay the chloracne claims.

4. The VA should establish Agent Orange compensation policy in a public manner open to participation by interested parties.

In a sense, this last point states the obvious. We all recognize that administrative agencies should promulgate rules of wide-ranging policy impact through administrative processes that allow public participation and are open to public inspection. Agent Orange is no exception and it requires no special pleading. The norm should apply.

But there is a special interest at stake that uniquely and specifically requires an open policy process. All the work necessary to secure an aggressive research agenda has too often obscured the fact that science cannot reasonably be expected to resolve all the questions raised by exposure to TCDD. Science may never provide us with the luxury of certainty. There will be few smoking pistols.

In the end, Agent Orange compensation policy, accordingly, will require delicate judgment calls that must weigh the ambiguities and then hazard an informed conclusion. That conclusion, in turn, will be dependent upon fundamental policy decisions weighing the appropriate burden of proof.

The arguments for public participation apply most strongly, I think, when you face a weighing process. If the final decision is subject to a kind of calculus that simply generates final policy, then the need to participate is less. But, if the final decision rests on balancing uncertainties, it is crucial that interested groups participate in the balancing. Without participation, their weight may not end up on the scales.

Mr. Chairman, let me state a few things about the yardstick I have chosen to measure VA policy.

The first, and perhaps most important, is that none of these actions individually, nor all of them taken together,

cost a great deal of money. Outreach, rulemaking, paying the chloracne claims, all would cost a fraction, indeed, a fraction of a fraction of a single percentage point of the VA's yearly budget.

Opening up the health care system for quality examinations on a reasonably available basis would cost more, but would hardly strain the VA's health care budget. In particular, note that my recommendation gives priority access for the exam only.

But, not only are these steps relatively inexpensive--not of them require authorizing legislation. Every single one of them can be done under the VA's existing authority.

Nor do any of these steps require the VA to prejudge any scientific questions. None are dependent on a new determination that any particular disability is causally related to exposure.

The yardstick I have drawn, in short, is simply a minimal human agenda. It is a small list of the obvious.

APPLYING THE YARDSTICK:

THE VA FAILS TO ACT

The results of applying the yardstick to the VA's actions can be simply stated:

1. The VA, to date, has refused to do outreach;
2. The VA, to date, has not clarified the priority of the Agent Orange exam, nor succeeded in ensuring the quality of the exam;
3. The VA, to date, has not created a presumption for

chloracene; and

4. The VA, to date, has not undergone rulemaking on Agent Orange compensation policy.

Perhaps, then, you can understand my sense of frustration. For recall that I applied a "short" yard, a minimal agenda. The VA has failed, to date, to do the obvious.

But as simply as this can be stated, it is worth looking at the details.

The VA has not only failed to do outreach to date--they have explicitly prohibited outreach.

The VA system is governed by "circulars" that articulate central office policy. The Agent Orange circular of the VA's Department of Medicine and Surgery (DM&S), Circular 10-79-83, explicitly states:

It is to be emphasized that at this time VA medical centers will refrain from efforts to induce veterans who are not currently part of their patient population to undergo an examination for possible health-related effects of herbicides.

DM&S Circular 10-79-83 expired on April 16, 1980, and VA policy is being redrawn, as noted in the new telex Circular, July 25, 1980, 10-80-152. In the interim, the old policy remains relatively constant.

The interim instructions on outreach, in particular, appear to remain the same, as reflected in the telex Circular. The exam is to be administered only to veterans who contact the VA or who are already in a VA facility.

As the projected change in the Circular makes clear, VA policy appears to be under pressure. In particular, effective April 28, 1980, Agent Orange policy was placed in new hands with the appointment of Dr. Barclay Shephard as Special Assistant to the Chief Medical Director with responsibilities to coordinate all Agent Orange activities of the Department.

We are hopeful that this change will result in a change in outreach policy. We are encouraged in this hope by Mr. Eizenstat's recent statement of September 22 that the VA is "expanding" its outreach efforts. Today's hearings may provide an important opportunity to clarify any projected changes.

The same type of explicit decision has been made to reject rulemaking. As will be outlined later in the testimony of National Veterans Law Center (NVLC), the NVLC explicitly asked the VA to undergo rulemaking, the VA refused and the NVLC went to court. Rather than settle by voluntarily undergoing rulemaking, the VA has chosen to fight the suit which now winds its way through the court.

In both cases, the VA's failure to act has compelled Congressional action. Early this month, the Senate voted 86-0, with one Senator, whose law firm is involved in the Agent Orange issue, voting "present," to adopt the Heinz/Cranston amendment which would compel the VA to undergo rulemaking. And, Senator Cranston (D-Cal) has joined the Vietnam Veterans in Congress (VVIC) in calling for outreach.

The VA's failure to do outreach has also compelled private and state action. Our organization began, in May, a national "toll-free" outreach project that has generated over 10,000 calls. The states of Minnesota and Wisconsin

have begun statewide outreach programs. New Jersey and New York have adopted legislation which should also result in outreach programs. The consensus for action is clearly there.

The chloracne problem presents a more complicated picture, but one with the same final meaning.

As of the VA's September testimony before the Senate, the VA had paid three (3) chloracne claims. In each case, payment was not based on exposure to Agent Orange, but rather on evidence in the veteran's military record of a skin problem while he was in Vietnam.

In explaining this, the VA repeatedly states that they do not need to know the causal path in order to pay a claim. They merely need to know the disability arose during a period of service. If the service record allows them to do that. They need go no further. Under this argument, Agent Orange exposure, of course, is irrelevant.

The rub in this argument is that most veterans were too busy staying alive to report skin conditions. Indeed, few front-line soldiers felt comfortable leaving their squads for minor medical problems.

There is, accordingly, only one serious question in the chloracne debate. Will the VA pay a chloracne claim when there is no evidence on a veteran's military record of a rash? Will the VA presume that a veteran who meets reasonable exposure criteria and who has chloracne got the rash as a result of service?

For you see, Mr. Chairman, the VA's generous sounding theory has a cruel twist. While the VA will pay without regard to causation if a disability is on a veteran's mili-

tary record, they will not pay, despite causation, if it is not on a veteran's military record, absent a presumption. The lack of a presumption on chloracne amounts to a policy of no compensation.

There is another rub. To administer a presumption on chloracne, the VA would have to be able to diagnose chloracne. To date, the VA has not established the capacity to meet this basic threshold task. Only as a result of pressure from Senator Cranston has the VA begun to establish a clinical screening program to identify chloracne.

The VA will perhaps say today, as they have several other places, that they are not seeing many cases of diagnosed chloracne. What I also hope they will tell you is that they had, as of June alone, more than 850 veterans with skin conditions that need rediagnosis. Hundreds of those veterans are possibly suffering from chloracne. But, the VA will not know until diagnoses are made, and that appears months away.

In the interim, the policy is clear. The VA has no presumption and, if they had a presumption, they couldn't administer it.

The problem of diagnosing chloracne brings us to the final issue of the VA's Agent Orange exam.

There is no simpler testament to the inadequacy of the examination program than the fact that the examiners cannot even diagnose chloracne, the single universally recognized marker disease of exposure. In a certain sense, that says all that needs to be said. If they can't isolate the marker, then they probably can't do much else.

In our June 1979 testimony, we brought a map locating

random distribution.

Mr. Cleland did not respond to Congressmen Bonior and Daschle's numbered questions.

To understand the impact of the Administrator's statements, it is important to realize that animal evidence on the carcinogenicity of TCDD has long existed. But, the VA has consistently stated that the animal evidence did not provide an adequate basis for compensation. Human evidence was required. But not, when some human evidence arrived, the VA, in a seemingly ad-hoc manner, was retrenching behind a new scientific barrier.

The defensiveness of the VA's response became increasingly clear as other peer reviews came in. First, the IWG stated in its August Report:

In spite of the reservations that are generally associated with these case control epidemiology studies, i.e. permissive criteria for establishing "exposure" which varied between the studies; memory bias by patients or relatives that there was "exposure" because of a traumatic event such as cancer, the studies show a correlation between exposure to phenoxy acid herbicides and an increased risk of some forms of cancer.

But at the same time, Congress's own Office of Technology Assessment (OTA) had been asked to review the studies. OTA sent the studies to an outside, independent expert who stated in his June analysis:

The case control investigations are among

The VA's apparent failure to even know about the Swedish studies creates a major problem. P.L. 96-151, for example, had mandated that the VA do a literature review and that it coordinate with other federal agencies, including, of course, EPA.

Responsive to this problem, Congressmen Bonior (D-Mich) and Daschle (D-SD) forwarded to the VA on April 4 the studies (hereinafter, the Bonior/Daschle studies) in a letter containing eleven (11) numbered questions addressing the state of the VA's knowledge and its Agent Orange policy.

It was discouraging enough that the VA apparently didn't even know of several major epidemiological studies, but what was more discouraging was their almost immediate defensive response.

In June, Administrator Cleland responded to the Bonior/Daschle studies by stating to the San Francisco Chronicle that the studies were not adequate because they were not done on Vietnam veterans. Apparently, there was some fundamental, biological distinction between Vietnam veterans and the Europeans studied that rendered the European data useless.

In an April 16 letter to Congressmen Bonior and Daschle, Administrator Cleland further elaborated his position:

I should note, however, that following preliminary analysis my scientific advisers have informed me that they do not think the papers make a major contribution to answering the problem that is of concern to all of us. I have been advised that these studies appear to be based on a

evaluation form to more carefully monitor the quality of the system. We have tried today just to select a series of cases that demonstrate both the national reach of the problems and some of their characteristic features.

REVIEWING THE SCIENCE

Mr. Chairman, I emphasize the four points caught in our "Bill of Rights" because I want to make clear that the Agent Orange problem is not interminable. Solutions are possible. The administration can respond in a limited, yet compassionate, manner. There are meaningful half steps.

Until very recently, in statement after statement, Mr. Cleland has asserted that there are no human studies showing any adverse long-term or chronic health impact from exposure to 2,4,5-T.

Of course, that was not true. The Environmental Protection Agency (EPA) had in January, for example, inserted into the public record of the 2,4,5-T hearings a series of Swedish studies correlating exposure to 2,4,5-T with an increased risk of cancer. The EPA brief, filed January 25, discussing the studies stated:

These epidemiologic findings are especially meaningful because they appear in several separate human populations and because the same types of adverse health effects have also been observed in experimental animals. Moreover, because negative epidemiologic findings may be consistent with an actual health effect of considerable magnitude, detection of a statistically significant increase in risk of cancer in several different populations is impressive evidence of a human health hazard.

examples that had come to our attention of veterans who reported for exams and received inadequate care. There were three types of problems that emerged:

1. Long periods before they secure an appointment and then frustrating waits in the hospital;
2. Inadequate and rudely administered exams; and
3. Occasionally, outright hostility.

We have brought that map with us again. But, in addition, we have prepared a new map of recent cases.

Mr. Chairman, I want to be very forthright in acknowledging progress where it occurs. In the last few months, we have received very few examples of outright hostility. More importantly, we have received reports of veterans who received the exam in a reasonable period of time and in a reasonably thorough manner.

I cannot emphasize enough the real service offered when the exam is reasonably available and reasonably thorough. Veterans who are properly handled feel that they, together with the VA, have taken an important step in addressing the potential risks they face. These reports confirm the value of the examination program.

But, Mr. Chairman, we continue, to hear, as reflected in the map, of a large number of veterans who face inordinate waiting periods and receive inadequate exams.

Our map does not represent a survey. It is not an "epidemiological" study. Over the next month, we will be mailing everyone who called our outreach project an

the most carefully conducted investigations of their type that I have ever seen. In toto, the Swedish work is credible if not fully conclusive. Certainly this work would seem to justify further investigation.

Mr. Chairman, my frustration does not derive from the fact that the Bonior/Daschle studies were above criticism. There were limits to the studies' significance, as there will be limitations to any studies' significance. These limits, reflected, for example, in the National Academy of Sciences' provisional review of the study, require delicate policy decisions and careful scientific review. Future studies with future limits will require the same delicacy.

The problem we face now, and will face, is not what to do with unqualified evidence, but how to make the delicate judgments that sift through the qualifications to reach a reasoned policy decision. The problem with the VA's defensive attitude is not that it amounts to "lying in the face of the evidence," but rather that it endangers the objective judgments uncertain scientific evidence will require.

The IWG and DTA assessments did, finally, have some impact on the VA's position. In September, the VA stated:

Pending a report from the Advisory Committee, I can state that the Veterans Administration supports the views expressed by the Scientific Panel of the Interagency Work Group, on which the VA is represented, and by the Office of Technology Assessment. We fully agree that these studies provide credible and valuable leads in the scientific pursuit of the health effects of exposure to phenoxy acids. We do

now believe, however, that they answer the question as to whether there exists a causal relationship between exposure to phenoxy acid herbicides as used in Vietnam and the appearance of various types of malignancies. We note the use of the term "correlation" by the Scientific Panel in commenting on the Swedish studies. I am informed that when used in the scientific context, the term means "co-existence" of two factors, not a "cause and effect" relationship.

Perhaps, Mr. Chairman, you, as well as I, can sense the continuing tone underlying this final statement. But, conclusions about tone are subjective. What is not subjective is that the whole process took literally months. And, at the end, Congressmen Bonior and Daschle have yet to receive from the VA answers to the questions in their letter transmitting the studies.

When Congressmen cannot even get straight answers from the VA, is it any wonder that Vietnam veterans can't?

CONCLUSION

Mr. Chairman, if I could leave you and the members of the Committee with one impression it would be, simply, that the Agent Orange problem can be dealt with. There is a viable program of action that could responsibly serve Vietnam veterans, not just at some future date, when the mythic "final data" is in, but now.

VIETNAM VETERANS OF AMERICA

329 EIGHTH STREET NE, WASHINGTON, DC 20002

NEWS RELEASEFOR THURSDAY RELEASE
SEPTEMBER 25, 1980 at 9:00 A.M.PRESS CONTACT: JOHN F. TERZANO
(202) 546-3700

Appearing today before the Oversight and Investigation Subcommittee on the Interstate and Foreign Commerce Committee, Robert O. Muller, Executive Director, announced the expansion of the Vietnam Veterans of America's toll-free "hot line" for veterans concerned about Agent Orange.

THE NUMBER IS: 1-800-424-7275

"The overwhelming response has documented the need," stated Muller. "The total failure of the Veterans Administration even to announce a commitment to begin, at some future date, an outreach project leaves only private organizations to meet the need."

The Agent Orange Outreach Project was begun on May 1, 1980. More than 10,000 families had called the "800" number as of September 15, 1980.

Continuation of the Outreach Project was made possible by a generous grant from the Paralyzed Veterans of America, a national not-for-profit veterans organization whose membership is made up of paralyzed veterans--many of whom served during the Vietnam era.

"As paralyzed veterans," noted Jack Powell, Executive Director of the Paralyzed Veterans of America, "we know something of what is at stake for the hundreds of thousands of veterans who may face severe disabilities as a result of exposure to Agent Orange. We especially know what a difference information can make, how important it is to take control over your own life."

- MORE -

* A not-for-profit national veteran's organization *



The Oversight and Investigation Subcommittee held the first major Congressional hearings on the Agent Orange issue in June 1979. In addition to noting the failure of the Veterans Administration to conduct outreach, Muller's testimony emphasized the VA's continuing failure to adequately open up its health care system to veterans concerned about Agent Orange exposure. Finally, Muller called for the creation of carefully limited presumptions to ease the way toward compensation for Agent Orange-related disabilities.

Veterans who call the Outreach Project reach a recording that asks them to leave a name and an address. Shortly afterwards, they receive in the mail a four-page Self-Help Guide to assist in applying for health care and compensation within the VA system, the DOD form necessary to secure a copy of their military records, and a special, comprehensive newsletter devoted to Agent Orange. In a second mailing, callers are sent a medical questionnaire which allows them to participate in the first major independent study, being conducted by faculty members at Columbia's School of Public Health, of the health impact of exposure to Agent Orange among Vietnam veterans.

Agent Orange was a defoliant used extensively in South Vietnam from 1964 through 1970 to deny the enemy cover. Made up of two chemicals, 2,4-D and 2,4,5-T, the 2,4,5-T was contaminated by a third chemical, a dioxin referred to as TCDD. Because of the health risks posed by exposure, in February 1979 the Environmental Protection Agency used, for the first time, its most extreme remedy and banned almost all domestic uses of 2,4,5-T. The VA estimates that 2.4 million Vietnam veterans were potentially exposed.

FACT SHEET

AGENT ORANGE OUTREACH PROJECT

MAY 1 - SEPTEMBER 15, 1980

TOTAL CALLS RECEIVED:

10,654

State	# of Calls	# of Viet Vets ^{1/}	State	# of Calls	# of Viet Vets ^{1/}
AL	129	46,000	NE	50	21,000
AZ	138	23,000	NV	33	7,000
AR	114	23,000	NH	54	11,000
CA	823	230,000	NJ	524	46,000
CO	139	46,000	NM	81	21,000
CT	160	21,000	NY	1,032	116,000
DE	56	7,000	NC	224	69,000
FL	391	92,000	ND	29	9,000
GA	97	46,000	OH	885	116,000
ID	11	16,000	OK	117	44,000
IL	345	92,000	OR	140	45,000
IN	244	46,000	PA	682	116,000
IA	102	46,000	RI	25	9,000
KS	154	23,000	SC	93	45,000
KY	101	46,000	SD	61	11,000
LA	204	46,000	TN	124	45,000
ME	67	16,000	TX	417	161,000
MD	117	23,000	UT	19	15,000
MA	203	46,000	VT	23	7,000
MI	912	92,000	VA	186	55,000
MN	141	46,000	WA	308	45,000
MS	49	23,000	WV	181	23,000
MO	137	69,000	WI	462	45,000
MT	47	11,000	WY	10	5,000

The WATS Line is limited to the continental United States, and so excludes Hawaii and Alaska. Calls also cannot be received from the state in which the line is installed--in this case, the District of Columbia.

^{1/}

Estimated number of veterans who served in Vietnam during the years of Agent Orange use. Estimates are based on VA figures, Data on Vietnam-Era Veterans, Reports and Statistics Service, Office of Controller.

Mr. GORE. [presiding]. Thank you very much, Mr. Muller. We will hear now from John Furst, chairman of the National Veterans Task Force on Agent Orange.

TESTIMONY OF JON R. FURST

Mr. FURST. Mr. Chairman, members of the subcommittee, ladies and gentlemen, the task force is a nonprofit coalition of veteran, religious, legal, social service, and environmental groups seeking to confront the problems exhibited by former American military personnel which are thought to result from exposure to agent orange. Many of the task force member group representatives provide counseling to veterans, as do I. The extremely powerful nature of one-on-one interviews with these veterans and their family members provides a perspective of this issue which has strongly influenced many of us. On behalf of the task force and those we serve, I shall attempt to accurately present their concerns to you.

I am pleased to be here and am thankful for the opportunity to present our perspectives on the questions at hand today. It is our hope that this can further all of our efforts to resolve the agent orange problems.

With your permission, I have two points of interest. One is our perspective of the interagency work groups scientific recommendations and the other is information which has been collected by veterans organizations.

It is our perception that the White House Interagency Work Group is to provide coordination and leadership to the Government's agent orange related research. They have placed before us several recommendations. In reviewing these recommendations, it is our understanding that they result from information provided by the Department of Defense and the Veterans' Administration. It has been our hope that the work group would help to further define this issue by providing a kind of check and balance; a verification of accuracy to DOD and VA information. It has already been alleged that the work group has not questioned the completeness and accuracy of the information upon which these recommendations are based. Therefore, it is a major concern of ours that attention be directed at the process from which these recommendations have come; as we believe this process will greatly affect the reception accorded their work in the Vietnam veteran community. They are, after all, experiencing a crisis in confidence regarding their governmental institutions. I would remind you that these Americans have worked with the Government before and that they perceive each contact very often to have resulted in disaster, betrayal and/or denial. It is, perhaps, one aspect of reality for many veterans that their military experience has resulted in a very peculiar relationship to their Government.

We propose that the often unflattering stereotype of the Vietnam veteran is inaccurate. They were mostly young people raised to be offended by injustice. They are in reality our sons and our daughters, our husbands, wives and lovers, our neighbors and our friends. They went where they were told to go and did what they were ordered to do. They are, and should be seen as Americans no more no less. What happened to them because of their involvement in

that war has never been adequately justified. The earned benefits have seldom fully benefited them.

At this point in time, we find them ill in increasing numbers with no greater potential of true assistance than what this country can offer through its military records and its massive VA health care system. Many, though still filled with great, unresolved anger at their past governmental experiences, chose to seek help from the Veterans' Administration. In the beginning, they were hung up on when calling to ask VA hospital personnel about cancer warning signals and birth deformities. They were denied medical assistance with demands to "prove they were exposed," or "prove agent orange caused your problem." We would remind you that only recently has the VA begun to move away from such an approach to this issue.

The veterans have requested assistance from the Department of Defense in the hope of gaining unit exposure information in hopes of opening the doors to medical care. They were told, in grossly inaccurate responses, that almost no one could have been exposed. Their distrust of DOD and VA as sources of credible information and sincere assistance has been repeatedly reinforced.

Because of such experiences, we must look to the Interagency Work Group for verification of DOD and VA information. We believe it is significant that the Department of Defense is seeking to develop a chemical warfare capacity in the face of such Soviet accomplishments. The work group is asking this same Department of Defense to provide us with what may well be a horror filled recounting of their last involvement with chemical warfare. Therefore, we perceive the Department of Defense to be faced with a major conflict of interest. It is in light of such perceptions that we are told the science panel of the work group has performed no independent evaluation of the Air Force efforts to reconstruct exposure data. One of the recommendations before us asserts that an agent orange ground troop exposure study cannot be done. We find it unreasonable, based solely on the inquiry performed to date by the Air Force, to make final conclusions about whether sufficient numbers of ground troops can be identified for study. Such conclusions, if they are to be reached, must reflect the veterans' concerns. They deserve no less than our full assurance that every avenue of identifying an exposed ground troop subpopulation has been exhausted. If unquestioned acceptance of this DOD assertion supports the basis for continuation of the ranchhand study or Vietnam service study, then they too are premature recommendations.

The work group's recommendation to expand the exposed ground troop study into a Vietnam service study is another awkward proposal. The veterans have been forced to exhaust enormous resources to demonstrate that they are, in ever increasing numbers, experiencing certain physical and emotional ill health. They have also been forced to research possible reasons for the occurrence of such symptoms, and have demonstrated that the components of agent orange appear most capable of causing such ailments. They have passed a very specific question to their Government.

To what degree is agent orange responsible for the deteriorating health exhibited by Vietnam veterans of this country? On behalf of

the task force and the veterans in contact with us, I reiterate that this question is viewed as having life and death importance.

If, in answer to this question, the work group chooses to study whether veterans have been harmed by Vietnam service, they chose to answer an already answered question and refuse to answer the question asked. Inasmuch as a Vietnam service study can shed light upon other hazards to veterans' health, such as synergistic toxic chemical considerations, it is worthwhile. Its worthiness exists, however, in qualifying the answer to the agent orange question. A Vietnam service study in addition to the exposed ground troop study is much more acceptable than to delete the one for the other. The task force sees these two studies as addressing different concerns that are not alike; nor are they interchangeable. To exclude the exposure study is seen as unnecessary, financially wasteful, and a waste of the veterans now unknown life expectancy.

The Government has for some time proposed that the Air Force study the ranchhand personnel. The logic of such a study is apparent to us inasmuch as their exposure to agent orange is documented. We are puzzled that available information indicates Ranch Hand personnel who complain of the familiar problems have surfaced in smaller numbers than other exposed groups and complain of a seemingly smaller range of serious problems. We wonder if veteran subgroups more severely afflicted would not constitute a more productive source of information.

There has been debate concerning the wisdom of allowing the Air Force to conduct the ranchhand study. We would remind you that for 2 years the Air Force has stated that agent orange is not harmful, and that for 2 years, the Veterans Administration has parroted Air Force supplied data in its policies and instructions. Veterans believe the Air Force and VA are biased against finding agent orange related problems. This bias has been perceived by the National Academy of Sciences and by the member groups of the task force. We believe this perception of bias is an accurate reflection of the veterans feelings.

One of the recommendations offered by the Interagency Work Group addresses this distrust. It is proposed that the ranchhand study be continued as planned, with provisions for a peer review committee. Task force members give no credence to Air Force statements regarding agent orange. We do not foresee that an Air Force performed study, with or without a peer review committee, can provide results which are believable to veterans.

Upon learning of the recommended peer review committee, task force members have vehemently stated their unwillingness to have any association with any Air Force generated study of agent orange. They pointedly reject the invitation to sit on such a peer review committee.

Speaking personally, I see no avenue by which credibility can be established for the VA or the Air Force in the minds of veterans. We believe that such a recommendation would not have been made had Vietnam veteran groups been polled, be they affiliated with the task force or not.

At the present time, there is no acceptable solution to the problems of credibility and bias within the Air Force; and we recom-

mend the Interagency Work Group consider again the National Academy of Sciences' conclusion that the ranchhand study be performed by independent researchers.

I would now like to make the subcommittee aware of something that the task force has done. I must use a personal example, because I cannot speak for the other members. I am a veterans counselor. My job is to talk to Vietnam veterans and they talk to me. The veterans talk to me; their wives talk to me; their parents talk to me. It is very, very hard. You know that. You have talked to them. In 1979 I met with Max Cleland in Kansas City. I tried to show him information from the St. Louis area, a woman named Lanna Skadden and I had gathered from Vietnam veterans who complained of agent orange. I asked him if he would please look at it. He insisted that I take it to Washington and provide it to the first meeting of the Veterans Administration Advisory Panel on Herbicides. At our own expense, with time off work without pay, she and I and others who cared enough came to Washington. We presented this information to the Veterans Administration, and we have heard nothing more about it.

We have expanded on it. We now have individual reports from each of the veterans, and these are not at all our entire files. The names have been removed out of respect for their concerns. It is fairly obvious, when 89 percent of the people you talk to experience a rash that seems to fit the description for chloracne, which is a result of exposure to the most toxic manmade substance ever known, that something is wrong. It is obvious when 80 percent of the people that we talk to experience chest pain, that something is wrong. We have given it to the Veterans Administration. We have told them it is not scientific. We are not scientists. We have asked them to help us know what is and is not scientifically important about the information. I have attached a list of 89 birth defects. [See p. 50.] The primary birth defects are deformities of the hands, fingers, feet, and toes; heart defects. What Barry Commoner of Washington University calls the fingerprint of dioxin exposure.

These veterans cannot get medical care. Is that what they have risked their lives for? We have given it to the Veterans Administration. We have not heard any more about it. I offer these things to the subcommittee for its importance.

Mr. GORE. Without objection, we would like to include the results of your work in the record of this hearing. Without objection, that will be ordered.

[Testimony resumes on p. 52.]

[The report referred to follows. Documents listing individual disorders may be found in subcommittee files.]

CAVEAT (Concerned American Veterans Against Toxins) St. Louis Area Office

This information contained in this report is not "scientific." Many efforts have been made to increase the potential value of this "Accounting" of "Symptoms," in the desperate hope that members of the scientific community can help us to see the significant, and less than significant information contained herein.

To better understand the manner in which this information was gathered, we offer the following:

1. Callers almost universally report they were motivated to call by media disseminated information of symptoms and resulting word of mouth from fellow workers, family members, and friends.
2. Information supplied to the media was provided from the following re-printed information, originally supplied by Concerned American Veterans Against Toxins, (CAVEAT) of Chicago, Illinois.

SOME REPORTED SYMPTOMS OF D I O X I N P O I S O N I N G

- NUMBNESS of fingers, toes, arms, and legs in varying degrees.
- NERVOUS DISORDERS, especially loss or decrease in sensitivity of the senses.
- PSYCHOLOGICAL EFFECTS, such as loss of memory, confusion, aggression, irritability
- SKIN RASHES, specifically chloracne, which resembles a severe case of acne, found usually on face, arms, chest, back, or legs.
- ALTERATIONS OF THE SEX DRIVE, especially diminished sex drive in men, possibly impotence; and increased sexual activity in women.
- CANCER, especially of the liver.
- BIRTH DEFECTS in children born to affected parents, primarily defects of the hands, fingers, feet, and toes; some hyperactivity and psychological problems reported.

3. Beginning on February 15, 1979, Vietnam Veterans and others involved in the use of the Herbicides 2,4-D and 2,4,5-T (ie, Highway Crew Members, Utility Company Employees, etc.) began overloading available phone lines.
4. The callers reported having experienced some or all of the symptoms reported in the media as possible consequences of exposure to Agent Orange.
5. Information was taken to facilitate recontact at a later time. Most reported having sought medical assistance for some of these problems without ever receiving any substantial relief. Those who had seen more than one doctor commonly reported differing diagnoses, or abrupt changes in proposed diagnosis after repeated visits.
6. When time allowed, the callers were recontacted for in depth information. The callers were told that we wished to acquire as much information as possible, before asking any specific questions regarding "Symptoms." No order, or direction was imposed on the caller except to ask for all information on mental and/or physical ailments or occurrence which they could recall. Before beginning, we insisted that any other possible cause for such problems be communicated, (for instance, hearing trouble since Vietnam duty should be qualified if caller served with Artillery Units, or other hearing risk occupations, civilian or military.)
7. Callers were cautioned that we were absolutely unable to define any cause for their problems; that we could only hope to look for similarities and depend on members of the scientific community to help sift the "noise" from the substance.
8. When the caller had exhausted all recollections of trouble, we asked them to respond to questions regarding specific "symptoms" which were being reported.
9. The caller was warned that this list contained bogus questions which were included to raise the validity of responses and to "keep everyone honest."
10. The list used did not actually contain any bogus questions, but was a growing list of actual problems being reported. As an example of how the list evolved, one caller, amid frustration at his inability to recall any further health problems since Vietnam, asked whether it might be important to note the loss of all his fingernails and toenails, for no apparent reason, just prior to leaving Vietnam. Callers, from that point on, were asked to respond to the question of such events, and some reported changes in their fingernails or toenails, but not always the loss of such. Information of this nature was incorporated into our questions in the hope of finding "symptoms" shared by the callers.
11. When possible, callers were asked to share the phone with their spouse, to aid in responding.
12. Due to the expense of the phone calls, (some lasted over two hours), we terminated in depth symptom reports. The information attained up to the point of termination is contained in this report.
13. Predominantly, full intake was accomplished as callers acquired their records from the National Personnel Records Center, and then recontacted us for further information. While circumstances cannot be truly defined, we believe said circumstances add to the randomness of these self selected callers.
14. All "symptoms" occur in varying degrees on a come-again go-again basis.

COMPLETED TOTALS FOR 55 VIETNAM VETERANS AND OTHER POSSIBLE DIOXIN EXPOSURES

CAVEAT, INC.
 (Concerned American Veterans Against Toxins)
 SAINT LOUIS, MISSOURI AREA

"SYMPTOM"	PERCENTAGE OF 55	NUMBER REPORTING
RASH	89.0%	49
NUMBNESS AND TINGLING	83.0%	46
CHEST PAIN	80.0%	44
SWEATS	74.5%	41
FATIGUE	69.1%	38
LOWER BACK PAIN	67.2%	37
GASTRO-INTESTINAL DISORDERS	65.5%	36
JOINT PAINS	65.5%	36
STARS	63.6%	35
VISION	63.6%	35
HEADACHES	60.0%	33
URINARY DISORDERS	50.0%	28
HEARING	45.5%	25
LIGHT SENSITIVITY	45.5%	25
IMMUNO-DISORDERS	43.6%	24
ALCOHOL (REDUCED TOLERANCE)	43.6%	24
SORE THROATS/GLANDULAR SWELLING	41.8	23
ABDOMINAL PAIN	40.0%	22
BOWEL HABITS (DRAMATIC CHANGE IN,)	36.4%	20
SINUS/ALLERGY (EMERGENCE SINCE EXPOSURE)	36.4%	20
SMELL (LOSS OF,)	34.5%	19
SPONTANIOUS NOSEBLEEDS	29.1%	16
POUNDING IN CHEST	27.3%	15
DRAMATIC WEIGHT LOSS (UNEXPLAINED)	25.5%	14

CAVEAT / SAINT LOUIS

SYMPTOMATOLOGY (Continued)

FAINTING SPELLS	18.2%	10
LOSS, OR CHANGE IN, <u>TOENAILS</u>	18.2%	10
LOSS, OR CHANGE IN, <u>FINGERNAILS</u>	14.5%	8
HAIR LOSS	14.5%	8
TASTE, INABILITY TO,	12.7%	7
APPETITE LOSS	10.9%	6
RESPIRATORY PROBLEMS	3.6%	2

-- BEHAVIOR --

MEMORY LOSS	65.5%	36
IRRITABILITY	60.0%	33
SLEEP PATTERN DISRUPTION	54.5%	30
AGGRESSION	43.6%	24
DECREASED SEXUAL DRIVE	43.6%	24
CONFUSION	29.1%	16
DEPRESSION (INCOMPLETE FIGURES)	20.0%	11
TREMORS	7.3%	4
GENERAL BEHAVIOR DISORDERS	3.6%	2

-- CHILDREN --

MISCARRIAGES	30.7%	16
RESPIRATORY PROBLEMS	26.9%	14
FEVERS OF SHORT DURATION (Unexplained)	25.0%	13
RASHES	23.1%	12
ALLERGIES	19.2%	10
SPEECH DEFICIENCIES	17.3%	9
HEART MURMURS	13.5%	7

THE FOLLOWING DESCRIPTIONS ARE BASED ON 650 CONTACTS FROM
PERSONS WHO MAY HAVE BECOME VICTIMS OF "DIOXIN" EXPOSURE.

THE DESCRIPTIONS SHOULD NOT BE CONSIDERED "SCIENTIFIC".

A DELIBERATE ATTEMPT HAS BEEN MADE TO AVOID MEDICAL WORDING.

INFORMAL DEFINITIONS OF "SYMPTOMS"

"SYMPTOM" NUMBER

1. VISION - Refers to occasional blurring of vision, which can be "blinked away", and has occurred at some point in time since expected exposure, (usually vietnam service). Usually described in one of three ways.
 - a. Like a film on eyes, can be "blinked away", but quickly returns only to be "blinked away" again. Interference with clear vision may last a moment or two, to sporadic events lasting a day or two.
 - b. Inability to readily focus upon items varying in distance. If reading, may need to blink and blink to change focus from book to object across room. Those reporting blurring in this way occasionally report inaccurate perception of light in closed room as if a lamp is dimming or brightening, but often "seen" in an area of the room where no lamp is lighted.
 - c. Eyes attempt involuntary "crossing", as if the person is desperately fighting to stay awake. "Just like a kid in church trying to stay awake, wrestling with himself to keep his eyes open." Such people seldom perceive themselves to be falling asleep... Just their eyes involuntarily trying to close.

2. RASH - This category does not restrict itself to "acne-like" skin eruptions. It should be noted that all involved in preparing this information were shocked at the predomination of "acne" cases in this category. Many reported one, or a very few, unusual skin eruptions occurring under the watch or ring. The usual description is of "eruptions surfacing in Vietnam, or since being there, (including recently,) which itch violently as a rule. The eruptions vary in size and kind. Some are reported to look like a small pimple, a large pimple, or perhaps not like an acne eruption at all. Psoriasis like patches are reported, and according to some, can be anticipated by a recurrent, oozing, poison ivy-like rash. Usually the skin eruption is perceived as an insect-like bite, which, if scratched becomes extremely tender and the itch more aggravated. The eruptions are often reported to resist actually coming to a "head", leaving a lump under the skin that becomes covered with scar tissue. They take a long time to go away, often leaving a small pock-mark. If, by the way, eruptions occur under one's watch, I am told that continued wearing of a watch will "encourage" repeat episodes.

Many report severe acne rash over much of their bodies. The nature of the rash varies greatly, and we have found that many who report having a rash do not associate "acne-like episodes" with their "rash". For instance, several reported having no rash, only to acknowledge with great emphasis the acne-like events.

*Ringworm-like
episodes -*

CAVEAT

3. NUMBNESS AND TINGLING IN EXTREMITIES - Described predominantly as very like the reduced circulation occurrence of a limb "falling asleep". Is sometimes reported to interfere with dexterity and strenght to such a degree as to preclude the skills of employability. Reported as occurring in varying degrees on a come and go basis.
4. CHEST PAINS - Described, in general, as angina pectoris would be described. Pain is usually sufficient provocation to seek medical advice, but almost all such inquires are discounted by physicians as no EKG findings verify the complaints. When severe pains are reported, the pains are described as "radiating down arm," with accompanying shortness of breath or inability to draw deep breath due to the triggering of "stabbing" pain which "shoots" from solarplexus region up to heart region (deep inside torso). The description include the words "stabbing" and "shooting" with such consistency that it is deemed appropriate to include these words in this information.

While the description of "severe" pain is greatly interesting, most who report chest pain experience a dull, somewhat persistent ache which is frightening but not nearly so dramatic. Many who have the less dramatic experience report at least one serious episode.

5. ABDOMINAL PAIN - Usually described as similar to "gas pains" most of the time. However, it appears that the "solarplexus-stabbing" pain related in "CHEST PAIN" section is present and confuses us as to which seems most likely. Keep in mind that constipation and diahrea are being experienced also.
6. SWEATS - A spell, occurring without warning or apparent common cause, which very nearly always includes ALL of the following:
 - a. Pervasive weakness.
 - b. Nausea.
 - c. Dizziness or Balance loss.
 - d. Profuse perspiration.
 - e. Clamminess.
 - f. Experiencing of hot or cold "flushes."
 - g. Rapid but weak pulse.
 - h. (In some) reduction of field of vision.

This is described as being "on the edge of passing out" with remarkable consistency. On occation, the caller will remark that they could feel their heart pounding through out their bodies. Most also say that it fails, oddly enough, to scare them, as if the experience somehow insulates them from fear. Much like shock, but a doctor should make such decisions.

CAVEAT

7. LOWER BACK PAIN - Described in three basic ways.

- a. Seems muscular.
- b. Seems "more internal"
- c. Seems spinal or skeletal in origin.

Often considered chronic by caller, and in some severely disabling on occasion. Severity fluctuates:

8. FATIGUE - Our best efforts seem to indicate this to be more a chronic problem. Is defined as both beyond what has been previously normal for individual as well as out of apparent relation to exertion.9. JOINT PAIN - Includes joint pain, joint swelling, and joint stiffness. Has been, when severe, capable of immobilizing a person. For some it is the cause of greatly increased absenteeism from work.10. HEADACHES - Most often described as a marked increase in frequency and severity of headaches. Often described as beginning around eye area, or temple area, - some reporting the severity as "blinding" - wives have said, on occasion "he dropped to his knees, held his face at his eyes, and simply began to sob."

We have heard this many times. We believe that it is significant to report many say pain only occurs on one side of head - some of the "symptoms" in this list seem to be related to only one side of the body - but different sides for different people - if a specific side of the body is affected on an individual - most of these problems will occur on that side.

11. IRRITABILITY - Usually identified as a major change from familiar behavior. It is a popular curiosity among those in contact with lots of callers to wonder if this might indicate a loss or decrease in basic coping skills. Callers say it is absolutely beyond what has always been normal for them.12. LOSS OF MEMORY - Again, a marked change in familiar individual behavior. Most appropriate paraphrase is "disruption of immediate recall", or so it seems. The wives of some individuals propose that the information seems not to have been received, therefore, cannot be recalled. The best analogy being the difference between "hearing" and "listening." Some say have become lost driving on their own street.13. SEEING STARS - Usually occurs when arising quickly - but a small number of those reporting "stars" see them while relaxed, watching, television or something equally passive. Many report experiencing this when performing heavy labor, or in conjunction with other "symptoms."14. SLEEP PATTERN DISRUPTION - Many callers report the inability to go to sleep on a reasonable basis. Other complaints include awakening with a start, and finding themselves unable to return to sleep. Wives often report that sleep will be avoided or unattainable for a time, only for sleep to come all at once for long stretches. "First he can't sleep, then nobody can wake him up, for long periods of time."

CAVEAT

15. HEARING - Most commonly described as a loss or decrease in the ability to hear well. In most, ability to hear fluctuates, and in some occurs in one ear more than the other.

A complaint of persistent shrill ringing in the ears, for periods of time, has been added to our list. We have no real information on the number of our callers who would report ringing, due to the lateness of our awareness - (in casual conversation with some of our possible exposure victims, it has been noted as a fairly common experience - and is apparently, not perceived as a "normal" experience.)

16. URINARY - Complaints under this heading may include any or all of the following:

- a. Minor burning at urination.
- b. Having, on occasion, to "force needed urinations.
- c. Rapid appearance and disappearance of "symptoms."
- d. Inconsistent response to medication.
- e. Occasionally experienced strong odor to urine.
- f. Cloudy or dark urine.

17. ALCOHOL INTOLERANCE - Perceived changes in ones ability to consume alcohol. These complaints center on fluctuations in the individual's ability to predict their reaction to alcohol.

Regarding the popular vision of the "overindulgent vietnam veteran," we were truly shocked at the number of callers who report they no longer choose, or are able, to consume alcohol.

It makes some violently ill, when they were able to consume moderate to large amounts of alcohol before vietnam, or assumed exposure to the substances in question.

Some report that as little as one beer can launch them into a considerable state of inebriation.

18. SINUS - Many of those tallied sounded as if they had a bad cold. Upon being asked if they had sinus trouble they reported the emergence of sinus trouble since their time in service.

19. DECREASED SEX DRIVE - This concerns those reporting a significant loss of sexual perspective in the lives. The probability is that the actual number of callers experiencing this is larger than reported. Several of those who allowed their wives to help with the intake had said there was no change in their sexual behavior. Only to be confronted with a very different perspective by their wives.

The drive seems to be, quite simply, absent. Sexual activity is very infrequent for some, sporadic for others, just fine for others.

