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FEDERAL TORT CLAIMS ACT IS AVAILABLE FOR OIF TBI VETERANS, DESPITE *FERES*

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INTRODUCTION

Operation Iraqi Freedom (OIF) has had a dramatic impact on America. The cost in American casualties is a major socio-political strike point across America. Sensitivity to this cost is increasing every day as thousands of families are enduring not only the daily anxiety of having a solder in the field of active combat, but also the ultimate sacrifice of the loss of life and the public health issues that severely impaired veterans create for society. This paper addresses the problems faced by OIF veterans after their medical discharge from active duty. Two issues are examined: (1) whether the medical treatment provided to OIF veterans with traumatic brain injury (TBI) is within the standard of care possible, since there is significant under-diagnosis, and (2) whether the compensation afforded by the Department of Veterans Affairs is adequate. This article focuses on TBI that has been either undiagnosed or insufficiently treated after diagnosis, and the hurdle to adequate compensation that OIF veterans face for those stateside injuries.

The argument in this article is premised on the social cost of OIF veteran TBI and additional compensation that veterans should have available within the statutory framework. The *Feres* Doctrine has been developed through a line of U.S. Supreme Court decisions dating from 1949 through 1987 and has been expansively used by courts for over fifty years to disallow additional compensation through the Federal Tort Claims Act (FTCA) for service-members who are injured while on active duty.[2] This discussion examines why the *Feres* Doctrine should

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[1] This article represents a legal-public health analysis of a critical issue in America today—the significant number of traumatically injured Iraq War Veterans who deserve attention as heroes in the service of all Americans.

[2] The *Feres* Doctrine is a common law bar to recovery for injuries resulting from military duty and takes its name from a particular case, *Feres v. U.S.*, despite the fact

not act as a bar to OIF veterans who suffer TBI. It is a practical and moral imperative to provide such additional compensation within judicial redress to these veterans. The benefits available through the veteran statutes do not adequately cover their life-long impairment and the cost burden to their families. The Defense and Veteran Brain Injury Center's director, Deborah Warden, M.D., currently estimates TBI in 67% of OIF veterans, which translates into thousands of affected families.[3] This discussion presents the daily reality of these veterans to the reader, the options currently available for care and compensation, and an analysis of the viability of additional compensation through policy initiatives and direct claims relief under the FTCA, despite the *Feres* Doctrine. The medical/rehabilitation, social, and economic needs of OIF TBI veterans have not been adequately addressed and an effort should be initiated for additional compensation either through the FTCA or specific legislation, together with the implementation of continued and accessible care through specialized community centers, such as in the Israeli model discussed herein.

This discussion initially explores the life-long medical and rehabilitation care issues, followed by an analysis of the availability of additional/alternative compensation through the Federal Tort Claims Act (FTCA). The background data and medical references for OIF TBI, including a historical perspective on veteran injuries, are presented in Section I. Section II includes a discussion of TBI assessments and comparison case studies of TBI, which illustrate the significant strides in medical treatment of TBI and the reality faced by these veterans. Section III covers the current state-of-the-art triage protocols, both on the field and upon arrival stateside at Walter Reed Army Medical Center, followed in section IV with a rehabilitation model that would provide a more realistic standard than what is currently available for these veterans with TBI.

The problem of inadequate compensation that is at the heart of OIF veteran TBI is examined in Section V. Section VI presents the statutory avenues that address military benefits, followed in Section VII by an overview of the development of the common law hurdle to

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that it was developed over a series of U.S. Supreme Court opinions interpreting various statutes. *See* introduction to Section VI and Section VII, *infra*. The Federal Tort Claims Act is a federal statute relating to injury claims against the federal government in various contexts and is discussed in detail in Section VI. A. 5, *infra*.

[3] A compilation of DOD statistics indicates that the number of wounded is 29,314 through the first part of 2008. *See* http://icasualties.org/oif (last visited March 19, 2008).

additional veteran compensation through litigation, commonly known as the *Feres* Doctrine. The crucial distinction perceived by the author with regard to the presentation of OIF veteran TBI claims under the FTCA (discharged military receiving inadequate medical/rehabilitative care), which should not be barred by the *Feres* line of cases, is detailed in Section VIII. The concluding section presents the policy rationale for the effective resolution of this vital issue.

I. OPERATION IRAQI FREEDOM VETERAN TBI

On January 25, 2006, Dr. Jonathan B. Perlin, Under Secretary for Health in the Department of Veterans Affairs sent an Information Letter to provide guidance to VA primary care clinicians noting: "[g]iven the high rate of exposure to conditions that may cause TBI, it is important that primary care clinicians routinely screen for its occurrence."[4] Dr. Perlin cited to an article in the New England Journal of Medicine, from 2005, which noted that fifty-nine percent of veterans admitted to Walter Reed Army Medical Center had brain injury.[5] It is significant that Dr. Perlin also clearly identified two significant long-term effects of these brain injuries: "[t]hese impairments may make reintegration into civilian life and return to family and work problematic. . . [l]ong-term treatment is likely to require continuation of multidisciplinary care and case management."[6] The VA recognized that TBI required special attention and that recognition led to the founding of the Defense and Veterans Brain Injury Center (DVBIC) in 1992.

The DVBIC is a nation-wide system of medical care, clinical research, and education centers under the VA and the Department of Defense (DOD), which funds it.[7] This medical system is dedicated to: (1) providing TBI-specific evaluation, treatment, and follow-up care for all military personnel, their dependents, and veterans with TBI; (2) conducting research to define optimal treatment and care for patients with TBI; and (3) developing and distributing educational materials for

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[4] Jonathan B. Perlin, *Screening and Clinical Management of Traumatic Brain Injury* (Jan. 25, 2006) at 2, *available at* http://www1.va.gov/environagents/docs/USH InfoLetterIL10-2006-004.pdf (last visited April 16, 2008).

[5] *Id.* at 1.

[6] *Id.* at 2.

[7] Defense and Veterans Brain Injury Center Home Page, http://www.DVBIC.org (last visited Mar. 29, 2008).

the prevention, treatment, and management of TBI. The DVBIC is headquartered at Walter Reed Army Medical Center in Washington, D.C. and includes eight "lead sites."[8] The high prevalence of TBI in OIF veterans (60-67%) has driven the VA to expand the system with a series of seventeen "Level II" units across the country that concentrate medical specialists, physical therapists, and counselors for these veterans, which constitute the "carrying out" of the treatment plan.[9] The DVBIC website lists the symptoms associated with mild TBI.[10] That listing is critical because there is a concern that due to the number of blast injuries suffered by combatants, there is a definite possibility that many veterans are being discharged without proper assessment or diagnosis—the "walking wounded" casualties of the war.[11] Given the prevalence of TBI, the potential for its missed diagnosis, and the life-altering sequelae of it, as well as the initial statements cited above, have the DOD, the VA, and the DVBIC achieved their mission of "returning patients to the highest level of function possible" through the implementation of current health care delivery policy?[12] Several issues must be considered in answering this question, including those that follow.

Tracing the pattern of wounds received during a particular war evidences a change over time. Several factors influence the morbidity types of the soldier injuries. These include: the types of munitions used, the protective equipment available to the rank and file soldier, and the level of sophistication in the triage protocol for the wounded.

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[8] These include: WRAMC, Washington, D.C.; Naval Medical Center San Diego, San Diego, CA; Wilford Hall Medical Center/Brooke Army Medical Center, San Antonio, TX; James A. Healey Veterans Hospital, Tampa, FL; Minneapolis Veterans Affairs Medical Center, Minneapolis, MN; Veterans Affairs Palo Alto Health Care System, Palo Alto, CA; Hunter McGuire Veterans Affairs Medical Center, Richmond, VA; and Lakeview Virginia NeuroCare, Inc., Charlottesville, VA. There are also satellite clinics at Fort Bragg, NC and Camp Pendleton, CA. Defense and Veterans Brain Injury Center, http://www.dvbic.org/cms.php?p=Dvbic_sites (last visited Mar. 29, 2008)

[9] Rosanna Ruiz, *VA centers to provide one-stop care for wounded; Houston unit is among those that will treat multiple injuries under one roof*, THE HOUSTON CHRON., Feb. 3, 2006, at A1.

[10] *See* Defense and Veterans Brain Injury Center fact sheet, *available at* http://www.dvbic.org/pdfs/DVBIC-Facts-2007.pdf. The symptoms listing includes: headaches, dizziness, excessive fatigue (tiredness), concentration problems, forgetting things (memory problems), irritability, sleep problems, balance problems, ringing in the ears, vision change.

[11] Ruiz, *supra* note 6 (quoting H. K. Henson, M.D.).

[12] *See* DVBIC website, *supra* note 4.

Of course, each one of these is dependent on the state-of-the-art technology; and, as the technology for each factor evolves, the pattern of wounds changes. The advancement of medical technology, together with the availability of improved delivery logistics has been the driving factor in decreasing mortality, and consequently, increasing the prevalence of wounded survivors over time. The author believes this result has concomitantly increased the significance of continuity of care policies and effective implementation of those policies.

