The Board of Veterans' Appeals

June 18, 2008

James P. Terry, Chairman

ADVISORY COMMITTEE ON GULF WAR VETERANS
June 18, 2008 (10:00-10:45)
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BVA Mission and Issues Unique to Gulf War Veterans

Good afternoon—Thank you for the opportunity to address the Advisory Committee on Gulf War Veterans. You asked that I address the mission of the Board of Veterans' Appeals as well as any issues that may be particularly unique to Gulf War Veterans.

The mission of the Board is derived directly from statute, and it is "to conduct hearings and dispose of appeals properly before the Board in a timely manner." Another statutory provision states that "all questions in a matter which are subject to decision by the Secretary shall be subject to one review on appeal to the Secretary." The provision further states that "final decisions on such appeals shall be made by the Board."

In order to understand how the mission of the Board is translated into performance and service to our Gulf War veterans, it is helpful to briefly discuss the overall caseload at the Board of Veterans' Appeals.

In Fiscal Year 2007, the Board increased its total decision output to a total of 40,401 decisions, up more than 1400 cases from 2006. Into the third quarter of Fiscal Year 2008, we find that this enhanced productivity has been maintained. Cases are decided pursuant to law based on docket order, unless a case can be made that the veteran is in severe financial difficulty, is suffering from a serious illness, or has reached the age of 75, all of which can warrant advancement on the docket.

The Board experienced an extremely productive year in Fiscal Year 2007. In addition to issuing 40,401 decisions, we conducted 9,971 hearings, an increase of 813 hearings over the total held in Fiscal Year 2006 and the most ever held by the Board. To the Board's credit, the number of cases pending before the Board at the end of Fiscal Year 2007 was 39,031, which was more than a 1,000 case decrease over the 40,265 cases that were pending at

the end of Fiscal Year 2006. This decrease in pending cases can be attributed, in no small part, to the increase in the number of decisions issued in FY 07. To better place in perspective how productive the Board was in Fiscal Year 2007, we issued, with 45 fewer full time equivalent positions, a total of 40,401 decisions, as compared to 43,347 in Fiscal Year 1997. Moreover, the Board's more recent decisions require, for the most part, much more time and effort to prepare due to the great number of issues per case and the increased complexity of the law to be applied.

We do have high expectations for our counsel and Veterans Law Judges in Fiscal Year 2008 as well. We ask each of our counsel to write at least three and 1/2 complete draft decisions a week, and each of our line Judges to review, modify as necessary, and issue approximately 19 decisions or more a week. Over the course of the year, the Board's fair share standards call for our attorneys to complete a minimum of 156 timely decisions of high quality, and for each of our line Judges to complete and issue at least 752 decisions. In addition, each Judge is expected to complete at least three or more week-long Travel Board trips per year, in which they are scheduled to hold 43 hearings per week at one of the 57 ROs.

Now lets turn to the unique nature of post-war and post-deployment syndromes. War syndromes have been observed to be associated with armed conflicts since at least the Civil War. These syndromes have involved fundamental, unanswered questions about the importance of chronic somatic and behavioral symptoms. One interesting aspect of the symptoms commonly associated with war related medical and psychological illnesses, i.e., fatigue, shortness of breath, headache, sleep disturbances, impaired concentration, and forgetfulness, is that they have been observed in each of our country's major conflicts.

During the U.S. Civil War, they were associated with Da Costa's Syndrome; in World War I, they were tied to what was called Effort Syndrome; in World War II, they were thought to be related to a Combat Stress Reaction; in Vietnam, they were associated with either Agent Orange exposure or Post Traumatic Stress Disorder. In the First Gulf War, they were categorized under the heading Unexplained or Undiagnosed Illnesses.

During the Gulf War, health complaints involving these symptoms were reported as unexplained illness during the conflict and they increased dramatically after the conflict. Environmental conditions may have

contributed to their acute presentation. The complaints involving these symptoms have spanned a variety of organ systems.