CAVEAT

20. GASTRIC DISRUPTION - In this category, we have included those who claim periods of a week, to a year or so, of markedly increased heartburn and/or indigestion.

Possibly significant, is the seemingly frequent report of ulcers since Vietnam, or the physicians' perceptions that the stomach and entire small intestine is highly inflamed, or so some of these people have been advised.

Most common response to the question about acidity, etc. has been "eat antacids like candy sometimes, or can't get through the day." It seems to come and go.

21. REDUCED IMMUNITY - These people believe they experience a higher frequency of colds, flu, and general illness. They also perceive they have more difficulty recovering from such illness.
22. THROAT PAIN/SWELLING - This category is for those who feel they have acquired a problem with frequent, (for them,) sore throats, and/or, glandular swelling of the throat. We are unsure of what this should be called for a better more defined explanation. One Medical School Student referred to the glandular swelling as "sub Mandibular non-tender."
23. CHANGE IN BOWEL HABITS - These complaints include periods of increased constipation and/or diarrhea. Callers who complained of such changes in their bowel habits characterize such changes as "not normal for them."
24. AGGRESSION - Again, we are hearing of a noticeable increase in aggression, as a MAJOR CHANGE in the individual's behavior - they say they don't understand their feelings. They, in their own words "can't cope" sometimes. Most common descriptions include an aftermath period of a day or two, during which many grieve for their behavior and discount altogether, any appropriate rationale for such behavior.
25. NOSEBLEEDS - Since Vietnam or other possible exposure to toxic substances, some individuals have had a period of time in which, for no apparent reason, they suffered nosebleeds. Most commonly these people have had a recovery of such problems.
26. WEIGHT LOSS - Spontaneous loss of weight has been reported by some. In some cases this is a result of one to three days of a revulsion to food. In some of the "revulsion" people, attempts at food intake were met with vomiting or intense nausea. However some report the loss of weight to have occurred without changes in daily routine or food intake.

CAVEAT

27. SMELL - This refers to loss of smell. Loss of smell is extremely difficult to determine during extended phone intake. As our most productive approach, we asked the caller if they had ever experienced the inability to perceive odors or fragrances which others in the room had commented on. Many disclaimed such inability as a fault of sinuses trouble. Some said they smoke cigarettes too heavily to trust it as a possible effect of "AGENT ORANGE." Others said loss of the ability was occasional, and still others, chronic.
28. CONFUSION - Again, beyond what the individual perceived "normal" for them. While we cannot be certain of the accuracy of the statement, we felt there was a very general consensus that this refers to an inability to cope with an event. Perhaps this is the quasi-panic that one feels under great stress when no options appear to exist and the circumstance is intolerable. A blanking of productive thought.
29. MISCARRIAGES - Self evident, since vietnam duty or other potential exposure.
30. TASTE - Difficulty or inability to taste is another problem with definition - too subjective. We chose to ask a qualifying question: "Do you need to heavily season your food?" - most wives who said their husbands might have taste impairment were emphatic - no matter the amount of seasoning - further seasoning seemed necessary on foods.
31. CHANGE IN, OR LOSS OF, TOENAILS - Some report the loss of toenails and/or fingernails while in vietnam or since possible exposure. Many who say they've never actually lost any without obvious reason they have dramatically changed in appearance. Commonly reported are the following: thickening, yellowing or other obvious color change brittleness, or easy splitting/ usually diagnosed as fungus, but sometimes amazes and confuses doctors.
32. CHANGES IN HAIR - Some report circular bald spots, ranging in size from dime to silver dollar size. Our question allowed for (1) scalp hair, (2) facial hair, (3) body hair. These bald spots recover their hair. Reports have included a black mans bald spots growing back with a very different texture, or loss of the mustache on half of the lip, which grows back, similar to the remaining half mustache, but never quite matching exactly. The body hair was reported the least. Often reported was the sudden graying of the hair at some point, usually in the last five years. Many report receding hairlines, but we have no figures on it.

CAVEAT

33. DEPRESSION - Most don't wish to talk of such problems. In those reporting depression, it was largely agreed that the depression had frightened them by its intensity. Due to the nature of the phone call intake and some "mechanical problems" with the count, we discount the 20% figure. We speculate that the figure is higher, and that the depression may be occurring in a come and go manner as do some of the other "symptoms".
34. LOSS OF APPETITE - See weight loss # 26.
35. FAINTING - Mostly, self evident we, on occasion heard the report that people knew they would pass out, but that it was never in time to act. Length of time unconscious varies from a split second to hours.
36. TREMORS - The same as the shakes. Involuntary twitching or shaking. Like a "brush with convulsions," doctors who have used muscle relaxants are reported.
37. EMERGING ALLERGIES - Allergic reactions to some substances, which have surfaced since vietnam duty or other possible exposure.
38. IMPOTENCE - A few felt this was possibly due to age! It varies in seriousness.
39. CHANGE, OR LOSS OF, FINGERNAILS - See Toenails #31.
40. UNEXPLAINED FEVER - Self evident/sometimes occational, sometimes chronic.
41. RESPIRATORY - Difficulties with the respiratory system.
42. SPEECH PROBLEMS (ADULT) - This complaint was in regard to a man who now stutters but never has before.
43. SKIN TUMORS - The development of fatty skin tumors is seen with more clarity if entire contact file is reviewed. Also, the appearance of boils or cystes is a fairly frequent complaint. A core is present which is some times possessed of a foul odor.
44. WEIGHT GAIN - Many said they had gained weight since returning from the service. Fewer felt they had gained weight since "symptoms" onset.
45. INCREASED SEX DRIVE - A rarity. Many, however, report no perceivable change in sexual behavior.

BIRTH DEFECTS AND OTHER REPORTED PROBLEMS IN OFFSPRING OF VETERANS

TOTAL CONTACTS AT TIME OF TALLY - 607
 FULL INTAKES REPORTED - 55
 DEFECTS REPORTED (ALL CONTACTS) - 89

Finger/Hand deformities	7	Genital Deformities	4
Heart Murmur	7	No Eustachian Tube	1
Wall of heart missing	1	Ear Deformities	2
Congenital heart disease	1	Enlarged Brain	1
Two holes in heart	1	Open Spine	2
Heart dysfunction	1	Bladder Cancer	1
Blood diseases	2	Underdeveloped Muscles in the Shoulders	1
Deformities of chest	2	Born without the Neckbone	1
Cleft palate	1	Synovitis	2
Toe/Feet deformity	20	Missing part of Chromosome	1
Kidney "problems"	9	Numbness & Tingling in their Extremities	4
Spinal defects	3		
Stomach disorders	5		
Ruptured abdomen	1		
"Down's Syndrome"	1		
Meningitis	1		
Lacking antibodies	1		
Cataracts at birth	1		
No sweat glands	1		
Joint Problems	3		

AGENT ORANGE is a 50-50 mixture of 2,4-D, and 2,4,5-T, two commonly used herbicides.

AGENT ORANGE was intended for use by the US Military In Vietnam as a means of defoliating jungle and destroying crops which were presumed a vital food source for the enemy.

Tests performed on unused 55 gallon drums of the defoliant showed the presence of 2,3,7,8 - TETRACHLORODIBENZO - PARA - DIOXIN, (DIOXIN), in amounts of 3 parts per million to 50 parts per million. Dioxin is considered to be "one of the most toxic substances known to man."

Long-term health effects of DIOXIN exposure are generally unknown and substantially untested.

In the last two years a very disturbing event has been replayed in various cities around the world. Those who were in a position to be in contact with AGENT ORANGE have been experiencing varied forms of physical and mental dysfunction since exposure. Traditional medical analysis and treatments have proven substantially inadequate for resolution of their problems.

Only when certain individuals publically announced the symptoms of dioxin poisoning, in the belief that US Servicemen/Women had been exposed, did the calls begin. Large numbers of people have now reported a wide variety of problems which are the same substantial complaints across the calling population. Systems announced publically are only the tip of a growing symptom list. The only common factors appear to be the sharing of the same physical and mental problems - and - the sharing of probable exposure to AGENT ORANGE or one of it's components.

Those close to the issue claim cancer, birth defects, and various other forms of debilitating or life threatening illness can be caused by exposure to 3 to 5 parts per trillion.

JON R. FURST

CAVEAT INC.

(Concerned American Veterans Against Toxins, Inc.)

Mr. GORE. Mr. Lent.

Mr. LENT. I would like to ask, Mr. Muller, if you could tell us what prompted your organization to undertake this study of agent orange or the outreach program instead of relying on the VA?

Mr. MULLER. We tried to get the VA to do it. We did not have the resources, we did not have the ability to do it at all. The only reason that we went into the void was to fill it. The need is there.

Let me be honest in my personal evolution, if you wish, on the issue of agent orange. I always regarded casualties in Vietnam to be the people that I knew in the hospitals, the ones that were shot up, blown away, blood and guts, and that was it. When I heard first about agent orange, I thought it was a bunch of environmentalists looking to grab a headline. I was really disbelieving the whole thing. What happened was we started getting calls into our offices. A pattern started to develop in what people were saying. Two and two started to fall together, and what I at first was very skeptical of, I became a personal convert to. What I think put the icing on the cake for me was when we had veteran after veteran after veteran coming in who was fine before they went into the service, have an exposure incident in Vietnam that they recalled, come back and have the same pattern of problems and also having children that were born with birth defects when, in quite a few cases, the same people had children before they went to Vietnam and they were fine and every attempt subsequently resulted in either a spontaneous abortion or a child with birth defects of some sort.

The need to fill the gap in terms of information, the need to get the word out there, is why we basically undertook the effort.

Let me just say on a related matter, with the readjustment counseling program, what we are seeing is what we have known. There are a lot of people out there who because they walked away from Vietnam and did not want to relate to it, did not want to think about it, just did not want to hear about it, went about their life.

You can talk to a veteran and say what your experience is, with a sense of emotional problems, or as we also know now with agent orange, to let them know that they are not alone. To let them know that, hey, it is not just you, you are not unique, understand that there well may be a basis for your problem.

That has done so much to help people. We have seen it over and over and over again when the light goes on and the association is made and they understand that it is not just them, it is helpful. That is why we undertook the outreach program.

Mr. LENT. OK. Now you are urging that the VA establish a presumption of service connection for cases of chloracne. Are there any precedent that you are aware of for such action in other VA operations?

Mr. MULLER. There are quite a few. The one I think most notably that we testified to last year, because of my work with the paralyzed veterans, was in the area of multiple sclerosis. MS is a disease that has no basis of understanding in science. Doctors, the military community, do not understand why MS happens, what causes it, when it is brought on, or whatever.

What the Veterans Administration did was that they said, in law now, any veteran that manifests any symptoms of MS, however slight or remote, up to 7 years after the veteran has been discharged and left the military, will be presumed, as a matter of law, to be service connected for MS.

Mr. LENT. Can you think of any others?

Mr. CHAMPLIN. Congressman, let me say that the MS was done by legislation. We think they can do this administratively. We believe they can do it without authorizing legislation because they acted in the last few years to administratively create a presumption for certain cardiovascular problems that appear in people who have severe amputations. They did that administratively. If you meet the amputation criteria and you meet the right kind of cardiovascular problem, then that cardiovascular problem is presumed to be the result of the original amputation.

So there appears to be the existing authority to allow them to proceed administratively on this. There certainly are—the framework in statute, because there are some 40-some presumptions already in the code.

Mr. MULLER. I was going to add to what he said. I think there are approximately 40 presumptions on disability compensation presently practiced by the VA. What we could do is give you a comprehensive listing of all of them.

Mr. LENT. I wanted to get an idea. If you tell me there are 40, we will go with that.

Mr. MULLER. I would like to throw another point in here. The presumption is a rebuttable presumption. If at any point the Government can come in and say that what we have assumed now to be related to your military service, because we could not explain it any other way is not and we now know why it is not, then that service connection presumption is reversed.

Mr. LENT. OK.

Mr. GORE. Will the gentleman yield? I would like to ask you to supply for the subcommittee, if you could, the list of 40 and we will give the Veterans Administration an opportunity to comment on them.

I also wanted to note that the cardiovascular presumption you refer to, as I understand it, was based upon one National Academy of Science study which has as yet not been confirmed. By comparison, there are numerous studies in this area which provide a base of scientific data far more comprehensive than the scant evidence that was used as the basis of a presumption in the case you mentioned.

Mr. CHAMPLIN. That is right on point, as we would say. If you applied the burden of proof that was used in the cardiovascular administrative process, if you applied that same standard of evidence and the same requirements to the existing agent orange data, you might be able to help an awful lot of people.

Mr. GORE. Thank you for yielding.

Mr. LENT. Mr. Furst, I have a couple of questions.

You say on page 3 of your testimony that the Vietnam veterans are ill in increasing numbers and this is an assertion that seems to be repeated throughout your testimony.

What information do you have that would indicate or would substantiate this view that Vietnam veterans are experiencing greater than normal health problems?

Mr. FURST. In the St. Louis area I myself have spoken in the last 18 months to over 1,000 veterans. Many of them for great lengths of time individually. I have spoken at great lengths of time with their parents, with their family members, their wives. Bobby Muller just told you his group is aware of over 10,000 people in the country who are concerned because of their own health problems.

Mr. LENT. What I am asking you is, Is there some medical evidence, scientifically arrived at, that Vietnam veterans, as a body, have a greater incidence of health problems than non-Vietnam veterans? Is there anything that has been developed along those lines?

You say this or asserting this in your testimony. I wondered, other than your own feelings or your own concepts of this, is there anything to back it up?

Mr. FURST. The task force has 25 member groups. We are collecting information from many, many veterans at this point. Now I am not a scientist. I cannot provide you with scientific testimony.

Mr. LENT. There is no control group you are measuring against?

Mr. FURST. Well, no, I do not believe if you are aware of the numbers that we are aware of that you would think people in the 25 to 35 age group would be experiencing the kind of disabilities and the rate of cancer death that we are seeing. I am not a scientist, but I would expect if borne out by scientists that we are quite right.

Mr. LENT. I thought maybe something had been written in one of the medical journals or some study had been made.

Mr. FURST. There are studies being made now. Part of what I have tried to offer the committee is what we have tried to offer the scientific community before, to ask them the scientific significance of it.

Mr. LENT. For example, we know people who smoke cigarettes have a higher incidence of lung cancer than nonsmokers. This has been developed. I wondered whether there had been any—whether you were able to cite any medical study that would bear out the assertion that you seem to make in your testimony continually that Vietnam veterans, as a group have much greater health problems than do nonveterans?

Mr. FURST. In 18 months, from personal observation, and from studying information from the scientific community, from access to information that is available in the public realm, we have come to the opinion that most of the people we have seen who are concerned about exposure to agent orange and other chemicals are severely disabled. I do not speak to you of someone who appears severely disabled necessarily, but a carpenter who cannot hold a hammer, a man who drives a truck who cannot trust his sense of balance or his vision cannot earn a living. From that standpoint of disability, I will stand by my allegations that they are disabled.

Mr. LENT. OK. On another question, at page 6, you indicated that the ranch hand personnel who had the most direct exposure to agent orange, the Air Force personnel, are displaying fewer than

expected adverse health effects from their experience. How—have you been able to determine why this might be so?

Mr. FURST. Only layman's logic, but I believe it is very persuasive. We have talked to ranch hand personnel who are experiencing problems. The degree of ailment, the severity of the ailments does not seem to be as apparent, as it is in certain other job groups.

Now the layman's logic that I mentioned is this: We know that dioxin results in the manufacture of the substance because it is heated, and we know that even the final substance, if further heated, will yield more and more dioxin.

We are in touch with truck drivers, we are in touch with combat engineers; and as a for instance, let me take combat engineers. Combat engineers often report to us that they sat off to the side of proposed landing zones in bulldozers waiting to clear them, while the landing zones were sprayed by C-130's with herbicides. They then moved in, with the herbicides wet on the leaves, bulldozed the foliage down, and burned it. It burned for days. They built the bases in the smoke, and they are experiencing a wider range of ailments, a greater severity to their ailments. They were not able to wash as were the ranch hands. They were often living in the clothes that were contaminated with that smoke and with that spray for months.

It seems to us again, sir, from laymen's logic, that that is an awfully large probability, that there is a connection with that.

Mr. LENT. You seem to have a feeling that the Air Force should not be involved in conducting this study of agent orange. Let me ask Mr. Muller, is your organization, the Vietnam Veterans of America, in agreement with Mr. Furst's organization?

Mr. MULLER. I have to think that the Air Force is capable of doing a ranch hand study. I have confidence in the people that are there, and I think that it can be done. I am not ready to—for reasons of a lot of the past feeling that many of us have had about the military et cetera—to dismiss that.

The facts should be remembered here, too, that there are independent peer review committees that will be part of that process; and I think that the integrity of the process can be maintained with confidence.

Mr. FURST. If I may respond?

Mr. LENT. Surely.

Mr. FURST. In my statement, I mean not at all to imply that the Air Force is scientifically incapable. That is not what I mean.

The idea has been to provide a study in answer to the Vietnam veterans which they will believe. The National Academy of Sciences, agrees with us, that under the present circumstances the veterans are unlikely to believe the Air Force, whether their study is well done or not. In the best interests of the veterans, and because we feel that the Air Force has demonstrated its inability to control its information and demonstrate the credibility of its information. Be that ongoing or not, the veterans have reason now to not believe it, whether it is valid or not; and I do not propose that they not conduct the study, because I think they are unable.

Mr. LENT. Mr. Chairman, I have no further questions at this time.

Mr. GORE. Let me try to get a handle on this, just from a viewpoint of somebody who is concerned and is confronted with what you said was not a seamless web but nevertheless is difficult to penetrate.

It seems to me that the real problem is dioxin. Am I going wrong there?

Mr. FURST. Possibly.

Mr. GORE. Possibly? We do not know?

Mr. FURST. It is the most appropriate focus, but we cannot discount 2,4-D which was part of agent orange and we should not discount out of hand the other agents that were there. The most probable focus, I think, is dioxin. Would you agree?

Mr. MULLER. Dioxin, in our review, our opinion, based upon an assessment of all the information that is available, is a clear problem. It is the cause of what we now know to be concerns in the Vietnam veteran community. We do not believe it is exclusively the cause. There very probably are other factors that went with Vietnam service that have added to the problem. You have heard about a lot of them many times. Even Dabzone although it is very speculative, which were the antimalarial pills that were given is considered possibly a carcinogen. It is considered a factor in granular cytolysis, especially with minority groups. We had our guys down in the platoons with FUO, fever of an unknown origin. I am still impressed by the fact that jungle rot, who knew what it was, who knew how to treat it? Every corpsman we talked to had a different kind of remedy. None of that should diminish or mitigate the seriousness of dioxin as what should be the focus of the study.

Mr. GORE. Let us focus on dioxin just for the moment. There may be a lot of other substances to which Vietnam veterans were exposed that also ought to be examined; but let us assume for the moment that the principal culprit here is the dioxin which was present in much of the agent orange used in Vietnam. It seems to me you have got four areas of uncertainty, each one of which causes some people to turn away from the problem and say this is too complicated, we cannot possibly come to any positive answers on this.

The first area of uncertainty is the amount of dioxin in the particular batch of agent orange that was used. We know that the early batches of agent orange used, in the early years of the war, were far more heavily contaminated with dioxin than later on. Indeed, in the first years of the war, it was used in an undiluted way. Those who were in close proximity to those batches of agent orange are in a high risk category; am I right there?

Mr. MULLER. As I understand, you are.

Mr. GORE. Now the second area of uncertainty is the number of veterans who were exposed to agent orange. Now how many Vietnam veterans are there totally?

Mr. MULLER. That served in Vietnam, 2.8 million.

Mr. GORE. Well, now, when I served in Vietnam, out walking through areas that were jungle and grassed and so forth, you had no idea as the average soldier whether it had been sprayed or not. But I have to assume that it was not sprayed, because you did not see skeleton-like trees and so forth. So I operate on the assumption that I was not really exposed to agent orange. I have believed that

most of the veterans of the Vietnam war were not exposed to agent orange.

So we are talking about a discrete subset of Vietnam veterans who were exposed to agent orange; is that a fair assumption?

Mr. MULLER. Probably.

Mr. GORE. We do not know how large that subset is. We do not know how many Vietnam veterans were exposed to it, but it seems to me fair to assume that when referring to those who were exposed in a massive way, we are talking about a relatively small percentage of Vietnam veterans. And we do not know that to be the case; we find other groups besides those who actually handled it. We find the ones you talk about who built things in the smoke immediately after the spraying. So we know there is a group of people out there who were exposed.

The reason I say that is a second area of uncertainty is a lot of people look at this problem and they trust their own perception of the Vietnam veterans that they know and they know a lot of them and they think, well, you know, some of these fellows are off base. I know a lot of Vietnam veterans. Most of them do not seem to be suffering from anything like this. So this is another area of uncertainty that needs to be cleared away.

Also, we know—going back to the first area of uncertainty—some people who were in proximity to agent orange that do not have such symptoms. These are the first two areas of uncertainty. No. 1, the batches that were heavily contaminated; No. 2, the subgroup of veterans that were heavily exposed.

Now we have the third area of uncertainty, which is the causation. This is the tough one. We have animal studies on dioxin that are conclusive as to what the effects are on animal populations. We have a well accepted scientific procedure which extrapolates the results of animal studies to human beings. There are uncertainties involved in that logic and that is one of the areas of uncertainty that gives the VA problems and gives many Americans problems.

But we have enough circumstantial evidence there to assume, without going out on a limb, in a pretty credible way that human beings exposed to dioxin can expect to experience severe health problems in the form of cancer, all of the health effects like chlor-acne, and that they can expect that a certain percentage of them will experience birth defects in their offspring.

Now the fourth area of uncertainty is the diagnostic evidence. I think a lot of Americans believe that some people will come in and attribute problems that may well have been caused by something else, for instance, exposure to some other substance, to their Vietnam service. Now we can say that they are just turning their backs, but the fact of the matter is that you know and I know that there will be some such instances. We cannot allow that to keep us from recognizing the fact that through all of these areas of uncertainty, there remains a significant number of Vietnam veterans who were exposed to agent orange contaminated by dioxin, a substance which definitely does cause serious health problems.

Now that group of people needs help, and they are not getting it.

Mr. MULLER. No, sir.

Mr. CHAMPLIN. That is an impressive worst case argument. In other words, what it is, you are saying there are a lot of uncertain-

ties; the problem may be larger than we know; but if we approach each uncertainty and we assume it is the most conservative of the range in the uncertainty, and proceed through the uncertainties to the most conservative sum effect, we still have a problem here. If we bracket all the doubts, we still have a problem here, yes.

Mr. GORE. In the Congress if we are going to come up with a solution to this problem, we are going to have to approach it on that basis. We are going to have to recognize that reasonable people looking at all the uncertainty that surrounds this problem are going to turn their heads and say that it is too confusing, that there is too much uncertainty. We have to work on a worst case basis and taking the worst case approach, we still have a significant group of people.

In order to reduce the amount of uncertainty, you are recommending a change in approach to adopt an outreach program, to gather more evidence from the human beings, the veterans who believe they were exposed and believe that their health problems were caused by this exposure; is that correct?

Mr. MULLER. Absolutely.

Mr. GORE. The VA currently does not conduct such an outreach, is that correct?

Mr. MULLER. Yes.

Mr. GORE. Why not?

Mr. MULLER. That you really have to pose to Max Cleland. I think the answer that he has given us is that he feels uncomfortable in alarming people about a problem that he is sufficiently convinced might exist. That is his answer; at least it has been.

Mr. GORE. OK. We will ask him. He is going to be in shortly.

[Testimony resumes on p. 76.]

[The following letter and attachments were received for the record:]

VIETNAM VETERANS OF AMERICA

212 FIFTH AVENUE, ROOM 703-NEW YORK, NY 10010 • 212/685-3152

SUBCOMMITTEE
OVERSIGHT & INVESTIGATIONS

October 9, 1980

RECEIVED

OCT 10 1980

The Honorable Bob Eckhardt
Chairman, Subcommittee on Oversight and Investigation
House Interstate and Foreign Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

Dear Mr. Chairman:

Thank you again for the opportunity to appear before the Oversight and Investigation Subcommittee during its hearings on Agent Orange.

Responsive to Congressman Gore's request, I have enclosed copies of Section 301 through 313 of Title 38, United States Code (Appendix A). These sections constitute the core statutory framework governing the existing "presumptions" of service connection.

Section 301 (3) lists forty (40) "chronic diseases" presumed, if they appear within the appropriate statutory time frame, to be service connected. Subsection 301 (4) contains a list of seventeen (17) "tropical diseases" similarly presumed to be service connected. In addition, Subsections 312 (a) (3) - (5) contain special provisions for "active tuberculous disease," "multiple sclerosis," and "Hansens's disease." Subsection 312 (c) contains further special presumptions for "psychosis" and for "nutritional diseases" including, but not limited to six (6) enumerated diseases.

Responsive to the direction of Congressman Gore's questions, I have also included two additional submissions.

The first (Appendix B) consists of the literature review conducted by the VA in determining to grant service connection for veterans with certain amputations who subsequently develop certain cardiovascular disorders. As the literature review makes clear, the National Academy of Science study, which did find a limited correlation, followed several studies that found no correlation.

In reviewing those studies, the VA concluded, at page 5:

The evidence presently available does not support a statistically significant link between atherosclerotic cardiovascular disease and amputation.

The point is not that the VA made an inappropriate inference. Rather, the concern is why, given this precedent, the VA continues, as exemplified in their testimony before your subcommittee, to use the apparently

The Honorable Bob Eckardt
page 2

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negative findings in the one (1) Zack and Zuskind study to dismiss, for policy purposes, the positive findings in the three (3) Swedish studies.

The second (Appendix C) consists of PL 87-645 which enacted the "presumption" for multiple sclerosis and the relevant sections from the Senate Report. The Congress, as well as the VA, is responsible for acting. This material on the presumption for multiple sclerosis goes to Congress' duty.

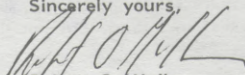
Note that the VA opposed the enactment of a presumption, as it opposes one now. Note also that the Department of the Army also goes to some efforts to separate themselves from the impact of any presumption. Nevertheless, the Senate, for example, acted on the basis of only one paragraph of discussion.

Of course, any bad past public policy would not require bad present public policy. But the multiple sclerosis legislation, with its almost total lack of documentation, does show that Congress responds more to its feelings about veterans than to the shape of the science.

That seems to confirm the deep feeling among Vietnam veterans that their case is being denied not because the evidence is lacking, but because the strong dislike of Vietnam veterans in certain Congressional circles has overcome the evidence that does exist. Where in the past sentiment helped, now it hurts.

The tragedy is that, I think, Vietnam veterans do not ask for help from sentiment. They are prepared to live with the evidence.

Sincerely yours,



Robert O. Muller

ROM/sa

APPENDIX A**CHAPTER 11—COMPENSATION FOR SERVICE-CONNECTED DISABILITY OR DEATH****SUBCHAPTER I—GENERAL**

Sec.

201. Definitions.**202. Special provisions relating to surviving spouses.****SUBCHAPTER II—WARTIME DISABILITY COMPENSATION****210. Basic entitlement.****211. Presumption of sound condition.****212. Presumptions relating to certain diseases and disabilities.****213. Presumptions rebuttable.****214. Rates of wartime disability compensation.****215. Additional compensation for dependents.****SUBCHAPTER III—WARTIME DEATH COMPENSATION****221. Basic entitlement.****222. Rates of wartime death compensation.****SUBCHAPTER IV—PEACETIME DISABILITY COMPENSATION****231. Basic entitlement.****232. Presumption of sound condition.****233. Presumptions relating to certain diseases.****234. Rates of peacetime disability compensation.****235. Additional compensation for dependents.****237. Wartime presumptions for certain veterans.****SUBCHAPTER V—PEACETIME DEATH COMPENSATION****241. Basic entitlement.****242. Rates of peacetime death compensation.****SUBCHAPTER VI—GENERAL COMPENSATION PROVISIONS****251. Benefits for persons disabled by treatment or vocational rehabilitation.****252. Persons heretofore having a compensable status.****253. Aggravation.****254. Consideration to be accorded time, place, and circumstances of service.****255. Authority for schedule for rating disabilities.****257. Combination of certain ratings.****259. Disappearance.****259. Protection of service connection.****260. Special consideration for certain cases of blindness or bilateral kidney involvement or bilateral deafness.****261. Payment of disability compensation in disability severance cases.****262. Clothing allowance.****Subchapter I—General****§ 201. Definitions****For the purposes of this chapter—****(1) The term "veteran" includes a person who died in the active military, naval, or air service.****(2) The term "period of war" includes, in the case of any veteran—**
(A) any period of service performed by such veteran after November 11, 1918, and before July 2, 1921, if such veteran served in the active military, naval, or air service after April 5, 1917, and before November 12, 1918; and**(B) any period of continuous service performed by such veteran after December 31, 1946, and before July 26, 1947, if such period began before January 1, 1947.**

(3) The term "chronic disease" includes—

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
 Myasthenia gravis
 Myelitis
 Myocarditis
 Nephritis
 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, of the brain or spinal cord or peripheral nerves
 Ulcers, peptic (gastric or duodenal)

and such other chronic diseases as the Administrator may add to this list;

(4) The term "tropical disease" includes—

Amebiasis
 Blackwater fever
 Cholera
 Dracontiasis
 Dysentery
 Filariasis
 Hansen's disease

Leishmaniasis, including kala-azar

Loiasis

Malaria

Onchocerciasis

Oroya fever

Pinta

Plague

Schistosomiasis

Typhus

Yellow fever

and such other tropical diseases as the Administrator may add to this list. (Amended P.L. 94-433, §§ 401(2), (3), § 404(1).)

§ 305. Special provisions relating to surviving spouses

(a) No compensation shall be paid to the surviving spouse of a veteran under this chapter unless such surviving spouse was married to such veteran—

(1) before the expiration of fifteen years after the termination of the period of service in which the injury or disease causing the death of the veteran was incurred or aggravated; or

(2) for one year or more; or

(3) for any period of time if a child was born of the marriage, or was born to them before the marriage. (Amended P.L. 86-491; P.L. 90-77, § 101(a); P.L. 94-433, § 404(2).)

(b) Subsection (a) shall not be applicable to any surviving spouse who, with respect to date of marriage, could have qualified as a surviving spouse for death compensation under any law administered by the Veterans' Administration in effect on December 31, 1957. (Amended P.L. 94-433, § 404(3).)

Subchapter II—Wartime Disability Compensation

§ 306. Basic entitlement

For disability resulting from personal injury suffered or disease contracted in line of duty, or for aggravation of a preexisting injury suffered or disease contracted in line of duty, in the active military, naval, or air service, during a period of war, the United States will pay to any veteran thus disabled and who was discharged or released under conditions other than dishonorable from the period of service in which said injury or disease was incurred, or preexisting injury or disease was aggravated, compensation as provided in this subchapter, but no compensation shall be paid if the disability is the result of the veteran's own willful misconduct.

§ 311. Presumption of sound condition

For the purposes of section 310 of this title, every veteran shall be taken to have been in sound condition when examined, accepted, and enrolled for service, except as to defects, infirmities, or disorders noted at the time of the examination, acceptance, and enrollment, or where clear and unmistakable evidence demonstrates that the injury or disease existed before acceptance and enrollment and was not aggravated by such service.

§ 312. Presumptions relating to certain diseases and disabilities

(a) For the purposes of section 310 of this title, and subject to the provisions of section 313 of this title, in the case of any veteran who served for ninety days or more during a period of war—

(1) a chronic disease becoming manifest to a degree of 10 per centum or more within one year from the date of separation from such service;

(2) a tropical disease, and the resultant disorders or disease originating because of therapy, administered in connection with such diseases, or as a preventative thereof, becoming manifest to a degree of 10 per centum or more within one year from the date of separation from such service, or at a time when standard or accepted treatises indicate that the incubation period thereof commenced during such service;

(3) active tuberculous disease developing a 10 per centum degree of disability or more within three years from the date of separation from such service;

(4) multiple sclerosis developing a 10 per centum degree of disability or more within seven years from the date of separation from such service;

(5) Hansen's disease developing a 10 per centum degree of disability or more within three years from the date of separation from such service;

shall be considered to have been incurred in or aggravated by such service, notwithstanding there is no record of evidence of such disease during the period of service. (Amended P.L. 86-187; P.L. 86-188; P.L. 87-645, § 3.)

(b) For the purposes of subsection (c) of this section, any veteran who, while serving in the active military, naval, or air service, was held as a prisoner of war for not less than six months by the Imperial Japanese Government or the German Government during World War II, by the Government of North Korea during the Korean conflict, or by the Government of North Korea, the Government of North Vietnam or the Viet Cong forces during the Vietnam era, or by their respective agents, shall be deemed to have suffered from dietary deficiencies, forced labor, or inhumane treatment in violation of the terms of the Geneva Conventions of July 27, 1929, and August 12, 1949. (Added P.L. 91-376, § 3(a).)

(c) For the purposes of section 310 of this title and subject to the provisions of section 313 of this title, in the case of any veteran who, while serving in the active military, naval, or air service and while held as a prisoner of war by an enemy government, or its agents during World War II, the Korean conflict, or the Vietnam era, suffered from dietary deficiencies, forced labor, or inhumane treatment (in violation of the terms of the Geneva Conventions of July 27, 1929, and August 12, 1949), the disease of—

- (1) Avitaminosis,
- Beriberi (including beriberi heart disease),
- Chronic dysentery,
- Helminthiasis,
- Malnutrition (including optic atrophy associated with malnutrition),

Pellagra, or
Any other nutritional deficiency,
which became manifest to a degree of 10 per centum or more
after such service; or

(2) Psychosis which became manifest to a degree of 10 per
centum or more within two years from the date of separation
from such service;
shall be considered to have been incurred in or aggravated by such
service, notwithstanding that there is no record of such disease during
the period of service. (Added P.L. 91-376, § 3(a).)

§ 312. Presumptions rebuttable

(a) Where there is affirmative evidence to the contrary, or evidence to establish that an intercurrent injury or disease which is a recognized cause of any of the diseases within the purview of section 312 of this title, has been suffered between the date of separation from service and the onset of any such diseases, or the disability is due to the veteran's own willful misconduct, service-connection pursuant to section 312 of this title will not be in order.

(b) Nothing in section 312 of this title or subsection (a) of this section shall be construed to prevent the granting of service-connection for any disease or disorder otherwise shown by sound judgment to have been incurred in or aggravated by active military, naval, or air service.

APPENDIX B

96th Congress }
1st Session }

SENATE COMMITTEE PRINT NO. 6.

CAUSAL RELATIONSHIP BETWEEN SERVICE-
CONNECTED AMPUTATION AND SUBSEQUENT
CARDIOVASCULAR DISORDER: A REVIEW OF
THE LITERATURE AND A STATISTICAL
ANALYSIS OF THE RELATIONSHIP

STUDIES

SUBMITTED BY THE

VETERANS' ADMINISTRATION

(Pursuant to Section 403 of Public Law 94-433)

TO THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE



FEBRUARY 15, 1979

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AMPUTATIONS OF EXTREMITIES AND CARDIOVASCULAR DISEASE

(By Richard A. Ryder, M.D.)

In accordance with Public Law 94-433, section 403(b), a comprehensive review and professional analysis of the subject of traumatic amputations of extremities and cardiovascular disorders has been undertaken. These results will be presented in a format which will analyze specific studies individually and then analyze coronary artery disease risk factors as they might be related to amputations. The studies are not arranged in order of importance but in an order which will allow maximal utilization of data from previous studies to analyze subsequent studies.

I. MINISTRY OF PENSIONS AND NATIONAL INSURANCE—ULTIMATE CONCLUSIONS OF THE ADVISORY COMMITTEE ON CARDIOVASCULAR DISORDERS AND MORTALITY RATES IN AMPUTEES [1]

On January 22, 1953, the conclusions of an extensive British study were submitted to the Director General of Medical Services, Ministry of Pensions, by E. Rock Carling, the Chairman of a nine-man Committee who responded to a request to "consider whether limb amputations and the wearing of a prosthesis predisposed amputees to cardiovascular disorders, and whether, by reason of amputation, their mortality rates differed from the normal for equivalent age and sex groups." This report, which was to adopt the name of its Chairman, "The Rock Carling Study", was further revised in November of 1954 when the "ultimate conclusions" of the Advisory Committee was submitted. This study was done in two parts.

First, from 27,000 amputees from the "1914 War", an investigation was carried out of one in three of the deaths, and compared to both leg wounds without amputation for the same war and the general population. Their results showed that of the amputees alive in 1930 there were 12.6 deaths per 1,000 amputees between 1939 and 1950. This compared to an 11.4 per thousand mortality for sex and aged matched controls from the general population. When the group who suffered wounds but did not have amputations were compared to their age and sex matched controls from the general population, the annual mortality per thousand was 13.15 as compared to 11.9 per thousand for controls.

Their final conclusions are as follows:

Limb amputations, and the subsequent wearing of a prosthesis, do not, in time, produce effects on the body as a whole which may initiate or aggravate cardiovascular disorders to any significant extent.

There is no material difference between the mortality rates of amputees, by reason of amputation, and that of the corresponding rates for pensioners who have suffered wounds not leading to amputations. Such excess as there is in both classes over that in the general population is quite small.

The second aspect of this study was to examine 4,500 amputees. These results were to be compared with 1,000 nonamputee pensioners who were to serve as controls. These results were "regrettable" and did not provide statistically significant evidence because "considerable numbers" of the amputees did not come for the examination. "So far as it goes the evidence obtained discloses no excess of high blood pressure among amputees and no material excess of cardiovascular disease."

II. A MULTIDISCIPLINARY STUDY OF LONG TERM ADJUSTMENT TO AMPUTATION [2]

In 1965 Nathan and Davidoff published the results of a study performed through the Outpatient Clinic of the Boston Veterans' Administration Hospital. They interviewed and examined two hundred thirty amputee veterans. The length of the study and followup is not given, but it appears to be a one-time encounter. The large majority of those examined were World War II veterans but there were twenty-one World War I and twenty Korean War veterans. The final sentence is:

The loss of a limb and the wearing of a prosthesis do not shorten the longevity of the amputee.

This statement appears to be based on the fact that twenty World War I amputees had survived an average of 70½ years. There are no controls for comparison and no long term followup of a large group of amputees to determine the number of deaths. Obviously, the conclusions this study draws about longevity of amputees is highly suspect.

III. CAUSES OF DEATH IN A SERIES OF 4,738 FINNISH WAR AMPUTEES [3]

Bakalin examined the records of the State Insurance Department of Finland and presented the causes of death from a total of 4,738 World War II amputees. He states:

The purpose of this study was to find out whether death from degenerative cardiac and vascular disease is more common among amputees than in the general population.

He found that the mortality rates of the amputees and the general population "was found to be in good agreement," when no division as to cause of death was made. However, when causes of death were differentiated, there was a 63.1 percent greater death rate in amputees than the expected death rate in the general population for degenerative cardiac and vascular diseases. Increased rates were also found for degenerative diseases of the central nervous system and for suicide. The reason the total death rates were comparable is that the higher rates for cardiac, cerebral and suicide deaths were offset by lower rates for pulmonary tuberculosis and malignant diseases.

When the figures are examined closely several problems arise. First, there appears to be a striking number of young cardiovascular deaths. When the statistics are broken down by cause of death in five-year age group intervals from age 20 to 85, one finds that 24 of the total 219 cardiac and vascular deaths occurred in amputees 39 years old or younger. When the deaths were compared to the general population, there was a 193.2 percent increase over the expected death rate from age 25-44 years as compared to a 38.9 and 28.6 per-

cent increase from ages 45-64 and 65-74, respectively. This can be explained by the fact that of the total of 687 deaths, 44 were before 1945; i.e., during the war, and that the deaths from pulmonary infarction and peripheral embolism are considered under the heading of degenerative cardiac and vascular diseases. It does not seem at all surprising to find an increased death rate if one includes the acute hospitalization period and thereby compares bedridden postoperative patients to normal controls.

Secondly, the comparison of a military population with a control group from the general population is introducing another variable. In the "Rock Carling Study" [1] a wounded, nonamputee control and the amputee population were compared to the general population. Both combat groups had slightly higher mortalities than the general population, but strikingly similar mortalities when compared to each other. Also, as has been shown by Seltzer [4], just the selection process which is used to screen for military induction makes comparison of military and general populations different, irrespective of whether or not they are involved in combat.

IV. HERZ AND AMPUTATION [6]

In 1960, Meyeringh studied the electrocardiograms of 1,033 traumatic amputees and compared them to 423 nonamputee controls. The ECG's were divided into 10-year intervals from age 20 to 60. Significantly, more abnormal ECG's were found in the less than 40-year-old age group. After age 40 there was no significant difference. Further, they found no more frequent ECG changes in amputees that cannot walk normally as a result of their amputation as compared to amputees who have returned to normal ambulation.

When the less-than-40 age group was further evaluated, the abnormalities were found to be in those patients who had gas gangrene as a complication of their amputation. The authors postulate that this is the result of myocardial involvement by the gas gangrene. This association of infection and myocardial disease is very interesting in light of the Rock Carling study [1]. In the Final Conclusions (which was followed by the Ultimate Conclusions), there was an association noted between atherosclerotic coronary artery disease and sepsis. This association was not emphasized in the Ultimate Conclusions.

V. LATE SEQUELAE OF AMPUTATION: THE HEALTH OF FINNISH AMPUTATED WAR VETERANS [5]

In 1965 Solomon et al. presented this study in which 311 World War II amputees were evaluated by an orthopedist, internist, radiologist and physiologist. Ninety-five nonamputee men (controls) who fought in World War II were age-matched to the amputees. The extensive evaluation of these men included several important cardiovascular studies.

The ECG's of the amputees were pathologic in 7 percent of cases which was not significantly different than the controls. Likewise, there was no statistically significant difference between the amputees and control in arterial blood pressure or heart size on chest x-ray. Interestingly, the cholesterol of the controls was higher (300.7) than the amputees (267.4). Finally, bicycle ergometry was performed for

5 minutes using either feet or hands with a workload of 10 or 15 kgm/sec. During the test ECG monitoring and maximum oxygen uptake were performed. Only the double lower limb amputees were less fit than controls.