The Department of Defense maintains historical data on its website.[13] The casualty charts[14] note as follows:

War/Conflict	Number Serving	Battle Deaths	Wounds Not Mortal	Casualty Morbidity[15]/ **Wounded**[16]	Casualty Mortality[17]
Revolutionary War 1775 - 1783		4,435	6,188	10,623 **58%**	42%
War of 1812 1812 - 1815	286,730	2,260	4,505	6,765 **67%**	33%
Mexican War 1846 - 1848	78,718	1,733	4,152	5,885 **71%**	29%
Civil War (Union Only) 1861 - 1865	2,213,363	140,414	281,881	422,295 **67%**	33%
Spanish-American War 1800	306,760	385	1,662	2,047 **81%**	19%
World War I 11917 - 1918	4,734,991	53,402	204,002	257,404 **79%**	21%
World War II	16,112,566	291,557	671,846	963,403	

[13] Chart at www.dod.gov, (last visited August 1, 2006) (Website is continuously updated by the Department of Defense, as per statute); chart at http://www1.va.gov/opa/fact/amwars.asp (last visited April 16, 2008).

[14] Injury distributions are totals and not allocated between services. OEF / OIF counts are as of August 1, 2006, 10 a.m. EST at http://www.defenselink.mil/news/OIF/OEFCasualtyUpdate.

[15] The "Casualty Morbidity" number is the total number of troops either wounded or killed.

[16] The percentages in bold lettering indicate the percentage of wounded survivors for each conflict.

[17] The percentages indicate the percentage of troops killed in combat.

1942 - 1945				**70%**	30%
Korean War 1950	5,720,000	33,741	103,284	137,025 **75%**	25%
Vietnam War 1964 - 1972	8,744,000	47,424	153,303	200,727 **76%**	24%
Persian Gulf War 1990-1991	2,225,000	147	467	614 **76%**	24%
OEF	*[18]	165	525	690[19] **76%**	24%
OIF	**[20]	2,043	8,789	10,832[21] **81%**	19%

It is evident that the mortality is decreasing in relation to deployment counts, and also that the percentage of those wounded in action and surviving is increasing over the history of American warfare. This change requires that an accommodation in the veteran health care delivery system be implemented to ensure that each veteran receives fully-funded life-time medical care optimal rehabilitation into society. This full-accommodation for lifetime benefits commensurate with serious injuries is not currently occurring with OIF TBI veterans, since the free/no-cost care has a two-year timeframe limit from the release from active duty to follow-up with subsequent care dependent on impairment ratings and deductible/copayments by the veteran.[22]

Just as the epidemiology of warfare mortality and morbidity has changed, a change has also occurred in what is commonly referred to as the "signature wound" of each war. Each one of these can be directly linked to the factors previously identified. At any given period of war, the survivors have faced a particular type of injury that has required the health care system to adjust. A brief outline of these historical signature wounds follows:

(1) "Empty Sleeves and Wooden Pegs"–The American Civil War veterans suffered the devastation of imperfectly healed wounds, false

[18] The DOD does not note deployment counts.

[19] Number includes deployment loss due to death and survivors not returned to duty as of August 1, 2006.

[20] The DOD does not note the deployment counts.

[21] Number includes deployment loss due to death and survivors not returned to duty as of August 1, 2006.

[22] 38 U.S.C. § 1710

joints and missing limbs from being torn apart by cannonballs and close-range bullets, since battles were fought by the majority on foot and with no protection.[23] The caricature of "Johnny Reb" that depicted a peg-legged soldier, with a crutch under one arm and a cane in the other, was used to promote financial support for programs that addressed the physical and emotional needs of disabled Confederate veterans.[24]

(2). "Gas Warfare Lung Damage"–World War I caused veterans to suffer lung damage from poison gases (including chlorine, mustard gas, and phosgene), released during the bombing into the trenches.

3). "Radiation Sickness"–World War II had a particularly insidious type of injury to veterans who were involved in the operations around Japan when the Hiroshima and Nagasaki nuclear bombs were dropped and also during the period following the bombing.

(4). "Cold Exposure" – Korean War veterans were exposed to extreme cold and insufficient insulating gear, which caused them to suffer chronic circulation and joint problems.

(5). "Agent Orange" – Vietnam War veterans were exposed to powerful defoliant chemicals that were used to enhance visibility zones. The toxins caused severe skin damage and also chronic systemic and neurological dysfunction that greatly impaired normal daily activities.

(6). "Gulf War Syndrome" – Recently, the veterans who returned from the Gulf War had a pattern of injuries that include chronic fatigue, skin rashes, and shortness of breath. It is believed that this syndrome was caused by their exposure to chemical warfare.

There is a clear pattern of progression from obvious physical impairment to more insidious chronic systemic injuries, which can be traced to improved post-engagement medical triage and to a change in the type of weapons used.

Today, what is recognized as the signature wound of the Iraq War veterans is even more difficult to adequately treat–"Traumatic Brain Injury" (TBI). The physicians at the initial U.S. treatment site, Walter Reed Army Medical Center (WRAMC) in Washington, D.C. have recognized that these injuries have a "hidden quality."[25] This makes the injury difficult to recognize and difficult to treat, since it

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[23] R. B. Rosenburg, *Empty Sleeves and Wooden Pegs*, in DISABLED VETERANS IN HISTORY 204, 206 (David Gerber, ed., University of Michigan Press 2000).

[24] *Id.* at 215.

[25] Gregg Zoroya, *Key Iraq wound: Brain trauma*, USA TODAY, Mar. 4, 2005, at 1A (quoting Warren Lux, MD).

occurs even without obvious physical trauma to the body. The physicians at two military medical centers have been tracking the ascertainable prevalence in the veterans being assessed: 60% of soldiers at Walter Reed and 83% of soldiers at National Naval Medical Center in Bethesda, Maryland.[26] These soldiers have been referred to as the "Invisibly Wounded" and "Walking Wounded," because they can walk and may not be missing any limbs, but are suffering from TBI effects: the inability to speak, to swallow, to read, or even to remember; and as Dr. Lux stated, they struggle much more than is apparent.[27]

Iraq War injuries have a particular distribution that is attributable to improved protective gear and field triage protocols, and also to the type of enemy weapons: the Improvised Explosive Devices, or IEDs. One study found that while small arms accounted for 25.1% of causative agents, artillery shells, mortars, grenades/rocket-propelled grenades (RPGs), land mines, and accompanying shrapnel or fragments caused 46.5%, with other/unknown weapons at 28.3%.[28] The individual body armor is made of ceramic plates covering the front and back of the chest and abdomen and is capable of stopping rounds fired from AK-47 and derivatives.[29] However, the extremities, pelvis, face, and lower portions of the back and abdomen are not protected, unlike the head, which is protected within the typical helmet. This body armor has lowered mortality, but has not prevented concussions or projectile trauma to the brain to a majority of the wounded. In addition, the soldiers' reluctance to wear protective goggles has resulted in a very high incidence of blinding injuries, with a devastating combination blindness-TBI wound.[30]

II. TBI ASSESSMENT–COMPARISON CASE STUDIES

The human brain has many functions that affect the mind-body system such that TBI after-effects can be severely disabling. One

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[26] *Id.*

[27] *Id.*

[28] James M. Zouris, M.D. et al., *Wounding Patterns for US Marines and Sailors during Operation Iraqi Freedom, Major Combat Phase.* 171 MILIT. MED. 246-252 (2006).

[29] Sean P. Montgomery, M.D. et al., *The Evaluation of Casualties from Operation Iraqi Freedom on Return to the Continental United States from March to June 2003.* 201 J. AM. COLL. SURG. 7, 8 (2005).

[30] Atul Gawande, M.D., *Casualties of War—Military Care for the Wounded from Iraq and Afghanistan,* 351 NEW ENG. J. MED. 2471, 2473 (2004).

predictor of outcome is the severity of the injury. Several scales are used to assess the potential severity of TBI. The Glasgow Coma Scale (GCS measures the intensity of the lack of cognition) the duration of time a patient is in a coma, and the length of the Posttraumatic Amnesia (PTA), are typically analyzed together to formulate a diagnosis of degree of trauma. The combination scales approach is presented as:

Classification of Severity of TBI:[31]

TBI Classification	GCS Score	Duration of Coma Length of PTA
SEVERE	3-8	> 6 hours > 24 hours
MODERATE	9-12	< 6 hours 1-24 hours
MILD	13-15	≤ 20 min.< 60 min.

Unlike other injuries that affect only tissues, bones and nerves, TBI is also destructive of the higher order of cognition, resulting in the addition of psychological to physical disability outcomes for OIF veterans. Although the advances in medical technology and triage protocols for wounded soldiers have saved their lives in increasing numbers, the residual injuries require a lifetime of therapies because the most critical organ in the body—the brain—is wounded.

In a recently-funded study, running from April 1, 2004 through March 31, 2007, one investigator developed a cognitive measure that would yield more precise and accurate psychometrics for TBI veterans.[32] The study notes that the current instrument used by the VA to monitor cognitive outcomes is the Functional Independence Measure (FIM), which has only five items (instead of the usual 300-500), which results in weak psychometrics and therefore does not accurately measure the "real-life cognitive challenges" that veterans with TBI face in their daily lives.[33] The study identifies a significant area that has not been addressed by the VA—a precise cognitive disability measure—to determine the efficacy of the "continuum of care" (acute, in/outpatient, six-month post rehab) that is currently offered by the VA.[34] The data

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[31] MCKAY M. SOHLBERG & C. A. MATEER, COGNITIVE REHABILITATION: AN INTEGRATIVE NEUROPSYCHOLOGICAL APPROACH 34 (Guilford Press 2001). *Id.* at 32-33, 37 (Sohlberg-Mateer TBI scales tables are at Appendix 2).