In the combined analysis of the VA and DoD Gulf War clinical evaluation programs, "'unexplained illness' has been characterized as one or more symptoms that do not conform to a characteristic clinical presentation, allowing for a specific diagnosis, which appear to be causing a decline in the veteran's functional status or quality of life." Most common symptoms reported by Gulf War veterans in these unexplained illness cases include muscle and joint pain, fatigue, headache, memory problems, skin rash, sleep disturbance, diarrhea, shortness of breath, and abdominal pain. The most common diagnostic categories in Part IV of Title 38, Code of Federal Regulations into which these reported ailments were placed were (1) musculoskeletal and connective tissue conditions; (2) mental disorders; (3) respiratory illnesses; (4) skin and subcutaneous conditions; and (5) digestive disorders.

In an excellent analysis conducted by the Center for Disease Control in 1998 that was written by Dr. Fukuda and associates, 3255 Gulf War veterans were studied and their symptoms surveyed to assess chronic multi-symptom illnesses (CMI). Of those studied, 39% of those who had deployed in-theater had mild-to moderate multi-symptom illnesses. More than 6% had severe symptoms. The group exhibiting chronic conditions (i.e., conditions lasting 6 months or more) with multi-symptom illnesses had one or more chronic symptoms from two of the following categories: Fatigue; mood and cognition (i.e., depression, memory or concentration difficulties, moodiness, anxiety, and sleep difficulties); or musculoskeletal (i.e., joint pain; stiffness; or muscle pain).

An important 2000 VA study by Dr. Han Kang and associates found that deploying veterans to the Gulf War had far higher instances of the following chronic conditions than their non-deploying cohort: sinusitis, gastritis, dermatitis other than eczema/psoriasis, arthritis, and frequent diarrhea. Similarly, with respect to the reporting of symptoms, deploying veterans reported more frequent symptoms than their non-deploying cohorts with the most frequent severe symptoms related to back pain, runny nose, joint pain, headaches, anxiety, difficulty sleeping, skin rash, excessive fatigue, heartburn, and indigestion.

Other important findings of the Kang study were the risk factors reflected in the percentages of those military personnel reporting symptoms or conditions who had deployed to the Gulf. For example, deployed National Guard and reserve personnel reported higher rates of undiagnosed illnesses percentage-wise than non-deployed Guard and reserve personnel. Among the deployed, Army personnel reported more symptoms percentage-wise than members of other military services. Dr. Kang's other findings included the fact that veterans who had been deployed were higher users of health services than non-deployed. Also, military personnel who had been deployed had a lower perception of the state of their general health than did non-deployed personnel. Further, those military personnel who had been deployed were found to later experience greater functional impairment at work than their non-deploying cadre.

In a third study completed in 2005, Dr. Blanchard and associates reviewed a sample selection of participants in a National Health Survey of Gulf Era Veterans. This study compared Gulf War veterans who had deployed with non-deployed veterans. The study examined medical and psychiatric histories and reviewed neurological, pulmonary, and neuropsychological test results of the selected participants. The Blanchard study used the Center for Disease Control definition of Chronic Multi-symptom Illness or CMI. That definition requires 2 symptoms from the following three categories: fatigue, mood and cognition, or musculoskeletal.

The Blanchard study found, not surprisingly, that Chronic Multi-symptom Illness was more prevalent among veterans who had deployed, with an important deployed veteran risk factor being higher combat exposure, and an important non-deployed veteran risk factor being active duty status versus non-deployed reserve or other inactive status. Those veterans, deployed and non-deployed, who suffered from Chronic Multi-symptom Illness displayed poorer function health scores than their non-CMI counterparts, experienced more clinic visits, and required more pharmaceuticals than their non-CMI veteran cohorts, as would be expected.