The conclusions drawn by this study were:

Disorders of the internal organs and peripheral disturbances in the circulatory organs were no commoner in the amputees than in the control group.

Relationship of coronary risk factors to amputations

If traumatic amputations were associated with an increased amount of atherosclerotic coronary artery disease, three logical associations are possible. First, the amputation could be an independent new risk factor for coronary artery disease. Second, amputations could be associated with some new risk factor which is yet to be defined as an independent risk factor. An example of such a factor is the previously mentioned association between amputation, sepsis, and coronary atherosclerotic disease as mentioned in the Final Conclusions of the Rock Carling Study. Finally, the amputation could affect one of the previously described coronary risk factors and thereby result in increased coronary atherosclerosis. An analysis of these risk factors in relation to the presently available literature on amputees should help to further clarify this subject.

J. Willis Hurst, M.D. [7] in his book "The Heart" defines the known coronary artery risk factors. His first category is "Nonmodifiable risk factors" which include age, sex and a family history of atherosclerotic coronary artery disease. It is obvious that a traumatic extremity amputation will not alter any of these. His second category, "Modifiable risk factors," is divided into two subgroups: Major and minor risk factors. His major risk factors are: (1) Elevated serum lipids; (2) habitual diet high in total fats, saturated fats, cholesterol, refined carbohydrates and salts; (3) hypertension; (4) cigarette smoking; and (5) diabetes mellitus. His minor risk factors include: (1) obesity; (2) sedentary life style; (3) personality type; and (4) psychosocial tensions.

Elevation of serum lipids as a result of an amputation seems highly likely. The only study which gave cholesterol measurements [5] found the cholesterol to be lower (267 vs. 300) in the amputees as compared to the controls. Certainly, one would want further controlled studies before believing that amputation could lower cholesterol.

The subjects of diet, cigarette smoking and diabetes mellitus, as specifically related to amputees and atherosclerosis, are not discussed in the literature. It is not likely that an amputation would alter any of these risk factors.

The subject of hypertension and amputation has been evaluated. Solonen [5] et al. found no significant increase in blood pressure in his 311 amputees as compared to controls. Loos [8] evaluated 742 amputees and also found no blood pressure elevation.

The minor risk factors of obesity, sedentary life style (physical activity), personality type and psychosocial tension have been evaluated. The subject of obesity is examined by Solonen [5]. He divided his amputees into three weight groups (overweight, normal and underweight) using 15 percent above or below normals. He found no difference between upper limb amputees and controls, but a clearly significant increase in the overweight group among the lower extremity amputees ($P < 0.01$). This difference was more marked in the above the

knee as compared to the below the knee group, and appears to be even more marked in the double amputees (though the number of double amputees is too small to achieve statistical significance). Loos [8] did not find more obesity among his 647 amputees.

The question of physical activity of amputees and its possible relationship to heart disease is not fully discussed in one article. However, some information can be obtained by analyzing multiple sources. Bakalim [3] states that "The increased consumption of energy taxes the circulation and the heart." Waters [9] found that the higher the level of the amputation the greater the amount of energy expended during prosthetic walking. Furthermore, crutch walking expended more energy than walking with a prosthesis, except in the subgroup of vascular above-the-knee amputations. The effects of this increased energy expenditure were evaluated by Solonen [5]. He had 311 amputees undergo ergometric testing in which they either peddled or hand-wound a bicycle ergometer. He found that the physical condition was as good in the amputees as in the controls, with the one exception of the double amputees.

The relationship of increased energy consumption to heart disease presents a more complex problem. Drews [10] evaluated cardiac index and stroke index in amputees and found them to be normal. Paffenbarger [11] evaluated 3,263, male longshoremen between the ages of 35 and 64 over a 16-year period and found the less active group had a 33 percent higher coronary death rate. Frank [12] evaluated 55,000 males and found that the "most active" males were at a significantly decreased risk of dying from a heart attack, as compared to "least active" male matched cohort. The conclusion to be drawn is not that wearing a prosthesis or walking with crutches "taxes" the circulation and thereby leads to heart attacks, but that increased work loads may be protective to the heart as regards coronary heart disease.

It would appear that if physical activity were to be a factor for relating amputation to coronary heart disease, the less active double amputee would be at greater risk.

The final minor risk factors deal with psychosocial interactions. It is obvious (and has been documented by Haber [13]) that amputation of either lower or upper extremity would have a profound effect on one's self-image and social interactions. Bakalim [3] found the suicide rate to be 37 percent higher than expected among amputees. Certainly, the amputee's life has a great deal more emotional stresses which have the potential for increasing atherosclerotic coronary artery disease.

In conclusion, the evidence presently available does not support a statistically significant link between atherosclerotic cardiovascular disease and amputation. The one study which does show a positive link, written by Bakalim [3], does not use a matched control and has mistakenly included the acute injury period in the analysis. A second study [2] claims to show no link between amputation and atherosclerotic coronary artery disease; however, there are no adequate controls to support this claim. Two other studies [5, 6] evaluate living amputees and controls with noninvasive (not requiring insertion of needles or surgery) techniques to determine the presence or absence of coronary artery disease. Unfortunately, significant coronary artery disease can be present and go undetected by these techniques. The only *in vivo* (while the patient is alive) technique which would give unequivocal evidence is cardiac catheterization, which has not been

performed in this group. This leaves the Rock Carling Study [1] as the only well-controlled study which looks at mortality rates as an end point. This study did not find a correlation between amputation and cardiovascular disorders.

For one to feel certain about such results one further study comparing deaths of amputees and a matched control group should be undertaken. Such a study should include a comparison of amputees with and without sepsis (infection) to resolve the question raised by Rock Carling [1] and Meyeringh [6]. Also, the study should include an analysis of the level of the amputation to evaluate the possibility that physical inactivity may lead to an increased coronary artery death rate. Finally, the study should attempt to define the weight of the amputees as compared to controls, to evaluate this as a possible risk factor in this group.

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APPENDIX C

Sept. 7

VETERANS—DISABILITY COMP.

P.L. 87-645

VETERANS—DISABILITY COMPENSATION

*For Legislative History of Act, see p. 2365*PUBLIC LAW 87-645, 76 STAT. 441

[H. R. 10743]

An Act to amend title 38, United States Code, to provide increases in rates of disability compensation, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That:

(a) Section 314 of title 38, United States Code,³⁷ is amended—

(1) by striking out "\$19" in subsection (a) and inserting in lieu thereof "\$20";

(2) by striking out "\$36" in subsection (b) and inserting in lieu thereof "\$38";

(3) by striking out "\$55" in subsection (c) and inserting in lieu thereof "\$58";

(4) by striking out "\$73" in subsection (d) and inserting in lieu thereof "\$77";

(5) by striking out "\$100" in subsection (e) and inserting in lieu thereof "\$107";

(6) by striking out "\$120" in subsection (f) and inserting in lieu thereof "\$128";

(7) by striking out "\$140" in subsection (g) and inserting in lieu thereof "\$149";

(8) by striking out "\$160" in subsection (h) and inserting in lieu thereof "\$170";

(9) by striking out "\$179" in subsection (i) and inserting in lieu thereof "\$191";

(10) by striking out "\$225" in subsection (j) and inserting in lieu thereof "\$250";

(11) by striking out "\$450" in subsections (k), (o), and (p) and inserting in lieu thereof "\$525";

(12) by striking out "\$309" in subsection (l) and inserting in lieu thereof "\$340";

(13) by striking out "\$359" in subsection (m) and inserting in lieu thereof "\$390";

(14) by striking out "\$401" in subsection (n) and inserting in lieu thereof "\$440";

(15) by striking out "\$150" in subsection (r) and inserting in lieu thereof "\$200"; and

(16) by striking out "\$265" in subsection (s) and inserting in lieu thereof "\$290".

(b) The Administrator may adjust administratively, consistent with the increases authorized by this section, the rates of disability compensation payable to persons within the purview of section 10 of Public Law 85-857 who are not in receipt of compensation pursuant to chapter 11 of title 38, United States Code.

37. 38 U.S.C.A. § 314.

Sept. 7

Sec. 2. (a) Subsection (r) of section 314 of title 38, United States Code,³⁸ is further amended by striking out "for all periods during which he is not hospitalized at Government expense" and inserting in lieu thereof the following: ", subject to the limitations of section 3203(f) of this title."

(b) Section 3203 of title 38, United States Code,³⁹ is amended by adding at the end thereof the following:

"(f) Where any veteran in receipt of an aid and attendance allowance described in section 314(r) of this title is hospitalized at Government expense, such allowance shall be discontinued from the first day of the second calendar month which begins after the date of his admission for such hospitalization for so long as such hospitalization continues. In case a veteran covered by this subsection leaves a hospital against medical advice and is thereafter readmitted to hospitalization, such allowance shall be discontinued from the date of such readmission for so long as such hospitalization continues."

(Sec. 3. Section 312(4) of title 38, United States Code,⁴⁰ is amended by striking out "three" and inserting in lieu thereof "seven".)

Sec. 4. This Act shall take effect on the first day of the first calendar month which begins after the date of enactment of this Act, but no payments shall be made by reason of this Act for any period before such effective date. The increased rate of compensation payable to any veteran entitled thereto on such first day shall be further increased, for such month only, in an amount equal to three times the monthly increase provided for such veteran by the amendments made by this Act.

Approved September 7, 1962.

VETERANS—DISABILITY COMPENSATION

For text of Act see p. 515

Senate Report No. 1806, Aug. 3, 1962 [To accompany H.R. 10743]

House Report No. 1469, Mar. 19, 1962 [To accompany H.R. 10743]

The Senate Report is set out.

Senate Report No. 1806

* * *

Section 3 of the bill increases the presumptive period for multiple sclerosis from 3 to 7 years. The committee took this action based on information obtained from the National Institute of Health that it was the opinion of its scientific staff that 7 years was not an unreasonable period to recognize as the interval between onset and diagnosis in multiple sclerosis and the committee would be justified in enacting legislation providing for a 7-year presumptive period for this disease.

* * *

DEPARTMENTAL REPORTS

VETERANS' ADMINISTRATION,
July 10, 1962.

Hon. HARRY F. BYRD,
Chairman, Committee on Finance,
U. S. Senate, Washington, D. C.

DEAR MR. CHAIRMAN: We are pleased to respond to your request for a report on H.R. 10743, 87th Congress.

* * *

Section 3 of the bill, which is identical with section 3 of H.R. 879, would extend from 3 to 7 years from date of separation from active wartime service the period during which multiple sclerosis becoming manifest to a degree of 10 percent or more shall, subject to rebuttal, be considered as having been incurred in or aggravated by such service. All chronic diseases, except multiple sclerosis, tuberculosis (3 years), and Hansen's disease (3 years) are limited to a 1-year presumptive period in wartime cases.

The mentioned report to your committee on H.R. 879 pointed out that from a medical viewpoint the present provisions of the law and regulations on this subject are considered quite liberal, and ample provision is made for those diseases that have a long incubation period. In addition, there are administrative provisions whereby chronic diseases generally incurred within a reasonable time after the present presumptive period following military service can be and are handled on an individual basis where there is a likelihood that the condition or disease had its inception during military service. Accordingly, the Veterans' Administration opposed section 3 of H.R. 879, and for the same reasons does not believe that there is justification for the enactment of section 3 of H.R. 10743.

* * *

Sincerely,

J. S. GLEASON, Jr., Administrator.

DEPARTMENT OF THE ARMY,
Washington, D. C., July 19, 1962.

Hon. HARRY FLOOD BYRD,
Chairman, Committee on Finance,
U. S. Senate.

DEAR MR. CHAIRMAN: Reference is made to your request to the Secretary of Defense for the views of the Department of Defense on H.R. 10743, 87th Congress, an act to amend title 38, United States Code, to provide increase in rates of disability compensation, and for other purposes. The Department of the Army has been assigned responsibility for expressing the views of the Department of Defense on this act.

* * *

With respect to section 3 of H.R. 10743, it is understood by the Department of the Army that the presumptive period of 7 years for service connection of multiple sclerosis, as contemplated by this proposed legislation, is applicable only in the determination of eligibility for benefits administered by the Veterans' Administration but is not intended to have a bearing on or relation to the service determination of fitness or unfitness for military service or eligibility for physical disability retirement benefits as set forth in chapter 61, title 10, United States Code. Specifically, an award by the Veterans' Administration of compensation based upon the provisions of this proposal will not, in itself, constitute proper basis for consideration in determining whether military or naval records shall be corrected under the provisions of title 10, United States Code, section 1552, for the purpose of establishing eligibility for physical disability retirement benefits.

* * *

Sincerely yours,

CYRUS R. VANCE,
Secretary of the Army.

Mr. GORE. I would like to thank you all again for appearing. I would like to ask unanimous consent to put into the record a statement received by the subcommittee from Frank McCarthy with a group called Agent Orange Victims International. We will include this in the record. [See p. 247.]

Our next witnesses are Joan Bernstein, General Counsel of the Department of Health and Human Services, and Dr. John Moore, deputy director of the national toxicology program.

[Witnesses sworn.]

TESTIMONY OF JOAN Z. BERNSTEIN, GENERAL COUNSEL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY LESLIE PLATT, DEPUTY GENERAL COUNSEL; AND JOHN A. MOORE, D.V.M., DEPUTY DIRECTOR, NATIONAL TOXICOLOGY PROGRAM, H.H.S.

Ms. BERNSTEIN. Thank you.

Mr. GORE. Without objection, the text of your prepared statements will be included in the record at the appropriate point. We will proceed first with you, Ms. Bernstein, to present any or all of your statement.

Ms. BERNSTEIN. Thank you. I would prefer to have my full statement entered into the record and simply make a few very brief points as an opening statement. [See p. 78.]

A few words about the work group which I chair. Last December Stuart Eizenstat, the Assistant to the President for Domestic Affairs and Policy, asked six departments of Government to constitute the Interagency Work Group on Herbicides. We got under way in February. We have held regular monthly meetings since then, reported regularly to Mr. Eizenstat and made those reports public. We have met in addition informally with veterans groups, some of whom have been here today, and this week we held our first public meeting for the purpose of briefing the public on what we have done so far, and to gather more information on our own part if it was available, and to allow people to ask questions of our operation.

Two other very brief points about the group. We have, I think, accomplished some things so far. We have identified all research activities being conducted by the Federal Government. Second, we have identified the areas in which we think additional research is necessary. And third, we have arranged for some funding on a cooperative basis to conduct that research.

We have, I would like to say, as a body, I think, constantly—and that is why I wanted to make the point about meeting with outside groups as well—tried to maintain our sensitivity to the seriousness of really human problems, personal problems, as we dealt with the research. We did not want them to become disconnected.

We also, I think, feel at this interim stage—and I will explain why I think it is an interim stage in a minute—all agree no matter what we do in the end it may be unlikely that science will be able to answer all of the questions about the effects of agent orange.

I will leave to my colleague, Dr. Moore, a description of the science we have reviewed so far and what we are recommending for the future, except to make one point about our recommendation which has been accepted on the Ranch Hand study. We were asked to review that study. As you know, it had been quite controversial. Our recommendation was that the Air Force should conduct the study with—we made some conditions, one of which was we recommended that if the Air Force did conduct the study, it should appoint an oversight committee to consistently work with it, so if changes needed to be made you would have the additional assurance that there would be credibility in the study when it was finished, in addition to the review of the protocol.

We also—as you probably know—have recommended a birth defects study to be conducted by the Center for Disease Control. All agencies were in agreement on that. We have arranged at the funding for that study.

Again, we will be glad to answer your questions. I will let Dr. Moore describe the science in more detail, and again the one point that I feel we must continually caution against is overexpectations about what science can teach us in this area.

Thank you.

[Testimony resumes on p. 95.]

[Ms. Bernstein's prepared statement follows:]

STATEMENT OF JOAN Z. BERNSTEIN, GENERAL COUNSEL,
DEPARTMENT OF HEALTH & HUMAN SERVICES

Mr. Chairman and Members of the Committee:

I am Joan Z. Bernstein, General Counsel of Health and Human Services and Chair of the Interagency Work Group to Study the Possible Long-Term Health Effects of Phenoxy Herbicides and Contaminants. I appreciate this opportunity to appear before the Committee to report on the Federal Government's ongoing efforts to study the possible long-term health effects on humans of exposure to these chemicals.

I will review the status of the Work Group's efforts, focusing particularly on the state of scientific knowledge about Agent Orange and its implications for future research.

As you know, the Work Group's task is extensive, including:

- o overseeing, coordinating and setting priorities among relevant Federal government research activities;
- o designing a research agenda; and
- o organizing the means by which the research agenda will be carried out and assuring its accomplishment in a timely and competent manner.

I believe that we have made significant strides in carrying out that task. The full Work Group has held monthly meetings at which ongoing research is reported on and planned research is discussed. The Science Panel also has met on a number of occasions.

Among our significant accomplishments to date are:

- o the identification of all research activities already being conducted by the Federal government which are related to phenoxy herbicides and Agent Orange.
- o the identification of those areas in which additional research is required; and
- o arranging for necessary funding to be made available on a cooperative basis to meet those research needs.

I am pleased to note that the Work Group's interim research agenda has been endorsed by the National Research Council of the National Academy of Sciences.

In addition, members of our Science Panel have been in contact with scientists outside of the Federal government who are involved in related research activities, including scientists in Europe and elsewhere who are conducting follow-up studies of occupational exposures to phenoxy herbicides.

We in HHS and the Work Group have taken seriously our pledge to conduct a thorough, objective and scientifically impeccable examination of the possible health effects of exposure to phenoxy herbicides, including Agent Orange. As I have said before, we owe the Vietnam veterans and their families nothing less.

I have been particularly impressed with the high level of cooperation individual members of the Work Group have brought to the Work Group effort. I have found a genuine commitment among them to carry out the task we have been given. They have regularly attended Work Group meetings and have provided staff and other support when needed. As a professional working group, it has been extraordinarily effective. It has also been a personal pleasure for me to work with them.

We have taken seriously the health concerns of Vietnam veterans. Individual members of the Work Group have spent considerable time with veterans groups and individual veterans. In addition, the Work Group held a public hearing in Washington on September 22 to provide an additional opportunity for dialogue with scientists, veterans and other interested persons. Seven of the eleven persons who presented statements to the Work Group represented veterans. In addition, members of the Work Group responded to written questions submitted in

advance of the meeting as well as questions from the floor. I believe that the public meeting was productive and was useful to both the public and the Work Group.

We do not underestimate or dismiss as unimportant the veterans' very real worries about their health or the health of their offspring. Nor do we dismiss as statistical aberrations the persistent anecdotal reports we hear suggesting unusually high incidences of particular diseases. In fact, our research agendas in the areas of birth defects and cancers have been prompted in part by just such anecdotal reports.

While we are making our best efforts to fulfill our commitment to the public, and especially to the Vietnam veterans and their families, it is becoming increasingly apparent that science is not likely to be able to answer all of our questions. Nevertheless, the Work Group intends to carry out the work that can be done and must be done in a thorough and timely manner.

State of Scientific Knowledge about Agent Orange

Given the base of knowledge about phenoxy herbicides that existed before the Work Group was formed, and recognizing that additional scientific inquiry will take time, the Work Group asked its Scientific Panel to report on the status of current knowledge about Agent Orange and the time that will be required

before gaps in our knowledge will be filled. In preparing its report, the Panel reviewed all research already under way as well as research still in the planning stage.

The Panel concluded that, with the exception of a few studies whose results will be known in the next few months, it is unlikely that our scientific knowledge about the long term health effects of Agent Orange will increase significantly in the next six months, and that two to three years longer will be required.

The basis for that conclusion is as important as the conclusion itself. A major stumbling block to conducting studies of the effects of Agent Orange on the health of Vietnam veterans continues to be an inability to identify a population of ground troops, the nature and extent of whose exposure to Agent Orange can plausibly be reconstructed or documented with any degree of reliability. Unfortunately, the fact is that records which were kept of Agent Orange spray missions and coincident ground troop locations, along with names of individual troop members, may not be adequate to document the nature and degree of exposure of individual ground personnel to Agent Orange.

For that reason, the Work Group examined other methods by which data can be obtained on the health effects of Agent Orange on veterans. The Work Group believes that the most promising alternative at this time is the Epidemiologic Study

of Ranch Hand Personnel proposed by the Air Force. Therefore the Science Panel and the full Work Group seriously considered the merits of the Ranch Hand study, which is designed to determine what health effects, if any, have occurred among this heavily exposed population.

The Work Group concluded that the study will be useful, despite the fact that its results will not be able to be used to establish a quantitative risk for specific health decrements among ground troops because the exposure of Ranch Hand personnel to Agent Orange is estimated to have been much greater. However, if the Ranch Hand study does detect adverse health effects, those results are expected to be useful in providing a focus as to the type of health effects that may possibly occur in other veterans.

However, even that potential use of Ranch Hand study results must be tempered with a caveat. The relatively small size of the Ranch Hand population -- and I would like to emphasize that it nevertheless appears to be the only population whose exposure to Agent Orange can at this time be reconstructed with some degree of accuracy -- does limit the level of confidence that we can place on failure to detect an increased incidence of a variety of health effects. The relatively rare health effect may not appear in the study results simply because its rarity, as compared to the size of the study population, is too great. Put simply, the Ranch Hand study will be useful

in providing directional signals for health effects we should look for in other veterans, but it will not provide us with a detailed roadmap.

Furthermore, neither the Ranch Hand study nor any future studies of ground troops will tell us whether Agent Orange is the cause of particular adverse health effects among veterans, especially if the studies do not identify any rare or unique diseases associated with Agent Orange exposure. Moreover, many of the adverse health effects about which concerns have been raised by veterans and others are already known to be found in the general population as the result of other factors.

What the Ranch Hand study and similar studies will be able to do, however, is define an association between exposure to Agent Orange and an increased risk of particular health effects.

Given the limitations on what scientists may be able to tell us in the future about the general long-term health effects of Agent Orange and its health effects on individual veterans, the Science Panel recommended and the Work Group agreed that additional studies be conducted which focus on the health status of Vietnam veterans. Such studies will permit a determination of whether service in Vietnam, rather than solely

Agent Orange exposure, may have placed Vietnam veterans at a greater risk of suffering certain adverse health effects.

Consistent with that view, the Work Group agrees that the focus of the Veterans Administration's epidemiological study of Vietnam veterans exposed to Agent Orange or dioxins, which is required by P.L. 96-151, should be broadened to include an examination of the overall health status of Vietnam veterans as a result of their service in Vietnam. We are pleased that the Senate recently voted to authorize the VA Administrator to expand the scope of the VA study in that manner. We are gratified by the show of confidence in the Work Group's judgment in this regard as indicated by the Senate's support of this modification. I also believe that the overall approach of the Senate proposal for a framework by which decisions can be made about veterans' claims for benefits based on adverse health effects suffered as a result of exposure to Agent Orange or other aspects of service in Vietnam is a creative response to a critical aspect of the Agent Orange problem which deserves careful consideration. The Administration is currently reviewing the details of this provision and will shortly be prepared to comment more fully on it.

In reaching its conclusions as to the VA study, the Work Group considered at great length the proposed Ranch Hand study designed by the Air Force. In addition to reviewing the study design, the Science Panel held a several hour discussion on the design with Air Force scientists. It also

reviewed the peer review group reports the Air Force had previously received on the protocol.

The Science Panel agreed with the other peer review groups that the size of the cohort (1160 individuals) the Air Force proposes to study does impose limitations on the statistical power of the study, i.e., the study's ability to detect the relatively rare health effect, which is the problem I mentioned earlier. However, the Panel agreed with the Air Force that increasing the size of the cohort by adding ground troops whose exposure to Agent Orange was clearly significantly less than that of Ranch Hand personnel, although not yet documentable, would dilute the effect of exposure of the cohort and therefore further diminish the likelihood of detecting adverse health effects.

The Science Panel also considered the recommendations made by the other peer review groups that the number of health indices which the Air Force proposed to study be reduced. The Panel agreed that the wide spectrum of health indices included in the Air Force study design may reduce participation in the study because of the substantial time commitment which will be required of study participants. The Panel noted, however, that the Air Force received no consistent recommendations from any of the peer review groups as to which health indices should be eliminated, reflecting a lack of unanimity among scientists as to which health indices are

of principal importance in evaluating potential herbicide toxicity. The Panel recommended that the Air Force consider reducing the number of health parameters in the study if it becomes evident that this factor poses a deterrent to participation in the study by a substantial number of Ranch Hand personnel or members of the control group.

After receiving the views of the Science Panel, the full Work Group considered the Ranch Hand study. On August 1, 1980, the Work Group forwarded its recommendations on the study to Stuart Eizenstat. The Work Group recommended that the Ranch Hand study be conducted. We conditioned our approval on a commitment by the Executive Branch and the Congress that the evaluation may have to continue for a period of time much longer than five years -- and perhaps up to twenty years -- in order to improve the chances of detecting and validating latent or subtle effects.

The Work Group also considered whether the public would perceive the study's findings as credible if the Air Force conducts the study. This issue of credibility was raised by the National Academy of Sciences and other peer review groups, although none of them questioned the ability of the Air Force scientists to conduct the study.

The Work Group recommended that the Ranch Hand study be conducted by the Air Force because it was -- and is -- convinced

that significant delays in beginning the study -- and thus in obtaining even preliminary results -- would otherwise occur. However, the Work Group recommended that the conduct of the study be overseen for at least the first five years by an independent peer review committee reporting to the White House Office of Science and Technology Policy or some other high level entity. The Committee should be comprised of representatives of the Work Group, scientists from the private sector and academia, and persons with scientific backgrounds nominated by veterans organizations.

Stuart Eizenstat has concurred with the Work Group's recommendation.

The Work Group has had discussions with the Air Force on how this mechanism would work. The Air Force believes that the Ranch Hand study can begin in the relatively near future.

In addition to the Ranch Hand study, the Work Group has considered and initiated a number of other scientific activities. VA, DoD and HHS will be signing an interagency agreement in the next several weeks to fund a birth defects study to be conducted by HHS' Center for Disease Control (CDC). The purpose of the two-year study is to determine whether Vietnam veterans are

at an increased risk of siring children with birth defects, a major concern among veterans.

CDC will conduct this retrospective case control study using its Metropolitan Atlanta Congenital Defects Surveillance Program. Since 1968, this program has maintained a registry of all children born with congenital birth defects at hospitals in the metropolitan Atlanta area. The registry now has about 10,000 cases on file, from a total population of approximately 250,000 births.

CDC plans to select the families of about 5,000 registry babies for study. This group will comprise those children with major anatomical birth defects. Families of normal babies will be selected as controls.

Families of each case and each control baby will then be interviewed, with a focus on the father's service in Vietnam. CDC estimates that 25,000 men reside in the Atlanta area who served in Vietnam and that, since their average age is approximately 30, many are likely to have had children in the past five years.

As I pointed out, the study will determine whether Vietnam veterans are at greater risk of having children with birth defects. It is not expected to provide any birth defects data specific to Agent Orange nor any data on infertility among Vietnam

veterans or on reproductive problems other than major birth defects. However, it is consistent with the Work Group's view that additional studies should be conducted which focus on service in Vietnam as a possible causal factor.

The Work Group also believes that the study will provide important information. As of this date, we have only persistent anecdotal reports suggesting the possibility of a higher than normal rate of birth defects among children of Vietnam veterans, and allegations that this higher rate is due to Agent Orange exposure. This study will be an important step in determining whether there are hard data behind the anecdotal reports, although it is not expected to establish whether Agent Orange is the causative factor.

The birth defects study will also build on the base of knowledge which has recently been enlarged by the results of an important study released last month on whether exposure of male mice to Agent Orange is associated with birth defects among their offspring or infertility. Dr. John Moore, Chair of our Science Panel, is one of the authors of the study. The study found no significant decrease in fertility among the exposed mice, nor any significant increase in birth defects among their offspring.

The male mouse study, together with ongoing tests of the mutagenicity of the constituents of Agent Orange, should permit our scientists to form a reasoned opinion in the next few months as to whether a scientific basis exists for concerns that Agent Orange exposure may increase the risk of males siring children with birth defects.

Vietnam veterans are also concerned that they may be suffering from a higher incidence of cancers than is expected in a population their age. In connection with that expressed concern, the Science Panel reviewed one German and four Swedish scientific papers on the carcinogenicity of chemical constituents of Agent Orange. The Panel concluded that, despite the studies' limitations, they do show a correlation between exposure to phenoxy acid herbicides and an increased risk of developing soft tissue tumors or malignant lymphomas. The Panel also noted that independent verification would further validate these studies.

Additionally, the National Cancer Institute and the National Toxicology Program have completed a cancer bioassay on TCDD, the dioxin contaminant in Agent Orange. The results confirm earlier reports that TCDD is carcinogenic in laboratory animals.

The Science Panel has recommended that studies be considered to determine whether the risk of cancer suggested by the animal

studies and the German and Swedish papers is resulting in the occurrence of tumors by examining the veteran population for excess cancer incidence.

The Work Group is convinced that we need to conduct a large-scale study of the Vietnam veterans population, similar in concept if not in all of the details to the study being conducted of the Australian veteran population. We need to know whether Vietnam veterans are as healthy as a population of their size, with comparable age and other characteristics, should be. If not, we need to know what specific health problems are occurring with abnormal frequency and then we can further refine our inquiry to try to determine to what cause or causes a particular health decrement occurring with higher than normal frequency may likely be attributed. This is in line with the Work Group's initiation of the CDC birth defects study, as well as its recommendation that studies of tumor occurrence in the Vietnam veterans population be considered.

The research activities I have described above represent what I believe are substantial steps toward finding some of the answers to the many still unanswered questions about the health effects of exposure to Agent Orange and other phenoxy herbicides. Vietnam veterans have expressed concerns that they are also suffering from other adverse health effects as a result of exposure to Agent Orange. These include a tingling sensation in fingers and toes, sleeplessness, loss of sex

drive, muscle weakness, liver dysfunction and other medical problems. It is hoped that by expanding the focus of the VA epidemiologic study, as the Work Group has suggested, to include service in Vietnam, the study will tell us whether Vietnam veterans as a class are presently as healthy as a similar population their age who did not serve in Vietnam, and will also tell us whether the anecdotal reports we hear about these other health effects attributed to Agent Orange can be confirmed statistically.

But I would like to repeat the cautionary words of my February testimony before other Committees of the Congress. While we believe that the research being planned or already underway is important and valuable, we must constantly bear in mind that even the best efforts of which our scientists are capable may not produce definitive, incontrovertible scientific information about the health effects of Agent Orange. Full answers may never be found, or may be found many years in the future.

At some point we may have to examine the available evidence and determine whether the scientific information upon which to base policy decisions is sufficient, knowing full well that science has not been and may not be able to provide a complete answer. It will not be the first time that social policy decisions have had to be made on less than total scientific

proof. At the very least, the research I have outlined today should be useful in formulating a fair and humane social policy.

In the months ahead, the Work Group will keep this Committee apprised of ongoing and planned research. We will also try to keep you and the public fully informed of our progress.

In that regard, we will supply to the Committee, and ask that they be made a part of the record, copies of the Work Group's second, third and fourth progress reports to Stuart Eizenstat, as well as its August 1, 1980 letter to Mr. Eizenstat regarding the Ranch Hand study. These documents provide additional details on a number of points I have discussed today, and explore many of the related features of our overall effort. I hope to be able to forward to the Committee in the near future updated timetables for our research activities and charts which detail the amounts of Federal funds being spent on this research.

I will be happy to answer any questions the Committee may have.

Mr. GORE. Dr. Moore.

TESTIMONY OF JOHN A. MOORE, D.V.M.

Dr. MOORE. I would like to ask my full statement be entered into the record, and I would like to touch on a couple of points. [See p. 97.]

I think one of the major points that is frustrating the science panel in trying to design a research agenda that would give answers specific to the Vietnam veteran issue is that you have to identify a population to study. With the exception of the Air Force Ranch Hand personnel, attempts to date to identify, say, a ground crew population in which there has been some degree of assurance that they have been exposed and when they were exposed have not been forthcoming.

Indeed, this completely frustrates any attempt—

Mr. GORE. Not been forthcoming from where?

Dr. MOORE. The Department of Defense, searches of its records.

Mr. GORE. Have you asked for it?

Dr. MOORE. Yes, sir.

Mr. GORE. Who has declined to give it to you?

Dr. MOORE. When I say it has not been forthcoming, we have received information from them describing their efforts, but the effort has not been successful.

Mr. GORE. Why not?

Dr. MOORE. I think basically the issue is that with the nature of the war being what it was, records were just not kept as to ground troops going into exposed areas.

Mr. GORE. So you think that is the problem, rather than any lack of effort at DOD, or is it a combination?

Dr. MOORE. No, sir. I think DOD, particularly in its most recent effort, the results of which were submitted to me 2 or 3 days ago, which will be reviewed by the science panel, represents a very good effort at trying to see that records that are available can yield information that correlates troop exposure to the Air Force's herbs tape which document with some precision where agent orange was sprayed and on what dates.

I think you appreciate the fact that if you cannot find a population with any degree of assurance, to the extent that you proceed making bigger assumptions as to possible exposure, the more likelihood that your results might be erroneous.

The ranchhand personnel, as I did state, represents a singular exception as to people known to be exposed. That study is going ahead, and we think it should go ahead. However, there are some reservations that must be attached to any results that might emanate from that study. One of the major reservations being that there are only 1,100-odd people. Because of that number, there are limitations as to the ability to detect some subtle health decrements, if they exist. The population just is not big enough.

The other area I would just like to mention in closing is in the area of birth defects. It has been our perception that this is one of the major concerns of a significant number of veterans; I think there has been some progress in this area. There recently was completed and issued August 1 a report referred to as the agent orange male mouse study, which attempted to see if one could

detect in a toxicology system whether or not relatively high exposure to agent orange and its contaminants did result in any decrements in fertility or increased incidence of malformations in offspring. That study was reported to be basically negative. It is in the process of being reviewed by the science panel to see if it agrees with the conclusions of the authors.

Second, the CDC birth defects study, which is using human records data from the metropolitan Atlanta area, will attempt to find any correlation between service in Vietnam and an increased incidence of certain types of malformations.

That study is being reviewed this morning by the science panel as to the exact protocol they propose to use.

[Testimony resumes on p. 105.]

[Dr. Moore's prepared statement follows:]

STATEMENT OF JOHN A. MOORE, D.V.M.,
DEPUTY DIRECTOR, NATIONAL TOXICOLOGY PROGRAM
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and Members of the Committee:

I am John A. Moore, a toxicologist, Deputy Director of the National Toxicology Program and Chair of the Scientific Panel of the Interagency Work Group to Study the Possible Long Term Health Effects of Phenoxy Herbicides and Contaminants. I wish to utilize this opportunity to appear before the Committee by describing several scientific activities that I believe are of relevance to Vietnam veterans. The testimony of Ms. Bernstein, Chair of the full Interagency Work Group, describes the Group's activities in a more comprehensive manner.

The activities of the Scientific Panel can be categorized in four broad areas:

1. identification of research activities being conducted or funded by the Federal Government including current status and targeted completion dates;
2. identification of areas in which additional research is required;
3. reviewing proposed research; and
4. review and interpretation of research results for relevance to the concern of Vietnam veterans that they are or may be at increased risk of suffering a variety of health impairments.

Future activities of the Scientific Panel will also include monitoring the progress of these research activities.

In an issue of this type, the preferred course for gathering scientific knowledge is to identify an exposed population and conduct the appropriate medical studies. Attempts to identify a population from among those ground troops who served in Vietnam have not been successful. This completely frustrates any study whose objective is to define what risk, if any, is associated with Herbicide Orange exposure. Without accurate knowledge as to who was actually exposed, you are likely to misclassify the study population and as a consequence erroneously interpret the study results.

The Air Force Ranch Hand personnel, who applied Herbicide Orange, are the only population whose frequency and duration of exposure are known. The degree of exposure may equal or even exceed that of people involved in the more intensive domestic uses of these types of herbicides. The Interagency Work Group has recommended that studies of the health status of this group be conducted since the detection of adverse health effects would provide an indication as to the type of health effects that may occur in other (ground troop) personnel. I feel obliged to caution the Committee there are definite limitations in the extent to which the results of this will be applicable to the total Vietnam veteran population. Two major limitations are that the small size of the Ranch Hand population restricts the

level of confidence that can be placed on a failure to detect an increased incidence of a variety of health effects; second, the detection of a health effect in this study would not permit the establishment of a quantitative health risk for ground troops since the Ranch Hand exposure is estimated to have been much greater.

It remains the opinion of the Scientific Panel that certain health decrements may be present in the veteran population that are a consequence of Vietnam service and are not directly associated with Herbicide Orange exposure. I suspect that any attempt to specifically and accurately identify who might have been exposed to other chemicals (which may include herbicides, insecticides, or drugs) or agents that may be peculiar to the Vietnam environment (such as fungal toxicants) would prove to be a most formidable, if not impossible, task. In view of these circumstances, coupled with the uncertainty of identifying personnel exposed to Herbicide Orange, the Scientific Panel suggests that a prudent approach to determining if Vietnam veterans are suffering health impairment is to design and conduct studies that would indicate if service in Vietnam is the causal factor.

Two possible health effects which are worrying many Vietnam veterans are birth defects and cancer.

Birth Defects

The principal issue is that veterans allege and fear that they are at an increased risk of siring malformed children years after exposure to Herbicide Orange. It is known that exposure of female rats and mice to 2,4,5-T or 2,3,7,8-TCDD (a constituent and contaminant of Herbicide Orange, respectively) can produce malformed offspring, fetal toxicity or fetal death. One cannot predict male effects from results obtained through studies of female exposure. Logic dictates that the ability to sire malformed offspring years after Herbicide Orange exposure could plausibly occur only if there was permanent genetic damage (mutation) to the spermatogonial cells. Current data on the mutagenicity of the Herbicide Orange components, 2,4-D, 2,4,5-T, and 2,3,7,8-TCDD, are judged to be inadequate. These chemicals are being retested using the best current techniques. The first results are now emerging and more will be forthcoming next year. The Scientific Panel will begin reviewing available data in the next two months.

A direct method of securing relevant toxicology data is through the administration of the constituents of Herbicide Orange to male laboratory animals and examining their sperm, ability to fertilize untreated females, as well as examination of their offspring for viability and malformations. The National Toxicology Program performed such a study in mice and reported its results in August. The study reported that there was no evidence of germ cell toxicity or adverse effects in the

development and survival of offspring as a consequence of paternal exposure to simulated mixtures of Herbicide Orange. This report is now being reviewed by the Scientific Panel.

A third approach is to study and evaluate human birth records data. The Scientific Panel evaluated the potential utility of a birth defects registry that has been maintained since 1968 in the metropolitan Atlanta area. The Panel recommended that a case control epidemiological study be conducted using this registry. The Panel felt that such a study would have a good probability of determining if Vietnam veterans are siring children with an increased incidence of specific malformations. Detailed planning of this study is underway at the Center for Disease Control. A detailed protocol for this study was recently submitted to the Scientific Panel, and will be reviewed September 25. While it will be useful as a means of determining if service in Vietnam resulted in an adverse health consequence, the study is unlikely to be able to indicate that Herbicide Orange was the factor responsible for increased incidence of malformations, should such a phenomenon exist.

Cancer

Veterans are concerned that cancer death, illness, or increased risk is associated with Herbicide Orange exposure.

Previously published studies had reported 2,3,7,8-TCDD (the contaminant in Herbicide Orange) to be a carcinogen in rats. Two additional animal cancer bioassays were recently completed by the National Cancer Institute and National Toxicology Program (NTP). The draft reports were reviewed for the National Toxicology Program by a group of independent scientists in June. This group of scientists concurred in the reports' findings that TCDD was carcinogenic in rats and mice. The recent study in rats confirmed the previously published reports; the mouse study extends the observation that 2,3,7,8-TCDD is a carcinogen to a second animal species.

The Scientific Panel also reviewed several case control epidemiology studies that were conducted by Swedish scientists. The Panel concluded that in spite of the reservations associated with case control epidemiology studies, the studies show a correlation between exposure to phenoxy acid herbicides and an increased risk of some forms of cancer. They also were of the opinion that independent verification would further validate these studies.

While these studies do establish a cancer risk from TCDD and possible phenoxy acid exposure, the data do not lend themselves to the establishment of a quantitative risk for veterans exposed to Herbicide Orange. To determine if "risk" is resulting in tumor occurrence, the veteran population should be studied directly.

A valid scientific criticism of such a study conducted at this time is that the study may be premature and prone to a false negative result given that the time elapsed since exposure in Vietnam is less than the 15-20 years that is typically required for excess cancer incidence to become manifest. However, the perception of cancer risk is a current concern, and in some instances, excess cancer may appear in a population 10 years after exposure. Therefore, such a study should be initiated. The rationale for this recommendation is:

1. A negative finding would allay the current and possibly increasing fear that Herbicide Orange exposure or Vietnam service already is resulting in excess cancer deaths.
2. A positive finding would establish service connection and permit appropriate policy decisions with respect to service connected disability and right to compensation.
3. A positive finding would identify the types of cancer for which there is increased risk and the medical community could focus attention on specific surveillance for early detection of tumors with a possible attendant increase in successful treatment.

4. An appropriate cohort will have been registered that can and must be resurveyed at appropriate time periods to detect changes in major morbidity or cancer incidence.

Such a study could easily be included as part of the Congressionally mandated Veterans Administration epidemiology study. Since results from this study are not expected for several years, other mechanisms will continue to be explored. The proposed Air Force Ranch Hand Study will study cancer incidence; however, the limitation of study size dictates that a larger study also be planned.

In conclusion, I am not optimistic that scientific studies will provide unequivocal data as to the significance of Herbicide Orange exposure to the health of Vietnam veterans. It is plausible that studies can determine if various health effects are associated with Vietnam service. The principal studies needed to provide such data may require several years to complete.