[32] Craig A Velozo, *Developing a Computer Adaptive TBI Cognitive Measure, available at* http://www1.va.gov/rorc/projects/Developing_Computer_Adaptive_TBI_Cognitive_Measure/cfm.

[33] *Id.*

[34] *Id.*

collection for this study was expected to commence in January 2006, leaving thousands of veterans with admittedly inadequate assessments in the interim.

In May 2006, the U.S. Government Accountability Office (GAO) published a report to Congress.[35] The basic findings of the report note that Post Traumatic Stress Disorder (PTSD) is often an accompanying injury to TBI.[36] In August 2007, a forum of VA mental health specialists in Alexandria, VA, noted that "[a]ny explosion intense enough to produce TBI is threatening enough to produce PTSD."[37] The initiatives taken by the VA include easily-accessed public information through the VA's National Center for Post Traumatic Stress Disorder.[38] The implications of the GAO report, which found inadequate assessment and very significant prevalence, together with the co-morbidity of TBI and PTSD noted by the 2007 VA mental health forum, run tandem to the importance of the premise presented herein: the OIF TBI veterans are being misdiagnosed and inadequately treated. Therefore, the compensation they are receiving for their government service and personal sacrifice should be augmented in accordance with the statutes that were enacted to provide adequate care.[39]

The May 2006 GAO PTSD report states that the DOD's benefits include mental health services for eligible veterans for 180 days post discharge or release from active duty, with additional services available for purchase for up to eighteen months.[40] OEF/OIF veterans

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[35] UNITED STATES GOVERNMENT ACCOUNTABILITY OFFICE, REPT. NO. GAO-08-276 MILD TRAUMATIC BRAIN INJURY SCREENING AND EVALUATION IMPLEMENTED FOR OEF/OIF VETERANS, BUT CHALLENGES REMAIN (Jan 2006) *available at* http://www.gao.gov/new.items/d08276.pdf; UNITED STATES GOVERNMENT ACCOUNTABILITY OFFICE, REPT. NO. GAO-06-397, POST TRAUMATIC STRESS DISORDER: DOD NEEDS TO IDENTIFY THE FACTORS ITS PROVIDERS USE TO MAKE MENTAL HEALTH EVALUATION REFERRALS FOR SERVICEMEMBERS (May 2006) *available at* http://www.gao.gov/new.items/d06397.pdf [hereinafter GAO REPT. 06-397].

[36] *Id.* at 1.

[37] Friedman, Matthew MD, PhD, Exec. Dir. VA National Center for PTSD, *Need of VA Docs to Treat PTSD Rising*, available at http://www.usmedicine.com/article.cfm?articleID+1608&issueID=102 (last visited April 16, 2008).

[38] *See* What is PTSD Fact Sheet *available at* http://www.ncptsd.va.gov/ncmain/doclist.jsp (last visited April 16, 2008).

[39] *See* discussion of TRICARE, Veterans Benefits Programs, MILITARY CLAIMS ACT, MEDICAL CLAIMS ACT, and the FEDERAL TORT CLAIMS ACT, Section VI, *infra.*

[40] GAO REPT. 06-397.

have benefits available at no cost for two years.[41] Using data provided by the DOD, the GAO report found that of the 178,664 OEF/OIF servicemember questionnaires reviewed, about 5% (n=9,145) "may have been at risk for developing PTSD."[42] Even more striking is the result of the at-risk cohort: only about 22% (n=2,029) were actually referred for further evaluation, with differing numbers of referrals across the services.[43] The report includes an alarming public health crisis: "DOD cannot provide reasonable assurance that OEF/OIF servicemembers who need referrals for further mental health or combat/operational stress reaction evaluations receive them."[44] This finding is alarming not only because of the prevalence in the study cohort, but also because the report admits that "early identification and treatment of symptoms through education, peer and family support, therapy, or medications may lessen the severity of the condition and improve the overall quality of life for those with PTSD."[45] This recent study supports the research presented herein regarding the significance of the inadequacy of medical evaluations of the OIF veterans.

Several types of mechanisms cause TBI, including: (1) mechanical forces (impact of the head against an object, such as a projectile or vehicle component when the bomb detonates); (2) acceleration-deceleration forces (brain moves inside the bony surfaces of the skull even though the head is still); (3) vascular tearing (mechanical forces on the brain strain and tear the blood vessels); and (4) diffuse axonal injury (DAI) (mechanical forces stretch, deform, and tear the neurons).[46] Of the combination of these, the most detrimental and impossible to treat is the DAI, which sets off a "cascade of destructive processes" that are directly related to the severity of the injury and consequently to the functional outcome of the patient.[47] The survival rate for the soldiers can be attributed to the incredible ability to deliver prompt intervention to the hemorrhaging and swelling of the injured brains through state-of-the-art field of combat medical care.

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[41] *Id.* Veterans have to meet eligibility rules, including disability ratings, and process the claims through the VA administrative process for further health and compensation benefits, discussed *infra.*

[42] *Id.* at 5.

[43] *Id.* (Referrals: Army = 23%, Marines = 15%, Navy = 18%, and Air Force = 23%).

[44] *Id.*

[45] *Id.* at 1 (citing Charles W. Hoge et al., *Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care*, 351 NEW ENG. J. MED. 13-22 (2004)).

[46] *Id.* at 27-29.

[47] *Id.* at 29.

However, the prevalence of blast injuries (62% in 2003, 67% in 2004)[48] results in a significant impact for the soldier population for two reasons: (1) DAI does not have a definitive ameliorative or curative medical intervention available;[49] and (2) there is a concern about the untreated cohort of soldiers who have unrecognized "mild" TBI, because they have suffered a closed head injury. As one VA rehabilitative care specialist has noted: "My biggest concern is those patients with mild to moderate head injuries that may not be more visible...invisible diseases...literally walking wounded."[50]

Although an unimpaired person faces difficulties in understanding the seemingly insurmountable hurdle of rehabilitation faced by the veterans with TBI who may not appear severely disabled at first glance, a compelling narrative provides an intimate perspective. The 3,000-page diary, written over the span of twenty-five years, of a World War II Russian veteran with severe TBI and vision loss is the core of *The Man with a Shattered World*.[51] The book is a collection of the journal entries of Sublieutenant Lyova Zasetsky, a member of the Russian army who was wounded on March 2, 1943 during the Battle of Smolensk. It also has an interspersed case history narrative by Dr. Aleksandr Romanovich Luria, (1902-1977) who was a professor of

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[48] DVBIC website, *Blast Injury FAQs*. http://www.dvbic.ort/cms.php?p=Blast_injury; Brad Amburn, *Brain injuries lead Iraq war injuries.* United Press International (July 23, 2004) (according to Deborah Warden, MD) *available at* http://www.upi.com/inc/view.php?StoryID=20040721-030507-2465r.

[49] A member of the Veterans Affairs National Research Advisory Council, Dr. Jeffrey M. Drazen, published a provocative article on the need for funding for stem cell research. Dr. Drazen notes that while biomedical research has made it possible to provide injured veterans with "biohybrid devices and neural prostheses," there is a need for additional research for neural therapies for the seriously injured. He notes that while it could have a real benefit, embryonic stem cell research is not permitted in federally funded research, which is what is needed to find a possible biomedical repair for the veterans' neurological injuries. As Dr. Drazen states, "[t]hese men have given their best efforts for their country; we owe them nothing less." Jeffery M Drazen, *Using Every Resource to Care for Our Casualties*, 352 NEW ENG. J. MED. 2121 (2005).

[50] Rosana Ruiz, *VA centers to provide one-stop care for wounded; Houston unit is among those that will treat multiple injuries under one roof*, HOUSTON CHRON., Feb. 3, 2006, at A1 (quoting H. K. Henson). Dr. Deborah Warden, a neurologist and psychiatrist who serves as the director of the DVBIC, headquartered at WRAMC, has noted that the closed head injuries are not diagnosed promptly. Susan Okie, *Traumatic Brain Injury in the War Zone*, 352 NEW ENG. J. MED. 2043, 2047 (2005) (according to Deborah Warden).

[51] A. R. LURIA, THE MAN WITH A SHATTERED WORLD (H Cole trans., Harvard University Press 1972).

Psychology at the University of Moscow. Sublieutenant Zasetsky presents self-observations, together with Dr. Luria's explanatory notes, in effect propelling the reader into the life of a veteran soldier with TBI.

Dr. Luria was a groundbreaking neuropsychologist and a prolific writer on a diverse range of topics within his field. He wrote his first book in 1922 on psychoanalysis and his last three on memory, language, and cognitive development in the last year of his life.[52] Dr. Oliver Sacks[53] considers him the "most significant and fertile neuropsychologist of his time," in that he continued the work of his teacher, Dr. Lev Vygotsky, on the influence of social interaction in the development of mental faculties.[54] This work, written over the span of thirty years, details an astounding clinical case history and purposefully presents the application of Dr. Luria's belief in the validity of a descriptive approach to the science of neuropsychology, melding the scientific with the biographical portrait of the patient.[55]

Sublieutenant Zasetsky suffered a brain-penetrating bullet wound that destroyed the left posterior parieto-occipital regions, but also affected the entire parieto-occipital left hemisphere and the medulla because of the formation of scar tissue.[56] This region of the brain—the "tertiary" part of the cortex—combines the visual (occipital), the tactile-motor (parietal), and the auditory-vestibular (temporal) sections that allow all of these sensory functions to "converge" and process information for proper functioning in daily

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[52] Oliver Sacks, *Foreword* to A. R. LURIA, THE MAN WITH A SHATTERED WORLD (1972), at vii.