The Blanchard study also found that Chronic Multi-symptom Illness suffered by deployed and non-deployed Gulf War era veterans was associated with fibromyalgia (muscle condition), chronic fatigue syndrome, arthralgia (joint pain), dyspepsia (gastric disorder), or metabolic syndrome (metabolism irregularity). Finally, the study reported a significantly higher cadre of those Gulf era veterans who had **not** been assigned to the theater to

have a better perception of their general health than their cohort that had been assigned to the region. The question that remains is the cause of these conditions.

For the attorney and veterans law judge reviewing Gulf War syndrome appeals, the chronic multi-symptom illness remains medically unexplained. We do know, however, that these unexplained illnesses are commonly associated with chronic fatigue syndrome, fibromyalgia, and irritable bowel syndrome.

We also know from looking at these claims that Gulf War veterans do experience a measurable decline in health. We also know from repeated studies that specific constellations of symptoms are often evident. These symptom groupings have **not** been shown, however, to represent a specific new disease entity in the eyes of the medical profession.

From the Board's perspective, the validity of the Gulf War undiagnosed illnesses is evident in the allowance rate for these claims on appeal compared with claims involving other cadres. Although this group of appeals totalled only 641 cases in 2006, the Board granted 28.5% of these appeals while upholding the VBA determination in 27.6%. What is interesting is that in FY 2006, while the Board was allowing 28.5% of these undiagnosed illness appeals, it was allowing only 19.3% of all other appeals—i.e., the non-Gulf War undiagnosed illness cases. This is a very significant disparity and reflects the seriousness with which the Gulf War Syndrome problem is viewed.

Similarly, in FY 2007, of the 683 Gulf War undiagnosed illness appeals considered, the Board granted 26.1%, while upholding the VBA determination in 27.5% of these claims. What is important is the fact that all non-Gulf War undiagnosed illness claims were granted, as in 2006, at a lower rate (21%) than the undiagnosed illness claims. A similar result has been witnessed to date in FY 2008. The Board has to date allowed 30% of all Gulf War undiagnosed illness cases, while upholding the VBA on 23.9% of these cases. In 2008 by comparison, all other appeals cases are being allowed at a rate of 22%. This is again reflects a serious recognition of the importance and validity of these Gulf War claims.

While the medical profession does not recognize Gulf War Syndrome as a uniquely recognizable disease, the Congress has done so through legislative

enactment. On November 2, 1994, Congress enacted the Persian Gulf Veterans Benefits Act which authorized the VA to compensate any Gulf War veteran suffering from a chronic disability resulting from an undiagnosed, or combination of undiagnosed illnesses, arising either during active duty in the Southwest Asia theater of operations during the Persian Gulf War, or to a degree of 10 percent or more within a presumptive period following service in that conflict. This was implemented by the VA through regulation (38 CFR 3.317) in February 1995.

In 1998, the Persian Gulf War Veterans Act was enacted. This Act authorized the VA to compensate Gulf War veterans for a diagnosed or undiagnosed disability determined by VA regulation to warrant a presumption of service connection based upon exposure to one of the following as a result of Gulf War service: a toxic agent; an environmental or wartime hazard; or a preventative medication or vaccine. This 1998 Act further added a new section 1118 to Title 38, which codified the presumption of service connection for an undiagnosed illness.

This was followed in 2001 with passage of the Veterans Education and Benefits Expansion Act. This act added the language "qualifying chronic disability" within 38 USC 1117 such that it would now include not only a disability resulting from an undiagnosed illness but also a medically unexplained chronic multi-symptom illness defined by a cluster of signs and symptoms. Examples include chronic fatigue syndrome, fibromyalgia, and irritable bowel syndrome. These changes were implemented by the VA in March 2002 through a revision to 38 CFR 3.317 to expand the definition of qualifying chronic disability.

From the foregoing, it is quite apparent that the Department has and continues to take the illnesses suffered by Gulf War veterans very seriously. The allowance rate for appeals to the Board suggests that those suffering from undiagnosed illnesses are treated fairly.

I would be pleased to answer any questions.