I would be happy to answer any questions the Committee may have.

Mr. GORE. Mr. Lent.

Mr. LENT. Thank you, Dr. Moore. You heard one of the earlier witnesses, Mr. Furst, say in his testimony that he felt very strongly that there was a higher incidence of health problems among Vietnam veterans than among the non-Vietnam veteran population. Is there anything in the medical bibliography to suggest there is any validity to that?

Dr. MOORE. I think all the data that is available dealing with the Vietnam veterans' higher incidence of any type of health problems is anecdotal right now. Indeed, I know of no firm evidence that says one way or the other. I think this is where—

Mr. LENT. Well, is there a higher child mortality rate among offspring of Vietnam veterans, or a higher rate of cancer, or a higher heart disease rate so far as has been determined?

Dr. MOORE. I cannot answer that question, because I know of no data on which to give you an informed opinion. Those studies have just not been done. Some attempts that have been done I think are incomplete or flawed. Some people might make the point that the number of veterans who are complaining about certain types of health defects certainly suggests that something is going on; but until you can look at those and have a denominator one does not know. Certainly there is no question that veterans have sired malformed children. But until you know what that rate is in veterans, say, against the normal rate of malformations in this country, you cannot draw a conclusion as to whether it is higher or lower. This is, for example, what the CDC birth records study hopes to be able to answer.

Mr. LENT. Well, there was another assertion that was made by Mr. Furst, that the Ranch Hands are suffering fewer health problems than might be expected. As a toxicologist, is there any explanation for this? Are you familiar with this assertion? Have you looked into it at all?

Dr. MOORE. I heard Mr. Furst make that assumption at our open meeting that we held Monday. I know of no numbers to back that up. I think it represents his opinion, as I understand it.

Mr. LENT. Is there validity, in your view, in the Swedish and the West German dioxin studies insofar as they relate to the agent orange problem?

Dr. MOORE. I think we put more significance on the Swedish studies than we do the West German studies, for technical reasons. I think there is a problem with studies of that type that is inherent. Those are called case control types of epidemiology investigations. There are some inherent problems in any type of approach like that. But after we reviewed those studies and discussed them rather extensively, even when you list all the reservations that you can find, we are still left with the fact that there does seem to be an association between a higher incidence of certain types of cancer. To the extent agent orange is made of phenoxy acid herbicides, it might be significant.

We feel there is need for a conformatory study by an outside group.

Mr. LENT. Ms. Bernstein, on page 5 of your testimony, you indicate the panel believes our scientific knowledge of the effects of

agent orange will not increase significantly over the course of the next several years.

In view of that fact, do you believe that there is any reason why the policy question that we are involved with here today should be delayed any longer than it has been? Or do you think we ought to move ahead with addressing that question?

Ms. BERNSTEIN. My view would be, sir, that we should move ahead with trying to address the policy question. That was one of the reasons we made that point, that there would be a hiatus in the emergence of further scientific conclusions.

Mr. LENT. How do you address the criticism that the ranchhand study involves too small a cohort to be valid?

Ms. BERNSTEIN. I would prefer Dr. Moore respond to that, because I think we did, but I am more comfortable, if I may, if he may answer that.

Mr. LENT. If you will.

Dr. MOORE. I think the concern, Congressman, is that if the study is negative in a variety of parameters, it might be a false negative, in that you just did not have a big enough population to look at to detect something that might be a result of agent orange exposure. I do not think there is any question in most people's mind that if, indeed, the ranchhand study were to show a positive effect for certain types of disease parameters, that indeed it might signal that those types of disease parameters might be a risk factor for others who were exposed to herbicide orange. It is the negative part that people are concerned about.

Mr. LENT. Do you see any value in doing both an agent orange study and a general Vietnam service health study?

Dr. MOORE. Yes, sir. I think they should be done. We feel that ranchhand should be looked at for two reasons. One, the ranchhand personnel represent 1,100-odd people who were involved in the application of 80, up to 100 million pounds of herbicide orange. They had to have had significant exposure. I think they merit such a study for themselves. Second, to the degree such a study might indicate certain types of effects, it is certainly suggesting what effects to be sure to focus on in a study of Marine or Army personnel.

Mr. LENT. So you feel there is merit in doing an agent orange study?

Dr. MOORE. Yes, sir. To the degree that we could identify a population of ground troops who we could plausibly say might have been exposed to herbicide orange, I think they should be studied. Even if we cannot find such a group, I do think there should also be a study that relates to Vietnam service, because there are a number of agents that were used in Vietnam that could also plausibly be associated with some possible health decrements. There were other herbicide formulations used, for example.

Mr. LENT. I have no further questions, Mr. Chairman, at this point.

Mr. GORE. Dr. Moore, you talked about the Swedish studies. Of course, any epidemiological study is often subject to varying interpretations. You indicated you were reluctant to endorse their conclusions because it had not been verified, and so forth. The finding specifically was that persons exposed to dioxin have a significantly

greater chance of experiencing certain forms of cancer. I would call to your attention for the record that the Office of Technology Assessment looked at that study. They had Dr. Richard Remington, dean of the school of public health at the University of Michigan, review it. He stated that the Swedish studies were "among the most carefully conducted investigations of their type that I have ever seen."

He called the study credible, if not totally conclusive.

Let me move to the ranchhand study. How many subjects are going to be studied in that?

Dr. MOORE. Accounting for what mortality might have occurred between Vietnam and now, for a variety of reasons, I think the maximum is somewhere around 1,165 people.

The attempt is to study them all. One of the major concerns that one has with the ranchhand is that that 1,100-odd is a small population to begin with for the types of study one wants to do. To the degree you get nonparticipation on the part of ranchhand personnel, you are further jeopardizing the interpretation of that study.

Mr. GORE. I understand. This subcommittee has spent a lot of time on hazardous chemical wastes. I do not want to go far afield, but we had a similar study that was proposed on the limited population in the perimeter around Love Canal; dioxin was one of the elements involved there. A lot of people said at the beginning this study will be of no use; the population is too small. Well, the findings were shocking when they came in. They have since been subject to question, as is always the case with such studies; but then some of the experts turned around and said no, they have validity after all.

Maybe we will find some answers from this study. I was interested to hear Mr. Muller say that in spite of the credibility problems that many veterans feel that the Air Force has, that he and his group think yes, go ahead, let them do it and let the peer review group solve the problems of credibility.

Just to clarify for the record, on this study, 1,165, or thereabouts, veterans are going to be studied by the Air Force. They were former Air Force personnel. I understand that the National Academy of Sciences review of the study design raised serious concerns about the credibility of the study; is that correct?

Dr. MOORE. Congressman, I think there is an important distinction to be made. They questioned—they had some concern about the public perception of credible results. They did not question the Air Force's ability to conduct a credible study.

Mr. GORE. That question has really been answered in part by Mr. Muller's statement here this morning and the statements of others that we ought to go forward with this.

One of the principal reasons for your group's recommendation to go forward with this study, in spite of the difficulties, is that this is the only discrete group where we can quickly gather actual documentation of exposure.

Now these are both the handlers, mixers, and pilots, and others; right?

Dr. MOORE. Yes, sir.

Mr. GORE. We ought to understand, going into this study, that the degree of exposure is going to vary?

Dr. MOORE. Yes, sir.

Mr. GORE. We ought to understand that the time of exposure should be a significant variable accounted for in the study. Is that going to be done?

Dr. MOORE. Yes, sir. There are some general estimates. For example, the console operator in the back who was responsible for turning on and off the herbicide spray probably has an exposure factor of maybe two-, three-, or fourfold higher than the people in the cockpit.

Mr. GORE. Also, the time during the war, the early on, the stronger mixtures that were used and so forth. You intend to take that into account in analyzing the results?

Dr. MOORE. Yes.

Mr. GORE. Do you feel comfortable in saying that the ranchhand personnel were more exposed than people on the ground? Take, for example, the group that we heard about this morning from Mr. Furst who came in immediately after spraying and during the burning, and so forth. It is perfectly conceivable, is it not, that some of these people would have been exposed even more than some of the ranchhand personnel; is that correct?

Dr. MOORE. I did not hear Mr. Furst's statement, but I assume you are referring to engineer battalions or engineer personnel who went into an area?

Mr. GORE. Correct.

Dr. MOORE. That is an area we noted with interest when he mentioned it to us Monday. We intend to explore that and see if we can identify such a population.

Mr. GORE. Good. Good. I am glad you all are establishing the kind of credibility with the people that have been pushing on this that you are. I want to thank you on behalf of the subcommittee.

I have other questions. I would like to ask your indulgence for just a moment. We have a vote in full committee downstairs. They cannot get a quorum without Mr. Lent and myself. As a result, we will ask your patience and adjourn this hearing for approximately 7 or 8 minutes. Then we will resume.

[Brief Recess.]

Mr. GORE. The subcommittee will come back to order.

I think I overstated the degree to which veterans were reassured about the decision to have the Air Force continue this study, although Mr. Muller so testified. I think it is important to note for the record that many other groups still have very serious concerns about the credibility of such a study. I can only hope that you, too, will do everything in your power to allay those continuing concerns and make sure that the study is as credible as it possibly can be.

I understand that the General Accounting Office issued a report last November, almost 1 year ago, evaluating the Department of Defense information on troop locations, strengths, and their proximity to spraying missions. Their report concluded, "Marines in the I Corps section of Vietnam from 1966 to 1969 were in or close to areas sprayed with herbicide orange on both the day of the spraying and within 4 weeks afterwards."

Further, the names and last known addresses of Marines assigned to units close to herbicide orange spraying are available from the Marine Corps records. They conclude, "We now believe that the group of personnel most likely to have been exposed could include ground troops as well as herbicide handlers and aircraft crew members. However, ground crew troops are not included in the ongoing studies."

My question is this: Have you consulted with the GAO on its work and on this specific part of its work?

Dr. MOORE. Yes, sir. As a result of the GAO report you reference, the activity that has been going on within DOD was a direct result of that, and I do know that DOD has been in consultation with GAO in the design of that study. We are asking GAO to appear before us a week from Friday to give us the benefit of their views on this matter.

Mr. GORE. I understand that this consultation only occurred within the last month and that it was at the initiative of GAO rather than the interagency group; is that correct?

Dr. MOORE. It is my understanding that GAO was consulted in the design of this battalion search that DOD did with a Marine battalion and an Army battalion at about the time of its inception, not just at its end. I could be wrong. That is my understanding.

Mr. GORE. That is correct, as we understand it, also. How many units did you look at?

Dr. MOORE. Congressman, that report appeared on my desk yesterday. I have not had a chance to read it. Basically, as I understand, what they did is they picked a Marine battalion and an Army battalion and followed them for 1 year. The selection of the battalion, I believe, was based on their estimate as to which battalion had the best records. Therefore, that may be the best chance of making a correlation between exposure.

Mr. GORE. Let me just advise you that this subcommittee is going to maintain a continuing interest in the progress that you make in this subject, and we are going to be asking you from time to time to give us an update just to provide that accountability and responsiveness which the veterans exposed to these substances deserve.

I want to thank you for your appearance here today, and we will be back in touch with you in the future.

Thank you.

Ms. BERNSTEIN. Thank you.

Dr. MOORE. Thank you.

[Testimony resumes on p. 120.]

[The following questions and answers were received for the record:]

QUESTIONS TO AND ANSWERS FROM HEALTH AND HUMAN SERVICES

Ranch Hand StudyQUESTION

1. "The IWG recommended that the Ranch Hand study go forward as designed with several modifications (i.e., peer review, extension of the follow-up period to 20 years), despite serious concerns expressed by the National Academy of Sciences and numerous veterans groups. Please state fully the rationale behind this recommendation."

Answer

The rationale underlying the Work Group's recommendation is set out in the report to the Work Group dated July 14, 1980 from the Chair of our Scientific Panel, which accompanied my August 1, 1980 letter to Mr. Eizenstat recommending that the Ranch Hand Study be conducted.

In Dr. Moore's report, which the Work Group endorsed, he stated the following:

The Scientific Panel is of the opinion that the Ranch Hand personnel represent an occupational group that is unique from the standpoint of known time and duration of exposure to Herbicide Orange. Their phenoxy acid herbicide exposure may equal or exceed that experienced by other groups involved in some of the more intensive domestic uses of these herbicides. It is not aware of any other group that is likely to be identified whose exposure can be documented or was of similar intensity and duration.

The Scientific Panel recommends that the Epidemiologic Study of Ranch Hand Personnel as designed by the Air Force be conducted. The Ranch Hand personnel were heavily exposed to Herbicide Orange and should be provided information that indicates if they are manifesting adverse health effects or are at increased risk of developing future adverse effects as a result of this exposure.

The detection of adverse health effects also would provide a focus as to the type of health effects that may possibly occur in other personnel (ground troops) exposed to Herbicide Orange.

Question

2. "You have admitted the limitations of the study, but said that the results would provide an 'indication' of the type of health effects that may occur among ground troops. Wouldn't you agree that fifteen years of animal studies should give sufficient clues of what to look for in ground troops?"

Answer

The animal studies already conducted have given the scientists a great deal of information. As Dr. Moore stated at our public meeting, "In general, I would say the animal toxicity studies give a good qualitative suggestion as to the nature of the effects or the organ systems attacked. What they don't do is give any quantitative estimate as to the likelihood of effects in humans from a given exposure." While animal studies are useful in predicting health effects in humans, current state of the art does not yet permit us to establish a definitive degree of risk, only the fact of risk.

For that reason, the Scientific Panel will monitor the results of follow-up studies of occupational exposures. The industrial accidents generally involved very heavy exposures, and one of the basic foundations of toxicology is that a dose-response relationship typically exists between exposure and the likelihood of health effects.

Question

3. "The Veterans Administration (VA) apparently views animal studies as being of limited usefulness. If one accepts the conclusions of the Toxic Substances Strategy Committee, it would appear that the VA does not understand the usefulness of animal studies. What is your reaction to the VA's position?"

Answer

I am not aware that the Veterans Administration has a stated position as to the usefulness of animal studies. It is my presumption that all medical scientists, irrespective of agency affiliation, accept the view that animal studies are reliable but not infallible indicators of toxicity. Animal studies may indicate the nature of the toxic effect, i.e., cancer, liver, fertility, etc., but the more difficult task is to extrapolate animal data into quantifiable risks. It is with respect to this latter issue that I believe the VA finds animal data to be of limited value.

Question

4. "One of the principal concerns of affected veterans is that results of this study will not be credible if it is performed by the Air Force - with or without peer review. How do you respond to that charge?"

Answer

A similar question was raised at our public meeting. My response is that the best way to reassure those who perceive a lack of credibility is to have a continuing mechanism to evaluate what it is the Air Force is doing, similar to the role of an oversight committee of the Congress. An external monitoring group can and should insure that there are no biases being consciously or unconsciously expressed.

Question

5. "It seems essential that any research effort on such an emotional issue not only be reliable and unbiased, but be perceived as such by those most directly affected by the outcome. Would you agree this is an important factor that should be considered and addressed?"

Answer

We agree that it is important that the Air Force research be perceived as credible, and it is certainly one of the factors that was considered. In our view, we addressed that concern by conditioning our approval of the Ranch Hand study on the establishment of an independent monitoring committee to oversee the Air Force conduct of the study.

Question

6. "One of the stated reasons for continuing the Ranch Hand study is that those personnel 'are the only population whose frequency and duration of exposure are known.' Further, it is said that exposure of these personnel was likely much greater than that of ground troops. Upon what are these conclusions based?"

Answer

During the Ranch Hand Protocol review the Air Force presented data which clearly indicated that exposure of Ranch Hand personnel did repeatedly occur. Given the nature of their task, their exposure would be to concentrated material as compared to ground

troop exposure to dispersed particles applied at the rate of several gallons per acre. Although precise figures for Ranch Hand exposure can not be set it is a conservative estimate that their exposure was greater than ground personnel by a factor of ten.

Question

7. "It is our understanding that the IWG's only source of exposure data has, until very recently, been the Department of Defense (DoD). As you know, the only review of that information to date-completed by the General Accounting Office (GAO) in November 1979-contradicts DoD estimates. Why was the GAO not consulted?"

Answer

As Dr. Moore testified at the hearing, DoD did consult with GAO in the design of its records search. In addition, GAO representatives attended the October 3, 1980 meeting of the Work Group to discuss informally DoD's efforts. The Work Group and Scientific Panel will continue to consult with GAO on this.

Question

8. "Isn't it possible that the study could produce false negatives and thereby have a negative impact on policy development or at the least, cause an even more significant shift away from assistance to veterans based on flawed science?"

Answer

As Dr. Moore testified at the hearing, the Work Group recognizes that, because of the relatively small size of the Ranch Hand cohort, the possibility of false negatives exists. However, we believe the Ranch Hand study should be conducted because, to the extent the study's findings do point to specific health effects, that information will be useful in suggesting what effects to focus on in a larger study of ground troop personnel.

I would like to emphasize that the Ranch Hand study is but one of many studies either ongoing now or in the planning stage. The Work Group does not intend to make nor does it believe appropriate policy recommendations on the basis of a single study, but rather on all the available evidence.

Standard of Exposure/Vietnam Experience StudyQuestion

1. "Is it your view that there is insufficient exposure data on ground troops to begin an epidemiologic study?"

Answer

We have insufficient exposure data at this point. For that reason, DoD is continuing its records search efforts and the Work Group is working closely with DoD and GAO in those efforts.

Question

2. "Would information solicited from veterans themselves be helpful in increasing the body of knowledge on exposure?"

Answer

Solicitation of such information would, in the overwhelming majority of instances, be unverifiable. Further, a variety of materials were sprayed -- insecticides as well as other herbicides. It is unlikely that a veteran who recalled when he was sprayed could identify what he was sprayed with sufficient certainty.

Question

3. "Would you encourage the VA to conduct an outreach program?"

Answer

Stuart Eizenstat stated at our public meeting that the VA's outreach efforts are being expanded and its educational programs for health professionals intensified. We support those efforts.

Question

4. "Is it reasonable to require evidence of actual exposure given the lack of empirical data on exposure pathways and the complex nature of chemical movement through the environment in any given situation? Isn't it possible that through existing DoD records--though not perfect--combined with details from veterans themselves, that at least the minimum requirements could be met to establish an exposed population?"

Answer

We recognize that the result of DoD's records search may be the identification of a population of ground troops which have a reasonable probability -- not certainty -- of exposure. We also recognize that if that is the best data the records search yields, problems will arise in attempting to interpret the study results, i.e., false positives.

Question

5. "With respect to the study mandated by P.L. 96-151, do you intend now that two studies be conducted -- an Agent Orange specific one and a "Vietnam experience study"?"

Answer

Any inquiries into the more general area of service in Vietnam will be in addition to -- not in place of -- the investigation concerning Agent Orange. However, at this stage in the design of the VA protocol, we do not yet know whether there will be one study with several subsets or two or more separate studies.

Question

6. "It has been stated that veterans' health decrements may be the result of exposure to other chemicals used in Vietnam. The Vietnam experience study would detect the incidence of health disorders without regard to causation and therefore include veterans who might otherwise have been overlooked. What else do you hope to gain from this study?"

Answer

The stated objective of such a study is simply to determine if service in Vietnam resulted in an increased incidence of certain health effects. It is conceivable that the study could be designed to ascertain if a certain military occupation, such as combat infantry, engineer or air maintenance, is principally associated with such health risks.

Question

7. "Will the study provide, in your opinion, sufficient scientific evidence for the VA to develop a compensation policy?"

Answer

We anticipate that the VA study, together with the findings of related studies, should be sufficient.

Question

8. "Is it your understanding then that the VA will be satisfied, for purposes of compensation, with a finding of higher incidence of cancer, for example, among veterans than the general population without the establishment of a cause and effect relationship?"

Answer

We understand that the VA does not require the establishment of a cause and effect relationship. Should the scientific evidence suggest a higher risk of a health decrement than is found in the general population, we understand that it is the position of the VA that they would seek a statutory presumption for that condition from the Congress.

Question

9. "Isn't it possible that once the study is completed, the VA may still feel that the scientific evidence is inadequate, that it is necessary to isolate those veterans exposed to Agent Pink, Purple or dapsone?"

Answer

Although I can only speculate as to the VA's future position, I do not believe that the VA will find it necessary to isolate those veterans exposed to other herbicides or chemicals.

Question

10. "So, it could still be a question of science and not policy, despite warnings from the IWG for months that it is unlikely that science will ever provide 'incontrovertible' evidence upon which to base policy determinations?"

Answer

Since I could do no more than speculate as to the VA's posture in the future (#9), a response to this question would be similarly speculative. However, I would predict that while future policy decisions as to Agent Orange will be based on science, nevertheless the available scientific evidence may never be sufficient to meet a standard of "incontrovertible." It is likely that the same statement would be equally applicable to attempts to formulate policies as to Agent Pink, Purple, or dapsone.

Study Mandated by P.L. 96-151Question

1. "As I'm sure you know, the VA's proposed study is the subject of a law suit by the National Veterans Law Center. Has the Scientific Panel reviewed the VA's Request for Proposal (RFP)?"

Answer

No. The Scientific Panel intends to advise the contractor ultimately selected to design the study of its views on the health parameters which should be included in the study design.

Question

2. "Wouldn't the expertise of the Scientific Panel be helpful in evaluating the quality of proposals submitted?"

Answer

While it is possible that the Science Panel could be helpful in evaluating proposals, there is no unique capability possessed by the Science Panel in performing this task. However, as indicated above (#1), the Science Panel will be working closely with the contractor selected to assure an optimal study design.

Question

3. "Because of an inherent conflict, the VA, as well as the DoD, appear to have a lack of credibility among many affected veterans. Wouldn't involvement of the Work Group from the early stages of this study add credibility as well as much needed scientific expertise? Wouldn't early involvement also tend to reduce the possibility of delay occasioned by a subsequent discovery of scientific inadequacy?"

Answer

The Work Group does intend to become involved in the VA study. As you may know, Stuart Eizenstat has directed that the independent monitoring committee to oversee the Ranch Hand study also oversee the VA study and provide technical advice, as needed, to the VA. That monitoring committee will be reporting on a regular basis to the Work Group.

Question

4. "It is the the understanding of the Subcommittee that the VA has no epidemiologists on staff. Would you feel that such circumstances would affect the VA's ability to conduct an adequate in-house study?"

Answer

The important point from a epidemiological standpoint is not whether one is on the VA staff, but that expert epidemiologists be utilized in the design and evaluation of the data. Furthermore, we understand that the VA does have epidemiologists on its staff.

Question

5. "Among the IWG's tasks, once the research agenda is designed, is 'assuring its accomplishment in a timely and competent manner.' It has been suggested by some veterans groups that this task could be well served by insisting that the study be done by outside experts to ensure both quality and credibility. How do you respond to that suggestion?"

Answer

It is not known whether the VA plans to perform the epidemiology study itself or through contract with outside experts. It is most important that an unbiased review group confirm that whoever conducts the study is judged to be capable of performing the job in a credible and competent manner.

Role of the IWGQuestion

1. "Please describe how you perceive the role of the IWG?"

Answer

The role of the IWG is to make certain that the Federal government has reliable scientific data and criteria upon which to make policy decisions regarding compensation.

Question

2. "The IWG's first public meeting occurred on September 22, nine months after its creation. What plans do you have for further public participation in the activities of the IWG?"

Answer

We do anticipate additional opportunities for two-way communication with the public in the future. We have not yet developed a schedule, however, for additional public meetings.

Question

3. "You stated in February 1980 before the Subcommittee on Medical Benefits and Facilities that 'even the best efforts of which our scientists are capable may not produce conclusive results.' You went on to say that these questions are 'fundamentally ones of broad social policy that both the Administration and the Congress must soon confront.' Yet there is every indication that those at the VA in policy-making positions in fact are relying on science to provide such answers. Does the IWG have authority to issue recommendations with respect to policy regarding compensation for veterans exposed to Agent Orange or for any Vietnam service disabilities? If not, do you feel it desirable for the IWG to have such authority?"

Answer

We believe that an important part of our task will be to make policy recommendations with respect to compensation based on the available scientific evidence.

Question

4. "Based upon testimony at the hearing, it would appear that certain veterans groups are dissatisfied with the performance of the IWG after 10 months with little evidence of progress. Would additional full-time staff assist you to carry out your responsibility? If so, please describe. Do you feel additional legal authority is necessary, and, if so, please describe."

Answer

We do not believe additional full-time staff are necessary. Competent, reliable scientific inquiry simply takes time and the Work Group is committed to assuring that the necessary scientific studies are conducted in that manner. The Work Group has made important, and widely recognized, progress by developing and organizing a full research agenda. The scientific tasks to be performed will take months or, in the case of the long-range studies, years. There is no way to short cut these scientific inquiries.

We do not feel additional legal authority is needed.

Mr. GORE. I would like to call now on Congressman Tom Daschle, who was here earlier this morning and had to leave in order to go over to the Senate floor on the very same subject to try to stimulate some legislative action that was pending on the Senate floor at the time.

We welcome you, Congressman Daschle.

Let me thank you for the leadership role that you are currently playing as the head of the Vietnam era veterans in Congress group and for your leadership on this issue in particular. Without objection, the entire text of your prepared statement will be inserted in the record. We invite you to proceed at this time with any or all of your statement as you see fit.

I would ask you in keeping with the traditions of this subcommittee, if you would raise your right hand and be sworn.

[Congressman Daschle sworn.]

TESTIMONY OF HON. THOMAS A. DASCHLE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF SOUTH DAKOTA

Mr. DASCHLE. Mr. Chairman, I want to thank you for providing me this opportunity. I want to commend you and Mr. Lent and the rest of the committee for giving us this opportunity once again to address an issue that is becoming one of the centerpieces of the concerns of Vietnam veterans anywhere in the country. I apologize for not being here sooner. As you correctly stated, we had a bill on the House floor today that is somewhat of a disappointment, because the bill as it came out of the Senate included some language that would have affected victims of agent orange. For some unknown reason, in my opinion, that legislation or that part of the legislation was dropped, as was stated by the leadership of the Veterans' Affairs Committee, for reasons of germaneness; but I am very disappointed with that action. For that reason, I went to the floor to discuss the reasons for it, for dropping that very important part of this particular bill.

I want to announce, however, that as a result of the colloquy that we have just had on the House floor moments ago, the leadership of the House Veterans' Affairs Committee have promised us that very early in the next session of Congress, we will take up for the first time an agent orange compensation bill.

I am delighted to make that report, and I think it shows the kind of progress that, as a result of hearings such as this, we have been able to make.

As chairman of the Vietnam veterans in Congress, I certainly share your concern on the issue of agent orange, and appreciate this opportunity to testify.

I introduced legislation, H.R. 6377, earlier this year, which authorizes compensation and priority medical treatment for those veterans, as well as change the burden of proof of exposure from veterans to the VA where it should properly rest.

So far over 100 Members of Congress, including many of the members of this subcommittee, are cosponsors of this legislation, which I believe, Mr. Chairman, is indicative of the sensitivity that there is in the Congress to the unique readjustment problems that

Vietnam veterans have had to bear as a result of their participation in an unpopular war.

This legislation, as you can imagine, has been resisted by the Veterans' Administration because they feel there is not sufficient evidence that exposure to agent orange causes any long-term health problems. In effect, they are saying more evidence is necessary. This really brings us to the whole crux of the problem. How much and what kind of evidence will it take to persuade the VA of the validity of the veterans' claims that exposure to agent orange is affecting their health?

Let me very quickly review recent evidence that has been compiled and analyzed by the Veterans' Affairs Committee and the Interagency Work Group on phenoxy herbicides. With regards to the recently released European epidemiology studies conducted by Swedish scientists, the IWG panel said: " * * they do show a correlation between exposure to phenoxy acid herbicides and an increased risk of developing soft tissue tumors or malignant lymphomas." I would like to emphasize that one of these studies found a sixfold increase in the risk of obtaining soft tissue sarcomas for exposed Swedish workers. The panel also commented with regards to a National Cancer Institute and national toxicology program study that: "dioxin was carcinogenic in rats and mice * * * and extends the observation that 2,3,7,8-TCDD is a carcinogen to a second animal species."

This study I might point out found thyroid tumors, fibro-sarcomas—cancer of the ligaments and muscles—and liver cancer. These confirm earlier studies on animals that have found cancer at low as well as high dosages. Again, I would ask how the VA can continue to ignore this evidence. The scientific panel also said that chloracne:

* * * should, as a practical matter, be accepted as a priori evidence of herbicide orange exposure.

Perhaps the VA will concur with the scientific panel and in their reexamination of 850 veterans with skin conditions find chloracne, and compensate accordingly.

I would also like to comment on a couple of other matters relevant to this issue. In hearings held 2 months ago before the Veterans' Medical Facilities and Benefits Subcommittee it was learned that the Dow Chemical Co. was aware in 1964 that in their production of 2,4,5-T an unavoidable byproduct was created, later identified as dioxin—TCDD. Unfortunately, Dow did not feel a professional or ethical obligation to notify any of the users of its product, most notably the USDA and DOD, of its discovery. Instead, they only informed various departments with the State of Michigan as well as the other producers. Dow claimed that they took steps to reduce the dioxin content in 2,4,5-T to 0.1 parts per million or 0.05 PPM, but analysis of agent orange stocks in the early 1970's found that the dioxin content was 10 to 20 times higher than the levels Dow said they were producing at and what is now allowable for certain domestic usages. Though Dow may have in fact lowered the dioxin content in its production of 2,4,5-T, it appears likely that the other chemical companies did not take such precautionary measures. As we are all aware, the Congress has passed legislation to establish a chemical superfund. I support this concept and I believe

that it could very well be applied to the chemical companies responsible for the manufacture of agent orange as well. I have asked the Department of Justice to look further into whether Dow and the other chemical companies may have violated any laws by withholding this information and whether they may be liable to pay reparations to veterans and their family members.

Another matter which concerns me is the Department of Defense's inability to document exposure of a ground force of battalion size for the VA's epidemiology study. Though it may be impossible to document actual exposure, I find it difficult to believe that a unit cannot be found that was in close proximity to an area recently defoliated. Not only was the GAO quite successful in documenting the approximate location of several Marine units in I Corps, but I know for a fact that records do exist for at least one ground unit—11th Armored Cavalry—which give precise locations of individual troop units for at least a 3-month period. These locations were often updated several times daily, and even by the minute, as various incidents including contact with the enemy occurred. It would not seem that difficult to match the grid coordinates of this unit with those on the herbs tapes as the GAO did to determine proximity to and likelihood of exposure.

In conclusion, it appears at this time that the VA will disregard any and all scientific evidence on the harmful effects of dioxin as they have in the past until their own study is completed on Vietnam veterans. If this is in fact the case, it is a repudiation of the independent scientific research, which is most unfortunate. If this is not the case, the VA must immediately establish a framework to govern the use of existing and future scientific animal and human evidence. If animal studies are inappropriate, what kind of, and how many human studies must be done? If the Swedish case-control studies are not statistically significant, how many people must be included for a case-control study to assume statistical significance? Precisely how much "suggestive" evidence will it take to become "conclusive"? The recently passed Heinz/Cranston amendment in the Senate was a proper step in this direction. I am sorry it was deleted today. Even if such a framework is adopted by the VA, and I quote from the Chair of the IWG: * * * it is becoming increasingly apparent that science is not likely to be able to answer all of our questions. I certainly share this view of the inherent limitations of epidemiology which emphasizes the futility of waiting for definitive evidence which may never appear. Thus, I propose that the policy decisions be made on the basis of existing evidence and that the VA and Air Force epidemiology studies be utilized to confirm or deny the link of dioxin to serious health problems and birth defects. But to make Vietnam veterans wait for additional inconclusive evidence when the evidence we already have is so amazingly clear, is to renege on our commitment to these men before they went to war and to discredit the very principles the VA was founded on.

Thank you, Mr. Chairman.

Mr. GORE. Thank you very much. I appreciate your testimony.

Mr. LENT. I have no questions. I want to commend my colleague on his interest in this subject and the leadership he has demonstrated.

Mr. GORE. Let me just ask a couple of questions. I think we have asked you to stay too long already, but one of the key steps that needs to be taken, it seems to me, is to get this information on the troop units that were exposed to agent orange. I wonder if you are familiar with the radiation study that the Department of Defense conducted to try to find the victims of radiation exposure?

My understanding of that is that they did not just stop with one or two units, but they kept looking. They persisted. They did not give up at the first rebuff. They were subsequently able to find 175,000 out of the 200,000 people believed to have been exposed during the bombing tests, and find them by name and locate them.

It seems to me that a similar kind of effort could be made in this case. Certainly the records are newer, and it should be possible, if they would put the effort into it.

Mr. DASCHLE. Mr. Chairman, I certainly agree with you. I am familiar with the radiation studies. Indeed, your number is quite accurate. I might relate just briefly of an incident that has just occurred in my own State of South Dakota. We have a Vietnam veteran who is deeply concerned about this issue and has been able to trace back to the exact locations those areas in which he was located in the I Corps; and in fact, has come to find out he was within 15 miles of those areas that were sprayed. If he can do it, given the resources of one individual, certainly the Air Force with their amazing computer capacity and the Veterans' Administration, working together, should be able to do the same for the rest of the veterans.

Not categorically, not without exception. I am sure there are times when there will never be a conclusive answer to the location of some people; but as you say, that can be done. It should be done.

Mr. GORE. As you know, this issue and the approach by the various bureaucracies to this issue has become kind of a symbol of the approach taken to the needs and problems of Vietnam veterans. It seems to me that that is yet one more reason why the Government ought to redouble its efforts to give the kind of response that is really called for and that is deserved by the people who are out there experiencing these problems.

Thank you again for coming today. I appreciate it very much.

Mr. DASCHLE. Thank you.

Mr. GORE. Our next witness is Mr. Lewis Milford, counsel for the National Veterans Law Center, accompanied by Lewis Golinker.
[Witnesses sworn.]

Mr. GORE. Without objection, the entire text of your statement will be inserted in the record. [See p. 128] Please proceed with the presentation of any or all of it as you see fit.

TESTIMONY OF LEWIS MILFORD, COUNSEL, NATIONAL VETERANS LAW CENTER, ACCOMPANIED BY LEWIS A. GOLINKER, COUNSEL

Mr. MILFORD. The National Veterans Law Center is a public interest law firm affiliated with the American University Law School in Washington, D.C. We represent the National Veterans Task Force on Agent Orange and also the National Association of Concerned Veterans, as well as thousands of other veterans in Federal class action lawsuits here in Washington. The testimony

we give here today is that of the center, which has been acting on behalf of these clients for more than 2 years to challenge the Government's actions in the agent orange area. I would like to give you a brief summary of our clients' concerns with the Government's actions in this area, particularly the closed and uninformed decisions which have been made by the Veterans' Administration concerning agent orange, the recent recommendations of the White House interagency group, and the recent decision by the Air Force to refuse to disclose to the public a report of agent orange spraying missions on the grounds of national security. That caused us yesterday to file suit in Federal court here to obtain that information under the Freedom of Information Act. I will talk about that toward the end of our testimony.

With regard to the VA, what is tragically wrong with the VA's actions in this area is that the VA consistently and with gross insensitivity has ignored the views of Vietnam veterans and independent scientists in the area of development of public policy in this area. Indeed, the VA has resisted all efforts to provide a public forum on these scientific and policy issues. This alone has caused a serious loss of public confidence in its ability to handle this problem. A brief history of the VA's action in this area sadly demonstrates this problem. You will note in Administrator Cleland's testimony a reference to the VA Advisory Committee. That committee is now in place and provides the VA with factual and scientific information on agent orange. What you will not find in that testimony is how the advisory committee came about. The advisory committee came about only after our clients threatened litigation against the VA to force it to hold public meetings after it was discovered that the VA was meeting in private with scientists, including representatives of the chemical manufacturers. That occurred in 1978.

Only then did the VA provide for public hearings. In addition, you heard this morning references to rulemaking. The VA has refused to conduct a public rulemaking proceeding on these controversial scientific and policy issues, and it has refused to do that for 2½ years. As the committee knows, in early 1978, the VA issued rules on agent orange. The rules now state that there are no long-term health effects which exist as a result of exposure to agent orange. That rule was issued in secret without any prior public participation, without the views of independent scientists, and without the views of Vietnam veterans. What is particularly curious about this is that 4 days later, after the issuance of this rule in April 1978, the Environmental Protection Agency instituted its first emergency suspension of dioxin, and has since then conducted open-trial-type proceedings on the health hazards that result from exposure to dioxin. The VA has relied on these rules to deny, as of the spring of this year, approximately 1,300 disability claims.

We filed suit on behalf of our clients in May 1979 to require the VA to act as other Federal agencies do to conduct public rulemaking proceedings on the compensation standards, the scientific evidence, and on many of the issues you have heard discussed this morning.

The VA has defended that suit for the last year and a half and argued vociferously that it has simply no duty to conduct public

rulemaking on the health hazards that result from agent orange exposure, on the compensation policy, or on any other issues that relate to agent orange.

Indeed, under these rules, the VA has required veterans to demonstrate exposure to agent orange before it would even really consider the claims. That is contrary to a statement you will see in Administrator Cleland's testimony that it has always been the policy of the VA to accept proof of exposure from a veteran's allegations without further evidence. It is simply the case that between April 1978 and February of this year, the VA required veterans to prove exposure, exposure that should have been demonstrated, the VA says, in the veteran's service record.

The failure to conduct rulemaking on the part of most Federal agencies is simply inexcusable. On the part of the VA, it is simply outrageous, because the VA, as you may know, is also completely insulated from judicial review by statute. All of these individual VA decisions we are talking about, the 1,300 denials, cannot be reviewed in Federal court. So the situation is that the agency is completely insulated from court review and from public scrutiny.

The third issue I would like to touch briefly on is the conduct of an epidemiology study. As you know, in December of last year Congress ordered the VA to begin a health study of agent orange. It did so because the VA refused to begin a health study of its own. In fact, our clients asked, in December 1978, that such a health study begin, and the Veterans' Administration refused.

In response, the VA began contracting out for that study.

The scientists we talked to said that a knowledgeable scientist would simply not participate in the contracting process as was described by the VA in its request for proposal of submission of bids. I would like to point out a couple of points about the contracting process. First, the VA made the decision that it would contract out for the design of the study; it would purchase or buy a study protocol, but the agency itself would be responsible to conduct the study and be responsible for the monitoring of the study. The VA decided this even though it has no epidemiologist on its staff and has not hired one since the beginning of the process.

In addition, the VA excluded from participating in this contracting process scientists such as Dr. Irving Selikoff, by name, and took the position that anyone with a prior publicized position on the health effects of phenoxy herbicides would be excluded from consideration in the contract. The VA explained to us what this meant. Its position on bias is as follows: It says that a scientist who has taken a prior publicized position, that is, someone who has stated in the press or had their position publicized, that phenoxy herbicides may be of some danger to human health, would be excluded from consideration in the contract, but on the other hand, a scientist who may have an industry affiliation or some association with the chemical industry would not be excluded from consideration in the contract if that person's position was not publicized. That strikes us as a very curious distinction which has nothing to do with bias.

Finally, the VA has simply refused to consider the views of Vietnam veterans and outside scientists before it decides to award the contract. The result again was that we filed a lawsuit in May

of this year for all of these problems; and now the General Accounting Office is reviewing these allegations and it is under review at this time.

You will note in Administrator Cleland's testimony that it is our lawsuit which is preventing the agency from going forward on the contract.

Our clients are concerned that this study be a good one and if it go forward, that it be a credible one. That is why we are presenting these claims and have filed the lawsuit.

The VA is not the only actor in this issue, of course. In December of last year the White House Interagency Group was created, presumably because of the policy failures demonstrated by the VA and the Defense Department. The work group certainly represents an important step which has elevated the Government's attention to this issue from one of relative indifference to one of real and sincere concern. However, we do have some basic differences with the two recent recommendations of the work group. The two recommendations which have been referred to are that the Air Force conduct the study of the ranch hand personnel on the condition that some sort of peer review group be established to shore up any credibility problems that the National Academy of Sciences noted several months ago, and that future scientific investigations of Vietnam veterans focus on the health effects that result from Vietnam-wide service rather than agent orange, because of the difficulties created by developing agent orange exposure data of ground troops.

As to the Air Force ranch hand study, you have heard this morning some differences of opinion on the credibility issues associated with the ranch hand study. The clients that we represent simply do not believe the results of the study that may be performed by the Air Force. That is not to impugn the integrity of the Air Force, their ability, or the merits of such a study, but we are talking about a serious issue of public credibility. As you heard this morning, this group is the best study group that may be developed of all possible exposed Vietnam veterans. Certainly that should be the best study. It should be a study that arrives at results that the constituents believe, that the Vietnam veterans believe. That is the purpose of the study. Those are the people we are concerned with.

I would like to point out an important distinction. The conflict of interest that has been raised and the credibility problems raised with the Air Force study are not simply esoteric questions. As I understand it, this is a common and serious problem with agencies that have the responsibility both for the protection of the public health and the promotion of agency programs that jeopardize public health, in this case toxic chemical weaponry. We have there a classic conflict of interest where an agency is conducting public health investigations in areas in which it has a vested interest.

Our clients say that a peer review committee simply will not resolve these credibility and conflict-of-interest problems. At best an independent agency should conduct that study, an independent agency whose results will be believed.

The second recommendation concerns the Vietnam service study. The principal basis for the Vietnam service study is that, as you have heard, it is impossible to document to a sufficient number of

exposed ground troops such that a good epidemiology study can be done. The question suggested this morning, and the important question, is how has this data been developed? How have the conclusions been reached that it is impossible to come up with a sufficient number of ground troop data? The problem is that it is the Air Force that has developed this information and has concluded that it is apparently impossible to develop sufficient number of ground troop exposures. The role of GAO in this matter, as you heard in December, questioned previous Defense Department estimates, and it is not clear at all what their role was in the independent evaluation of this information. There were suggestions made about the radiation study. I think those are good. As you have heard, there has been a serious, concerted effort to identify those people. We are talking about the identification of 200,000 names and perhaps current addresses of these people in the radiation area.