[53] Dr. Sacks' work was brought to light for the general public in the American film, *Awakenings*, starring Robin Williams and Robert de Niro, based on his book *Awakenings*. Dr. Sacks is a neurologist trained at Oxford, who is widely recognized as an authority on chronic and deep psychological disorders requiring in-patient confinement. He is currently Professor of Clinical Neurology and Clinical Psychiatry at Columbia University Medical Center and has received numerous awards for his work. For a short profile of Dr. Sacks and his work, *see* http://www.oliver sacks.com/about.htm (last visited March 19, 2008).

[54] *Id.* at viii.

[55] Dr. Sacks includes a quotation from a letter he received from Dr. Luria in response to his review of Dr. Luria's work: "he sent me a reply (getting a letter from Luria was like getting a letter from Freud) defining, among other things, his attitude toward his own work: '...it is a kind of "Romantic Science" which I wanted to introduce, partly because I am strongly *against* a formal statistical approach and *for* a qualitative study of personality...I was ever conscious and sure that a good clinical description of cases plays a leading role in medicine, especially in Neurology and Psychiatry.'" *Id.* at x-xi.

[56] *Id.* at 21-22.

activity.[57] In Zasetsky's wound, his visual field optics were also damaged, leaving him blind on the right side. As Dr. Luria explains:

> ...But if the bullet passes through the fibers of the "optic radiation" and destroys part of these, blind spots occur and an entire part (sometimes one-half) of the visual field disintegrates. A person will also continue to perceive discrete objects (since the "secondary" sectors of the visual cortex have remained intact), to have tactile and auditory sensations, and to discern speech sounds. Nonetheless, a very important function has been seriously impaired: he cannot immediately combine his impressions into a coherent whole; his world becomes fragmented.[58]

Dr. Luria facilitates the reader's involvement with the patient's post-TBI predicament by his clear explanation of the neuropsychological bases for the content of the patient's journal entries.

As Zasetsky explains, the problems with his vision are almost overwhelming since he cannot see any "whole" objects, only parts of them, including persons, things, and even the words he is writing in his journal. These sensory "convergence" impairments affected his speech, his ability to walk and eat, and even caused him to hallucinate about what he believed that he perceived. This lack of integrative perception extended to his body and bodily functions: although he knew he had a right side, he could not perceive it, so it felt as if his right half had disappeared. He also had no sense of how he was connected together, as if his body had been shattered into bits and pieces.[59]

However, the most troublesome effect of his wound was that Zasetsky lost what he called his "speech-memory."[60] Although he could speak, his ability to remember words was greatly impaired and the loss of the ability to communicate was a severe disability to his daily life.[61] Zasetsky knew that he had been a student at the

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[57] *Id.* at 30.
[58] *Id.* at 31.
[59] *Id.* at 43.
[60] *Id.* at 87.
[61] Dr. Luria explains: "He referred to his major disability as a loss of "speech-memory." And he had good reason to do so. Before he was wounded, words had distinct meanings that readily occurred to him. Each word was part of a vital world to which it was linked by thousands of associations; each aroused a flood of vivid and graphic recollections. To be in command of a word meant he was able to evoke almost any impression of the past, to understand relationship between things,

polytechnic institute, but now he was devastatingly illiterate. The breakthrough for Zasetsky occurred when one of the physicians asked him to write "automatically," without trying to think about what he was doing. This changed his life because Zasetsky realized that he could do this much more easily than converse or read, as he could write a word once he remembered it. His 3,000 pages of journal entries, written over the space of twenty-five years, represent his struggle toward making some sense of his shattered world and convey the horrific consequences of TBI on daily living in a very intimate dialog with his reader. Although published in 1972, this seminal prospective study of a veteran's TBI provides a clear perspective on the issues confronting Iraq war veterans with TBI today.

On Sunday, January 22, 2006, *The New York Times* ran a front-and-center story on Corporal Jason Poole, an OIF veteran who was completing his rehabilitation from severe TBI.[62] A roadside bomb had injured him about one and a half years prior to the story, while on foot patrol near the Syrian border on June 30, 2004. The bomb blew off the left side of his head: shrapnel from the bomb pierced through the left side of his face emerging under his right eye, the metal fragments fracturing his skull, and injuring his brain, one of the major brain arteries, his left eye and ear. All his facial bones were broken, shattered, or pulverized (jawbone). The blast was so severe that three others in the patrol were killed, but Corporal Poole survived despite his severe injury, bleeding, swelling, infection, and a reconstruction with 75 to 100 titanium plates and screws, and bone and skin grafts. Corporal Poole is one example of the astounding survival rate of the OIF veterans: seven to eight survivors for every death, despite the horrific nature of blast injuries.[63]

Corporal Poole has no memory of the blast, but he has dreams where he sees the skies turn red. In addition to learning how to walk, Jason had the same hurdles as Sublieutenant Zasetsky: his left-side injury to his brain left him deaf, blind in his left eye, weak and unable to notice the right side of his body. But, his frustration was that he could not talk or comprehend speech, and lived with his thoughts

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conceive ideas, and be in control of his life. And now all of this had been obliterated." *Id.* at 101.

[62] Denise Grady, *Struggling Back From War's Once-Deadly Wounds*, N.Y. TIMES, Jan. 22, 2006, at A1.

[63] This is compared with two survivors for every death in WW II. The sequelae of bomb injuries include: mangled limbs, amputations, burns, combinations of damaged spinal cords and brains, vision and hearing loss, and the neuropsychological residual effects such as post-traumatic stress and depression. *Id.* at A1.

"trapped inside his head."[64] Just as he had to learn to walk by learning how to place his arms on the supports and balance, Corporal Poole had to learn to communicate by finding words that named objects around him, although at first he could name only half of the objects in his room. A year of therapy has raised his reading level from zero to first or second grade, but a page of words is beyond his capacity. Unlike Zasetsky, Poole has extreme difficulty writing and his writing is often illegible and incoherent.

Although modern medicine saved his life, he is not able to function normally in daily living and he is "not competitively employable."[65] Because he still requires various types of therapy several times a week, Jason was moved as an outpatient into an apartment in nearby Cupertino, California, the city where he had grown up.[66] However, his therapy needs in Palo Alto require that he take three city buses twice a day, managing schedules and crossing wide streets with heavy traffic—a serious hazard to the brain-injured who have impaired balance, perception, and judgment. Also, because his reconstruction is so amazing, passers-by and bus drivers cannot readily recognize his severe disability nor make timely allowances for his delayed reaction times. Despite all of his physical and neuropsychological injuries, Corporal Poole has not lost his friendly personality and his hope: to teach art therapy, children's theatre, or do social work, even if it is just as a volunteer. Just as many other TBI veterans, including Zasetsky, Corporal Poole is struggling to regain his life.[67]

III. OIF VETERAN TRIAGE

Survival rates for the OIF veterans have been enhanced by the triage planning for the wounded. Three levels are available at or near the field: Level I is a battalion aid station, where initial protocols are performed; Level II is a Forward Surgical Team[68] (FST) that provides

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[64] *Id.* at 20.

[65] *Id.* at 21.

[66] Cpl. Poole is a patient at the VA medical center in Palo Alto, California, one of the member centers of the Defense & Veterans Brian Injury Center (DVBIC).

[67] *See* Grady, *supra* note 62.

[68] The FSTs travel in six Humvees that move directly behind the troops and can set up a 900-ft^2 hospital: 4 ventilator-equipped beds and 2 operating tables within 60 minutes. The hospital is made up of three attached Deployable Rapid Assembly Shelter (DRASH) tents. The equipment is carried in five backpacks: an ICU pack, a surgical-technician pack, a general-surgery pack, and an orthopedic pack, that each

surgical intervention for stabilization; Level III is the Combat Field Hospital[69] (CFH) with surgical and specialty care available; Level IV is evacuation to Landstuhl Regional Medical Center in Germany or other fixed European medical facility (Kuwait and Rota, Spain); Level V care is initiated at Walter Reed Army Medical Center (WRAMC) in Washington, D.C.[70] During the first months of the war, it took an average of eight days to get a soldier from the battlefield to WRAMC, but the field surgeons have adapted to "staged" triage and this timeframe has been cut to arrival in the US in less than four days, with a severely acute individual case noted at WRAMC within thirty-six hours after the mortar attack.[71] The result of this high-level of immediate triage and casualty transport capability is that the wounded survival rate is the highest of any war to date.[72] Also, the efficacy of on-site triage means that survivors can be more extensively disabled than those of previous conflicts, thus requiring a concomitant adjustment in the delivery of post-trauma rehabilitation. The rehabilitation aspect of Iraq veteran health care must be addressed as an on-going commitment, particularly for those 60% or more with TBI.

Electronic communication has facilitated coordination between overseas providers and the admission team at WRAMC. The availability of continuous flow of patient status information and transport logistics data has made the management of admissions into WRAMC efficient with regard to resource, operating room, and

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hold sterile equipment, medicines, drapes, gowns, catheters, and a handheld unit that is used for hemograms and electrolyte/blood gas measurements with a drop of blood. The FSTs also have an ultrasound machine, monitors, transport ventilators, an oxygen concentrator for up to 50% oxygen, 20 units of packed red cells, and six roll-up stretchers with stands. The supplies are sufficient to evaluate and perform surgery on as many as 30 wounded and can provide up to six hours of intensive care. Gawande, *supra* note 30, at 2472.

[69] The CFHs are 248-bed hospitals with laboratory and radiology services, some specialty surgery services, and six operating tables. They are mobile modular hospitals that are moved by air, tractor-trailer, or ship, and are fully functional in 24 to 48 hours. The maximal stay for any patient is three days, with transfer to Level IV for all who will require a longer stay. *Id.* at 2473.

[70] Montgomery, *supra* note 29, at 8.

[71] Gawande, *supra* note 30, at 2473.

[72] Although the DOD tables do not include deployment counts, the May 2006 GAO PTSD Report (GAO-06-397) noted that the report reviewed 178,664 post-deployment questionnaires (DD2796) dated between October 1, 2001 through September 30, 2004. GAO-06-397, *supra* note 35, at 3. The DOD casualty charts for August 1, 2006 noted 11,522 OEF/OIF servicemembers. *See supra* note 13. This percentage is much lower than the previous statistics on the DOD charts. *Id.*

surgical services allocation.[73] The wounded arrive via the Air Evacuation System (Aerovac) run by the Air Force, which has an office at WRAMC. The manifest of the wounded and their estimated time of arrival is made available to the different services at WRAMC electronically, making it possible to know the particular specialty consult services that will be required for each flight arrival and to coordinate with the nursing supervisors and administrators on the appropriate personnel, equipment, and bed space required for each transport of patients.[74] The advance planning not only allows for hospital logistics coordination, but also expedites the formal admission paperwork, staging of initial evaluations, and orders on each patient at admission, including pharmacy, radiology, laboratory, and nutritional services.[75]

On arrival, the triage team has lead orthopedic and general surgery residents with the assistance of an anesthesia resident, a pharmacist, a radiology technician, the charge nurse, a critical care nurse, aides, and technicians.[76] Those requiring surgery are taken directly into the operating room for wound exploration, irrigation, debridement, and, less frequently, definitive treatment; those not taken to surgery are either directly admitted to the hospital or to one of the WRAMC outpatient facilities for management.[77] The admissions are made by either the orthopedic or the general surgery services, and the junior orthopedic resident or intern submits nine routine consultations throughout the hospital for every OIF/OEF patient: audiology, discharge planning, nutrition care, occupational therapy, pastoral, psychiatry, physical medicine and rehabilitation, physical therapy, and social work, with an additional infectious disease consult for contaminated open wounds.[78]

Surgeons at WRAMC and in the field have noted that battlefield trauma presents a departure from the civilian trauma faced in the typical stateside emergency department. A former Surgeon General of the US Army has noted the high incidence of major penetrating traumas (5,000+ Purple Hearts) that are a result of the change from small arms in the initial 2003 march into Baghdad to IEDs and "vehicular-borne

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[73] William C. Doukas & M. A. Javernick, *Process of Care for Battle Casualties at Walter Reed Army Medical Center: Part I. Orthopedic Surgery Service*, 17 MILIT. MED. 200, 200 (2006).
[74] *Id.*
[75] *Id.*
[76] *Id.*
[77] *Id.*
[78] *Id.*

explosive devices," that also include land mines, resulting in a distribution of 67.5% of injuries from explosive devices.[79] This high percentage of explosive devices as the causative agents of wounds explains the high prevalence of TBI among the Iraq veterans—64%,[80] which is the current focus of the Defense and Veterans Brain Injury Center, headquartered at WRAMC. The national director of the center, Dr. Deborah Warden has stated that the percentage may be as high as 67%, and the on-going sequelae include cognitive and emotional problems with a high rate of depression.[81] These long-term effects require continued outpatient therapies that are dependent on logistics that can be problematic on a long-term basis and a burden on veteran families.

IV. TBI ASSESSMENT–COGNITIVE REHABILITATION TREATMENT MODEL

Susan Okie, M.D., published an often-cited article detailing several case histories of OIF TBI.[82] Dr. Okie detailed the residual effects of TBI in two veterans, Sergeant David Emme and Staff Sergeant Jason Pepper. Sergeant Emme was in a convoy truck in Talafar when an IED exploded right next him, suffering a left-side head injury similar to Sublieutenant Zasetsky and Corporal Poole. Staff Sergeant Pepper had an IED detonated next to his personal carrier in Karbala, taking the force of the blast in his face, losing both of his eyes and sustaining a skull fracture on the left side. Both of these veterans, just as Corporal Poole, were treated on-site at the CFH in Baghdad, and then eventually transferred to WRAMC in Washington. They were admitted into the neuroscience unit and evaluated for their injuries.[83]

The soldiers at WRAMC are assessed on the severity of their TBI based on the duration of loss of consciousness and posttraumatic amnesia, according to Dr. Louis M. French, the clinical director of the DVBIC at WRAMC.[84] A data-loss problem is inherent in this

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[79] J. B. Peake, *Beyond the Purple Heart–Continuity of Care for the Wounded in Iraq*, 352 NEW ENG. J. MED. 219, 219-222 (2005).

[80] *See generally* Defense and Veterans Brain Injury Center, http://www.DVBIC.org (last visited Apr. 25, 2008).

[81] Brad Amburn, *Brain injuries lead Iraq war injuries*, July 23, 2004, *available at* http://www.upi.com/inc/view.php?StoryID=20040721-030507-2465r (last visited Apr. 25, 2008).

[82] Okie, *supra* note 50, at 2043.

[83] *Id.* at 2045

[84] *Id.*

paradigm, since the physicians at WRAMC do not have accurate details on the exact time sequence from the moment of blast impact to the actual initial recovery of consciousness. This is the result of the circumstances of war—no one is actually with a stopwatch and clipboard taking notes as the injuries occur in the field. This problem was noted in a correction to the report included by Dr. Okie, published as a Letter to the Editor in a subsequent journal: "[I]n practice, we often use the duration of post-traumatic amnesia to determine the level of severity, since that information is available to us more often than are data on loss of consciousness."[85] An additional factor in the under-diagnosis of mild TBI is the lack of visible abnormalities on brain imaging for those patients, which makes clinical confirmation more difficult.[86]

Due to the issues identified above, veteran health care policy should be revised to allow re-assessment for those OIF injured who may not have been properly diagnosed. In addition, improved continuity of care should be provided for those included in the known prevalence of 60-67% OIF TBI, because TBI is a significant injury. The life-altering sequelae of TBI include: persistent headaches, sleep disturbances, sensitivity to light and sound, attention and memory deficits, language impairment, inability to problem-solve, judgment deficiency, mood changes, emotional outbursts, anxiety, and depression. TBI definitely overlaps with post-traumatic stress disorder, which Dr. French has found in his patients at WRAMC.[87] One of the physicians at the VA Palo Alto medical center, where Corporal Poole is being treated, notes that it is important to remember that the brain heals very differently from the rest of the body: since it functions as the "repository" for a lifetime of learning, any replacement cells would be "dumb, they wouldn't have access to all the information you've acquired over a lifetime."[88] Another clinical researcher has noted: "medical history is replete with cases in which traumatic brain injuries have robbed their victims of some mental faculties but not others, and there is a simple reason for this: different parts of the brain coordinate

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[85] Deborah L. Warden & L. French, *Letter to the Editor*, 353 NEW ENG. J. MED. 633, 633-634 (2005). In addition, Dr. Warden referenced the differences in the reference values for mild TBI used by neurologists: 30 minutes v. 20 minutes v. "brief" (< 1 hour) timeframes for loss of consciousness.

[86] Okie, *supra* note 50.

[87] *Id.*

[88] Jason Margolis, *Traumatic Brain Injuries in Soldiers Often Go Undetected* (quoting H. Zeiner) *available at* http://www.birf.info/home/library/vet/vet-undetecged.html (last visited Mar. 29, 2008).

different functions."[89] The fact that each patient requires an individualized treatment plan, depending on the extent and nature of residual impairments, further enhances the significance of a policy change to enable: (1) adequate assessment of the level of TBI before discharge, (2) adequacy of a treatment plan relative to the assessment; and (3) provision of available post-discharge therapy resources not only for the patient, but also for the veteran's long-term daily care providers. Currently, the system falls short in all three aspects.[90] Prompt treatment is crucial in TBI, and Spc. Wilson's case noted below, among others, demonstrates the shortfalls in the system of OIF TBI.

A. Cognitive Rehabilitation Model

If adequacy of treatment plan is to be considered a critical factor, then this policy discussion must include consideration of the "cognitive rehabilitation" treatment model. This approach integrates the principles of neurophysiology and psychology, in effect a neuropsychological treatment paradigm. For patients with TBI, the injuries are focal (bleeding, swelling, fractures) and diffuse (DAI: stretching and tearing of the neurons), together with secondary injuries from neuronal depolarization, brain ischemia, and delayed hemorrhages.[91] In cases involving multiple traumas, which is often the

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[89] WILLIAM J. WINSLADE, CONFRONTING TRAUMATIC BRAIN INJURY: DEVASTATION, HOPE, AND HEALING 17 (1998).