I would just bring up the last point. This goes to the excessive reliance of current Government agencies' actions on the Air Force. Several months ago, a graduate student who we represent requested from the Air Force a report that it was preparing of the operation ranchhand missions. She had reason to believe that the report constituted a rather critical self-evaluation of the ranchhand operation, of the entire spraying operation from 1962 to 1971. It was being prepared by the Air Force Department of History. The response under the Freedom of Information Act is that the report is classified "Top Secret" because it contains national security information.

That has been the position of the Air Force for the last 6 months. Yesterday we filed a lawsuit here in Federal district court to require disclosure of that report. Again it presents some very serious questions about the efforts of the Air Force in this area to disclose all the information that is available in operation ranchhand. If it is being relied on for these estimates, we have to consider carefully the kind of, perhaps, selective information that is being released.

To conclude, many of the actions in this agent orange area demonstrate Government at its worst: uninformed, influenced by self-interest, and all too often acting without any compassion. These sick and dying veterans deserve much more than that.

[Testimony resumes on p. 192.]

[The prepared statement of National Veterans' Law Center follows:]

STATEMENT OF THE
NATIONAL VETERANS LAW CENTER

Submitted by:

Lewis M. Milford
Ronald Simon
Lewis A. Golinker

Mr. Chairman and members of the Subcommittee, my name is Lewis Milford, at the witness table with me are Ronald Simon and Lewis Golinker. We are lawyers with the National Veterans Law Center (NVLC) in Washington, D.C. The Law Center is a public interest law firm affiliated with the American University School of Law, specializing in the legal problems of veterans. The Law Center is General Counsel to the National Veterans Task Force on Agent Orange, a national coalition of veterans organizations concerned with the Agent Orange issue, General Counsel to the National Association of Concerned Veterans, a national Vietnam veterans membership organization, and counsel on behalf of thousands of Vietnam era and other veterans in numerous federal class action lawsuits and federal administrative hearings.

We are pleased to be before the committee to discuss the government's actions regarding the herbicide Agent Orange, hereafter referred to as Agent Orange. In particular, our testimony will address the actions of the Veterans Administration (VA) and Department of Defense in this controversy, as well as those of the Inter-Agency Work Group on the Health Effects of Phenoxy Herbicides (Work Group).

We are here to discuss the actions of the Veterans Administration in response to the growing number of complaints that many Vietnam combat veterans are suffering from cancer, liver problems, genetic damage, and a host of other health problems. These actions demonstrate a history of closed and uninformed decision-making by the Veterans Administration. The agency consistently has made decisions that have kept the public, Vietnam veterans, and informed scientists out of the process of deciding whether health problems may be related to exposure to Agent Orange. The agency has refused to conduct a comprehensive outreach program, has not complied with the most fundamental federal laws on the participation of the public in its decision-making, and has recently begun a process of conducting a health study in violation of basic procurement laws and the express will of Congress.

In effect, the agency has made the wrong policy and scientific decision at every critical juncture in the development of this issue. Sadly, this two year history of closed and secretive decision-making continues to the present, in the way in which the Veterans Administration has begun to conduct the epidemiological study of Vietnam veterans mandated by Public Law 96-151. The Veterans Administration actions are evidence of neither the serious consideration of this problem as a potentially significant public health crisis or the recognition of the need for the development of comprehensive scientific information in a public forum. This secretive and closed decision-making has had tragic consequences.

The agency established to protect and care for veterans essentially has lost the faith of those veterans. The scientific basis which is necessary to develop sound public policy in this area has only begun to be developed some two years after complaints of health problems began to arise. Veterans and their families have become distraught and have less faith in their government's ability to resolve this problem. How this tragic example of indifferent public policy and insensitive action began is instructive because the errors which have been made in the past can be avoided so that we can move on to attempt some future resolution of this problem.

Perhaps the greatest consequence of these actions is that the agency has ignored a basic democratic principle: the traditional devotion to open discussion of conflicting views. The VA, as a result, appears to have expressed hasty and unconditional support for scientific conclusions which have not been tested by the traditional notions of open scientific and political discussion.

In December, 1979 the Work Group was established principally to provide a central place in the government for dioxin-related activities. The Work Group has demonstrated expertise in these areas and has become a hopeful sign for intelligent policy making in this area. However, recent recommendations of the Work Group and its Scientific Panel deserve the close public scrutiny which hearings such as this can provide.

We approach this issue from the perspective of lawyers familiar with the administrative process and the historical Congressional insistence that administrative agencies be open and responsive to the public. This insistence is reflected in the passage of numerous federal laws requiring public disclosure and public participation, such as the Administrative Procedure Act, 5 U.S.C. § 553, the Freedom of Information Act, 5 U.S.C. § 552 and the Federal Advisory Committee Act, 5 U.S.C. App. 1.

What follows is a history of the Veterans Administration's actions in the Agent Orange area in disregard of these laws, the critical problems created by these unlawful actions and a discussion of the Work Group efforts which could influence significantly the conduct of future scientific investigations and public policy concerning Agent Orange. We will also discuss the recent Agent Orange legislation which passed the Senate a few weeks ago.

To summarize our basic recommendations, we propose that (1) Congress mandate the VA to conduct a national outreach program concerning Agent Orange; (2) Congress mandate the VA to comply with existing law and conduct a public rulemaking proceeding on the health effects of Agent Orange exposure; (3) Congress order the VA not to award the contract for a study design in accordance with Public Law 96-151 until the Government Accounting Office has concluded its investigation of procurement and other

violations that have been alleged regarding the contract process; (4) Congress order the VA to consider the views of Vietnam veterans and outside scientists before a contract for a study design is awarded and the opportunity for a credible study is lost and urge the VA to contract the entire study to independent scientists; and (5) the House of Representatives consider carefully the merits of the recent recommendations of the Work Group which were adopted on September 4, 1980 by the Senate in the form of an amendment to Public Law 96-151, in particular the elimination of Agent Orange-exposed veterans as the principle group to be studied and the shift in focus away from Agent Orange-related research to studies of Vietnam service-related ill health effects.

Early History of Veterans Administration
and Defense Department Actions

The public history of the Agent Orange issue is now a familiar one. The hundreds of disability claims, extensive press coverage and agency pronouncements are matters of record. But the more revealing history of the less publicized scientific and policy decisions has not received the needed public scrutiny. For more than two years the Veterans Administration has been engaged in a series of secretive, closed and often ill-informed actions that are tragic examples of how the Veterans Administration has failed to respond and in fact has exacerbated a major

public health crisis. The agency's actions have been characterized by one significant fact: the VA consistently has resisted necessary public scrutiny of its actions and as a result consistently has made incorrect and often unlawful decisions.

Soon after many veterans began complaining of health problems in late 1977 and early 1978, the Veterans Administration haltingly responded. The first agency meetings to evaluate the Agent Orange problem and prepare a position were held in early 1978. Representatives of the government and two representatives of the herbicide manufacturers attended. No members of the public, in particular Vietnam veterans or non-industry scientists were invited to participate in these crucial meetings, where the groundwork for the current "no health effects" position was established. On behalf of its client, the National Association of Concerned Veterans, the Law Center threatened the VA with a lawsuit charging that the agency was conducting these meetings in violation of the open meeting provision of the Federal Advisory Committee Act, (FACA), 5 U.S.C. App. 1. Only after being threatened with litigation and after one full year had passed, did the Veterans Administration open such Agent Orange meetings to the public and invite other scientists and the public to participate in these deliberations. These threats led to the creation, in April, 1979, of the Veterans Administration Advisory Committee on the Health Related Effects of Herbicides. However, the pattern of VA unlawful action had begun.

This Advisory Committee is now relied on by the Veterans Administration as an example of the open and informed manner by which the agency obtains informed scientific information on Agent Orange. However, these pronouncements ignore not only the Advisory Committee's history but its limited use by the agency on important Agent Orange matters. For example, the Advisory Committee has yet to be consulted on the VA preparations for the epidemiology study, now ordered more than seven months ago by Congress. The VA plans to allow the Committee's input only after the award of the contract for the study design, when it would be essentially too late to influence the study process. In the same way, the Committee was never formally requested for suggestions on the preparation of the Request for Proposal for the study design. As a practical matter, the Advisory Committee has been ineffective as a device to obtain scientific advice on Agent Orange matters. This is a result which is the agency's by design, not the fault of the Committee members.

Because of the agency's initial decision to ignore the open meeting mandate of the FACA, months of valuable time were wasted and the public, and veterans in particular, were left with the impression that the agency did not want public input from those persons the agency was designed to protect or from scientists most knowledgeable about the problem.

Soon after the creation of the Advisory Committee, in December, 1978, we wrote on behalf of our client the National Association of Concerned Veterans a lengthy letter to Administrator Cleland, suggesting several courses of action in the Agent Orange area. Among other things, we suggested that the agency conduct a comprehensive, outreach program to locate veterans and ask them to come into the Veterans Administration hospitals for complete medical examinations to determine whether they were experiencing unusual health problems. We suggested that the agency conduct an epidemiological study to determine whether an increased incidence of health problems was occurring among Vietnam veterans. We also suggested that the agency discontinue the practice of denying Agent Orange disability claims since the agency conceded that it did not have adequate information on exposure or causation to decide intelligently the merits of these claims.

In a May 30, 1979 response, Administrator Cleland completely rejected our suggestions. He stated that an outreach program would not be appropriate for the following reason: "[a]t this time of inconclusive scientific information on the effect of herbicide exposure there appears to be no medical basis for the Veterans Administration to engage in a special outreach program." Since no outreach program has yet been instituted, the agency apparently takes the position that some form of definitive proof of the harmful

effects of Agent Orange exposure is needed before a more compassionate outreach program is needed. The absurd logic of this position is painful: that there are insufficient data on harmful effects to justify an outreach program the purpose of which would be to generate data on possible harmful effects and then provide a basis for the VA to warn veterans of any such effects. The Administrator also rejected the outreach program suggestion because he said that such action would needlessly create fear about Agent Orange among Vietnam veterans. This oft repeated argument of raising fear is not only a patronizingly repugnant way to view our combat veterans but is also fallacious because whatever fear has been engendered, is increased more by ignorance rather than by providing needed assistance and information.

In the same letter, Administrator Cleland stated that a clinical evaluation of veterans who presented themselves at VA hospitals would be a sufficient scientific method to identify unusual health problems. He also approved the agency's practice of denying all Agent Orange claims despite the fact that the agency had inadequate information to evaluate the exposure and causation issues. This practice continues to the present, with substantial harm to unsuccessful claimants who, once rejected, may never return to the compensation system to take advantage of any future liberalization of the eligibility rules concerning Agent Orange claims. The VA never has individually notified eligible claimants of favorable changes in benefit rules.

The Veterans Administration consistently has maintained that no data exist to connect Agent Orange exposure to any long term human health effects. This opinion was first developed in early 1978 as a result of the agency's meetings with the herbicide manufacturers, and has been reinforced during the next two years by the agency's contact with the U.S. Air Force. During this same period, however, the Environmental Protection Agency, which for ten years has been investigating questions of toxicity of the Agent Orange component 2,4,5-T and its dioxin contaminant, has reached a diametrically opposite conclusion. In four inter-related actions EPA has concluded that dioxin is sufficiently hazardous to warrant the ban of certain uses of products containing 2,4,5-T.

On April 21, 1978, four days after the Veterans Administration issued in secret, without public notice or opportunity to comment, its seven paragraph, one page Agent Orange Program Guide, which stated that chloracne was the only long term health effect that could be associated with Agent Orange exposure, the Environmental Protection Agency published in the Federal Register a 40 page Rebuttable Presumption Against Registration ("RPAR") for 2,4,5-T. This RPAR document summarized the basis for the EPA conclusion that 2,4,5-T was hazardous to man, and included a bibliography containing 179 articles and study reports.

Eleven months later, the Environmental Protection Agency took its second action, by issuing an "emergency suspension" of certain uses of products containing 2,4,5-T. This order also was published in the Federal Register, was issued with widespread public notice, was 94 pages long and provided even greater information concerning the human health risks posed by 2,4,5-T. In addition, this order was immediately challenged in Federal Court by the herbicide manufacturers, but the EPA suspension order was upheld. At present, a formal cancellation proceeding, designed to make permanent the ban on these uses of 2,4,5-T is in progress. This cancellation is a trial-type administrative proceeding which is expected to require 18 months to complete.

During this entire two year period, in which one agency of the government, the EPA, has moved vigorously to end certain 2,4,5-T uses, the Veterans Administration has issued nothing more formal than its one page Agent Orange Program Guide. The Veterans Administration has never stated the basis for its "no health effects" conclusion; thus, this conclusion cannot be scrutinized by the public, in particular, by independent scientists. On March 7, 1979, a mere 7 days after the EPA suspension order was issued, the Veterans Administration steering committee reported that the EPA emergency suspension action was "premature," and that "[t]he studies on which the EPA ban was based do not offer definitive evidence for an adverse effect of herbicides on human health." In one

week the Veterans Administration concluded the EPA action was not persuasive. Moreover, when asked through a Freedom of Information Act request for any scientific evidence that would support this analysis, the agency responded that no documents were available.

In the one year that has passed since that judgment about the EPA suspension was made, there has been no further discussion of this matter at either the VA Agent Orange Steering Committee or even at the VA Agent Orange Advisory Committee on which an EPA representative participates. In addition, when the VA held two "educational conferences" on Agent Orange for its hospital staff, EPA was not invited to participate or make a presentation. Moreover, when Congressmen Bonior and Daschle requested the VA to consider the significance of 5 newly discovered human epidemiology studies on workers and others exposed to dioxin, which EPA has spent considerable sums to evaluate, and which have been incorporated prominently in that agency's brief in its cancellation proceeding, the VA responded in a mere 12 days and concluded that they were not sufficiently persuasive to suggest any further action by the VA. Finally, notwithstanding all of the evidence that has been developed by the EPA and others during the past two years, as recently as May 6, 1980, Administrator Cleland stated that the basis for his opinion that Agent Orange does not cause any health problems is a 1974 National Academy of Sciences report.

The Administrator's most recent statement that he is relying on a 6 year old report for his opinion that there is no evidence that Agent Orange causes long term health effects also is evidence of the failure of the VA, in the two years that have passed since the VA has faced the Agent Orange issue, to perform a literature review or analysis of the substantial research that exists concerning the health effects of dioxin. Indeed, in order to comply with the statutory mandate of P.L. 96-151 which states that the VA shall conduct an Agent Orange literature review and analysis, the agency's response has been to issue a Request for Proposal for the whole project to be performed by an independent contractor. If the VA's existing position on Agent Orange toxicity had been based on such a literature review, however, the agency might be less emphatic in denying that Agent Orange causes long term health damage.

Thus, the Veterans Administration, which acknowledges that it has no expertise in the area of environmental toxicology, has formulated and maintained a public policy conclusion that is a divergent, if not completely contrary view of the health effects of dioxin exposure as that taken by the agency of the government with the greatest expertise in this area. Again, these positions were taken without any participation of independent scientists, Vietnam veterans or members of the public.

Of course, the EPA scientific conclusions concerning regulatory action on 2,4,5-T and dioxin are not in and of themselves determinative of the compensation decisions that must be made by the VA. Nonetheless, the scientific investigation of the EPA must be given careful consideration by the VA if sound public policy is to be made.

Development Of Agent Orange Disability Rules

The internal and informal position of the Veterans Administration that Agent Orange causes no health problems became formal agency policy in April, 1978, when the agency issued a document called the Agent Orange Program Guide. The Program Guide was distributed to all Veterans Administration regional offices to be used to adjudicate veterans' claims for Agent Orange-related disabilities. This document reflected the agency's position that the scientific evidence did not support a finding that Agent Orange caused any of the health problems alleged by Vietnam veterans. In addition to this "no health effects" position the document contains two other important rules that the agency has used to deny Agent Orange claims. One rule states that the agency will not compensate veterans for any alleged genetic damage that they claim is caused by Agent Orange. The agency takes the position that it does not have the authority to award compensation for this type of disability. The second rule contained in the document is that a veteran is required to demonstrate evidence of exposure to Agent Orange in order to receive

compensation on a disability claim. ^{*/} By the spring of 1980, this program guide was used by the agency to deny approximately 1,300 claims filed by Vietnam veterans for alleged Agent Orange-related disabilities.

The importance of this document cannot be overstated. This document reflected the position of the Veterans Administration that the scientific evidence did not demonstrate any health effects from Agent Orange exposure. This document was drafted in secret without the participation of any other government official knowledgeable about this scientific evidence. For example, no official from the EPA or the Department of Health, Education and Welfare (now the Department of Health and Human Services) was consulted before the development of this agency position. No outside scientific information from interested members of the public was solicited before this document was prepared, nor was any member of the Vietnam veterans community consulted before the development of this position.

Federal law requires that an agency must first solicit public comment before issuing rules that adversely affect members of the public, particularly rules that reflect

^{*/} This proof of exposure requirement was changed by the agency in early 1980. Now the agency accepts allegations of exposure in the adjudication of a claim in the absence of contrary evidence. However, there is no indication that the agency has reviewed or reversed any previous decisions which were denied because exposure was not established.

controversial scientific and public policy determinations. 5 U.S.C. § 553. These public notice and comment rulemaking requirements were flagrantly violated by the VA when it issued these Agent Orange rules without prior public participation.

Faced with this unlawful absence of public participation in the development of highly controversial scientific and political decisions, we filed suit on May 31, 1979 in the Federal District Court in Washington, D.C. William G. White, et al. v. Max Cleland, et al., Civil Action No. 79-1426 (D.D.C. filed May 31, 1979). We filed this class action suit on behalf of all veterans who have been affected or will be affected by this rule, perhaps several hundred thousand Vietnam veterans. The suit was also filed on behalf of several veterans' organizations that are concerned with the Agent Orange issue. The lawsuit challenges the program guide as constituting a formal rule that was neither published in the Federal Register nor promulgated following a public notice and comment rulemaking proceeding, in violation of both the rulemaking provisions of the Administrative Procedure Act, 5 U.S.C. § 553, as implemented by agency regulation, 38 C.F.R. § 1.12, and the mandatory publication requirements of the Freedom of Information Act, 5 U.S.C. § 552. The purpose of the suit is to implement the mandate of Congress that agencies' promulgation of rules of importance that affect substantial numbers of the public should be based upon the full public and judicial scrutiny that is central to a public rulemaking action. The Veterans Administration

failed to conduct such public proceedings and refused to evaluate for the record and for subsequent judicial review the substantial body of scientific evidence concerning the possible ill-health effects resulting from dioxin exposure.

The White case requests four-fold relief. We have asked the court to invalidate the Program Guide and the position taken in that document. Secondly, we have asked the Court to invalidate all Agent Orange claims decided since April 1978, when the Program Guide was issued, because those decisions were made in accordance with unlawfully promulgated rules. Third, we asked the Court to require the agency to conduct public rulemaking proceeding on the issue of Agent Orange rules. Fourth, we asked the Court to require the Veterans Administration to notify all individual claimants that they can defer action on their claim until the agency has conducted a full and fair public rulemaking proceeding and developed Agent Orange rules. Oral argument on our motions for summary judgment and class certification was heard in the case on February 1, 1980, and the decision from the Court is awaited.

The Veterans Administration's litigation position in the White suit is another example of the agency's failure to recognize at least the common decency of listening to Vietnam veterans and the importance of listening to independent experts on this issue. The agency has taken the position that the veterans have no right, that is, they have no standing, to challenge the agency's refusal to conduct public rulemaking. They make the rather incredible argument that

that Vietnam veterans have not been sufficiently injured by the rule to challenge the fact that public rulemaking was not conducted before the rule was adopted and used. Second, the Veterans Administration takes the position in the White case that 38 U.S.C. § 211(a) prevents a court from reviewing its decision not to conduct rulemaking. That interpretation of Section 211(a) appears to be the broadest interpretation to date of the scope of that section which has been interpreted by several United States Court of Appeals to bar review of only individual Veterans Administration decisions. ^{*}/ The agency takes the extraordinary position that it has the discretion, unlike any other federal agency, to decide whether it would comply with its own regulations at 38 C.F.R. § 1.12 which require the agency to conduct rulemaking. Indeed, the agency has argued in open court that the conclusions about science in the challenged Agent Orange Program Guide would have been the same, even if a rulemaking proceeding had been conducted. This indifference to the principle of open and participatory government decision-making is inexplicable in light of express Congressional mandates, but particularly because of the highly controversial nature of this issue. Confronting this law-

^{*}/ See, Evergreen State College v. Cleland, No. 79-4372 (9th Cir. June 23, 1980); University of Maryland v. Cleland, No. 78-1211 (4th Cir. May 15, 1980); Merged Area X (Education) v. Cleland, 604 F.2d 1075 (9th Cir. 1979); Wayne State University v. Cleland, 590 F.2d 627 (6th Cir. 1978).

less position compels the obvious remark that such a view leads to a government of men not law. One would also assume that the agency would desire the most objective and comprehensive scientific and public policy information before it issued rules on this subject.

Unfortunately, the issuance of the Agent Orange rules and the litigation which followed is all too familiar and consistent with the pattern of Veterans Administration closed decision-making. This type of decision-making is not confined to the Agent Orange area. ^{*/}

It must be emphasized that the VA at any time could decide or Congress could mandate the VA to conduct public rulemaking on the Agent Orange issue. The agency need not hide behind the pending litigation and there are no other reasons why the agency should not make this decision. Indeed, the agency's own regulations require rule-making (38 C.F.R. § 1.12).

^{*/} The Veterans Administration took similar action regarding disability claims filed by the veterans who participated in the atmospheric nuclear testing program and in the clean-up operations in Hiroshima and Nagasaki. In August of 1979, the agency issued another Program Guide which contained the compensation rules to determine whether those veteran's disabilities were related to radiation exposure (44 Fed. Reg. 49090). The agency again failed to conduct a public rulemaking proceeding on the issue of the health-related effects of radiation exposure. That Program Guide is the subject of the other litigation filed by the NVLC, Gott, et al. v. Cleland, et al., Civil Action No. 80-0906 (D.D.C. filed April 10, 1980). Relief similar to that requested in the White suit has been requested in the Gott suit. The agency is expected to take a similar position that veterans cannot contest such actions in court and the agency has unbridled discretion to decide whether rule-making should be conducted.

Veterans Actions Regarding Agent Orange

The agency's refusal to allow the participation of outside experts and veterans in this matter has had expected results. These actions have precipitated a mass movement on behalf of Vietnam veterans. This movement has begun because of the perception by many Vietnam veterans that the government simply is not doing enough to give them proper consideration on their complaints that their health problems are related to Agent Orange. Perhaps more than any issue since the Vietnam war Agent Orange has brought together many people affected by that war to join in the struggle to compel fair and compassionate government action.

These Vietnam veterans organizations which have organized around the Agent Orange issue are a model for citizen self-help activity in the face of government inactivity and unresponsiveness. Numerous veterans organizations have come together to assist their fellow veterans when the government has refused to act, and to force government actions to perform the tasks that traditionally have been considered the function of a protective government. These groups fail to see how a government can ignore its most basic function -- to protect and care for its citizens.

Many organizations have come together and joined in a coalition of Vietnam veterans organizations operating with the National Association of Concerned Veterans known as the National Veterans Task Force on Agent Orange. This coalition, as well as other veterans groups ^{*} has begun to

^{7/} Such as Vietnam Veterans of America, Citizen Soldier, and the Minnesota Veterans Coalition.

conduct outreach programs, develop information on the health status of Vietnam veterans, and disseminate information about the possible effects of Agent Orange to veterans who are in need of such help. These organizations have developed self-help materials such as the Veterans Self-Help Guide on Agent Orange, thousands of which have been distributed around the country to veterans to assist them in filing claims with the Veterans Administration. In addition, one member group of the coalition, the Vietnam Veterans of America, has instituted a toll free number to aid veterans with Agent Orange related problems. In conjunction with that effort, the Self-Help Guide, as well as detailed health questionnaires have been distributed to thousands of veterans to obtain information on the health of Vietnam veterans. Members of the Task Force also have assisted thousands of individual veterans acquire medical examinations from the Veterans Administration and begin to press benefits claims with that agency. In addition, these organizations have begun to provide basic support services by developing a network of local doctors and counsellors to assist Vietnam veterans with possible Agent Orange-related problems.

All of this has been made necessary because of the VA's failure to conduct an outreach program, to disseminate information around the country on the possible effects of Agent Orange exposure and because the VA refused to sponsor an epidemiological study until Congress seven months ago ordered that such a study be done. The VA has done virtually nothing to provide genetic counselling and family support services. Everything that veterans groups have done with

meagre private funds and dwindling support staffs should have been done by the VA long before self-help efforts became necessary. The VA argument that an outreach effort to provide information and inform veterans of available care would needlessly scare veterans becomes particularly specious when one considers the vital demand by veterans for accurate information and intelligent medical care.

Recent Scientific Efforts Of The
Veterans Administration

The VA pattern to refuse public participation in decisions concerning Agent Orange is not a matter of curious historical interest. This resistance to public scrutiny and participation has continued to the present. Without consultation with appropriate government agencies, the veterans community, or independent and informed scientists, the Veterans Administration has embarked on a program to develop scientific information about Agent Orange that will confound rather than resolve the outstanding issues about the health effects of Agent Orange. In particular, the VA has begun to implement the Congressional mandate of P.L. 96-151 by again excluding Vietnam veterans and independent knowledgeable scientists from participating in the study process.

On December 20, 1979, President Carter signed into law Public Law 96-151. This law requires the Veterans Administration to be responsible for an epidemiological study of the long term health effects on Vietnam veterans of Agent Orange. Senator Alan Cranston, Chairman of the Senate Veterans Affairs Committee who was the floor manager of the bill in the Senate, spoke about the importance of such a study. He remarked that the VA had denied all veterans claims for disability based upon the exposure of Agent Orange.

"The denial of almost all Agent Orange claims by the VA is viewed by some Vietnam veterans as suggestions that a deliberate 'cover-up' of irresponsible action by the Federal Government is being carried out in much the same way as information about adverse health effects from radiation was withheld from nuclear weapons test participants in the 1950s and 1960s. . . ."

125 Congressional Record 7831.

Senator Cranston also stressed that it would be "inexcusable if any resulting harm to them (Vietnam veterans) was not discovered because the issue was inadequately studied." 125 Cong. Rec. 7831. He also noted the "anxiety . . . and complaints of psychological origin" that Vietnam veterans have begun to experience about the issue. Senator Cranston also emphasized the need for "scientifically and valid and definitive information about the effects of dioxin on our Vietnam veterans." 125 Cong. Rec. 7831.

In the House of Representatives the obvious need for epidemiological expertise for such a study was recognized by this Committee and the authority of the VA to go outside the agency for such scientific assistance was noted: ". . . the VA has authority, pursuant to Section 213 of Title 38, to enter into contracts with private or public agencies or persons for any necessary services or in connection with any portion of the mandated study". 125 Cong. Rec. 11648 (Explanatory Comments).

On March 19, 1980, the Veterans Administration made available for prospective offerors a Request for Proposal (RFP). The RFP solicited offers from contractors to design an epidemiological protocol or design for the study mandated by Congress. The decision to contract in this manner meant that the VA planned to contract-out for a study design but conduct the study, including the collection and analysis of data in accordance with the study design, by the personnel and with the facilities of the VA. This decision was made despite the fact that the VA does not have an epidemiologist on its staff, nor evidently, does it plan to hire one for the study.

These aspects of the RFP and their affect on the scientific validity and credibility of any results of the planned Veterans Administration study must be analyzed. Significantly, this is the first substantive scientific action initiated by the agency to develop new scientific information on this issue. The signi-

ficant limitations inherent in the RFP are of three types: (1) the defects in the manner in which the proposals have been solicited, (2) the criteria used to evaluate the offers submitted, including the exclusion from consideration of persons who are suspected of having demonstrated bias, and (3) the manner in which the offers will be evaluated for cost and quality of the proposed study designs.

The RFP contains vague and ambiguous specifications that are so fatally defective that qualified offerors would have been discouraged from participating in the solicitation. This inevitably had the result of reducing the number of highly qualified epidemiologists who would submit proposals to the RFP and narrowed the range of qualified scientific evidence that would be obtained through such a study. The VA contract process violates the basic principles of public contract law favoring open competition which is designed to elicit the best product.

Examples of defects in the solicitation are legion. The proposal omitted important data that would be necessary to develop a scientifically valid epidemiological study design, such as the facilities of the agency, the personnel to be used, the type of study populations available for the study, the nature of access to the study population, or the funds available to gain access to this study population. The absence of this essential data is not typical of other government research proposals. Indeed, scientists who reviewed this proposal for the Law Center concluded that only a scientist with inside information about the study design could likely submit an acceptable proposed design.

Further, the absence of such information means that a study design based on that proposal would not adequately address the variety of health questions associated with Agent Orange. Incredibly, the RFP made no reference whatsoever to the detection of cancer, birth defects, or psychological problems among the study population, three health problems specifically noted by Congress in the legislative history of Public Law 96-151. This added further to informed speculation that a person or persons with inside information about the proposal were expected to submit proposals and be awarded the contract. The inadequacy in this RFP establishes a clear contravention of the express will of Congress that the study be scientifically valid, objective and efficient and that the study determine whether there may be long term adverse health effects in veterans who were exposed to Agent Orange.

One of the most significant defects in the proposal is the unwarranted exclusion from participation in the scientific study of highly qualified epidemiologists who could add immeasurably to the knowledge of this issue. The proposal includes an evaluation restriction that the contract would not be awarded to someone "associated with a prior publicized position regarding the effects of phenoxy herbicides and/or their constituents on human health." The restriction is not only vague and ambiguous but there is no significant relationship between the restriction and the need for a scientifically valid study design. That is, this contract contains a per se qualification exclusion which is

both ill defined and unnecessarily broad and will not exclude those persons with real bias from being awarded the contract. Although the evident purpose of the exclusion is to eliminate biased scientists from the process, the real effect will be to eliminate scientists with any knowledge of or interest in the possible human health effects of dioxin. All of the leading scientists in the dioxin field have published their findings in a range of study conclusions and those obviously have "publicized" positions of this issue. The phrase will either unnecessarily restrict the number of qualified offers for the contract on the ground of prior scientific work or will disqualify potential offerors on the ground that they have spoken out in public about their findings. Dr. Jeanne Stellman, an associate professor of public health at the Columbia University School of Public Health has stated that this restriction serves no useful purpose and is an insult to the professional integrity of scientists who have conducted research in this area.

On its face, the provision is also overbroad and arbitrary because, as Dr. Joseph Highland, Chairman of the Toxic Chemical Program of the Environmental Defense Fund, stated:

It does not exclude all parties who might be biased about the question of health effects of dioxin exposure.

That is, scientists who might be biased about the issue but who do not have what the VA considers a 'prior publicized position' on the question would not be excluded from consideration on the contract. For example, this exception would not exclude individuals who have not taken a public position with regard to phenoxy herbicide but who have performed research as employees or paid consultants through a corporation or trade association involved in the manufacture or use of phenoxy herbicides.

Indeed this is precisely the position of the agency which was revealed during a deposition taken in a lawsuit that the Law Center has filed on the contract. Dr. Lawrence Hobson, a VA medical official deposed, stated quite clearly that this restriction would apply only to those persons who have somehow advocated a position in the press, but would not exclude industry scientists if those scientists have not publicly advocated their presumably biased position in the press. Dr. Barry Commoner of Washington University of St. Louis and Dr. Irving Selikoff of Mt. Sinai School of Medicine were scientists specifically mentioned by Dr. Hobson as those who would automatically be rejected for the contract. On the other hand, industry research scientists, according to Dr. Hobson, would be suitable for the contract and would not be excluded by the provision. Thus the proposal contains no real guarantees that grossly biased scientific analysis would not result from the awarding of a contract under the current VA proposal.

These statements reflect an appalling lack of sensitivity to the complex issue of scientific "bias," particularly in this controversial area. This position on bias is ironic in light of Dr. Hobson's own statements regarding the need for scientific integrity of the VA concerning the study. In documents obtained by the Law Center under the FOIA, Dr. Hobson remarked that the integrity of the study "should not only be above reproach, but seem to be above reproach." How a study performed by industry scientists could be beyond real or apparent impropriety is another in a growing list of questions about the ability of the VA to handle this matter.

The third and perhaps the most important problem with the proposal concerns the way in which the agency will evaluate the proposals that are submitted. The agency has determined that it would award a fixed price contract with the award being made to the offeror with the lowest bid price and with an evaluation score above a cut-off point of 80 points or better (points are arbitrarily assigned to qualifications, design factors, etc.). By this provision, the agency has determined that short term cost, rather than the quality of a study design, is the most important factor in the conduct of this study. Under the provision the agency could and probably will award a contract to the offeror with the lowest bid price even though the design might be substantially inferior to a more expensive but scientifically superior study design. It appears that design differences, exclusive of cost, will not be determinative and as a result the scientifically valid study will

not necessarily be approved. The cost determinative method of contract award would not produce the best study design and is the wrong method for obtaining research proposals such as this. Thus, the proposal violates the clear intent of Congress that a scientifically valid study be conducted.

This and other objections were raised by the Law Center in a class action lawsuit filed in Federal District Court in Washington, D.C. National Veterans Task Force on Agent Orange v. Cleland, et al., No. 80-1162 (D.D.C. filed May 7, 1980). Although the Court did not enjoin the opening of the offers for the contract on these grounds, jurisdiction over the suit was maintained by the Court. Also, the Court requested the Comptroller General to review the government procurement violations which we have alleged. Several Congresspersons also requested a GAO review of the contract, including Chairman Roberts of the House Veterans Affairs Committee. Despite these objections the VA has gone forward and has decided that it will award the contract based on this proposal as written.

In addition to these objections, several other points about the integrity and public acceptance of this contract process deserve comment. First, once again the agency has refused to allow public participation from veterans or scientists of offers submitted to the agency. During the entire process, the agency refused to identify the scientific panel on the ground that identifying the members would inhibit the procurement process. Inexplicably, the VA identified the panel members in written Senate testimony on September 10, 1980. The agency

refused outright the Law Center's recommendations to establish a reputable panel of Vietnam veterans and independent scientists to review the proposals and insure valid results throughout the contract process. The agency also refused to require proposed contractors to develop ways to include veterans' input in the conduct of the study, thus ignoring the most critical problem of agency credibility with the veterans community. Moreover, we understand that the agency now states to persons who ask for the identity of the potential contractors that the litigation we instituted prevents the disclosure of the names. There is absolutely nothing we have alleged that would prevent such disclosure; indeed, we have been denied the names by the VA on the ground that procurement law prevents such disclosure.

In addition, the agency has ignored completely the serious problem of real or apparent conflict of interest in the agency conducting the study in-house. This position has been taken despite the most recent comments by the National Academy of Sciences that if an Air Force study of Operation Ranch Hand personnel were conducted in-house, it probably would not be believed by the populations affected. For this reason the NAS concluded that such a research project would have dubious value should equivocal results be reached. That the VA will move forward in the face of this expected criticism again reveals a basic misunderstanding of the sensitive nature of public policy in this area.

Work Group Actions

The most recent government actions in the Agent Orange area are the recommendations of the Inter-Agency Work Group on Phenoxy Herbicides (Work Group) and its Scientific Panel. On August 1, 1980, the Work Group recommended to the White House that the Ranch Hand study be conducted by the Air Force, despite the objections of the National Academy of Sciences concerning the credibility of such a study. The Scientific Panel of the Work Group offered recommendations, which have not been adopted by the Work Group, that future studies of Vietnam veterans should focus on whether overall service in Vietnam, rather than Agent Orange, may have caused an increased incidence of health problems among Vietnam veterans.

We have faith in the ability of the Work Group to develop sound policy in this area, particularly with the active cooperation of the VA which apparently has yet to be accomplished. However, we do have a major criticism of the Work Group's recommendations. In particular, despite the good will and well-intentioned motives of the persons involved, the conclusions reached are unsubstantiated by any factual basis independent of the information supplied by the agency with an obvious self-interest in the outcome of this issue, the Department of Defense. Many of the significant assumptions simply are undocumented and apparently were reached primarily on the basis of Defense Department data that has not been verified independently by any private or government body, including the

Scientific Panel. Nowhere are these conclusions supported by facts or are the factual bases for the conclusions presented. Indeed, the only independent review of this data conducted by the General Accounting Office contradicted Defense Department estimates. The Work Group recommendations are short on actual documentation and are replete with conclusory statements about the difficulty of the scientific tasks that face the Panel. We are concerned that these recommendations represent a major shift in the scientific inquiry of Agent Orange, and believe that much more thorough and independent thinking is needed to avoid hasty adoption of the assumptions supporting the Panel's work. An inadequately justified change in scientific perspective at this time could have irreversible consequences for this sensitive issue.

Public discussion of these issues is essential before any action is taken to implement these recommendations, including the recent Senate amendment to Public Law 96-151. As will be discussed further below, the recent amendment adopts completely the Scientific Panel recommendation.

The two recommendations of the Work Group and the Panel raise a number of inter-related issues. Indeed, many of the same reasons for recommending the Ranch Hand Study have been used to justify the shift to a Vietnam experience, rather than an Agent Orange, health study. Our testimony will first address the Ranch Hand recommendation. Our basic criticism of the

recommendations is two fold. First, we address the exposure data about Ranch Hand personnel and the credibility of an Air Force study. Second, we address the exclusion of ground troops from further study based upon the failure to identify data about ground troop exposures and the likely exposures of other veteran sub-populations. We will then address the recommendation to conduct a Vietnam experience study, as well as the assumptions which underlie the recommendations.

Recommendations to Conduct a Ranch Hand Study

On August 1, 1980 the Inter-Agency Work Group recommended to Stuart Eizenstat, Assistant to the President for Domestic Affairs and Policy, that the Air Force proceed with its planned study of the health effects of Agent Orange on Air Force Ranch Hand personnel. The recommendation was based on the Scientific Panel's conclusion that the study should be conducted because the Ranch Hand population is the only identifiable population the nature of extent of whose exposure to Agent Orange can plausibly be documented with any degree of reliability. The Work Group recommended that the Air Force itself conduct the study and that an independent peer review committee monitor the conduct of the study. The Work Group concluded that this action "together with the quality of scientific expertise which the Air Force will bring to the study, can and should assure a high quality, unbiased study." One reason the Work Group recommended this course of action was because of the likelihood that delays would result if some other entity were chosen to do the work.

Ranch Hand Exposure

These recommendations were based in part upon a July 30, 1980 status report of the Work Group Scientific Panel. Several of the assumptions contained in that status report evidently were adopted by the Work Group to support the Work Group's Ranch Hand recommendation. These assumptions fall into two categories: those about Ranch Hand exposure data and those about ground troops and other sub-populations of likely exposed veterans. First, the Scientific Panel concluded that the Air Force Ranch Hand personnel constitute a population whose dates of service and frequency and duration of exposure are "documented" and "known," whose exposure is estimated to equal or exceed that of exposed domestic applicators of herbicides, and whose exposure is estimated to be "much greater" than ground troops. Second, the Panel concluded that attempts to identify a population of exposed veterans from ground troops who served in Vietnam have not been successful, and that to embark upon a study of ground troops "without accurate knowledge as to actual exposure" would jeopardize any study results of ground troops.

Based on these Scientific Panel assumptions, the Work Group endorsed the Ranch Hand study and stated that appearance of an organizational conflict of interest in the conduct of the study by the Air Force could be addressed by an independent peer review committee that would monitor the study. We agree with the Panel's position that some sub-population of likely

exposed Vietnam veterans should be studied. Our concern is with the approach of the Panel that the Ranch Hand group is the only group for which there exists exposure data sufficient to conduct an epidemiology study and that no other group of Vietnam veterans can be studied because of problems with exposure. Several questions are raised by this position. First, the Panel makes no reference whatsoever to any documentation supporting the conclusion that the Ranch Hand exposures in fact are "documented," "known," in excess of domestic applicators or "much greater" than ground troops. If such documentation exists, it should be disclosed and careful analysis of such data should accompany recommendations of such significance. In addition, the Panel report makes no attempt to define or refer to the government records on exposure that are extant. Without a full inventory of such records, conclusory statements on exposure have less than the credibility that is required to maintain faith in the nature of the Panel's work.

The absence of such references and the lack of documentary support raises another troubling concern. It would appear from the style and tone of the report that the information on exposures was obtained principally, if not solely, from the Department of Defense. Obviously, that agency is the custodian of such information and it can be expected to be a source of such information. However, it appears that the statements about exposure data are based solely on the Defense Department's

analysis of such data. We question whether any member of the Scientific Panel conducted an independent evaluation of the exposure data. If that has not been done, we question why it has not been done. If such an independent evaluation has not been done, serious questions should be raised about the independent nature of the Panel's work and credibility of these recommendations. This evaluation is particularly important since the only independent analysis of previous Defense Department estimates of exposure date have been contradicted. */ This GAO report is not even mentioned by the Panel.

Questions about the actual nature of Ranch Hand exposures are not academic exercises to forestall a study. We have real questions whether the Ranch Hand personnel were in fact heavily exposed, or at least more exposed than other sub-populations.

Exposures of Other Veterans

Apart from the matter of the factual basis for Ranch Hand exposures, there remains the issue of other exposed sub-populations. This raises questions about the efforts which have been made by the Scientific Panel to identify other exposed sub-populations for further study. These efforts are of particular importance because of admitted difficulties with the Ranch Hand study, particularly the credibility of such a study and the obvious conflicts of interest that are still inherent in the conduct of the study by the Air Force.

*/ Report by the Comptroller General of the United States, "U.S. Ground Troops in South Vietnam Were in Areas Sprayed With Herbicide Orange," November 16, 1979.

That is, the failure to identify other sub-populations for study appears to be a critical factor in the decision to endorse the Ranch Hand study. If this reason is suspect, the basis for adoption of the Air Force study also is suspect.

The Panel report of July 30, 1980 states that efforts to identify a study population of ground troops "have not been successful" and that this "completely frustrates" a study of risks associated with Agent Orange exposure. The Panel then went on to note Defense Department efforts to identify ground troop populations of battalion size, the results of which are to be known in September.

As with the Panel's Ranch Hand conclusion on exposure, the tone of the report suggests that all the efforts to identify other sub-populations of exposed groups are those only of the Defense Department. The report does not refer to and there is no supporting documentation to suggest that any efforts independent of the Defense Department have been made to identify any other exposed sub-populations. Again, the question arises as to whether any member of the Scientific Panel inventoried extant records on possible exposures of non-Ranch Hand personnel, and conducted an independent review of these records to identify any other exposed sub-populations for study. If this was not done, there should be an explanation of the efforts, if any, which were undertaken to verify Defense Department estimates that no sub-population other than Ranch Hand could be identified as having exposures adequate

to create a study population. Assuming that no such independent study was conducted, it is not surprising that the Ranch Hand estimates are the principal support for the Panel's recommendations, and the subsequent endorsement of the Air Force study by the Work Group.

We believe that it is the basic moral and scientific responsibility of this government to explore the feasibility of conducting studies on a variety of exposed sub-populations of Vietnam veterans. And that responsibility does not rest, nor should it rest, with the Defense Department. We assumed that the Work Group, in addition to the role of coordination, was established because there were doubts about the quality of work performed by the agencies then responsible for the issue, the Veterans Administration and the Defense Department. We assumed then that the Work Group was established to insure that those agencies performed quality work. Thus, we expected the Work Group to do more than ratify the decisions and conclusions of those agencies. At a minimum, we expected the Work Group to exercise independent judgment and develop supportable factual bases for its conclusions on this issue, independent of those prepared by these agencies.

In this regard, we suggest that there are several possible sub-populations that could serve as a group for further investigation into the exposure issue. The most obvious sub-group is the ground personnel. The apparent exclusion by the Scientific Panel of the ground troops from

further studies is particularly troublesome because of the conclusions in a recent GAO report concerning the likely exposure of ground troops to Agent Orange.*/ The report concluded that it is possible to estimate the number and proximity of certain ground troops to herbicide missions, even though actual exposure could not be documented from available records. The report was able to identify approximately 6000 Marines who were assigned to units within one-half kilometer of areas sprayed with Agent Orange in the same day, as well as another group of 16,000 Marines who were within one-half kilometer of spraying missions within four weeks of the spraying missions. The report concluded that Marine Corps records and files provide a roster of all personnel assigned to a battalion during a given month and that current unit addresses for those still in active duty could be maintained, as well as information on the current names and addresses of those individuals. The report concluded that the chances that ground troops were exposed to Agent Orange were much higher than the Department of Defense had previously acknowledged. The report recommended that Congress direct relevant agencies to determine whether a study is needed on the health effects of Agent Orange based on the ground troops identified.

*/ Report by the Comptroller General of the United States, "U.S. Ground Troops in South Vietnam Were in Areas Sprayed With Herbicide Orange," November 16, 1979.

Remarkably, the GAO study of this group of possibly exposed ground troops was never mentioned in any of the Scientific Panel's reports. And there is no indication that GAO officials responsible for the study were ever asked to brief the Scientific Panel. The only briefing mentioned is that conducted by the Defense Department. This omission is totally inexplicable, particularly in light of the fact that these exposure estimates are the only documentation prepared independent of the Defense Department. Importantly, in this the only independent investigation of exposure information yet conducted, the Defense Department estimates were contradicted.* This fact underscores the need for an

*/ The impact of the GAO report was noted last year by Senator Cranston, the Chairman of the Senate Veterans Affairs Committee, in the debate over P.L. 96-151:

This GAO report raises two major concerns. First, that U.S. ground troops actually may have been exposed to agent orange and its high toxic contaminant - dioxin, second, that for over 1 1/2 years DOD apparently may not have leveled with Vietnam veterans, their families, and the public about the conduct of the herbicide spraying missions in Vietnam, the so-called ranch hand project.

Cong. Rec. S 17994 (daily ed. Dec. 6, 1979).

Indeed, in later floor debate on another Agent Orange proposal, Senator Cranston stated that the GAO report "refuted earlier Department of Defense assertions that troops did not enter sprayed areas until a significant period of time had elapsed since the spraying . . . "

Cong. Rec. S 316 (daily ed. Jan. 24, 1980).

independent evaluation of the estimates relied upon by the Scientific Panel to exclude other sub-populations as the subjects of further epidemiological studies.

The basic issue is whether the government can identify for study other sub-populations of likely exposed Vietnam veterans. The troubling question is whether anyone is really trying. The investigations described generally by the Panel appear to consist of record review of troop movements and spraying missions currently the responsibility of the Defense Department. The Work Group should not serve as a rubber stamp for the conclusions reached by the Defense Department. Without an independent evaluation of the raw data and underlying facts for the DOD conclusions, the Work Group is not exercising the valuable independent function for which it was established. If the Work Group does not have the capability or the expertise to do this work, it should have at least recognized in its report specifically what should be done and insist that it should be done. Nowhere, for example, are there any references to in-depth investigations that would involve follow-up of individuals to obtain information about exposures that would serve as the basis for identification of other sub-populations. We have consulted experts who assure us that it is standard epidemiological technique to conduct extensive interviews by questionnaires of potentially exposed individuals to develop exposure data for epidemiological studies. The question is whether these techniques have been attempted, or even considered by the Scientific Panel.

Excluding ground troops from study consideration would appear to ignore a population heavily exposed to Agent Orange. Our discussions with Vietnam veterans reveal examples of heavy and persistent exposure. The DOD methods for excluding ground troops from study must be examined. The relevant questions would examine the methods which have been used by the Defense Department to conclude that estimating ground troop exposure is impossible. We understand that one of the major stumbling blocks is troop movement and the resulting inability to pinpoint troop locations during spraying missions. We assume that not all troop movements have been examined, which leaves the question of what criteria were used to examine those troops studied. Whether these movements are representative of troop movements throughout the country also is a critical question.

In addition to identifying ground troops from Vietnam as an exposed sub-population, there are several other likely exposed sub-populations that may have received significant exposures to Agent Orange. These are the Army helicopter crews who conducted Agent Orange spraying missions, the service helicopter support units who flew alongside the spray helicopters to provide protection, the combat engineers who operated heavy equipment to clear areas after defoliation and burned the debris, and the Army personnel who mixed and handled Agent Orange. Certainly the handlers represent the classic worker exposure. We question whether any attempts have been made to identify and investigate the exposures of these groups.

The controversy over exposure levels of Ranch Hand people, as compared to ground troops or other groups, is important for several reasons. The apparent conclusion that the Ranch Hand group is the best group to study means that the Air Force, according to the Scientific Panel, may be conducting the most important study of all veterans who may have been exposed to Agent Orange. This has obvious problems for all the reasons cited by the National Academy of Sciences. But, in addition, the Scientific Panel may have undermined the value of any study conducted pursuant to Public Law 96-151. The reason for this concern is that the study contemplated by P.L. 96-151 probably will include ground troops as well as Ranch Hand personnel. Indeed, there is no indication to date of any limitation on the size or scope of the group to be studied. Nevertheless, the complex issue of level of exposure is one which this study is expected to address in developing a study design. Having made these recommendations, the Scientific Panel appears to have decided the study population question and has precluded any serious effort to conduct a searching analysis of the exposure issue by that study. Despite any misgivings about the way the VA is carrying out the Congressionally mandated study which have been expressed by our clients, the American Legion, the Veterans of Foreign Wars, as well as the Center, it appears that the role of that study, ordered by Congress less than a year ago, has been ignored, without any factual basis.

Another example of the undocumented and conclusory nature of the Panel's work concerns the appropriate standards for exposure for an Agent Orange study. The acceptable standard for exposure to be met for any study is a significant threshold question. The standards for exposure that have been adopted by other federal agencies is an important benchmark to evaluate the Scientific Panel's firm and unsupported conclusion that "accurate knowledge as to actual exposure" is needed before any epidemiological study can be conducted.

The dispute over standards for exposure in fact concerns differences over the level of certainty minimally required to embark on a study. But the standard for exposure expressed in the Panel's recommendation is not defined or explained other than a reference to "actual" exposure. Thus, the conclusions about actual exposure of Ranch Hand personnel compared to the undetermined exposures of ground troops has little value without this definitional context. This matter should be evaluated in light of other agency standards used in epidemiological studies for regulatory action.

The exposure standards which have been used in the Environmental Protection Agency (EPA) emergency suspension of 2,4,5-T are an important case in point. The EPA action to suspend registration of 2,4,5-T is based in part on an epidemiological study of women in the Alsea, Oregon, region. These women were reported to have experienced an increased incidence of miscarriages and abortions within a certain period after spraying of 2,4,5-T occurred. This study is important

for its discussion of the standards for estimating likely exposure. */ EPA recognized the complexity of exposure assessment and attempted to set out general considerations and particular applications to individuals around aerially-exposed areas. The agency noted the lack of empirical data on the number of exposure pathways and the inherent complexities of chemical movement through the environment. Nevertheless, the agency recognized that its exposure assessments involved nothing more than attempts at modeling the likely contact of "potentially exposed individuals." The Alsea study, for example, contained no data showing actual exposure and noted that scientists have never demonstrated that there is a level of exposure to 2,4,5-T that has no adverse effect on humans. Thus, the agency assumed that the women in the Alsea study were exposed to 2,4,5-T. The level of certainty, or lack thereof, inherent in that study is important here. The agency concluded that the exposures of individuals in areas of spraying was similar to pesticide applicators and persons involved in pesticide application support activity. Thus, the agency equated, for purposes of the study, the exposure patterns of those individuals. The agency concluded that, while it could not

*/ The Alsea report has been criticized on several grounds. However, the EPA evaluation of exposure pathways has not been the subject of this criticism and is important for the full understanding of the Scientific Panel's recommendations on exposure, particularly among the Ranch Hand troops.

determine the actual routes of exposure, there was sufficient information to make assumptions about possible "chances for exposure." Therefore, "exposure potential" was the basis for study conclusions, rather than any proof of actual exposure. The study demonstrates that the standards for exposure used by the Scientific Panel may have been much more conservative than is typically used by other government agencies in health studies.

This is not to suggest that all "potentially exposed" sub-populations be included in a study, because we do recognize the possible diluting effect of including less exposed individuals in any study population. The purpose of this discussion is to suggest other avenues for defining possible sub-populations for study and to emphasize that this ad hoc group has come to conclusions without a rigorous review of the facts and without consulting outside experts before reaching such conclusions.

The most disturbing aspect about these exposure assumptions is the Panel's determination that no more than 1160 of several hundred thousand Vietnam veterans can be a proper study sub-population. More investigation of other sub-populations needs to be done before this conclusion is adopted. We cannot accept the notion that the Agent Orange experience in Vietnam is in some sort of black box about which we know little and can find out little else. Are we to accept the notion that the failure to locate the actual

movements of every soldier in selected locations means that nothing can be done? Are we to settle for an exposure reconstruction effort that does not involved detailed follow-up of veterans who know more about their exposures than a set of bare records? Are we to settle for Defense Department statements that everything has been tried, and we will never know who was exposed? Perhaps ultimately we may have to reach these conclusions, but we should do so only after public scrutiny of all the facts and a presentation of the reasons for these conclusions.

The excessive reliance on the Defense Department and the Veterans Administration for answers to these questions has gone on for more than two years. The White House Work Group was established because of the past failures of these agencies. The exposure question, among others, presents the Work Group with an opportunity to take independent and creative action to prevent further policy failures.

Ranch Hand: Credibility and Participation Rate

The Work Group in its August 1, 1980 recommendation approved on several conditions the conduct of the Ranch Hand study by the Air Force. The Work Group concluded that the establishment of an independent peer review committee to monitor the Air Force study would alleviate the concerns about credibility and conflict of interest raised in the National Academy of Sciences criticisms of the proposed study. The Work Group also recommended that the evaluation period for the study be extended from five to twenty years.

We believe that the lack of credibility inherent in the Air Force study cannot be alleviated by the establishment of any monitoring body. Veterans simply will not believe the results of a study conducted by the same agency that was and is still responsible for developing and implementing policy relating to chemical warfare.. */ How can it be expected that veterans will believe that a fair, serious and credible study will be conducted by the agency which, six weeks before its study proposal was announced, stated that

[W]e do not believe that a study of the health of any Vietnam veterans would add to the knowledge of the long-term health effects of herbicide orange or dioxin. It is extremely doubtful that a retrospective epidemiological study of that population would produce reliable results . . . **/

Such deep seated antipathy to learning the truth about Agent Orange cannot be alleviated by the creation of this outside panel. Whether any veteran with credibility in the veterans community would serve on such a committee is dubious, especially considering the loss of credibility such a person would suffer. Whether the Work Group spoke to any Vietnam veterans and their willingness to serve on a committee should be explored. If this recommendation was submitted without confirming the willingness of knowledgeable veteran leaders to

*/ See W. Pincus, "Pentagon Speeds Development of Toxic Chemicals," Washington Post, September 5, 1980 at p. 23.

**/ April 4, 1979 letter from Deputy Assistant Secretary of Defense Marienthal to one of our clients.

serve, this would be yet another example of the Work Group's willingness to reach conclusions without conducting any investigation of underlying facts. We have spoken to leaders of the National Veterans Task Force on Agent Orange and the National Association of Concerned Veterans who have flatly rejected serving on such a panel. The reaction of these veterans group leaders raises serious questions about the possible success and sincerity of this attempt to shore up a questionable study.

One last concern with the Ranch Hand study relates to the small size of the group and the participation rate needed to have a satisfactory level of confidence in the study results. Relevant to this point is a matter raised before the Senate Affairs Committee when the Air Force testified sometime earlier this year. As the Scientific Panel noted, the limited size of the study group of the Ranch Hand personnel is a severe limitation on the statistical power of any results reached in the study. The Panel concluded that the way to enhance this power is through a high rate of participation in the study by Ranch Hand personnel. One factor which may significantly adversely affect both the participation rate, as well as the veracity of answers submitted to the Air Force, is the current status of many Ranch Hand personnel. We understand that many of the former Ranch Hand personnel are now commercial pilots certified by the Federal Aviation Administration. Such certification requires, among other things, statements that the individuals are in good health. True and accurate

reporting to the Air Force about actual adverse ill health effects may jeopardize many of these persons' jobs and FAA certification. Thus, many of the former Ranch Hand people may have a strong disincentive to participate in the study and answer truthfully questions about current ill health effects. This matter evidently was not addressed by the Scientific Panel and is one that may seriously undermine any results of the Air Force study.

In conclusion, the recommendation that the Ranch Hand study be conducted by the Air Force is based on a number of untested assumptions and questionable conclusions. The issues we have addressed deserve a great deal of public scrutiny and independent investigation by the Work Group and the Scientific Panel, and the private scientific community. The purpose of these objections is not to delay further scientific inquiry, but to prevent hasty and ill-informed decisions and judgments that may further erode public credibility on this issue.

Several assumptions which support the decision to endorse the Ranch Hand study also were relied upon to recommend that a Vietnam-wide experience, rather than an Agent Orange study, be the focus of future scientific investigation. That recommendation and its supporting information are the subject of the next portion of our testimony.

A Vietnam Experience Study

The Scientific Panel concluded that future large scale epidemiology studies should focus on determining if service in Vietnam is a causal factor of ill health effects, rather than Agent Orange. Specifically, the Panel stated that

"certain health decrements may be present in the veteran population that are a consequence of Vietnam service and not directly associated with herbicide Orange exposure. Since the nature and degree of herbicide Orange exposure is apparently impossible to ascertain, it is our opinion that a prudent approach is to design and conduct studies that indicate service in Vietnam as the causal factor."

The Scientific Panel then noted the Australian investigations which acknowledge contact with other herbicides as possibly associated with adverse health effects.

This second recommendation of the Scientific Panel represents a major shift in the scientific investigation of the Agent Orange issue. As with the Ranch Hand recommendation, this position is based upon untested and questionable assumptions that should be examined and verified independently before any further scientific inquiries are initiated. Indeed, this position may be the most controversial and disturbing government action in the two-year history of government activity in the Agent Orange area. It certainly will have the most far reaching consequences of any government decision that has been made. That the recommendation is based on no facts and no presentation of supporting evidence, and apparently without outside consultation, is indefensible.

The Scientific Panel articulated two reasons for the major shift toward future epidemiological investigations of Vietnam experience rather than Agent Orange. The first reason is the impossibility of ascertaining the requisite nature and degree of Agent Orange exposure. This reason was cited in the July 30, 1980 herbicide Orange status report to the Work Group. The second reason for recommending this shift in scientific focus is the purported occurrence of possible chemical and other exposures in Vietnam that may be associated with adverse health effects and which would allegedly make Agent Orange correlations impossible to achieve through epidemiological studies. Other unarticulated assumptions have been suggested as supporting this recommendation. One concerns the shorter time a service study could be completed. Another suggested reason for this recommendation concerns the ostensibly lower level of proof of service connection needed for VA Benefit compensation. These assumptions are discussed in turn below.

Exposure Estimates

The Panel's conclusion about the impracticability of documenting Agent Orange exposure conveniently serves as the reason for recommending a Ranch Hand study and also as the critical reason for concluding that no other Agent Orange study can be conducted. Indeed, the July 30, 1980 Panel

opinion that such exposure is "impossible to obtain" appears to be the determinative reason why the Vietnam experience study was recommended. The Vietnam experience recommendation also fails because of the lack of independent verification of the Ranch Hand exposure data and the Panel's failure to develop independently other exposure populations. For if the Panel did rely heavily or solely on the Defense Department assertions of impracticability regarding exposure levels and troop movements, it is not too much to ask for an independent investigation, especially considering the significant weight evidently given these opinions in the Vietnam experience recommendation.

Multiple Exposures

But the more troublesome aspect of the recommendation is the Panel's conclusion that the "use of a variety of other herbicides, drugs and chemicals in Vietnam" provides "compelling reasons" for abandoning an Agent Orange perspective in favor of Vietnam experience studies. (July 16, 1980 Progress Report.) The basic criticisms of the assumptions supporting the Ranch Hand recommendation are fully applicable here.

The Panel's report contains no documentation whatsoever to identify the substances suggested, the nature or extent of exposures to these substances, the time and places where the substances were used, or the toxicity of these substances; indeed, there is no factual or scientific support presented for the multiple exposure position. The absence of any

references or summaries of data to support the position is rather startling. We fear the popular press accounts of multiple exposures has played a significant part in the development of this issue. As with the Ranch Hand recommendation, several questions must be made raised. The first question is whether any member of the Scientific Panel independently has inventoried available government records to determine the nature and use of other substances in Vietnam, or whether the Panel relied principally on the Defense Department for such information. The second question is whether any member of the Scientific Panel conducted an independent investigation to document exposures to these substances, considering the time and place of such exposures, the numbers of troops exposed, as well as the likely confounding nature of such documented exposures on the results of future Agent Orange epidemiological studies. Assuming that the answer to these questions is no, the third question is why not? The Panel at least should have explained the factual bases for the position it took, even assuming that no independent analysis was undertaken.

The questions of documentation and independent verification are particularly important. With this recommendation, the Panel has concluded that the exposures of ground troops to Agent Orange is impossible to document. That conclusion serves as the principal reason for the endorsement of the Ranch Hand study. Yet the Panel then proceeds to conclude that ground troops were in fact exposed to a variety of other substances such that an Agent Orange study cannot be conducted. How has

the Panel determined the exposures of all herbicide, drug and chemical substances other than Agent Orange? Have greater efforts been undertaken to determine the exposures of these substances than were undertaken to determine ground troop exposure to Agent Orange? Or is it more likely that no investigation of any exposures was conducted and that these conclusions were reached without an independent review by the Panel of available data? Moreover, there is no indication that the Work Group discussed these issues with the GAO, which is now conducting an in-depth review of Agent Orange programs, including the multiple exposure issue. This investigation has been underway for several months at the request of Congressman Downey.

These basic questions are important because, it must be emphasized, the Panel has suggested that a reliable Agent Orange epidemiological study cannot be done. Surely, to come so quickly and abruptly to this conclusion with this limited data cannot be defended or supported. This is especially troubling because of the concern of veterans and the existence of a Congressional mandate to do such a study. Raising the multiple exposure issue obviously complicates problems confronted by epidemiologists and public health agencies conducting studies and making complex regulatory risk assessment decisions. Although we are not scientists, we have discussed the matter with epidemiologists and toxicologists and we offer from a lay perspective our concerns with the Panel's analysis.

Even assuming that there were multiple exposures to harmful substances in Vietnam, the question remains whether those multiple exposures so confound the scientific investigation of Agent Orange that answers to whether Agent Orange is the causative agent cannot be obtained. We offer a somewhat different view on the question of confounding or multiple exposures, a view that appears to be consistent with the nature of epidemiological investigations of worker populations and civilians exposed to toxic chemicals. The issue of multiple causes for long-term health effects is one that has been faced by epidemiologists and public health officials. However, their conclusions appear to be significantly different than those arrived at by the Scientific Panel. That is, the consensus of scientific investigators appears to be that ill health effects such as cancer result from several environmental factors as well as other influences such as genetic and hormonal factors, all of which play varying roles in particular carcinogenic responses. Indeed, the consensus of these experts is that cancer frequently results from exposure not to a single substance but to several substances. These are working assumptions in the conduct of all epidemiologic studies of persons likely exposed to toxic or radiologic substances. Thus, the problem of multiple exposures which, without factual support has impelled the Panel to abandon further exploration of this issue through the study mandated by Public Law 96-151, is the central issue faced by epidemiologists.

Our point is that the issue of multiple exposures is the beginning rather than the end of typical epidemiological inquiries. The methodological response to this problem typically is to design studies that factor out the likely effects of multiple or confounding exposures to arrive at conclusions as to the principal cause for the ill health effects observed. The question in this case is why the Scientific Panel, with full knowledge of this common problem of multiple exposures and the appropriate methodological methods, proceeded to decide that no answers could ever be found to the question whether Agent Orange may be the cause of long-term health effects. And to do so without explanation or documentation is inconceivable where the credibility of the government on this issue is at stake. Again, the question is basic: what attempts were made by the Panel to have experts consider a study that would factor out the possible effects of these competing substances? Indeed, has any member of the Panel even requested the basic data from the Defense Department to attempt such an investigation? If no attempts were made, the question again is why not? The government has a basic responsibility to initiate such independent action before major recommendations such as the Vietnam service study are proposed.

What we suggest should have been done is identify a variety of control groups who were and who were not exposed to these other substances for future studies that would attempt to factor out the effects, if any, of exposure to those substances. The purpose of such studies would be to determine the actual effects of exposure to Agent Orange distinct from the effects of the other exposures. We understand from consulting with other experts that such studies could be conducted.

Several factors suggest the feasibility of such an approach. The first is the demonstrated toxicity and potency of dioxin. That it is the most toxic chemical ever created suggests that its effects would be pronounced in comparison to the effects suggested to result from other exposures. In addition, the varied places and times where other substances were used would make possible the creation of several control groups in an Agent Orange focused study. Again, the issue is whether this approach is possible. The Panel's answer that it is not possible simply has no credibility without further evidence. The August materials do not begin to address this matter in a convincing manner.

Another reason suggested to support the Panel's Vietnam experience recommendation is the Veterans Administration service connection scheme for compensation of military related disabilities. The Panel appears to accept the VA's repeated assertions that the actual cause of disabilities possibly related to Agent Orange is not needed to award service

connected disability compensation. Without an elaborate analysis of the practical application of this standard in disability cases, we suggest that the Panel not rely on this reason to change the nature of scientific inquiry.

The VA standards of proof in disability cases are so vague, ill-defined, inconsistent in practice and generally inapplicable to latent diseases that reliance on these standards to guide scientific inquiry is misplaced. Because the agency's individual benefit decisions are not subject to judicial review, there has not developed a clear body of law on the standards of causation needed to establish a service-connected disability. This has left the line between causality in latent and non-latent disease cases blurred. Indeed, the agency never has articulated the actual compensation standards and levels of proof that would be required to establish service connection for Agent Orange related diseases, or for the ill health effects from exposures to radiation, asbestos or similar substances.

Senate Amendment to Public Law 96-151

These recommendations now assume increased significance because they underly the recent amendment to Public Law 96-151 passed by the Senate on September 4, 1980. Public Law 96-151 enacted in December, 1979 would require an epidemiology study of whether Agent Orange has caused ill health effects among Vietnam veterans. The recent amendment would change the law in two important ways that deserve close scrutiny.

First, the amendment would change the group of veterans to be studied, from those who "were exposed" to those who served in Vietnam. According to Senator Cranston, a co-sponsor of the amendment, this means that "the threshold problem of identifying a population exposed to dioxins is removed..." 126 Cong. Rec. S12012 (daily ed. Sept. 4, 1980) (Emphasis added). This amendment appears to change completely the focus of future Agent Orange-related investigations. Whether removing the exposure questions means that the answers to Agent Orange may not be answered is the real question about this portion of the amendment. Without identifying Agent Orange exposed groups, it is unclear how any correlations between Agent Orange and ill health effects could be established.

The second aspect of the amendment concerns the change in the actual focus of a study to a Vietnam service study as recommended by the Scientific Panel. This has been referred to as an "expansion" of the basic Agent Orange focused study. Again, without an Agent Orange exposed group, it is unclear how any expanded study could determine whether Agent Orange causes any ill health effects.

Conclusion

The history of the Veterans Administration policy on Agent Orange reveals several troubling problems. Unlike the actions of the Environmental Protection Agency and other agencies concerned with related health areas, the Veterans Administration has taken a closed and secretive approach to decision-making on issues of health and scientific inquiry. Scientists, veterans and other interested members of the public have been closed out of important agency deliberations on the rules for adjudication and the conduct of scientific inquiry.

Opposition to such open discussion goes to the heart of this problem and is contrary to the basic principles of scientific integrity: that all relevant data and interpretations be taken into account before important public policy decisions are made. We are too far along in the area of public health and environmental debate to deny the uncertainty of scientific information and the social judgments that must be made on the basis of such imperfect information. To compound these difficulties by making such admittedly difficult decisions without the full range of advice and criticism invites public skepticism and often results in the wrong decisions.

The absence of informed and independent opinion in these deliberations has meant that the VA has not considered on the record the central scientific and public policy considerations that are necessary to develop sound standards and levels of proof required for compensation decisions in toxic

substances exposure areas. The issues are extremely difficult and deserve attention immediately. That the Veterans Administration has relied almost exclusively on scientific evidence developed by the Department of Defense is consistent with the agency's refusal to consider outside independent information in these sensitive areas.

The other purpose of our testimony is to emphasize the significant nature of the Work Group's recommendations and to make public the inadequate support offered for them. We also would like this Committee and the public to examine the quality of decision making concerning Agent Orange at the highest levels of this government. Questions about the respective roles of the Work Group, the Defense Department, and the Veterans Administration also are raised by these recommendations.

At a fundamental level, the credibility of government Agent Orange efforts cannot be restored while the Defense Department continues to play an increasingly significant role in these public health decisions. Truly independent efforts to evaluate the existing data on Agent Orange and other possible exposures are necessary before these recommendations should even be considered.

We attempt here to set out several suggested approaches to dealing with the problems identified above. First, open and participatory public decision-making is essential in this controversial scientific and political area. The agency should be required to conduct public rule-

making on the issue of whether health effects may result from dioxin exposure and on the basic issues of level of proof and toxic substances victim compensation policy. The agency also should contract out completely the epidemiological study mandated by Congress in Public Law 96-151. The inherent defects in the process which have been revealed to date, criticisms by veterans and presumably by the National Academy of Sciences on the lack of credibility of an in-house study fully support this position. The sensitive nature of this problem mandates that an independent and objective study be conducted immediately.

In addition the agency should discontinue the practice of denying claims for Agent Orange related disabilities until public rulemaking is completed. At present the agency has denied all claims based on the current level of information. This has caused a significant harm to current claimants who may be discouraged and not pursue their claims after these initial denials. Also, the agency should conduct a national, comprehensive outreach program to inform veterans of the current information on Agent Orange, obtain necessary health data and begin to provide a full range of genetic and family counselling services.

Finally, aggressive oversight and direction by the White House Interagency Work Group on Phenoxy Herbicides on policy and scientific matters is absolutely necessary. The VA has demonstrated remarkable indifference to open and participatory policy making on these health and science matters. Other agencies of government concerned with related health issues must intervene before Vietnam veterans and the public lose whatever hope is left of resolving this issue.

Mr. GORE. We are going to proceed with questions, but first let me ask you for your patience. I apologize to the others in the room. This is the last week of the Congress before adjournment. There is yet another bill in committee. They do not have a quorum without the members here. It will only take about 3 or 4 minutes. We are going to run and vote and come right back up. We will recess for a very brief period.

[Brief recess.]

Mr. GORE. The subcommittee will come to order.

See, there, you did not believe me when I said 3 minutes.

Mr. LENT.

Mr. LENT. I just have one or two questions to ask you, Mr. Milford. You are critical of a VA plan to conduct the mandated epidemiological study of Vietnam veterans. In later testimony we expect Mr. Cleland will indicate a determination as to who will conduct the study is yet to be made. To your understanding, is this a change on the part of Mr. Cleland?

Mr. MILFORD. It is hard to tell. We have heard about 3 or 4 things in the last 7 months, about who is going to conduct the study. Our best guess, based on our conversations and also our deposition of the person responsible for the study, is that the VA would be responsible in some fashion, be principally responsible for controlling the actual study. I think the question goes to how there might be contracting out of certain portions of it, but ultimately, the study would be controlled by the VA. That is our understanding of the way the study would be conducted.

Mr. LENT. In your opinion, does Congress now have enough data on hand to effect significant legislative changes with respect to agent orange and problems thereto related?

Mr. MILFORD. Well, I think the agency at this point has been presented with sufficient data that it should begin to develop policy on this issue. The work group has made clear that this ultimately is a policy issue, that the science will never prove conclusive on any of these issues, and that at best we are left with a policy determination of whether agent orange-related illnesses should be compensated. The discussion of that, the analysis of those policy considerations, can begin now and should begin now, and there is no reason why it should begin only when more epidemiological data becomes available.

Mr. LENT. Thank you.

I have no further questions, Mr. Chairman.

Mr. GORE. Mr. Maguire.

Mr. MAGUIRE. No questions, Mr. Chairman.

Mr. GORE. Mr. Walgren.

Mr. WALGREN. No questions.

Mr. GORE. You are saying the VA study relies too heavily on cost factors and does not have enough emphasis on quality?

Mr. MILFORD. That is correct.

Mr. GORE. You disagree with their intention to exclude scientists with previous positions on the agent orange controversy?

Mr. MILFORD. The point is that their effort is an attempt to exclude biased scientists from consideration in the contract. The purpose is a good one. The problem is how they went about doing it. To exclude scientists like Dr. Irving Selikoff, who is one of the most prominent health scientists in the country and on the other hand to suggest that industry scientists be freely considered for consideration in the contract makes no sense.

Mr. GORE. The RFP has not been reviewed by the work group, nor will it be until the contract is awarded and the study design begins. Would you support active involvement of the work group in—at an earlier stage?

Mr. MILFORD. I certainly would. The responsibility of the work group in this area is a clear one. The work group should be involved at the earliest possible stages where any of the scientific and policy decisions are being made. I think that is why it was created.

Mr. GORE. Would you be available to answer additional questions in writing?

Mr. MILFORD. Certainly.

Mr. GORE. Thank you very much for appearing here today.

We will next hear our final witness, Mr. Max Cleland, Administrator of the Veterans' Administration.

What we are going to do is start in on your testimony, Mr. Cleland. We have a vote on the floor.

At this late date in the Congress, these are not trivial votes. We are voting on matters of real substance and we will have to take a break in about 5 minutes, so please understand that.

If you would raise your hand please?

[Mr. Cleland was sworn.]

Mr. GORE. Thank you very much.

Let me welcome you to the subcommittee and in a personal way welcome you as a friend and as a fellow Vietnam veteran.

I want to express my thanks to you for all the hard work you have been putting in down at the VA.

We will, without objection, put the entire text of your statement in the record and ask you to proceed with any or all of it as you see fit. [See p. 199.]

TESTIMONY OF HON. MAX CLELAND, ADMINISTRATOR, VETERANS' ADMINISTRATION, ACCOMPANIED BY DR. DONALD L. CUSTIS, CHIEF MEDICAL DIRECTOR; DR. WILLIAM J. JACOBY, JR., DEPUTY CHIEF MEDICAL DIRECTOR; GUY H. McMICHAEL III, GENERAL COUNSEL; DR. BARCLAY SHEPARD, SPECIAL ASSISTANT TO THE CHIEF MEDICAL DIRECTOR; AND CHARLES PECKARSKY, DIRECTOR, COMPENSATION AND PENSION SERVICE, DEPARTMENT OF VETERANS BENEFITS

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

Let me say it's interesting that I would come before this committee, because about 15 years ago I was an intern to a Member of Congress who was a member of this committee.

Let me say that in tackling the agent orange issue, this is the most frustrating and most difficult, the most controversial issue that I have ever dealt with in terms of Vietnam veterans.

I first started testifying before congressional committees more than 10 years ago about Vietnam and some of the problems that I was having in my own rehabilitation and readjustment.

Later on, I testified in the mid-1970's in regard to jobs and employment and the GI bill, training, and so forth. When I first became Administrator in 1977, I testified on the need for psychological help and readjustment counseling.

The issue of agent orange is an extremely complex one, and I find myself both as a Vietnam veteran and as an Administrator bogged down in a whole new jargon of terms that I never knew existed before. The complexity has led me to attempt to lean on the advice and counsel of others, both in my agency and in the other parts of Government.

Let me say that in this effort to tackle the agent orange issue, I am particularly delighted to have as Chief Medical Director, Dr. Donald Custis, who himself is a former Surgeon General of the Navy and who also is a Vietnam veteran.

Dr. Custis was the commander of the naval hospital in Da Nang in 1969 and saw more than 75,000 casualties come through that hospital.

Aiding him as a special assistant on agent orange is Dr. Barclay Shepard, who himself was a Navy Surgeon General in Vietnam.

I find it interesting that the three line officials in the VA in charge of this issue, Dr. Custis, Dr. Shepard, and I are all three Vietnam veterans.

Two of us were exposed to agent orange. Dr. Custis was involved in an incident that he might be able to describe to you better himself.

I was on the ground in 1967 and 1968 in the central highlands and up in I Corps.

I am personally interested in the resolution of this question. As a matter of fact, I would really like to have a lot more answers than I have now. The question is, "how do we go about getting those answers and getting those answers in a scientific and objectively valid manner?"

Let me just hit a few points:

Let me start by saying that in looking at the agent orange issue for the last 2 years in detail, it has come to my attention that maybe what we need to do in addition to tracking the agent orange

is to really do a comprehensive analysis of the health status of Vietnam veterans.

It seems to me that it is extremely frustrating to try to determine whether one element in the environment actually did damage or did not do damage to the health of the Vietnam veterans.

In this light, we welcome the idea that the Congress broaden the VA's mandate to do a full-blown study on agent orange on Vietnam veterans to look at the larger question of the entire health status of Vietnam veterans. I wanted to say that at the outset, because it does look like this is really, ultimately the larger issue: whether or not Vietnam veterans are having their health impaired or had their health impaired by any element in the Vietnam environment.

With that, let me just articulate some of the things that we are trying to do in the interesting question of the VA and agent orange, or the Government and agent orange.

Mr. GORE. May I interrupt you there?

I do ask your indulgence and apologize to you.

No discourtesy intended; we do have a significant vote on the floor of the House of Representatives.

Therefore, we will recess for approximately 10 minutes and we will be back and resume.

[Brief recess.]

Mr. GORE. The subcommittee will come to order.

Mr. Cleland, please proceed with your statement.

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

On the specific question of agent orange, I would like to articulate some of the things that we are doing to try to get on top of this issue.

First of all, let me just say that I am very much aware, and the agency is very much aware, that real fear has been a part of this issue. Many believe that they have been exposed to the chemical and that it does indeed do bodily harm.

I want this committee to know that we in the VA are quite aware of this concern and we are committed to the rigorous pursuit of a resolution of this complex issue in a forthright and scientific manner.

To that end, we have taken several actions. First of all, we are beginning to work with the Governments of Australia and New Zealand, nations which participated in the Vietnam war, and whose veterans also have expressed fears and concerns about their exposure to agent orange.

Let me just see if I can highlight a few things that we are doing and then we can get into some questions.

About 2 years ago, in 1978, when the issue began to break in the media, I formed an interagency advisory committee that later was formalized into a VA Advisory Committee, and this Advisory Committee now meets on a regular basis.

It has representatives of veterans' groups and those interested in the question of agent orange as well as distinguished scientists and experts in the field of herbicides.

Among other things, the committee has considered the various aspects of an epidemiological study of Vietnam veterans exposed to agent orange. It has recommended that the VA closely monitor

epidemiological studies performed on other population groups exposed to the chemical.

It has discussed the aspects of agent orange on the male reproductive system. It has discussed the variables involved in attempting to define a threshold level of exposure to dioxins which might result in toxic effects, and it has explored the types of animal studies that might be performed in order to define the effects of human exposure to agent orange.

In addition to the Advisory Committee, the chief medical director appointed Dr. Barclay Shepard as his special assistant to the chief medical director on agent orange.

Dr. Shepard has these responsibilities: To help us all, especially the Department of Medicine and Surgery, to more adequately respond to agent orange inquiries; to recommend policy to the newly formed Policy Coordinating Committee which our General Counsel, Mr. Guy McMichael, heads; to direct the activities of the VA Advisory Committee; to establish liaison with other Federal and non-Federal agencies; to oversee agent orange functions of the some 180 agent orange coordinators that we have in our outpatient clinics and medical centers around the country; and to conduct and coordinate the conduct of special agent orange studies and serve as special adviser to me and the chief medical director.

I mentioned the Policy Coordinating Committee. We realize that the question of agent orange impacted the entire VA, not just our health care system. It impacted our Department of Veterans Benefits and other offices.

In order to more appropriately coordinate this whole attack on the issue, I appointed our General Counsel as head of an internal coordinating committee to expedite our approach as an agency to the question of agent orange.

We do have the Interagency Work Group which has been alluded to, and I might say this group has been very helpful. It has provided a reference point for those of us in the VA. It is made up of the Department of Health and Human Services, the Department of Defense, and the VA, with the Departments of Agriculture, Labor, and the White House Office of Science and Technology Policy, and the Congressional Office of Technology Assessment participating as observers.

The agent orange Registry does not provide a scientific analysis of what we are seeing in our investigation and screenings of veterans who come to us with alleged agent orange problems, but it does provide a certain base line of information.

It is a registry that we can use both to contact those who have been exposed or who feel that they have been exposed and it is very helpful to us in that it provides baseline information about this self-selected group of Vietnam veterans.

In order to get at the information we are collecting from the screenings we are doing, we have appointed a data analysis task force which is expert at getting at the data we have already collected. We are aware that we need very much to have a plan to follow those 30,000 veterans who have come to us, and we intend to do that.

We have established in regard to chloracne a special task force recently assembled under the aegis of the chief medical director to

make sure we are making the proper diagnosis and the proper decisions in regard to chloracne.

I am sure the committee is aware of the fact that the VA has been given the responsibility of performing to a full blown epidemiological study of Vietnam veterans possibly exposed to herbicides and, in addition, we are charged with an analysis of the world's literature on phenoxy herbicides.

I think the committee is aware of our status in terms of the epidemiological study. We would like to get that underway and we are awaiting General Accounting Office clearance.

Let me say with respect to the epidemiological study, that we fully intend to comply with the intent of the provisions of Public Law 96-151, including cooperating with and seeking the advice of the Office of Technology Assessment. The protocol will also be reviewed by the VA Advisory Committee on Herbicides, the Inter-agency Work Group, and the National Academy of Sciences.

In response to a question that I heard here earlier, we are still openminded on whether or not the VA itself ought to do the study or to contract it out. However, the law does say that the VA cannot avoid its responsibility for, in effect, performing the study administratively and commenting on it afterwards.

The Ranchhand study is a study that the Air Force is now proceeding to do. I personally think that it's a vital link in this whole effort to get on top of the facts in regard to agent orange. With the ranchhand study you have some things that are very valuable.

First, you have a defineable population that was exposed.

Second, the population is small enough to get close to 100 percent of the population in the study, and the Surgeon General of the Air Force has briefed me on the study and desires to brief me again. I am just glad to see that that study is moving ahead.

I think it will provide us some very valuable information.

Let me say that in regard to the literature analysis, that it is moving along and we can provide some details for the record. There are other research activities underway in regard to agent orange. The Center for Disease Control, which has membership on our advisory committee in the VA, is interested in doing a study to determine if Vietnam veterans have a greater than normal risk of fathering children with birth defects.

This question has been the source of considerable concern among Vietnam veterans and their wives. We believe that a carefully designed and conducted study of this type would shed considerable light on this vexing and emotional issue.

The CDC has received preliminary approval of the study from the Interagency Work Group, and the protocol is currently in the review process. The study will be jointly funded by HHS, DOD, and the VA. We are also continuing our cooperation with the Armed Forces Institute of Pathology in regard to an agent orange registry that they are keeping.

There are some 79 cases in this registry, and it continues to grow.

In terms of managing the agent orange issue in the VA, one of the things that I found out that we had to do was make sure, as best we could, that VA field facilities are alert to the issue. One of

the things we did in addition to appointing agent orange coordinators at our hospitals and outpatient clinics was to hold two different training conferences on the question of agent orange just in the last year.

Outreach has been a question as to how far to go and what to say and how much to outreach. This has been something that we have tried to monitor and tried to be responsive to. We have now a pamphlet out entitled, "Worried About Agent Orange?"