[90] The case of Spc. James Wilson is illustrative. He was fighting in Sadr City in the fall of 2004, when bombs rocked the Humvee he was in and he split his helmet with the impact on the windshield. Although he was bruised in the attack, and felt very dizzy and lightheaded, he was diagnosed with post-traumatic stress disorder by the Army medics and evacuated; what he would learn much later was that he had classic closed-head TBI. He was flown first to Landstuhl, and then to WRAMC in October 2004. He visited the Pentagon in December 2004, and got so dizzy that he vomited all over the carpet while meeting with Deputy Secretary Paul Wolfowitz in his office. Despite his symptoms and the circumstances of his injury, the physicians at WRAMC believed he had "conversion disorder with symptoms of traumatic brain injury (arising from a psychological rather than physical etiology) and was accused of being a liar; this was June 2005. Wilson and his wife persisted in attempting to get medical treatment, and in December 2005, over a year after he arrived at WRAMC, Spc. Wilson was sent for a neurological workup. Further, a re-examination of Wilson's MRI studies done at admission to WRAMC in October 2004, together with his presenting symptoms, indicated that Spc. Wilson should have been treated for TBI during that admission. Mark Benjamin, *Losing their minds,* Jan. 5, 2006, *available at* http://www.salon.com/news /feature/2006/01/05/brain_trauma/print.html (last visited Apr. 25, 2008).

[91] McKay M. Sohlberg, *supra* note 31, at 27-31.

situation with OIF TBI, the impediment to respiration and thus oxygenation deprivation effects on the cerebral tissues is a factor, together with scarring and/or hydrocephalus that lead to seizure disorders.[92] This treatment model includes a succession of therapies after medical status has reached conscious awareness: quiet atmosphere to decrease agitation and restlessness in initial stages of awareness; followed by therapy toward maintaining conscious memory during the PTA stage; then work on motor activities toward restoration of orientation, strengthening and normalization of muscle tone/balance/posture/gait; and the last state of in-patient care is directed at language, speech, attention, and memory deficits, with training in compensatory strategies.[93] Despite the fact that at this stage patients do not have adequate appreciation of their impairments, nor the ability to communicate fully or to understand or implement successful decisions in problem situations (where am I going, which bus am I riding, why am I going, how can I cross the street), and are also suffering from psychological disabilities affecting mood, emotions, and behavior, the great majority of individuals with TBI are discharged home following inpatient treatment.[94] Currently, veterans who are discharged from the Palo Alto Brain Injury Rehabilitation Unit are followed for one year "to assure seamless transition to home, work, school, or return to active duty."[95] This short-lived treatment model runs counter to the statement by the Department of Veterans Affairs that TBI results in "life-long physical, cognitive, behavioral, emotional and social impairments and disabilities" and requires a policy change in the delivery of care to OIF TBI veterans.[96]

B. Israel's Treatment Model

Israel has had extensive experience in dealing with TBI resulting from bomb attacks. After adverse experience in treatment modalities for survivors of the Six Day War and the 1973 Yom Kippur

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[92] *Id.* at 31-32.

[93] *Id.* at 35.

[94] *Id.* at 36. One recognized cognitive functioning scale is the Rancho Los Amigos scale, which runs from "No response" (value=1) to "Purposeful and appropriate" (value=8).

[95] *Traumatic Brain Injury*, *available at* http://www.palo-alto.med.va.gov/show?asp?durki=1356 (hard copy on file with author).

[96] *TBI – Traumatic Brain Injury: A Partnership for Care of Active Duty Military and Veterans*, *available at* http://www1.va.gov/health/rehab/SpecProg_TBI.htm (hard copy on file with author).

War, the long-term care protocols were dramatically modified.[97] Initially, the injured were treated for their physical symptoms.[98] Because of the lack of understanding of the mechanisms and implications of cognitive deficits resulting from TBI, they were then often placed in institutions for the mentally ill with either a psychiatric or physical rehabilitation orientation (chemotherapy or physical therapy), but there was no recognition of the need for cognitive rehabilitation.[99] This approach resulted in survivors, who were transferred to psychiatric institutions or nursing homes because they were unable to function in the job market, even if they did not have severe behavioral problems. But they often had serious problems in family or social situations because of the lack of appropriate community services.[100] The prevalence of this situation in the veterans, together with the strain on the families resulting from the economic and psychological burdens, was a significant social concern. The families requested that the Israeli Ministry of Defence's. Department of Rehabilitation finds an acceptable answer for their problems, since institutionalization was not an appropriate response.[101]

The Ministry of Defence responded by asking the psychology department at Tel Aviv University to find a solution to serve this cohort of Israeli TBI veterans and their families.[102] A service was set up at the university to provide cognitive therapy, family counseling and individual/group psychotherapy.[103] This was the first of the Israeli community-based programs targeting TBI survivors and their families.[104] It was a limited access program, and in 1972 the Ministry of Defence requested additional help from the Psychology Department at Bar-Ilan University.[105] This second initiative set up a rehabilitation center in Tel Aviv, whose purpose was to provide an alternative to open-market employment by establishing a research and demonstration project of sheltered employment and recreational

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[97] Shlomo Katz & Victor Florian, RETURNING THE INDIVIDUAL WITH TRAUMATIC BRAIN INJURY TO THE COMMUNITY: AN OVERVIEW OF PROGRAMS AND SERVICES IN ISRAEL, 1 Monograph No. 50 at 14 (International Exchange of Experts and Information in Rehabilitation, 1990).
[98] *Id.* at 14.
[99] *Id.* at 14-15.
[100] *Id.* at 15.
[101] *Id.*
[102] *Id.* at 17.
[103] Katz & Florian, *supra* note 95, at 17.
[104] *Id.*
[105] *Id.*

services, thereby improving the quality of life not only for the veterans, but also for their families.[106] The success of this center prompted its transition from demonstration project to permanent service center.[107]

Following the 1973 war, additional community centers similar to the Bar Ilan were established: (1) a day center at Beit Lowenstein Medical and Rehabilitation Center, and (2) a recreation and treatment center in 1975 at Beit Halochem, with the staff from the Tel Aviv University.[108] In 1981, the Ministry of Defence Department of Rehabilitation, the National Insurance Institute, and Keren Mifalei Shikum (an affiliate unit of the Ministry of Labor and Social Services) set up a community-based service center in Haifa, under the direction of the National Institute for Rehabilitation of the Brain Injured.[109] The center in Haifa serves civilians, as well as veterans. The structure and development of these specialized treatment centers for veterans with TBI in Israel evidences the truth of Dr. Katz's rationale: "Because Israel has had prolonged severe security problems, disabled veterans have a special status in Israeli society."[110]

The Tel Aviv veteran center that was developed through the Department of Psychology of Bar-Ilan University has a "modified rehabilitation workshop" structure,[111] which is based on two principles: (1) "meaningful activity," and (2) "autonomy.[112]" The first principle requires that the center relate to the veterans' need to make meaningful use of their individual personal and social resources. Despite their impaired cognitive functioning, they want to work and to have intellectual activities, which build self-esteem and self-actualization.[113] The second principle encourages participation by the veterans in the administration, decision-making, and daily operation of the center, and further enables the veterans to regain their dignity.[114] The goal is to provide a sheltered environment with opportunities for autonomous responses, maximum freedom of choice and responsibility for their lives, thus nurturing self-worth and accomplishment.[115] The center is

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[106] *Id.*
[107] *Id.*
[108] *Id.* at 4-5.
[109] Katz & Florian, *supra* note 9, at 19.
[110] *Id.* at 21.
[111] *Id.* at 23.
[112] *Id.*
[113] *Id,* at 23-24.
[114] *Id.* at 23.
[115] Katz & Florian, *supra* note 95, at 25.

set up with a number of activity centers in which the veterans participate according to their needs and abilities.[116]

The workshop was designed with the knowledge that the traditional vocational models include mainly monotonous tasks that pass time and are therefore non-fulfilling to the patients. In Tel Aviv, the workshop was set up with work stations made up of three to four patients who were slowly given the full administration of their station, with only minimal guidance from the staff.[117] The change from production into administrative duties not only increased productivity, but also resulted in a stronger group, a sense of responsibility, and an increase in personal initiative.[118] Currently, the profits from the work center are placed into a common fund, and are used for social activities: day/overnight trips and parties at the center.[119] In addition to the workshop, the center also offers vocational, educational, therapeutic and social activities that include religious services. Family members are included in the therapy programs and counselors from the center visit in the homes of the center patients.[120] The goal of the center is to facilitate activities that balance abilities and performance so that personal growth and self-actualization are facilitated; this, in turn, results in a "positive feeling of self-worth and dignity."[121] The Israeli rehabilitation center model is the result of an Israeli veteran health care policy that has realized long-term continued health care is a national debt to those veterans—medical, social, and moral. This approach—a comprehensive treatment model that includes the necessity of rebuilding self-worth and a family dynamic that accommodates the limitations of disability, for as long as is required (to include the veteran's lifetime)—is what the American veteran health care policy should work toward achieving, instead of the "treat them, follow-up for a year, and leave them" policy that is the current reality for Cpl. Poole, Sgt. Emme, SSgt. Pepper, and Spc. Wilson, detailed above.

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[116] *Id.*
[117] *Id.* at 25-28.
[118] *Id.* at 28-29.
[119] *Id.*
[120] *Id.* at 32.
[121] Katz & Florian, *supra* note 95, at 35-37.

V. DISREGARDED STATUTORY MANDATE–UNMET NEEDS

American Veterans receive their medical benefits, in part, through a corollary to the Medicare-type national health care system known as TRICARE.[122] The statutory purpose is stated as follows:

> The purpose of this chapter is to create and maintain high morale in the uniformed services by providing an improved and uniform program of medical and dental care for members and certain former members of those services, and for their dependents.[123]

Despite this clear mandate in the funding statute for veteran health care delivery, the following discussion underscores the reality that OIF TBI veterans are suffering from the under-funding and resultant short-staffing at the very treatment centers that are receiving the injured veterans.