It has, as best we can put together, a short, clear and hopefully concise statement of where we are on agent orange. That was cleared through the Interagency Work Group.

We are about to come out with two educational films on the subject of agent orange and the publication of a monthly bulletin.

I think it can be said that regardless of the research efforts and how long they take to render some more information on the subject, I can't state in strong enough terms that in the interim it will be the stated policy of the VA that no eligible veteran will be denied medical care and treatment by the VA because the answers are not in.

We do want to continue with our screening processes. We do want to treat veterans when something in that exam shows up that needs treatment regardless of whether or not it's agent orange related.

This is a responsibility that I take quite seriously.

Let me just conclude now, Mr. Chairman, with my preliminary remarks. I would like to introduce Guy McMichael, the general counsel of the VA, Mr. Charles Peckarsky, head of our compensation and pension service, and Dr. Bill Jacoby, the No. 2 man in the Department of Medicine and Surgery, who was also a physician in the Navy.

Mr. Chairman, thank you very much.

[Testimony resumes on p. 222.]

[Mr. Cleland's prepared statement follows:]

STATEMENT OF
MAX CLELAND
ADMINISTRATOR OF VETERANS' AFFAIRS
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATION
OF THE
INTERSTATE AND FOREIGN COMMERCE COMMITTEE
HOUSE OF REPRESENTATIVES
SEPTEMBER 25, 1980

Mr. Chairman and Members of the Committee:

Good morning. I am happy to appear before you today to give you a detailed appraisal of what progress the Veterans Administration has made to date with respect to the problem of the possible adverse health effects experienced by American service personnel as a result of exposure to herbicides used in Vietnam.

With me today are Dr. Donald L. Custis, Chief Medical Director; Dr. William J. Jacoby, Jr., Deputy Chief Medical Director; Mr. Guy H. McMichael III, General Counsel; Dr. Barclay Shepard, Special Assistant to the Chief Medical Director; and Mr. Charles Peckarsky, Director, Compensation and Pension Service, Department of Veterans Benefits.

Mr. Chairman, since veterans' concerns about Agent Orange issue first surfaced in 1978, it has generated a great deal of public concern regarding the possible health impact of this defoliant upon our Vietnam veteran population and their families. This concern is genuine and is evidence of the real fears of many of those who believe they may have been exposed to this chemical agent. I wish to assure this Committee that the Veterans Administration is fully cognizant of these concerns and fears and of the need to find answers as soon as possible. As you know, the

problems are many and often their solutions are elusive and extremely complex. There is much we still do not know about the possible adverse health effects of the components of Agent Orange upon a human population, and it should be recognized that we may never be able to clarify completely the entire matter of the long-range health effects of Agent Orange. We are committed, however, to the rigorous pursuit of a resolution of this complex issue in a forthright and scientific manner.

Today I would like to describe to the Committee the several Agent Orange related activities in which we have been engaged since the issue first arose in 1978. The VA, of course, is only one of many bodies that are working to resolve this issue. Our activities have involved us in establishing a closer working relationship with other Federal and non-Federal agencies and scientific institutions, as well as with individual scientists and researchers who are working in this area.

We have been in contact with the Governments of Australia and New Zealand, nations which also participated in the Vietnam conflict, whose veterans have also expressed fears and concerns about their exposure to Agent Orange.

In my testimony today, I will provide a brief overview of the use of Agent Orange in Vietnam. I will also discuss for you the VA's activities relating to the Agent Orange issue.

HERBICIDE USE IN VIETNAM

Herbicides were used extensively in Vietnam to deprive the enemy of jungle and forest cover and to destroy food crops so as to prevent their use by the enemy. They were given code names including White, Purple, Pink, and Green. Agent Orange, so named because it was shipped to Vietnam in orange-striped barrels, consisted of a 50-50 mixture of two defoliants, 2,4-D and 2,4,5-T which have been used widely throughout the world since the 1940's

by farmers, foresters, and homeowners to kill unwanted vegetation. During the peak years of herbicides use in Vietnam (1965-1970), Agent Orange represented 94% of all the defoliants used.

Although I do not mean to dismiss the use of the other herbicides, our attention today and the investigations that we are conducting focuses primarily upon Agent Orange because it was the principal defoliant used in Vietnam. The toxic effects of the two individual components of Agent Orange were extensively studied for two decades before their use in Vietnam. It was concluded that these chemicals had very limited toxicity for either animals or man. The problem, however, stems from the fact that Agent Orange was found to contain minute quantities of a highly toxic contaminant which was formed during the manufacture of 2,4,5-T. This contaminant is TCDD (2,3,7,8 tetrachloro-dibenzo-paradioxin) or "dioxin."

In April 1970, the Secretaries of Agriculture; Health, Education, and Welfare; and the Interior suspended the use of 2,4,5-T, a component of Agent Orange. This suspension resulted from published studies which revealed that 2,4,5-T had toxic effects in animals. This toxicity was subsequently tied to the contaminant TCDD. The Department of Defense then suspended the use of Agent Orange in Vietnam.

Dioxin is of concern because it has caused cancer, miscarriages, and birth defects in the offspring of pregnant female laboratory animals exposed to it. Although a number of animal studies have been conducted, we do not yet know precisely how dioxin affects humans; nor do we know very much about the likelihood of veterans developing diseases as a result of exposure to dioxin in Vietnam. We do know that humans who have been exposed to dioxin during industrial accidents have developed a specific skin condition known as chloracne which closely resembles the common forms of acne. In addition, headaches, blood disorders, nausea, alterations in

liver function, and nerve damage have been reported. These conditions appeared shortly after exposure and with the exception of chloracne were of limited duration.

A number of studies of humans who were previously exposed to dioxin have been conducted or are under way now. The National Academy of Sciences in a 1974 report entitled "The Effects of Herbicides in South Vietnam" concluded that there was no definitive evidence of lasting damage to human health from the herbicides used in Vietnam. Other reports, however, have suggested that people exposed to dioxin have a higher incidence of some forms of cancer. There are also reports that dioxin can cause enlargement of the liver and a decrease in the speed of transmission of nerve impulses.

Recently there have been completed a series of studies conducted in Sweden and West Germany on workers exposed to dioxin. These studies have suggested an increased incidence of soft tissue sarcomas among the exposed workers. The Scientific Panel of the Interagency Work Group where the VA has representation, and the Office of Technology Assessment have reviewed these studies and have concluded that they provide credible and valuable leads in the scientific pursuit of the health effects of exposure to phenoxy acids. We do not believe, however, that they answer the question as to whether there exists a causal relationship between exposure to phenoxy acid herbicides as used in Vietnam and the appearance of various types of malignancies. We note the use of the term "correlation" by the Scientific Panel in commenting on the Swedish studies. I am informed that when used in the scientific context, the term means "co-existence" of two factors, not a "cause and effect" relationship. We endorse the observation of the Scientific Panel that independent verification would further validate these studies.

In studies involving accidental exposure of pregnant females, a higher than normal rate of spontaneous abortions has been suggested. Because of the concern relating to birth defects and miscarriages, a number of scientific studies are under way or being planned to shed more light on this issue.

At present, there is no scientific evidence to suggest that a veteran exposed to Agent Orange is likely to incur sperm damage which might lead to the birth of a deformed child. In this connection, a recently completed study of male mice exposed to the components of Agent Orange shows no decrease in fertility, increased risk of stillbirths, or birth defects among the offspring of these exposed males. In addition, a study of birth defects of children of Vietnam veterans by the Center for Disease Control is also planned.

VA ACTIVITIES ON AGENT ORANGE

I would now like to inform you as to what the Veterans Administration has specifically done about the Agent Orange issue.

On April 12, 1978, very shortly after the VA learned of the growing concern about Agent Orange, the first VA-sponsored ad hoc interagency meeting on herbicides was held in Central Office. The committee membership was expanded to widen its expertise for the subsequent meetings held on July 7, 1978, and September 25, 1978. The primary goals of this ad hoc committee were to exchange information on what was known up to that time about herbicides and their possible adverse health effects, to advise the VA on future courses of action (including possible research), and to minimize duplication of effort among the various agencies represented.

The committee was successful in making progress toward the accomplishment of these goals. However, to comply with the

Federal Advisory Committee Act, the VA requested and received approval for the establishment of the current VA Advisory Committee on Health-Related Effects of Herbicides in April 1979. The Committee has continued its valuable role in providing for the exchange of scientific information concerning herbicides and their possible adverse health effects, advice to the VA on future courses of action, including appropriate research efforts, and coordination among the various agencies represented. This Committee's function remains that of assembling and analyzing the information which the VA needs in order to formulate policy and implement procedures in the interests of our Vietnam veterans. The Committee, in this regard, has a fact-finding and advisory role and may on occasion recommend policy for consideration by the Agency. We believe that the Committee membership is balanced and reflects a broad range of scientific and medical expertise, as well as representing various veterans' groups who are concerned with the Agent Orange issue.

The Advisory Committee holds quarterly meetings which are open to the public. The Committee has held five meetings since June 1979, the most recent being held August 6, 1980. We encourage the submission of questions by representatives of the public or private agencies and by concerned individuals who may be in attendance at these meetings. In accordance with the provisions of the Federal Advisory Committee Act, a formal transcript of these meetings is prepared and is made available to various government offices and interested individuals.

The Committee has acted on several significant Agent Orange related issues including the following:

1. Considered the various aspects of an epidemiological study of Vietnam veterans exposed to Agent Orange;

2. Recommended that VA closely monitor epidemiological studies performed on other population groups exposed to the chemical components of Agent Orange in conjunction with agriculture and forest management as well as exposure resulting from industrial accidents;
3. Discussed the effects of Agent Orange on the male reproductive system;
4. Discussed the variables involved in attempting to define a threshold level of exposure to dioxin which might result in toxic effects in humans;
5. Explored the types of animal studies that might be performed in order to define the effects of human exposure to Agent Orange.

Copies of the recent study of male mice exposed to the components of Agent Orange and of the Swedish and West German studies on workers exposed to dioxin which I referred to earlier have been provided to members of the Advisory Committee for their review and analysis. We are now in the process of assembling and reviewing the comments on that study which have been submitted by the Committee members.

The Advisory Committee on the Health-Related Effects of Herbicides will continue to function as an important focal point of our efforts to find answers to the questions about adverse health effects resulting from the use of phenoxy herbicides in Vietnam or elsewhere and to communicate with the public concerning these matters.

OFFICE OF SPECIAL ASSISTANT TO THE CHIEF MEDICAL DIRECTOR

When the issue of Agent Orange first surfaced, it was difficult, if not impossible, to foresee the level of activity in which we would ultimately be engaged. At first, the task of coordinating Agent Orange activities was given to our Assistant

Chief Medical Director for Professional Services within the Department of Medicine and Surgery (DM&S) as one of his many areas of responsibility. With the increased level of interest and activity, it became apparent that a centralized control point within DM&S, exclusively devoted to handling the heavy demands of the Agent Orange program, was necessary. To provide this essential administrative control, the Office of Special Assistant to the Chief Medical Director for Herbicide Orange Affairs was established in April 1980. Dr. Barclay M. Shepard was selected to serve in that position. It is the responsibility of that office to:

1. Respond to Agent Orange inquiries;
2. Recommend policy to the newly formed Policy Coordinating Committee, about which I will comment in a moment;
3. Direct the activities of the VA's Advisory Committee on Health-Related Effects of Herbicides;
4. Establish liaison with other Federal and non-Federal agencies and institutions;
5. Oversee the Agent Orange functions of the 180 environmental physicians in our 172 VA medical centers and 8 independent outpatient clinics;
6. Coordinate the conduct of special Agent Orange studies, and
7. Serve as special adviser to the Chief Medical Director on all matters concerned with the Agent Orange issue.

The tasks assigned to the office are many and varied. It is an office which we believe will best serve the needs of this Agency in responding to the Agent Orange problem and ultimately serve the needs of our Vietnam veteran population and their families.

POLICY COORDINATING COMMITTEE

The magnitude and complexity of the Agent Orange issues have also dictated the need to establish a high-level policy coordinating body for the entire Agency. Consequently, in June 1980, I established the Agent Orange Policy Coordinating Committee (PCC) and appointed the General Counsel, Mr. Guy McMichael, to serve as its chairman. This Committee serves as the central coordinating point to review all aspects of Agent Orange activities within the VA and to develop and establish new policy initiatives. Members are selected because of their relationship to, or knowledge of, the Agent Orange program and represent a base of expertise essential to the mission of the Committee. This Committee generally oversees the activities of the Special Assistant to the Chief Medical Director and maintains a close liaison with that office and the day-to-day activities for which it is responsible. The relationship is one of mutual support in implementing policy developed by the PCC and carrying out the medical aspects of that policy by the Office of Special Assistant. We anticipate that this newly formed Committee will prove useful in coordinating the many and diverse Agent Orange activities with which the Veterans Administration is involved.

INTERAGENCY WORK GROUP

In addition to seeking advice and recommendations from our own Advisory Committee, we have actively participated in the efforts of the Interagency Work Group to Study the Possible Long-Term Health Effects of Phenoxy Herbicides and Contaminants which was established by the White House in December 1979. The Interagency Work Group (IWG) is responsible for monitoring and coordinating Federal research efforts and other activities

regarding the possible health effects of herbicides such as Agent Orange and is charged with reporting to the White House the results and implications of these efforts as well as recommending policy to the White House. The Work Group is chaired by Joan Z. Bernstein, General Counsel of the Department of Health and Human Services. It includes representatives of the Department of Health and Human Services (DHHS), Department of Defense (DoD), and the Veterans Administration. Representatives of the Environmental Protection Agency, the Departments of Agriculture and Labor, the White House Office of Science and Technology Policy, and the Congress' Office of Technology Assessment also participate as observers. The IWG, which meets on a monthly basis, utilizes the services of its Scientific Panel to review, analyze, and comment on research activities already under way or being planned by Federal agencies and non-Federal research organizations. Recently, the Work Group held a public meeting and received statements from interested scientists, veterans organizations, and private citizens and responded to questions and comments raised by them.

We believe that the efforts of the IWG and of its Scientific Panel have been extremely helpful to us and we look forward to continued active participation and cooperation.

AGENT ORANGE REGISTRY

The Agent Orange Registry was initiated in 1978 shortly after the VA became aware of the serious nature of the herbicide issue. It was one of the early steps taken by the VA to attempt to evaluate the magnitude of the problem. The purpose of the Registry was to identify those veterans who were concerned about the possible health effects resulting from exposure to herbicides in Vietnam and to document baseline medical information on individual veterans who might later develop illnesses which

could be related to earlier herbicide exposure. The information was derived from the answers to a questionnaire, a physical examination and a set of baseline laboratory tests. It should be clearly understood that it was never intended that the Registry would serve in any way as a portion of a research study. It was intended to be and remains simply a catalogue of a self-selected group of Vietnam veterans with some baseline medical information relating to them.

To date, approximately 30,000 veterans have been examined and the data from approximately 12,000 have been entered into the computer. We have, of course, been curious as to what insight an analysis of this information might yield. To assist us in the evaluation of the information contained in the Registry, a Data Analysis Task Force has been established. This group of individuals with special expertise in the areas of biostatistics and automated data processing technology, as well as familiarity with existing VA computer files, has been carefully examining various aspects of the Registry in order to evaluate its current and future usefulness. The Task Force is currently reviewing the available information and is developing a data retrieval system which will provide a description of some of the health problems being experienced by those veterans who are enrolled in the Registry. The Registry continues to remain a useful mechanism for identifying concerned Vietnam veterans, for providing some medical information concerning these individuals, and for assisting us in maintaining contact with all participants. We are now developing a follow-up plan to reassure all individuals in the Registry that we will make every effort to maintain contact with them and keep them informed on any new developments relating to the Agent Orange issue.

CHLORACNE TASK FORCE

As was indicated earlier in this testimony, chloracne is the only chronic condition which has been widely accepted as resulting from exposure to dioxin. A diagnosis of chloracne is based upon the distribution and type of lesions and a history of exposure to dioxin. However, it is not always easy to distinguish between chloracne and other, more common forms of acne. In response to concerns expressed before the House and Senate Veterans' Affairs Committees and in order to take advantage of the best possible expert advice, a special Chloracne Task Force was recently assembled. This group, which consists of four distinguished dermatologists, has been given the responsibility of designing a protocol for chloracne examinations and of preparing special educational materials to be utilized for the training of other dermatologists and our environmental physicians. The Task Force has also been given the responsibility of identifying a larger group of dermatologists who could serve as special consultants for chloracne cases, as well as aiding in the adjudication of such cases by the VA. We are now in the process of reviewing previous adjudications in this area to assess the validity of our earlier findings. Some educational materials have already been prepared by the Task Force and are currently being reviewed. It is our goal to make these materials available to our physicians in the near future.

SPECIAL ACTIVITIES

Pub. L. No. 96-151 mandates the conduct of two major efforts by the VA relative to Agent Orange: An epidemiological study of Vietnam veterans exposed to phenoxy herbicides and a review and analysis of the world's literature on phenoxy herbicides.

Epidemiological Study:

The Veterans Administration is undertaking to contract with an epidemiologist from outside the Federal Government to design the protocol for the required epidemiological study. We have utilized an open, competitive bidding process. The proposals which we received have been critically reviewed and evaluated by a panel of experts, the majority of whom came from outside of the Veterans Administration. The membership of this panel included: Dr. Robert Hoover, Assistant Chief, Environmental Epidemiological Branch, National Cancer Institute; Dr. Gilbert Beebe, Clinical Epidemiology Branch, National Cancer Institute; Dr. Joyce Lahoff, Assistant Director, Health and Life Sciences Division, Office of Technology Assessment; and Dr. John Kurtze, Chief, Neurology Service, VAMC, Washington. Also serving on the panel as a nonvoting member was Dr. Lawrence Hobson, who at that time was Deputy Assistant Chief Medical Director for Research and Development. A recommendation has been made by the panel and negotiations for a contract will be initiated in the near future.

The process of selecting a contractor has been impeded somewhat by actions taken by the National Veterans Law Center. In May of this year the Center attempted to obtain a temporary restraining order to preclude the Veterans Administration from opening any proposals for a contract for the design of the epidemiological study. The basic contention of the Center was, and continues to be, that in their view the solicitation would not result in a proper and adequate protocol for the mandated study. Further, it contended that the Veterans Administration should not carry out the study but rather the responsibility for conducting the study should be given to some unbiased and independent organization. Judge Harold Green of the United States District Court for

the District of Columbia denied the Center's motion for a temporary restraining order, stating that the complaints made by the Center were premature, since it could not be determined that the ultimate study design would be deficient or defective until after it was prepared and subjected to careful review and analysis. The Court retained jurisdiction of the case and advised the parties that if, after the development of the protocol, the Center still believes it has been harmed in some fashion, it could again seek a preliminary injunction. Subsequent to the denial of the motion, the National Veterans Law Center filed a protest with the General Accounting Office, alleging irregularities or violations of procurement laws, rules, and regulations committed by the Veterans Administration in the procedures utilized to select a contractor. We are unable at this time to forecast when a final resolution by the General Accounting Office will be achieved. We are, therefore, somewhat constrained from proceeding with the mandated epidemiological study at this time.

Once a contract has been awarded, a study design will be prepared, and will be submitted to several groups for their review and comments. These reviewers will include the Veterans Administration Advisory Committee on Herbicides, the Interagency Work Group to Study the Possible Long-Term Health-Effects of Phenoxy Herbicides and the Congressional Office of Technology Assessment. Additionally, we are planning to request the National Academy of Sciences to select a panel of epidemiologists to review the proposed protocol. Once the protocol has been approved, a determination will be made as to what organization will carry out the study. In arriving at that decision, we will be seeking the advice of several non-VA groups. Consensus will be sought from the

Interagency Work Group, the Advisory Committee and other appropriate groups or individuals.

It is hoped that this study will be under way by late 1981. It should be emphasized that although some early findings and conclusions may be reported, more definitive answers will not be available for at least a decade or more. While this is frustrating to all who want quick answers to this complex issue, the fact remains that any possible long-term adverse effects on human health must of definition wait for a sufficient passage of time. We can reasonably expect some conclusions resulting from a study of the magnitude, but should not expect that this, or any other study, will provide all the answers we might want to obtain. In any event, on both a short- and long-term basis, the VA will vigorously seek answers to this most complex issue. Nevertheless, some basic information about the health status of Vietnam veterans should be available in a few years. The data from this study, together with the information received from the Ranch Hand Study and other ongoing studies should enable us to make those informed governmental policy decisions that will need to be made.

One of the most vexing problems in conducting an epidemiological study relating to the health effects of Agent Orange on human health is the problem of how much exposure individual troops received. The war was a fluid combat experience with many small units involved and no fixed battle lines. We are informed by the DoD that they do not possess accurate information on the disposition of many of the 2.6 million troops who served in Vietnam. This circumstance makes it very difficult to determine precisely whether any individual might have been exposed. The GAO has reported that there is some information about the movements of Marine troops, particularly in

the I Corps area, although it is unclear to what extent the amount of exposure to Agent Orange can be determined even with this group. Additionally, we have been informed that representatives of the DoD and the GAO have been attempting to learn whether more precise data exists. This problem has apparently proven to be a very complex one that may not be able to be resolved easily. We further understand that a report will soon be issued on these efforts.

I would like to state in this regard that the issue of whether a particular veteran has been exposed to Agent Orange is important insofar as the Veterans Administration is concerned for purposes of carrying out the mandated epidemiological study. For purposes of adjudicating claims for disability alleged to have resulted from exposure to Agent Orange, it is, and has been, the stated policy of the Veterans Administration to accept, in the absence of positive evidence to the contrary, a Vietnam veteran's contention of exposure.

Literature Analysis

The second major effort mandated by Public Law No. 96-151 is a review and analysis of the world's literature on phenoxy herbicides. The Veterans Administration has already undertaken an extensive review of the literature and is aware of much of its content. The goal of the mandated study is the preparation of a bibliography with an annotated review and analysis of the literature on phenoxy herbicides and of the contaminant dioxin or TCDD.

In view of the large volume of literature and the technical complexity of the subject matter, it was decided that this task would best be accomplished by contract. A number of proposals have been submitted and a panel of experts has begun its review of them.

OTHER RESEARCH ACTIVITIES

The Veterans Administration is monitoring with interest the many research activities being conducted by other Federal agencies concerned with the toxicity of phenoxy herbicides.

Earlier this year, the Center for Disease Control (CDC) proposed a study to determine if Vietnam veterans have a greater than normal risk of fathering children with birth defects. This question has been the source of considerable concern among our Vietnam veterans and their wives. We believe that a carefully designed and conducted study of this type would shed considerable light on this vexing and emotional issue. The CDC has received preliminary approval of the study from the Interagency Work Group and the protocol is currently in the review process. This study will be jointly funded by HHS, DoD, and VA.

We are also continuing our active cooperation in the Agent Orange Registry at the Armed Forces Institute of Pathology (AFIP) for pathologic materials from veterans with possible exposure to herbicides during the Vietnam war. Currently, there are 79 cases in this Registry. An analysis of these cases is being conducted as the material is submitted. Although the number of cases is still very small, to date there is no evidence to suggest any increase in prevalence of a disease or group of diseases above the expected incidence. In order to expand the number of cases submitted, the VA has requested the AFIP to increase its efforts to encourage both civilian and Federal hospitals to submit materials whenever appropriate. The VA has been given every assurance that the AFIP is willing and able to comply with this request.

The VA is likewise monitoring with interest the progress of the Ranch Hand Study. Because of the unique nature of this study cohort with regard to known exposure to Agent Orange,

this effort has peculiar and significant importance. The VA strongly endorses this study and has recommended that it be given full support.

VA AGENT ORANGE INFORMATION AND EDUCATION ACTIVITIES

Mr. Chairman, we are cognizant of the concerns of Congress and of our responsibility to inform individuals of our activities regarding Agent Orange and of keeping them abreast of the latest developments concerning the Agent Orange issue.

Some of our more significant activities in this area have included an education conference on Agent Orange which was held in Silver Spring, Maryland, on May 26-28, 1980. This follow-up conference to the one that was held in Washington in September 1979, was attended by our 180 environmental physicians and 54 adjudication staff from our Department of Veterans Benefits. Presentations were given by several of the country's leading experts on herbicides and included discussions of current knowledge regarding:

1. The chemistry, toxicology, and metabolism of Agent Orange in experimental animals.
2. The manner in which herbicides were used in Vietnam.
3. The environmental fate of Agent Orange constituents.
4. Known and suspected human health effects of Agent Orange constituents.
5. Approaches to the epidemiological study of the effects of Agent Orange on humans.
6. How Vietnam veterans view the Agent Orange issue.

7. Latest VA Agent Orange initiatives and policies.
8. The need for compassionate service to veterans concerned about Agent Orange.

In our continuing efforts to keep our Vietnam veterans advised concerning Agent Orange activities, an information pamphlet, "Worried About Agent Orange?" has been prepared and distributed to our 172 VA medical centers, 8 independent outpatient clinics, 91 Vet Outreach Centers, 58 VA Regional Offices, members of Congress, State Veterans' Affairs Offices, veterans' service organizations, and to other concerned agencies and individuals. The pamphlet, prepared in cooperation with the IWG, provides a concise overview of Agent Orange.

Additionally, we are in the process of preparing two educational films on Agent Orange, the first of which will further inform veterans concerning what is known about Agent Orange and advise them of the Agent Orange Registry. The second film will soon be initiated and will serve as a training device for VA physicians and administrative personnel. Both films will be available for general public use upon request.

We will shortly begin publication of a bulletin which will serve to provide information and guidance to our 180 environmental physicians and other VA medical staff concerning Agent Orange related activities. We will continue to review our education and information programs on a regular basis and make such modifications as warranted by the situation.

CONCLUSION

In conclusion, I believe that the VA is conducting a well-organized and broadly based program for helping to resolve the issues of Agent Orange effects on human health. As we have become more involved in the pursuit of answers to this problem, we have come to appreciate more fully the complexity of the many variables which impact on the Agent Orange problem. The seriousness of the issue and the very real concerns of Vietnam veterans and their families are a constant motivating force for responsible and effective actions and programs. Unfortunately, we cannot provide all the answers to the many questions being raised today, nor will we be able to do so in the near future. As has been indicated on many previous occasions, the scientific inquiry process necessary to produce accurate, reliable information does not lend itself to quick answers. We hope that the epidemiological study, the literature analysis, and all other research endeavors concerned with Agent Orange will assist us in providing definitive, scientifically valid answers. It must be stated that this process will take many years with no guarantee that all the answers will be found. We only guarantee that our search for answers will be supported by the full energy and resources at the disposal of the Veterans Administration. As you know, the VA, in cooperation with other government agencies, has been constantly gathering information and increasing our body of knowledge on this subject. We are acutely aware that policy decisions must be made in the near future. We expect that in a few years, we will have the information that we will need to make those decisions.

I cannot state in strong enough terms that in the interim, it has been and will continue to be the stated policy of the Veterans Administration that no eligible veteran will be denied medical care and treatment by the VA because the answers are not in.

As I have indicated, the VA, in cooperation with other government agencies, has been constantly gathering information and increasing our body of knowledge on this subject. We are acutely aware that policy decisions must be made in the near future. We expect that in a few years, we will have the information that we will need to make those decisions.

I cannot state in strong enough terms that in the interim, it has been and will continue to be the stated policy of the Veterans Administration that no eligible veteran will be denied medical care and treatment by the VA because the answers are not in. Our goal remains to provide compassionate and understanding service. This is a responsibility that we take very seriously.

Mr. Chairman, this concludes my testimony. I will be happy to respond to any questions you may have.

ATTACHMENT

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Mr. MAGUIRE [presiding]. Thank you very much, Mr. Secretary.

I wonder if I could start by asking you why it has taken so long for you to respond to the April letter of Congressmen Bonior and Daschle, which included a number of specific questions which you did not respond to in your interim reply of last April?

They asked for an early response with close attention to the 11 questions, and there has been no response to those 11 questions. It is now 6 months later.

Mr. McMICHAEL. In part our difficulties arose from the number of people we have had to submit the studies to for comments. They have been submitted to a number of bodies, including our own VA advisory committee which Senator Cranston of the Senate Veterans' Affairs Committee requested we do.

We are still awaiting answers from the advisory committee about those studies. As soon as those responses are in, I think we can give a factual and complete response.

Mr. MAGUIRE. You hope that will be when?

Mr. McMICHAEL. Before the next meeting of the advisory committee. That should be in the next month or so.

Mr. MAGUIRE. You know, it is appalling to me that we go on month after month, year after year on this matter, talking about how every detail of the scientific case has not yet been established and that, therefore, no compensatory claims can be accepted at this time.

I have a couple of questions about that. First of all, all the evidence is never in. Obviously, we are looking not for tying down a precise cause and effect relationship, which is very difficult to do, but we are looking for the best cases that we have.

Now, for years, we have used animal studies as the best indicators that we have of hazard to human beings. That is why we do animal studies. The animal studies have shown increased frequency of cancers, particularly sarcomas, liver and lung cancers have been documented.

Liver, kidneys, lungs, nervous system, blood forming organs of the reproductive system have shown to be at hazard in the animal studies.

Abortions, early death, abnormal development of offspring in laboratory tests on animals exposed to dioxin. Compared with what we have in many other instances by way of scientific evidence and where we have taken action to protect the public, these studies are pretty compelling to me.

I have spent a lot of work on this kind of issue with EPA and the Health and Environment Subcommittee, on which I also serve. I am just wondering how after we have spent untold billions of dollars fighting this war in Vietnam, how it is that years later we cannot provide the sums necessary to assist those who have serious health effects which the animal studies at least strongly suggest would be related to their experience and their exposure in Vietnam to dioxin, agent orange, and other herbicides.

Why do we have to have, Mr. Administrator, the last bit of cause/effect scientific evidence in the notebook before we take care of those men and their families?

Mr. CLELAND. It seems to me the clear, evident response to that is that the laboratory was not Vietnam and that what we really

need is data in regard to Vietnam veterans and the Vietnam experience. That seems to me to be what we really need and that is why the Congress has asked the VA to do a full-blown study backed up with scientific methodology to get at the question.

Mr. MAGUIRE. If I may say so, sir, I think you are absolutely wrong. If we have animal studies that show that exposures to dioxin cause cancer and we have every reason to believe, therefore, that that is also true in human beings, and we know that our soldiers in Vietnam were exposed to dioxin, then it seems to me that we can make a reasonable presumption that while we may not have every final shred of evidence in a particular case, that basic fairness would require that the people of the United States, acting through a government that is concerned about the lives of these men and their families, who have sacrificed so much, would be taken care of with respect to their health.

That is the way it looks to me.

Mr. CLELAND. As one who was on the ground there during two out of the three peak spraying years, I understand your concern. The problem is that the laboratory was not Vietnam, and we haven't compiled the kind of data that we really need to compile. I will ask the General Counsel to comment and then Dr. Custis.

Mr. McMICHAEAL. Let me just say a couple of things.

First, I think I would agree with your observation that policy decisions are going to have to be made about compensation before all of the final scientific evidence is in.

Indeed, we may never get all of the final scientific evidence with respect to cause and effect.

What we do need and what we are required by law to do is attempt to determine whether an individual who presents himself to the VA has a disability and, second, whether we can reasonably relate that disability to his period of service.

We know that lots of people get cancer. Lots of people who never go to Vietnam are going to get cancer. If you are suggesting that anybody who is a veteran simply by the fact that he gets cancer ought to be compensated, then that would be a departure from the types of laws that have governed our procedures so far.

Mr. MAGUIRE. No; I would suggest anybody who was a veteran serving in Vietnam in the times and places at which those herbicides containing cancer-causing agents were used, that would be a better—

Mr. McMICHAEAL. Any case of cancer at all? I assume also that if saccharin produces cancer in rats, then any veteran who ingested saccharin while in the service and gets cancer also presumably should be service-connected compensated as well?

Mr. MAGUIRE. I happen to think the American public ought to be protected against cancer. That is the way I voted in this House. I take animal studies very, very seriously. I think they are the best indicator. Let me ask you this:

Does the Congress have to act here in order to establish the principle that people are going to be compensated? We did it with black lung where we couldn't prove beyond the shadow of a doubt that this individual person was actually going to have black lung or did have black lung, but they had the symptoms, they were exposed over a period of time, and we knew that in 9 out of 10

cases there was a correlation, if not a cause and effect relationship and, therefore, they are compensated.

What about cardiovascular diseases among amputees? You compensate for that. What about MS? You compensate for that, on the basis of one study. Do we have to tell you to do it? Is that what we are talking about here?

Mr. CLELAND. I am not a physician. I would like to have Dr. Custis comment. It seems the data on those diseases in humans is pretty solid.

Dr. Custis?

Dr. CUSTIS. I can only affirm what you say. I think there is no end to the argument that we are off and running here. For example—

Mr. MAGUIRE. The end would come if people would meet their responsibilities, Doctor.

Mr. McMICHAEL. We believe we are meeting our responsibility as the law requires. It is clear the Congress can establish presumptions. Congress has established the presumption with respect to multiple sclerosis. If Congress wanted to establish other presumptions such as any cancer developing at the present time, we could pay as well.

What I am suggesting is if we can get some baseline data about the health status of Vietnam veterans, some idea of whether or not Vietnam veterans are suffering health decrements at a greater rate or a rate that seems qualitatively different than a nonveteran group, then I think we are at the position you are at right now where we can make policy decisions.

Mr. MAGUIRE. I did interrupt Dr. Custis.

I do want you to have the opportunity to make a response. I would point out while Congress established the presumption on MS, you established the presumption on cardiovascular diseases. I yield to my expert colleague from Tennessee.

Mr. CLELAND. Based on a study of human beings.

Mr. McMICHAEL. That was not a presumption. That was a direct cause-and-effect medical decision that had been made.

Mr. MAGUIRE. I yield to the gentleman from Tennessee. In fact, I would like to reinstall him in the chair.

Mr. GORE [presiding]. Thank you very much.

Maybe my understanding of the cardiovascular situation is deficient. I thought that it was a presumption that if somebody developed a specific set of symptoms then they were entitled to compensation even though the scientific data does not directly establish the causal linkage, there being only one study conducted by the National Academy of Sciences on the subject.

Mr. McMICHAEL. The studies were done on veterans, I might add. Let me ask Mr. Peckarsky, head of our compensation and pension service, to explain the difference.

This is a fairly complicated area. I am aware this committee is not the authorizing committee which deals with these issues of disability.

Mr. GORE. Well, if you would come forward and identify yourself, we will have to put you under oath.

[Mr. Peckarsky is sworn.]

Mr. PECKARSKY. My name is Charles Peckarsky.

I am the Director of the Compensation Service of the Veterans' Administration. I would like to point out a clear distinction between the issues raised on multiple sclerosis and cardiovascular disorders in amputees.

Multiple sclerosis is a pure presumption of law. It is based on no prior evidence; manifestations which develop to a 10-percent degree within 7 years following service by enactment of Congress must be service-connected. That is pure presumption of law.

With regard to cardiovascular disorders, I might point out to the committee that the veteran's basic disability is service connected. The amputation was incurred or aggravated coincident at the point in time with his military service. It is a basic principle of our law that any extension of that disability will also be service connected.

Medical evidence in the epidemiological study performed by the National Academy of Sciences said that when an amputee develops cardiovascular disorders, those are a part and parcel because of the added risk of the basic service-connected amputation. As such, what we did was extend the service connection for the amputation to the subsequently developing cardiovascular disorder.

We make no presumption as to the etiology. We merely extend the service-connected disability and its manifestations.

Mr. GORE. My point is that there is a lot more scientific evidence that a human being exposed to dioxin, where it is in the service of his country or in some other way, will exhibit a certain set of symptoms, and the evidence linkage exposure to dioxin with the health effects which come from exposure to dioxin is more comprehensively documented than the linkage between amputation and the cardiovascular effects. At least I am told that is the case.

Mr. PECKARSKY. Yes, sir. Let me, if I may, try to put this in context.

It is not required in veterans law that there be an etiological or causal relationship established between a disability and a period of active duty. All the law requires is a finding that the disease was incurred or aggravated or the physical disability arose coincident at point of time with the military service.

Now we have only been keeping records of claims in the agent orange category for a little over 2 years. We have, however, been granting service connection to all veterans and Vietnam veterans in particular since the Vietnam era.

In that category, we are now compensating some 550,000 Vietnam era veterans and an additional approximately 2 million have service-connected disabilities that are not compensable.

The problem is not whether or not you recognize a relationship. The problem is more than that. If there is such a relationship, at what point in time should it be initially manifested?

I submit to you that any of those disease entities that were either manifested in service—and the studies would show a close proximity between exposure and manifestation of disability—if any of those were manifested in service or within a reasonable period thereafter, they are already service connected.

The cases that give us problems are the ones that the Administrator spoke of. A questionable exposure; by questionable, we do not mean that we question that the veteran was exposed. We question the degree to which he was exposed, back in, let's say,

1968, 1969, or 1970 and the first manifestation of disability some 10, 12, or 13 years, not after the exposure, but after the termination of his military service.

Mr. MAGUIRE. Would the gentleman yield?

Mr. GORE. Yes; I would be glad to yield.

Mr. MAGUIRE. That is precisely the nature of the hazard that we are discussing; namely, it takes a number of years to develop and, second, it is the type of hazard that can result in serious health effects, including cancer, on the basis of exposures to very small quantities such that the scientific community has not been able to establish a threshold below which the exposure would be regarded as safe.

So under those circumstances, if you have someone exposed, and you know that person was exposed, and you know how the substance in question affects animals in the studies that have been conducted, which are the best indicators we have of hazards to human beings, it seems obvious to me that at that point you draw some conclusions and you say here is a class of people that in all likelihood have suffered the consequences of this exposure and that, therefore, ought to be compensable.

Does that not seem like a logical formulation to you?

Mr. PECKARSKY. Yes, sir, as far as it goes.

Mr. MAGUIRE. Excellent. That puts us way, way, ahead, Mr. Chairman, of where we have been for the last 2 years.

Mr. CLELAND. May I say I think what we are talking about is two different things. One thing Mr. Peckarsky is talking about is the fact we had trouble with the delayed syndrome because that tends to run against what I understand is the medical and scientific evidence on the point.

I would like for Dr. Custis to speak to that.

Dr. CUSTIS. I would just like to say there have been references to documented evidence, and I would like to disagree with that. There is no documented evidence that individuals, humans exposed to agent orange have in consequence any chronic disease entity recognized at the present time.

Mr. GORE. Let me ask you this: You are the Chief Medical Officer for the VA?

Dr. CUSTIS. That is right. I say this from the standpoint—

Mr. GORE. Are you familiar with the Swedish studies that were the subject of testimony here earlier today where people exposed to dioxin, a constituent of agent orange, resulted in a significant increase in several forms of cancer?

Dr. CUSTIS. Mr. Chairman, if I may finish, please, I am talking about validated, agreed-upon-by-expert studies. The only thing conclusive about the current status of the Swedish studies is that there would appear to be some correlation, but it has not been validated from an epidemiologic standpoint.

Also, we have the evidence of a very long-term followup of the victims in Nitro, W. Va., now some 30 years since the occurrence of that accident, over 200 people closely followed with no evidence of cancer and no evidence of any chronic lingering diseases from that significant dioxin exposure.

I might also say that it is not the role of the Department of Medicine and Surgery to have any decision responsibility in the

matter of compensation, but we are obliged upon on the basis of literature research, and after obtaining the best advice from the known experts in the country to give an opinion as to any cause-and-effect relationship. We have found no evidence yet by which we can answer that question affirmatively.

Mr. GORE. Let me make a statement here, because I am fighting back the same kind of anger that has been evident among many of the veteran organizations with respect to this problem.

Let me tell you how I see this, Max, if I may call you so on the record.

I think you have a personal concern about this problem. I believe that. I saw what you did in calling up the veterans' hospitals around the country and saying I am a veteran; I think I have been exposed to this; what should I do? Then you were amazed personally by the response.

I think that you are surrounded by people down there, if I may be so bold as to suggest, that don't share that appreciation for the problem. I personally think that the comparison that was just made, Mr. McMichael, to saccharin exposure is an outrage to a people who are suffering from the constellation of symptoms which medical evidence does attribute to exposure to dioxin, and I think that the chief medical officer's view that has just been given of the medical evidence as you see it excludes the well-known Swedish studies that have been reviewed by the Office of Technology Assessment, the dean of the medical school, the University of Michigan who said it was one of the finest studies that had ever been conducted of its kind.

I know that the studies on dioxin exposure are new. This is a new field. Epidemiological studies are always subject to controversy. We saw a study just recently of exposure to dioxin among the people in the areas surrounding Love Canal in New York. It was fraught with controversy and there were recriminations back and forth, but when all the arguments were over with, the majority opinion in the medical community was that yes, there appears to be significant damage from the exposure in that area.

Just because it's a new field doesn't mean that the VA has to take the attitude that it's probably nonexistent.

Now, let me tell you where I was going with this, Max.

I am willing to believe that we are talking about a relatively small number of people here, compared to the total number of Vietnam veterans and, therefore, as I said earlier before you arrived, several areas of uncertainty that you have to fight your way through, and when people look at each one of those areas of uncertainty they get confused, they get frustrated, and the easiest course of action is to turn your back and say, no, there is probably not a problem or at least the problem is so difficult to find that it's not worth the effort.

The first area of uncertainty is who was exposed and who wasn't exposed. An awful lot of people went to Vietnam were exposed to such a minimal degree they didn't suffer any effect.

The second area of uncertainty is what is it in agent orange or some of those other substances that cause problems. Dioxin certainly is a suspected culprit, but there may be other such elements, and the time of exposure.

We know there were heavier concentrations in the earlier years of war. When you have the other area of uncertainty associated with all the epidemiological studies and the scientific data. You have to fight your way through that maze. Then there is the uncertainty associated with anecdotal evidence that is continually presented to the VA.

You know there are a lot of people who come in and say I have problems, I believe they were related to agent orange, and you have reason to believe that they weren't.