A recent publication of the *Military Medicine* medical journal included "lessons learned" from the *beginning* of the war.[124] In the area that is critical to cognitive rehabilitation, occupational therapy, WRAMC had a team made up of two occupational therapists and two certified OTAs (occupational therapy assistants).[125] The article notes the number of Patient Visits to the department staffed solely by these overwhelmed technicians during the duration of the reference dataset: 2003[126]

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[122] 10 U.S.C. § 1071 (2006) *et seq.* TRICARE is the short-form identifier for the medical benefits program for members of the armed forces (basic reference is to army, navy and air force, but includes the specialized forces as well), and their dependents . *See* discussion at Section VI. A. 1. *infra.*

[123] 10 U.S.C. § 1071. Additional coverage is provided under the Veterans Benefits Statutes. *E.g.* 38 U.S.C. § 1701, *et seq.*

[124] The March 2006 issue of Military Medicine included a four-part analysis of the protocols for the assessment and treatment of incoming wounded at WRAMC during 2003. The manuscript was received for review by the journal in October 2004, about a year after the data, and was accepted for publication in April 2005. It was actually published in March 2006, about three years after the data was gathered. William C Doukas *et al., Process of Care for Battle Casualties at Walter Reed Army Medical Center: Parts I, II, III, IV*, 171 MILIT. MED. 200 (2006).

[125] William C. Doukas & William J. Howard, *Process of Care for Battle Casualties at Walter Reed Army Medical Center: Part IV, Occupational Therapy Service*, 171 MILIT. MED. 209, 210 (2006).

[126] *Id.* at 210.

April	May	June	July	Aug.	Sept.	Oct.	Nov.
Amputees:							
62	71	88	125	198	171	269	220
Total OIF/OEF:							
175	226	277	289	308	382	424	39

These numbers are excessive for a total staff of four and the article notes, "the staffing in April and May was clearly inadequate to handle the volume and intensity of patient care. The complex nature of war/battlefield cases requires a higher level of individual attention for each patient."[127] The solution: authority to hire three additional contract staff personnel—two to service the amputees and one for general inpatient rehabilitation. In April, the service received two reserve therapists, making a total of nine therapists with four dedicated to amputee care, to serve a growing population of veterans with TBI at WRAMC.[128] Despite this data that establishes the inadequacy of the therapist-patient ratio, albeit from 2003, the article notes that the medical team treats the wounded "from the battlefield back to the medical center, with transition back to active duty or to the Veteran's Affairs system to assist with mainstreaming these men and women back into the workforce as productive members of society."[129] As noted previously, the follow-up care after discharge from a DVBIC site is one year; that is inadequate for an injury that the VA has noted results in "life-long physical, cognitive, behavioral, emotional and social impairments and disabilities," and therefore, admittedly requires life-long continuity of care for the patient and the support caregivers at home.[130]

Given the neurophysiology, the neuropsychology, the epidemiology, the individual cases presented, the mandate in the statute, and the published statements by physicians who have treated these patients, there is a basic disconnect between the concluding passage in the *Military Medicine* journal article and the reality of what life is for OIF TBI veterans. Dr. Helene K. Henson, rehabilitative care chief at the Houston DeBakey VA Hospital has noted: "[w]e have very young guys and gals coming back with severe injuries that will likely have a lifelong effect . . . The cost is still anybody's guess."[131] The

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[127] *Id.*
[128] *Id.*
[129] *Id.*
[130] *TBI – Traumatic Brain Injury*, *supra* note 96.
[131] Rosanna Ruiz, *supra* note 9.

DVBIC indicates in its website that it is dedicated to developing "evidence-based standards of care" and "assessment" and "follow-up care after blast-related TBI within the military environment."[132] However, the concerns about failure to diagnose and/or misdiagnose noted above, from the Director of the DVBIC Dr. Deborah L. Warden and other specialist physicians at DVBIC centers, indicate that all three goals: standard of care assessment (accurate diagnosis and appropriate referral), standard of care treatment (given what is known about cognitive rehabilitation for TBI: continued no-cost therapy to maximal rehabilitation even if it takes longer than two years), and standard of care continuity of treatment (life-long access to care for life-long impairment) have *not* been met. Further, if the DOD casualty counts are accurate,[133] and Dr. Warden is correct about the prevalence at 67%, then the *conservative* number of OIF TBI veterans who have not been provided standard-of-care TBI medical treatment is 5,889.[134] Clearly, the current policy on health care delivery to these national heroes is ineffective and requires an "about face" review to ensure that each and every veteran is appropriately assessed, referred, rehabilitated, and provided life-long no-cost continuity of medical care for him/herself and assistance to his/her caregivers.

The viability of adequate ongoing effective treatment for these veterans is dependent on funding. However, the principal source of funding for research and coordination of referral and self-advocacy for TBI programs is the 1996 Traumatic Brain Injury Act.[135] For Fiscal Year 2006, the Bush administration and Congress provided only level funding for this program that went to the Centers for Disease Control (CDC) to track the incidence and prevalence of TBI, with implementation of state reporting and no funding for the Health Resources and Services Administration (HRSA) to coordinate, expand and enhance service delivery to TBI patients; and for the National Institutes of Health (NIH) to conduct research on TBI, all of which directly or indirectly benefit the services provided by the DVBIC to

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[132] DVBIC website, http://dvbic.org.

[133] Included in chart as of August 1, 2006 to be n= 8,789, *supra.*

[134]This number is "conservative" because it does not include the percentage of the misdiagnosed/undiagnosed.

[135] Public Law 104-166 of 1996 authorized states' surveillance reporting to the CDC (Centers for Disease Control) regarding the incidence of TBI to facilitate the CDC's report to Congress on the incidence, severity, associated disabilities and prevalence of TBI. The report is available at http://www.cdc.gov/ncipc/tbi/tbi_congress.htm (last visited March 19, 2008).

OIF TBI veterans.[136] President Bush's Fiscal Year 2007 budget had reduced funding for the CDC TBI programs and no appropriations for HRSA programs outlined under the 1996 Traumatic Brain Injury Act.[137] This cessation of funding for a statute that benefits these severely and permanently impaired veterans is a direct contravention of the statutory mandate under TRICARE and evidences the skewed reality of the Bush administration in this area.

An editorial writer for *The New York Times* noted a conversation between Ron Suskind[138] and a top aide at the White House that appeared in a Sunday *New York Times Magazine* article. The aide advised Mr. Suskind that a previous article he authored had made the White House "unhappy": "[t]he aide said that guys like me were 'in what we call the reality-based community,' which he defined as people who 'believe that solutions emerge from your judicious study of discernible reality . . . That's not the way the world really works anymore. We're an empire now, and when we act we create our own reality.'"[139] President Bush used his power to send troops into Iraq, and the reality is that the great majority of the veterans are returning with life-long TBI that is not adequately assessed, treated, or provided continuity-of-care, as possible under the Israeli model presented.[140] As noted above, Dr. Drazen stated the moral responsibility for OIF TBI veterans succinctly: "These men and women have given their best efforts for their country; we owe them nothing less."[141] Given the evidence presented herein, as to the initial question posed: whether these heroes are being returned to their highest possible functioning through adequate medical treatment (standard of care met as to diagnosis, assessment, treatment/rehabilitation and continuity of care), the answer is a resounding, "No."

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[136] Brain Injury Association of America, *Traumatic Brain Injury Act Reauthorization & FY 2006 Appropriations, available at* http://www.biausa.org/word.files.to.pdf/good.pdfs/advocacyweek2005/reauthorizationTBIact4-8x11new.pdf.

[137] Brain Injury Association of America, *Traumatic Brain Injury Act Appropriations, available at* http:// www.biausa.org/word.files.to.pdf/govfactsheets/appropriations.2006.3.pdf.

[138] A noted writer for THE NEW YORK TIMES.

[139] Bob Herbert, *Bush's Blinkers*, N.Y. TIMES, October 22, 2004, at 23

[140] *See* discussion as to lack of funding for TBI, *supra.*

[141] Drazen, *supra* note 49.

VI. ALTERNATIVES FOR VETERAN COMPENSATION

TBI veterans clearly merit special attention and compensation, medical and economic, due to their permanent heroic sacrifice. The issue to be discussed hereafter is what, if any, are the possible avenues for such compensation? The initial inquiry in Section VI examines the various statutes applicable to veteran injuries resulting from negligent (inadequate or absent) medical treatment and is followed in Section VII with a discussion of the development of the judicial interpretation of those statutes with regard to the *Feres* Doctrine bar to monetary recovery. The *Feres* Doctrine refers to a line of U.S. Supreme Court cases that have addressed the availability of Federal Tort Claims Act (FTCA) compensation for injured servicemembers, and have generally held that the statute is very limited and bars most claims by injured military personnel. Section VIII presents legal arguments why the *Feres* doctrine bar does not and should not apply to these claims. Finally, the analysis will conclude with the Constitutional and democratic policy considerations that require a prompt resolution of this irrational situation for those to whom America owes so much.