There are a lot of those people, for sure. But when you recognize all of those uncertainties, still you have a group of people remaining, and I have seen them in my district, they came and showed me their hands. They came and showed me the skin problems resulting from it and described the other symptoms that they experienced and they are always the same. They attribute it to exposure.

It's a relatively small number of people. You know, if I have seen a dozen, that may be overstating it, in the 3 years I have represented one district in Congress.

If you multiply that by 435 and take into account all of the people who didn't come to see me about it in my congressional district, you are talking about a significant number of people out there who probably are experiencing severe, frustrating, debilitating health problems because of exposure to this substance.

Just because it's difficult to find them, just because there are uncertainties that we confront when we try to establish the line of causation and identify them, doesn't mean that those people don't deserve a better performance from the VA than they have got and a better performance by the government as a whole than they have gotten.

For you to come here and compare it to saccharin, for that person when you finally get to him, it's just not satisfactory.

Mr. CLELAND. May I respond?

Mr. GORE. Absolutely.

Mr. CLELAND. First of all, I would like to say that I think those whom I rely on to deal with the question of agent orange and advise me, these two gentlemen here on my left both were in Vietnam, and the chief medical director himself was exposed. So I hope we can get rid of the question of insensitivity here.

What we are trying to establish is a very difficult question of scientific linkage here, one that I am not expert to make, which is why I have to rely on others.

I personally went around my advisory group and asked them the question what they individually thought, did agent orange cause cancer, did it create birth defects?

Not one individual in there was willing to say that agent orange created birth defects, and most were very hesitant in terms of linking agent orange with any form of cancer.

It's a very difficult issue. That is with people who deal with herbicides and the scientific community all the time.

If you say, well, the VA's Agent Orange Advisory Committee isn't any good, the White House created an independent group itself, others outside the VA are now looking at this question, we welcome that. We welcome the Air Force, we welcome HHS, we

welcome CDC, we welcome anyone interested in this issue, because we are trying to get at the facts.

We are not equating agent orange with saccharin. What we are trying to point out here, and my testimony points it out, and the key word was chronic, Dr. Custis says chronic, there is no question but what dioxin can create pretty severe symptoms at the time.

The problem we have, as Mr. Peckarsky mentioned, is 10 years later, after there is no evidence on the medical record, no evidence at the exit physical, no evidence right afterwards, then 10 years later, which is contrary to medical literature at this moment, based on advice that I have been given, then the individual says: Here I have a problem.

That is the problem; not the question about initial exposure to dioxin and what it can do, and not the question about where animals, laboratory animals such as monkeys and rats are fed dioxin.

We know it's a poison, a very toxic substance, which is what concerns us. Our problem is, it seems to me, this is the crux of the matter, how does the laboratory situation of infecting rats or monkeys or feeding rats and monkeys, how does that equate with an experience in Vietnam?

Now that seems to me a very difficult question, which is why the Congress has directed the VA to go and get thousands of Vietnam veterans, call them in for a full-blown investigation of this question, and ask all of the difficult questions over a period of 10 years to see if there is anything in that statistically valid group that would point up health care problems.

Mr. GORE. Let me finish my questioning and then, I apologize to my colleagues for taking so long.

I am concerned that if you take Vietnam veterans generally and ask if they have health problems at a higher rate than the general population, then I question whether that finding in and of itself is going to get us much closer to answering the questions associated with agent orange.

I appreciate the difficulties and uncertainties, and I don't want to ascribe a personal insensitivity to any of the witnesses. I do believe that there is an institutional attitude of the same kind that you confronted when you called the regional hospitals and said, and just identified yourself as a Vietnam veteran who was experiencing problems and got a nothing answer.

Then you took action to say, "Look, let's clean up our act," I believe was your phrase.

But, I think that same kind of institutional attitude exists in other parts of the VA, and I know it's a touchy problem and there are a lot of uncertainties.

Mr. CLELAND. But, Mr. Chairman, if the VA was absolutely negative on this issue there are other elements of Government; there is the private sector, medical schools all over this country; there is a body of literature available to be researched in the world which is what we are taking a look at.

You know, we are going to find out more and more about this issue. We happen to think that in the VA we can help lead that. Ultimately, it's going to be our veterans and our responsibilities anyway, but I think that the Congress and those of us dealing with

the question are trying to get as much information from as many points of view as possible.

That is where I welcome this congressional oversight into what we are doing.

It seems to me it's not necessarily bureaucratic obstructionism that is the problem. It seems to me, as one who would like to get at the facts as quickly as possible, if for no more reason than it would take me off the hot seat, is a question of scientific evidence.

Now, are we to think that on the basis of one study of any kind that that is the whole picture? No. But I think the question that Mr. Maguire raised is exactly to the point. That is that ultimately in this saga there is a judgment made knowing that all the facts, in effect, will never be in.

All the facts on multiple sclerosis, all the facts on cancer, radiation, they are not all in. We are making decisions on those disabilities every day and service connecting them.

There is a point, a thin red line, a judgment call made that OK, we make a presumption here. In our case, the Congress has given us a liberal enough law so that we don't even have to necessarily completely tie it to agent orange. But, what we have a problem with is that if there is no other evidence of disability or problems in the service, that is the thin linkage we have to go on, and right now, that is a pretty thin linkage.

We would like more evidence; I think speaking more for myself we would like more evidence. I think that evidence will be forthcoming one way or the other.

Mr. MAGUIRE. Mr. Chairman, I wondered if I could ask you to yield on that point?

Mr. GORE. I was going to recognize Mr. Lent.

Mr. LENT. I will yield.

Mr. MAGUIRE. Thank you.

I appreciate the statement that you have just made. I want to ask you, though, whether you feel confident that the kind of statement that we heard a moment ago from the chief medical expert, Dr. Custis, to wit:

That there is no validated human case and that there is no cause and effect relationship that has been shown, are you satisfied that you are getting the best scientific advice that you can get when Dr. Custis makes statements like that?

Mr. CLELAND. In all due respect, the key to his statement was chronic. I think he was focusing on the question of the delayed reaction which is one that is very weak, I am told, in medical literature. But there is plenty of other evidence up front. That is part of the problem. Right up front, within a few weeks of exposure to dioxin, a lot of symptoms, and a lot of problems, can happen.

Mr. MAGUIRE. Let me say this: Whether Dr. Custis did or did not serve in Vietnam, whether he was or was not personally exposed, I think it not an issue here. What is at issue in my mind as I listen to what he says is whether his background and knowledge is adequate to the task that is before us, because I heard him make statements that I regarded as the most appalling, unscientific statements that I have heard in a long time. They seemed to allow no importance to animal studies which the Toxic Substances Control Strategy Committee has determined, as have eminent scien-

tists the world over, that animal tests are valid ways to identify what causes cancer in human beings. His statements completely leave that aside. Based on what I heard from him today, Mr. Administrator, I would suggest that you start by asking for his resignation. I do not think that he is qualified to give you advice on this subject.

Mr. GORE. We will give the witness an opportunity to respond.

Dr. CUSTIS. May I respond, Mr. Chairman?

Mr. GORE. Yes.

Dr. CUSTIS. It would appear my statement is either misunderstood or needs clarifying. I was referring to evidence in human beings, not in laboratory animals. I was referring to chronic diseases, and I think perhaps I did not make the exception for chloracne. There is evidence—in some cases, of a protracted course for chloracne. In the case of the Swedish studies, the authors themselves, specifically Dr. Axelsson makes the statement that he does not consider his study—although recognized to be an excellent study by extremely reputable researchers, he and they, do not consider the study to conclusively prove a cause-and-effect relationship between dioxin exposure and malignancies.

I assure you that my opinion is not based only on my own experience. I am indeed not an epidemiologist. I have, we have as an agency, as a department, sought out the best expertise that we can find in the field. I am only trying to convey to you what I learned from them and what has been brought to us by an intensive search of the literature. We would be delighted and look forward to the day when these questions regarding agent orange can unequivocally be settled.

I think that you would be even more critical of me were I to advise the Administrator that something exists which indeed does not; and what does not exist today is recognized evidence, in the case of human beings, that there are such chronic results as birth defects, cancer, all of the other things that have been claimed as outcome from dioxin exposure.

As far as sensitivity goes, as far as the intensity of our effort goes, if there is anything more we can do, we will be most anxious to do so.

Mr. GORE. Thank you, doctor.

I recognize Mr. Lent.

Mr. LENT. Thank you, Mr. Chairman. Thank you, witnesses, as well. There is only one or two loose ends I would try to get down. I think most of the other questions that I had have been well covered. I want to thank the witnesses for their answers.

Mr. Cleland, on pages 16 and 20 of your statement, you indicate, and I will quote, "For purposes of adjudicating claims for disability alleged to have resulted from exposure to agent orange, it is and has been the stated policy of the Veterans' Administration to accept, in the absence of positive evidence to the contrary, a Vietnam veteran's contention of exposure."

There is a similar quote, as I indicated, at page 20. This seems to contradict statements that we have had from prior witnesses that in the case of chloracne, for example, we are told that only of some 850 claims have been honored, and we are told as well that between April 1978 and February 1980 the VA had been requiring

the veterans to prove exposure from their service record or from some extraneous record.

Can you explain the apparent contradiction in the testimony, your testimony and that of, I believe, witness Furst?

Mr. CLELAND. Accepting a veterans word that he was exposed, we will do that. The problem comes in trying to link any diseases or disability with that exposure. Mr. Peckarsky deals with this question every day. Charley.

Mr. PECKARSKY. Yes, sir. Initially we attempted to establish some exposure level by asking that evidence be submitted as to the nature and extent of the veterans exposure. It became apparent after we had looked at a few hundred claims in this category that No. 1, we could not get any adequate exposure data; and, No. 2, in the context of our not requiring a relationship between some incident of service and the disability, but only a cause and effect relationship from point in time, that the exposure itself would be conceded; and so we did that. We told our field stations do not ask for evidence of exposure. If the veteran says he was exposed, he was, unless you have absolute proof that he could not possibly have been.

Because that really is an irrelevant issue in the adjudication of claims. The issue has been adequately explored in the time lapse between the first manifestation of disability and exposure, if there was any. So that the statement is absolutely true. We do not and have not, since February of this year required evidence of exposure.

Now there have not been 800 claims for chloracne. There have been, to my knowledge, 22 claims of chloracne; 191 of those, on examination, did not have chloracne. Three of them are service connected. The 800 are skin conditions of various types which might have been misdiagnosed and conceivably in the light of expert examination might now prove to be chloracne. We have service connected 217,000 Vietnam era skin conditions. That includes scars. Amongst those conceivably there are any number of chloracne cases. I do not know. It is a question of diagnosis. It does not matter. If the veteran showed up with skin disability or disease in service, we service connected it. If it was manifested as scars on his discharge examination, we service connected it. If it came up closely after separation and he says it started in service, we service connect it.

The 800-some cases, that is an investigation of an entirely different matter.

Mr. CLELAND. May I make one other point here? We have been focusing on the question of compensation. Keep in mind that there are two other things that we do while we are exploring research on the question of agent orange. One is we are constantly screening Vietnam veterans. Two, if there is anything that shows up in that exam, we will deal with it, we will treat it, whether or not it is agent orange related. The only thing that we are unable to do now in terms of service to a veteran in regard to agent orange is pay that disability compensation for that disease or disability; and that is because there seems to be at least a paucity of evidence in that regard or at least the evidence that exists is conflicting.

You know, a lot has been said here today, but the Nitro, W. Va., study is one study that you cannot refuse to look at. The National Academy of Sciences looked at this question back in 1974 or the Air Force study in 1977.

All of—both of which concluded, based on scientific evidence, the question of whether a Vietnam veteran's health was impaired was "highly remote." That is quoting from the 1974 NAS study.

The point is that that leaves us in the VA in a very difficult position when the evidence is either small or when what evidence exists in humans is conflicting. That is why we are going all out for further research. The point is that that research data is slow in coming; but we think that the Air Force study, our study, the CDC study, and some others are legitimate studies that can indeed shine some light on this question which we would all like to have.

Mr. LENT. One final question. When we heard from Mr. Furst earlier today of the National Veterans Task Force on Agent Orange, he told us that he had submitted some voluminous evidence or data on health problems of Vietnam veterans in the St. Louis area to the VA and that so far as he knew, nothing had ever transpired with respect to that data. Does anyone here know anything about it or where that information or data might be?

Mr. CLELAND. Dr. Shepard?

Dr. SHEPARD. I have met with Jon Furst on a number of occasions and have enjoyed a good relationship with him. When we appeared on a talk show a couple of months ago, he gave me some material that he wanted me to look at just informally. To my knowledge—and I may be incorrect, but to my knowledge, he has never submitted any kind of formal request to the VA that his data be analyzed and furthermore that we return some kind of a report to him.

Mr. LENT. Well, I think there was implicit in the delivery of his data that he expected someone in the VA to take a look at it and add it to the general body of knowledge on the subject.

Mr. CLELAND. We will be glad to do that.

Mr. LENT. I would appreciate it if we could hold the record open, Mr. Chairman, and perhaps give the VA an opportunity to go over that data or whatever it is and give us an analysis or a report of it, and then we can forward that on to Mr. Furst.

Mr. CLELAND. We will be happy to do that, Mr. Chairman.

[The information requested was not available to the subcommittee at the time of printing.]

Mr. LENT. I have no further questions, Mr. Chairman.

Mr. CLELAND. May I just add to that point?

Mr. LENT. Yes.

Mr. CLELAND. Because we do not have the answers on agent orange does not mean we are not looking for them.

Now my problem as Administrator is that this is an area out of my normal baliwick in the sense that it is highly technical and highly complex. My problem is that I have to lean as Administrator on the advice and counsel of others that are expert in the field. That is one reason why we formed the advisory committee. That is another reason why the interagency work group was formed. We are trying to press the question as hard as we possibly can, both in the field and in terms of research and collecting more information.

I think that more can be done. We are going to try to do a better job, but I think we would all like to have more answers; and the fact that we do not have them is very frustrating to us as it is to you.

Mr. LENT. Thank you.

Mr. GORE. Let me clarify this last point. We have here a transcript of the proceedings of the Advisory Committee on Health-Related Effects of Herbicides at the VA, June 11, 1979. It appears to indicate at that time, Mr. Furst gave information to the board and Dr. Haber received the information. At any rate, Mr. Furst is here. Maybe on an informal basis at the conclusion of this proceeding, you can pursue that. We will be interested in the outcome.

Did you have other questions?

Mr. MAGUIRE. No. I have no more questions, Mr. Chairman. I just wanted to say, having listened to Dr. Custis' response and clarification a few moments ago, I continue to believe that the way that he states his points suggests to me that he is not particularly knowledgeable about the scientific research on carcinogens. I do think, Mr. Administrator, you might want to take a look at whether you are getting the best possible advice in analyzing the relative weights that ought to be assigned to animal studies, epidemiological studies, what the technical pitfalls are with each of those types of studies and what conclusion can properly be drawn in terms of public policy when we have given amounts of evidence that is compelling in some categories. You cannot knock out studies that have positive results, that clearly show relationships, and dioxin is one of the few substances in the world that has been shown to be a powerful cancer-causing agent in animal studies. You cannot knock out positive studies by saying that there are some other negative studies on the other side.

I would suggest that you get what you can from the National Cancer Institute, for the toxicology program at the National Institute of Environmental Sciences, and some other expertise in this field.

Mr. CLELAND. They are both on our advisory council and have been for more than a year.

Mr. MAGUIRE. I am concerned when I hear statements of the sort I heard today. The chairman was also concerned about them. They are made from your closest people and they purport to be scientific.

Thank you, Mr. Chairman.

Mr. GORE. Let me thank all of you on the panel for appearing here today. I understand that it is unusual for you to come before another committee. We have jurisdiction over the entire inter-agency group. We are going to continue to give attention to the activities of all the participants in trying to find a resolution to these admittedly very difficult questions.

I understand how difficult they are.

Let me ask you if you would, if the subcommittee has a few followup questions in writing, if you would be willing to respond in writing, if that would be all right?

We will, without objection, leave the record open for that purpose.

Thank you all for coming here today.

[The following statement and letters were received for the record:]

VETERANS ADMINISTRATION
OFFICE OF THE ADMINISTRATOR OF VETERANS AFFAIRS
WASHINGTON, D. C. 20420

NOVEMBER 26 1980

Mr. Bob Eckhardt
Chairman, Subcommittee on Oversight
and Investigations of the Committee
on Interstate and Foreign Commerce
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

In your letter of October 20, 1980, you requested that the Veterans Administration answer several questions which you and Mr. Lent submitted in connection with our testimony before your subcommittee on September 25, 1980. Those questions follow, accompanied by my response to each of them.

CHLORACNE

(1) According to testimony at the hearing, some 850 claims for skin disorders have been submitted to the VA of which only three have been granted as chloracne. What was the basis for distinguishing these three claims from the 847 which were denied?

Insofar as chloracne per se is concerned, we have received just 22 claims specifically claiming service connection for chloracne. In only three of these cases was chloracne actually found to exist on VA dermatological examination. All three of these cases have been service connected on the basis that manifestations thereof were noted in service medical records.

The 847 denied claims represent claims wherein the veteran claimed service connection for "skin condition" or "eczema" or "fungus infection" or some other dermatological entity. In none of these cases was chloracne found on VA examination. They were all denied because the evidence failed to show inception either during military service or within a reasonable period immediately following separation from service.

(2) What is the standard process for evaluating such a claim (on a step-by-step basis)? Is an examination at a VA medical facility required? If so, are those examinations performed by dermatologists? If not, do you feel that, due to the difficulty in diagnosing the condition, a dermatologist should be required?

After the veteran has filed a claim for chloracne or any other skin condition allegedly due to Agent Orange exposure, the VA develops all the facts and circumstances surrounding the veteran's skin condition and the manner of its occurrence. This development includes a request for all military service and medical records, a request for reports of post-service hospitalization, a request for statements from any doctor who has treated the veteran following his discharge from the service, and a request for any examination which may have been conducted at a VA Medical Center. If an examination has not been performed at a VA Medical Center, the veteran is scheduled for an appropriate examination at a local VA medical installation. Skin examinations for Agent Orange now are being performed by dermatologists, whenever possible.

(3) What criteria is the VA using to review the chloracne claims and what is the status of that review?

The Office of the Special Assistant to the Chief Medical Director for Environmental Medicine has established a chloracne task force comprised of VA dermatologists whose responsibility it is to develop training materials and criteria to aid our environmental physicians in the diagnosis of chloracne. After those criteria are established, we plan to review all claims of Vietnam veterans who believe that they have a skin disorder which came about as a result of exposure to Agent Orange, including those which have already been adjudicated.

STUDY MANDATED BY PUBLIC LAW 96-151

(1) What is the status of the study mandated by Public Law 96-151?

The award of the contract for the design of the epidemiological study has been delayed by means of legal actions initiated by the National Veterans Law Center which has challenged the Veterans Administration's bid solicitation and award procedures. The matter is currently under review by the General Accounting Office as a result of this action. It is anticipated that the issue will be resolved by GAO by mid-December.

(2) What group of persons, outside the VA, reviewed the Request for Proposal (RFP)?

The RFP was developed and reviewed entirely by VA employees.

(3) Because of an inherent conflict, the VA, as well as the DoD, appears to have a credibility problem with respect to some affected veterans. You indicated at the September hearing that you welcomed the involvement of the Interagency Work Group (IWG) in these matters. Wouldn't involvement of the IWG from the early stages of this study add credibility as well as scientific expertise? Wouldn't early involvement also tend to reduce the possibility of delay occasioned by a subsequent discovery of scientific inadequacy?

I cannot agree with your premise that there is an "inherent conflict." The Veterans Administration is not concerned with establishing culpability or responsibility for any adverse health consequences flowing from service in Vietnam. Our sole concern is to address the needs of those veterans who are suffering from disabilities which may be traced to their military service. To do this effectively, first requires us to identify those disabilities. Hence, our strong support for the epidemiological study mandated by Pub. L. No. 96-151. We recognize, however, that some individuals may perceive a bias if we were to design the protocol. For that reason, and to ensure the most objective study possible, we decided to contract out the design of the study and to have that design subjected to multiple reviews by a variety of scientific bodies. We agree that the involvement of the IWG will add credibility and scientific expertise and we have every intention of ensuring that they continue their involvement in all matters pertaining to the epidemiological study. This involvement will become more significant as soon as the study has been designed. In fact, as I indicated, the design for the study will be critically reviewed not only by the IWG, but also the National Research Council-National Academy of Sciences (NAS-NRC), the Office of Technology and Assessment (OTA), and the VA Advisory Group on the Health-Related Effects of Herbicides.

(4) Who will actually conduct the study?

This has not yet been determined. This decision is contingent upon the design requirements of the accepted protocol.

EXPOSURE DATA

(1) In light of questions over the availability of exposure data, what is your evaluation of the Department of Defense (DoD) records in this regard?

The DoD has attempted to explain the magnitude of the problem of utilizing their records to identify units and individuals who may have been exposed to Agent Orange during service in Vietnam. The DoD has reported the extent and quality of their records. The Veterans Administration is not in a position to verify or evaluate the actual usefulness of the data at this time.

(2) In view of the information possessed by veterans themselves, why have you not conducted an outreach program to increase the body of knowledge on exposure?

Every effort is being made within the auspices of our Agent Orange Registry to identify Vietnam veterans who are concerned about exposure and request their participation in the examination process. The questionnaire utilized in the examination is designed to elicit information (i.e., narrative history of exposure) which will assist us in our efforts to obtain additional information. For the purposes of the VA adjudication process, we accept the word of veterans that they were exposed unless there is clear evidence to the contrary. In the context of our epidemiological study, the anecdotal experiences related by veterans may be of only limited value. The issue of exposure will have to be addressed in the study protocol and some method of obtaining credible exposure data must be established.

(3) Is it reasonable to require evidence of actual exposure given the lack of empirical data on exposure pathways and the complex nature of chemical movement through the environment in any given situation? Isn't it possible that through existing DoD records--though not perfect--combined with details from the veterans themselves, sufficient data could be obtained to establish an exposed population?

It is anticipated that the design of the epidemiological study will provide for determining the exposure of entire military units rather than identifying a specific individual's exposure. In this manner, it may be possible to determine the probability of exposure of units identified through DoD records and located with respect to recorded spraying missions conducted under the auspices of the Air Force's "Operation Ranch Hand."

(4) Given the small population examined in the Ranch Hand study, what steps can be taken to guard against the possibility of false negatives resulting?

This study will be conducted in its entirety by the Air Force. We have been advised that safeguards will be "built" into the study, but we do not have detailed information concerning them.

VIETNAM EXPERIENCE STUDY

(1) Is it your understanding that both the Vietnam experience study and the Agent Orange specific study will be conducted?

The epidemiological study has not yet been designed because of the legal challenges to the VA's contract award procedures. It is this design which, when completed, will specify the variables to be examined. It appears to us at this time to be reasonable to include three groups of veterans in the study:

- a. Military units exposed to Agent Orange in Vietnam.
- b. Other units serving in Vietnam, but not exposed.
- c. Units not in Vietnam and presumably not exposed.

Such a study would be designed to detect differences or effects due to Agent Orange exposure and due to the Vietnam experience other than Agent Orange exposure.

(2) If the Vietnam experience study does show deleterious health effects associated with Vietnam service, how will that effect [sic] VA compensation policy?

The VA will take whatever steps are necessary to ensure that this nation's veterans are compensated for disabilities which occurred during service. In the event that scientific evidence is developed which establishes a definite linkage between exposure to herbicides and a specific disability, the VA will recognize that as an adequate basis for conceding service connection for that condition.

(3) Would you automatically assume service connection for those disabilities detected in Vietnam veterans despite the fact that those same disabilities occur to a lesser degree in the general population?

Any decision made by the Veterans Administration relative to presumption of service-connection will be based on scientifically valid supportive evidence. The epidemiological study, and perhaps the Ranch Hand study, will assist in making such decisions. Depending upon what information is developed, Congress may also wish to establish a statutory presumption which governs in the determination of service connection as it has done in other cases.

(4) Would you implement such a policy without the establishment of a more specific cause and effect relationship?

Under the law, conditions for which service connection is granted must have occurred during or been aggravated by active military service. As previously indicated, Congress may wish to address the subject by the establishment of a statutory presumption.

(5) The Center for Disease Control found in an epidemiological study of veterans related to the nuclear test, Shot Smokey, an incidence of leukemia exceeding by three times the incidence in the larger population. In view of the VA's compensation policy, with respect to these veterans, is it realistic to expect a favorable VA compensation policy with respect to Vietnam veterans based upon either kind of study?

Although there are some questions about the Center for Disease Control study, medical science now knows a good deal about the relationship between radiation exposure and a resulting increase in certain types of cancer. The Veterans Administration is able to grant service connection for some cancerous conditions based upon the type and amount of radiation received and the length of time since exposure. Should similar information be developed on the relationship between Agent Orange exposure and some long-term adverse health effect, the Veterans Administration would make similar determinations with respect to the granting of service connection for the condition.

POLICY MAKING

(1) Joan Bernstein and Dr. John Moore have testified to the effect that it is unlikely science will ever provide incontrovertible evidence upon which to base policy determinations with respect to compensation. To what extent do you agree or disagree with that opinion and does your viewpoint affect the development of a comprehensive compensation policy?

We agree that it is quite possible that what Joan Bernstein and Dr. John Moore say with respect to obtaining incontrovertible evidence may be true. However, we are not insisting on incontrovertible proof that Agent Orange is the cause of a veteran's current disability. The policy of the VA is that service connection may be established for either the immediate or delayed results directly traceable to any incident of service, including exposure to Agent Orange. We will issue more specific guidelines in this area just as soon as it is shown that there is a reasonable probability that any specific condition can be the result of in-service herbicide exposure occurring years previously.

(2) Please provide your best estimation of a timetable for development of a compensation policy. In this regard, it appears that results of the epidemiologic studies will not be available for a number of years. Will you wait for those results before developing a compensation policy?

We are hopeful that research efforts now underway will be productive in the foreseeable future, but we have no way at this time of making any kind of an accurate forecast.

ROLE OF THE INTERAGENCY WORK GROUP

(1) Please describe how you perceive the role of the IWG regarding questions of compensation standards.

We are looking forward to the IWG continuing to provide substantial assistance to the VA, especially in connection with the major epidemiology study of the possible long-term health effects in veterans of service in Vietnam. The IWG expertise will provide valuable assistance to the VA. What course the IWG might take is not known. However, the VA rule for all disabilities of whatever origin including conceivable Agent Orange residuals, is that "reasonable doubt" as to service incurrence or aggravation will be resolved in favor of the claimant. (Title 38, C.F.R. § 3.102.) Following a determination that the condition is service connected, compensation is provided based upon the degree of severity. (Title 38, United States Code, section 314.)

(2) Would it be helpful to the VA for the IWG to issue recommendations regarding possible compensation policy for veterans exposed to Agent Orange or for any other Vietnam service disabilities?

The VA compensation program is comprehensive and provides for the compensation of all disabilities "traceable to service--including Agent Orange. Veterans whose disabilities are service connected are awarded benefits under chapters 11 and 13 of title 38, United States Code, which has proven to be a viable model for benefit rates and other aspects of entitlement, and represent the consensus of Congress as to the Government's obligation to service-disabled veterans and their survivors. In view of the complex and controversial nature of the Agent Orange controversy, however, we welcome the valuable interchange of ideas and information we have already had with the IWG. Any recommendations made to the VA by that body will, of course, be given every consideration.

MEDICAL TREATMENT

(1) Veterans testifying at the September hearing complained about the quality and timeliness of examinations and treatment they have received. Is a standard examination given by all VA facilities to veterans concerned with Agent Orange exposure? If so, please describe. If not, please comment on the reason for any variance.

A standard Agent Orange examination protocol is required and utilized in accordance with specific directives sent to each of our health care facilities (see attachments). All VA health care facilities have been advised that these directives are to be the sole basis of the conduct of the Agent Orange examinations. We continue to monitor our VA medical centers and outpatient clinics to ensure that they are in compliance with directives issued from VA Central Office. In concert with staffing resources, every effort is made to provide timely examinations. Where possible, examinations are provided on a walk-in basis.

(2) Do such examinations include tests which may detect evidence of dioxin exposure, such as resulting living [sic] dysfunction?

The Agent Orange examinations include an examination of the skin and a blood workup. Chloracne, of course, is considered the hallmark of dioxin exposure and would be detected upon examination. The blood workup which is performed would reveal a liver dysfunction. As we have previously indicated, the utilization of fat biopsies is not recommended for those veterans requesting an Agent Orange examination. It should also be noted that liver dysfunction is not specific to dioxin exposure. This condition is common, for instance, in patients with a history of alcohol abuse.

(3) The Subcommittee received testimony to the effect that some veterans without established service-connected problems encounter lengthy delays in seeking examinations and treatment. What steps is the VA taking to alleviate this situation?

It is not essential for the veteran to have a service-connected disability in order to receive an examination. Every effort is made to provide an Agent Orange examination to Vietnam veterans upon request. In many instances, they are provided on a walk-in basis. Other examinations are scheduled at the convenience of the veteran. Priorities must be established in providing examinations and care. Agent Orange cases are not considered, in general, to be "emergencies" requiring immediate examination by the physician, so in some cases the examinations may be delayed. Veterans with a service-connected disability are accorded a higher priority for treatment than nonservice-connected veterans in accord with 38 U.S.C. § 612(1). Medical emergencies, of course, also receive priority over other patients.

Sincerely,

MAX CLELAND
Administrator



Veterans
Administration

OCT 21 1980

Honorable Bob Eckhardt
Chairman, Subcommittee
on Oversight and Investigations
House of Representatives
Washington, D.C. 20515

130 OCT 21 1980
SUBCOMMITTEE ON
OVERSIGHT & INVESTIGATIONS



Dear Mr. Chairman:

We were pleased to have the opportunity to testify before the Subcommittee on Oversight and Investigations of the Interstate and Foreign Commerce Committee on September 25, 1980, on the subject of Agent Orange and the possible effects of this substance on Vietnam veterans.

We are greatly concerned with maintaining the confidence of the American public in our dedication to the resolution of this problem as well as the public's perception of our competence to seek and discover answers to the extremely perplexing problems involved. One of the matters which concerns us relates to the testimony of Mr. Lewis M. Milford of the National Veterans Law Center, who testified before the Subcommittee on the same date.

Mr. Milford made reference to a civil action brought by his organization, and for which he is the plaintiffs' attorney of record, styled White v. Cleland, U.S.D.C., D.D.C., Civil Action No. 79-1426. The action seeks a declaration by the U.S. District Court that the VA did not properly issue a "program guide" section dealing with the handling of disability claims based on exposure to Agent Orange, and thereby violated the Administrative Procedure Act (APA) (5 U.S.C. § 553) and the Freedom of Information Act (FOIA) (5 U.S.C. § 552(a)(1) and (2)) by our failure to publish the provision in the Federal Register. Mr. Milford correctly stated that the case is still pending, with the court considering cross motions to decide the case as a matter of law, without further proceedings. He then went on to say that: "The VA has defended that suit for the last year and a half and argued vociferously that it has simply no duty to conduct public rulemaking on the health hazards that result from Agent Orange exposure, on the compensation policy, or on any other issues that relate to Agent Orange."

2.

Honorable Bob Eckhardt

Mr. Milford's characterization of the Government's defense is incorrect. This agency acknowledges its responsibility to comply with the above-cited statutory provisions, and in fact does so routinely in issuing regulations. This involves a process of publication in the Federal Register of proposed regulations, accepting comments from the public, and publication of final regulations with a preamble explaining the extent to which public comments were, or were not, adopted and the reasons therefore. In spite of an existing statutory exception to public rulemaking for "loans, grants, benefits, or contracts," found in section 553(a)(2) of the APA, the VA has adopted a regulation voluntarily binding the agency to this process, even where "benefits" are involved. (See 38 C.F.R. § 1.12)

The crux of the Government's defense in *White* is that the program guide section does not contain regulatory material, and that it does not constitute a "rule" within the meaning of the APA and the FOIA. In fact, a VA Program Guide is nothing more than an internal instructional document, in the nature of a manual, which has no substantive impact on the rights or obligations of claimants. The program guides used in the VA, as well as manuals and circulars covering internal VA procedures, are available to the public upon request, and are routinely forwarded to veterans service organizations who represent claimants before the VA, as well as to our Congressional Oversight Committees.

Because the pleadings in the case involve numerous large documents, many with voluminous attachments, we have not endeavored to enclose any copies. However, these could be made available to you on request. Instead, we offer one quotation from the Government's principle memorandum of law filed in the case:

" . . . [T]he Agent Orange Program Guide [P.G. 21-1, section 0-18] is neither a new rule, nor is it a change in existing rules. It is informational, designed to inform agency employees of the existing state

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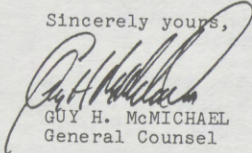
Honorable Bob Eckhardt

of factual knowledge and, to a lesser extent, the state of the law. The Program Guide clearly requires reference to existing regulations regarding service connection, and adds nothing to these provisions. It is intended to remind the agency employee that the standard requirements for recognition of service connection are applicable in these cases, and that, therefore, mere evidence of service exposure and recent disability is not enough for service connection. It reminds that medical evidence must be introduced to link up the two, if compensation is to be awarded. It advises the agency adjudicative personnel that, except for chloracne, the state of medical knowledge does not permit a general assumption that exposure to herbicides may result in disabilities many years later."

In his prepared statement (pp. 17-19), Mr. Milford places a rather extreme interpretation on the other two defenses advanced by the Government in White. As a lawyer, Mr. Milford knows that technical legal defenses, such as lack of standing of particular plaintiffs and lack of jurisdiction by the court, do not translate into an unwillingness on the part of the VA to listen to Vietnam veterans. To the contrary, our goal in defending the White case is to keep resolution of this serious issue out of the courts and in the legislative and policy arena where it should be. We believe a much more desirable solution will be reached by the VA, other Executive Branch agencies, and the Congress working together, rather than by the Federal judiciary. Our willingness to involve the public in our effort, primarily through our Advisory Committee, is well documented.

We would appreciate your insertion of this letter in the hearing record following the testimony of the Administrator and the other VA officials, or elsewhere, as you deem appropriate. Your attention to this request is greatly appreciated.

Sincerely yours,



GUY H. McMICHAEL
General Counsel

**NATIONAL
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LAW
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4900 MASSACHUSETTS AVENUE NW
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November 15, 1980

The Honorable Bob Eckhardt
Chairman, Subcommittee on
Oversight and Investigation
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

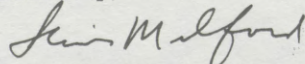
Thank you for the opportunity to respond to VA General Counsel McMichael's October 21, 1980, letter concerning my testimony before the Subcommittee on Oversight and Investigations.

Mr. McMichael referred in the letter to a lawsuit which the Center has filed against the VA, White v. Cleland, No. 79-1426 (D.D.C. filed May 31, 1979). The suite challenges the VA's failure to conduct public rulemaking on the scientific and policy bases for its Agent Orange position. Mr. McMichael states that my testimony is an "incorrect" characterization of the government's defense that the agency has no duty to conduct rulemaking and that the court has no jurisdiction to decide the litigation. The agency attempts to trivialize the meaning of these legal defenses and denies that these defenses translate into an unwillingness on the part of the agency to listen to Vietnam veterans.

Arguments such as plaintiffs' lack of standing and no jurisdiction are legal defenses that need not be raised in each case. The decision to raise legal arguments cannot be divorced from the impact of these arguments. The agency could have decided not to raise these arguments and allow veterans to litigate their claims on the merits.

The government can decide not to raise arguments and therefore allow litigants their day in court. The VA has decided to raise these legal arguments and should be held accountable for the plain meaning of its actions.

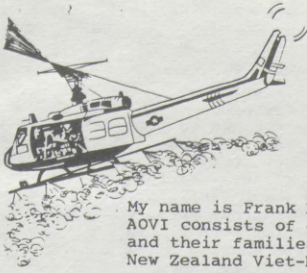
Sincerely,



Lewis M. Milford, Esq.

encl.

LMM:bas



Agent Orange Victims International

Frank McCarthy
42 West 13th St.
New York, N.Y. 10011

September 22, 1980

STATEMENT

My name is Frank McCarthy and I am President of AОВI. AОВI consists of over 10,000 American Viet-Nam Veterans and their families, as well as, 4,000 Australian and New Zealand Viet-Nam Veterans and their families.

I am here today to testify as to the plight of the Agent Orange Victims and especially the type of medical and psychological treatment administered to Viet-Nam Veterans and their families by the Veterans Administration.

I must first make you aware of the fact that I am not a doctor, attorney, nor am I a scientist. I represent a humanitarian organization of Agent Orange Victims. I am not here to argue whether Agent Orange or Dioxin causes long term or short term ill health effects. I am here to bring you the experiences of those Veterans who have gone to VA hospitals seeking help for problems they feel could be related to their exposure to Agent Orange and Dioxin.

Everyday Viet-Nam Veterans are entering VA hospitals in Boston, Syracuse, New York, Philadelphia and throughout the nation. Most of these Veterans are in urgent need of help, both physically and psychologically.

We sent no sick men to fight in Viet-Nam. The first combat units were sent in 1965, the same year that the Air Force began operation "Ranch Hand". Since that time Viet-Nam Veterans have endured being stereotyped as losers, psychopaths and undesirables. They have endured the nonrecognition of their sacrifices and honors in combat, the lack of jobs and they have endured the nightmares, both of Viet-Nam and the Veterans who died there. The majority have not lashed back at society, nor have they lost their love for our country. They have, in fact, turned the other cheek, tried to gather up their traumatized lives and raise a family.

Until one day a heroic Viet-Nam Veteran named Paul Reutershan appeared on television and said, "I Died in Viet-Nam and Didn't Know It", and Agent Orange, Dioxin and chemical poisoning shocked every Viet-Nam Veteran and his family. THIS, the Viet-Nam Veterans will not endure! This, not only threatens our lives, again, but threatens our childrens lives as well!

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Since Paul appeared on television thousands of Viet-Nam Veterans and their families came to him for help. Paul founded AОВI because he realized that very few people knew about Agent Orange, and Dioxin and someone had to take the responsibility to help until the VA would come to our aid. Paul died on Dec. 14, 1978. Before he died he asked me to carry on the necessary work of AОВI. Paul's family, myself and many other Veterans and their families have come together to provide that help. Courageous Vets like Edmund P. Juteau have died carrying on the work of AОВI. Other Veterans like Steve Zardis and Charles Hartz are dying this very moment and when they die there will be other Veterans who will take their place. A sea of sick and dying Veterans whose children are born with horrible birth defects. The wives and mothers are left alone to raise their fatherless children.

I must point out the fact that AОВI has had to do the job of the VA for almost three years. Our branch offices and information points are operated by sick and dying Veterans who have had to provide legal, medical, referral, counseling and outreach programs and the financial cost of operating these units have come from our pockets. I, personally, have gone into debt to a sum of over \$40,000.

AОВI brought this issue to the Congress. I, as well as, other AОВIM officials have testified before Congressional and Senate hearings on Agent Orange and on May 31, 1979 to President Carter personally. We have been scrutinized by the major medias throughout the nation and 17 foreign countries. We have initiated the largest products liability litigation in the history of this nation against Dow and the other manufacturers of the Herbicide. AОВI has been instrumental in the creation of Laws passed in various States pertaining to Agent Orange and Dioxin. AОВI brought this issue to Max Cleland and the VA, along with the Network Media, and, in turn, the VA has forced AОВI to do the job of the VA for almost three years. We have no where and no one else to turn to!

We realize the scientific and medical complexities of the Agent Orange issue and for almost three years we have kept faith while we desperately tried to calm the fears of our pregnant wives, to prevent the needless abortions and vasectomies and we have buried our dead with Dignity and self respect. We have never blamed our Government or the VA for this tragedy. We feel that the responsibility lies with Dow, Monsanto and the other manufacturers. However, the Veterans Administration has the responsibility for the Health and Welfare for all Veterans and until the evidence is in they are mandated by Congress to provide the Viet-Nam Veterans with proper medical examinations, medical testing and treatment. This they have not done!

Statement of Frank McCarthy

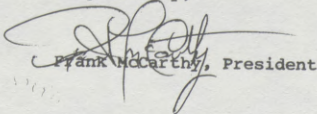
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As a point of fact, the VA has gone beyond ineptness, in terms of the Agent Orange issue, and has perpetuated a conscious effort to bury our claims (two Veterans compensated out of approx. 28,000), to permit unlicensed doctors to practice medicine on our Viet-Nam Veterans and as in the case of the Syracuse VA hospital, to permit the physicians assistant to perform the examination, to violate the VA directives which call for extensive exams and, instead provide only a blood test, a urine analysis and one chest xray, which violates the Congressional Mandate, to out right lies to the Veteran as to his physical condition and issueing massive doses of psychotropic drugs and told that their problems are all in their minds. Max Cleland, himself, has telephoned nine VA hospitals and was told lies. Aside from being lied to, the Veterans have been degraded, abused and have had false information entered into their medical recors and the VA medical questionnaires which will be used by the VA in their National Study. Further, I do here by charge Max Cleland and the entire VA medical system with unethical and immoral deception, with lying to Congress, the Viet-Nam Veteran population and the American public, with contributing to the high suicide rate of Viet-Nam Veterans and I charge him with being an enept and inefficient Director and I call for his emediate resignation!

In closing, I wish to say that I realize the seriousness of these charges and this entire statement and I, as well as AОВI, are ready, willing and able to substanciate these charges with documents and testimonies from Veterans throughout this nation. AОВI should not exist, we do not want to exist and our primary objective is to go out of existance. However, we shall exist as long as there is a need. I call upon Congress to take this horrible burden off of the shoulders of AОВI and force the VA to do what is their responsibility to do!

Respectfully,


Frank McCarthy, President

[Whereupon at 1:10 p.m. the hearing was adjourned.]

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