A. Statutory Scheme

One of the rationales for the *Feres* bar to recovery in a long list of cases is the consideration of "enactments by Congress which provide systems of simple, certain, and uniform compensation for injuries or death of those in armed services."[142] Before a FTCA suit can be filed, an administrative claim must be pending before the particular agency, in this case the Department of Veterans Affairs, for at least six months.[143] Each federal agency covered by the FTCA has the authority to promulgate its own procedural regulations for the administrative claims, as long as they follow those established by the Attorney General under the act.[144]

A 1985 study by the Administrative Conference of the United States found that the administrative process required prior to judicial filing in fact is a major hurdle that prevents the majority of such claims from further litigation.[145] One of the problems that the study revealed

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[142] Feres v. U.S., 340 U.S. 135, 144 (1950).
[143] 28 U.S.C. § 2675 (2006).
[144] 28 U.S.C. § 2672; 28 C.F.R. § 14.1 *et seq.*
[145] George A. Berman, *Federal Tort Claims at the Agency Level: the FTCA Administrative Process*, 35 CASE W. RES. L. REV. 509, 510 (1985).

was that the Justice Department routinely presented its jurisdictional defense in FTCA actions couched in terms of technical regulatory, not statutory defects, despite the particular agency's administrative merits denial of the claim.[146] In sum, this investigation for Congressional reporting on administrative processing of claims found that the system was "inchoate," even given the clear policy directive to favor fair compensation for legitimate tort claims.[147] Cumbersome as it may be, claimants must initiate the administrative claims process and wait six months before filing their claim under the FTCA in the district court.

The following are the basic veterans' benefits statutes.

1. Tricare Statute

The military medical benefits statute was initially enacted in 1956 and the legislative intent is clear:

> The purpose of this chapter is to create and maintain high morale in the uniformed services by providing an improved and uniform program of medical and dental care for members and certain former members of those services, and for their dependents.[148]

The statute is unequivocal in making a direct connection between the "morale in the uniformed services" and the availability of "an improved and uniform program of medical and dental care" for the military and their dependents.[149] This is a subscription health maintenance program for active duty and retired military and their families.[150] The benefits under this statute are provided by the Department of Defense.

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[146] *Id.* at 661.
[147] *Id.* at 658-59.
[148] 10 U.S.C. § 1071.
[149] *Id.*
[150] The military are insured under TRICARE, whereas the dependents' system is called CHAMPUS.

2. Veterans Benefits Program

For those military who are not still in active duty, but "who *served* in the active military, naval or air service," and who have been "discharged or released therefrom under conditions other than dishonorable," there is separate coverage under the Department of Veterans Affairs.[151] Technically, when the military servicemen have been given this "discharge or release" they are also considered "retired" from "active" or full-time duty.[152] Under this benefits statute, the veterans are eligible for hospital, nursing home and extended home care (when funded), if they have a disability that was "incurred or aggravated in the line of duty."[153] "Line of duty" is defined as requiring that the veteran, "was, at the time the injury was suffered or disease contracted, in active military, naval or air service, whether on active duty or authorized leave."[154] The statutory definitions establish that for the Iraq veterans who are processed through the Department of Veterans Affairs hospital system, initially through WRMC, have been "discharged or released," and therefore at the time of their medical care are not in "active" duty status, a critical demarcation line under *Feres*, which has barred active duty injuries claims. These veterans would be eligible for either or both disability compensation benefits and disability pension (total and permanent disability).[155] The statute includes provision of additional disability benefits for "an injury, or an aggravation of an injury, as the result of hospitalization, medical or surgical treatment" through the Veterans Administration.[156] A section in the statute allows for a "qualifying additional disability" if the disability was proximately caused by "carelessness, negligence, lack of proper skill, error in judgment, or similar instance of fault on the part of the Department in furnishing the hospital care, medical or surgical treatment, or examination."[157] The filing of this VA administrative claim is a pre-requisite to filing under the FTCA.

There is an uncertainty and delay to these VA administrative claims. The procedure involves an administrative claims presentation,

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[151] 38 U.S.C. § 101 *et seq.*, § 101(2). (emphasis added)
[152] 38 U.S.C. § 101(18), (21).
[153] 38 U.S.C. §§ 1710(a)(2)(B), 1710A, B.
[154] 38 U.S.C. § 105(a).
[155] 38 U.S.C. § 1101, *et seq.*; 38 U.S.C. § 1501, *et seq.*
[156] 38 U.S.C. § 351.
[157] 38 U.S.C. § 1151(a)(1)(A).

review, hearing, determination, further review and appeal, which is cumbersome, with limited potential attorney's fees.[158] The outcome ultimately lies entirely with the factual determination of the agency regarding the underlying claim.[159] The U.S. Court of Appeals for Veterans Benefits reviews the VA claims under a "clearly erroneous" standard of the interpretation of the statutes and regulations in the claim, but not of the facts or the rates determinations.[160] Further appeal is to the U.S. Court of Appeals for the Federal Circuit.[161] As discussed below, the process is particularly unsettling given that this cohort of veterans is under a mental disability and any such benefits received are subject to set-offs by any additional source of benefits.

3. Military Claims Act

A provision in the Armed Forces title of the US Code allows for a $100,000[162] award for "personal injury" that is either caused by a civilian officer or employee of the armed forces, "acting within the scope of his employment," or "otherwise incident to noncombatant activities" of the department.[163] This administrative claims procedure is meant to complement the FTCA, as it covers claims not covered by

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[158] The Court had upheld as reasonable and constitutional the $10 allowable attorney fees payable for the VA hearings, which has been in place since inception. *See,* Walker v. Radiation Survivors, 473 U.S. 305 (1985). Subsequent to that case, the Judicial Review of Veterans Claims Act was enacted, that granted the review jurisdiction under Article 1 to the United States Court of Appeals for Veterans Claims. 38 U.S.C. § 7292. Currently, the attorney's fees provisions in the statute allow for payment of a contingent fee up to 20 percent of the past-due benefits received after the successful completion of the claim. 38 U.S.C. § 5904

[159] *See,* 38 U.S.C. § 7101 *et seq.* (Board of Veteran's Appeals).

[160] 38 U.S.C. §§ 7251, 7261. For a perspective of the range of pension award possible, and given that these veterans have been discharged under disability prior to the requisite 20 years of service, the computation is based on the following formula: [Average monthly Base Pay for last three years of service] X [Years of Service] X 2.5% - [1% for each year of service under 30 years]. In addition, as of 2004, the base pay ranges from $900 per month for privates (< 2 years of service) to $10,000 (4-star generals). DAVID CLAYTON CARRAD, THE COMPLETE QDRO HANDBOOK (2nd ed. Chicago: ABA 2004).

[161] 38 U.S.C. § 7292(c) (challenges to validity or interpretation of statutes and regulations; interpretation of provisions as prescribed in 28 U.S.C. § 2072).

[162] 10 U.S.C. § 2733(d). An additional "meritorious" amount in excess of $100,000 may be submitted to the Secretary of the Treasury under 31 U.S.C. § 1304.

[163] 10 U.S.C. § 2733(a)(3) (applies to acts by members, or civilian officers or employees of the Army, Navy, Air Force, Marine Corps, or Coast Guard).

the FTCA.[164] The act covers the Army, Navy, Air Force, Marines, Coast Guard, and Department of Defense. Whereas the FTCA covers negligent acts or omissions, the Military Claims Act covers two types of claims: (1) those arising out of noncombatant activities, whether negligent or not; and (2) negligent acts performed within the scope of employment of the military.[165]

4. Medical Claims Act

The waiver of claims for medical negligence under the FTCA is exclusive under that act.[166] The Armed Forces title provides that any medical negligence claim brought against a health care provider employed or contracted by the Department of Defense is subject to removal and re-filing under the FTCA as against the United States, with the defense under the Attorney General.[167] This statute also expressly states that the FTCA exception under 28 U.S.C. § 2680(h)[168] shall not apply to claims arising out of negligent health care, including "related health care function" (including clinical studies and investigations).[169] Under this provision, the excepted claims as to assault, battery and misrepresentation, are all potentially available, despite § 2680(h) in the FTCA, if the claims, such as for these veterans, entail claims of "negligent or wrongful act or omission" of military health care providers.[170] The statute allows for remand should the U.S. district court determine on motion that the claims do not fall under this statute.[171]

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[164] 28 U.S.C. §§ 1346(b), 2671 *et seq.* *See e.g.,* Ward v. U. S., 331 F. Supp. 369, 370 (W.D. Pa. 1971), *rev'd on other grounds*, 471 F.2d 667 (3d Cir. 1973).

[165] 10 U.S.C. § 2733.

[166] 10 U.S.C. § 1089(a).

[167] 10 U.S.C. § 1089(b), (c).

[168] In the "Exceptions" or exclusions from coverage section of the FTCA, the following is included:

(h) Any claim arising out of assault, battery, false imprisonment, false arrest, malicious prosecution, abuse of process, libel, slander, misrepresentation, deceit, or interference with contract rights:. . .

28 U.S.C. § 2860(h).

[169] 10 U.S.C. § 1089(e).

[170] 10 U.S.C. § 1089(a), (e).

[171] 10 U.S.C. § 1089(c).

5. Federal Tort Claims Act (FTCA)

In 1946, the initial codification of the waiver of sovereign immunity under specific claims, now the FTCA, recognized that some acts of the government should be available for redress.[172] The waiver and federal court jurisdiction of tort claims for the negligent actions of federal employees is exclusive.[173] This statute makes state negligence actions available as against federal employees, with specific procedural and substantive limitations.[174] Generally, there are six facets to claims available under the statute: (1) for money damages only, (2) for damages to property, personal injury, or death, (3) for injuries caused by either a negligent or a wrongful act, (4) for injuries caused by a federal employee, (5) for injuries resulting from a federal employee acting within the scope of employment, and (6) for injuries under circumstances that would place liability on a private person under state law.[175] The act specifically provides that the military services are included, that members of the military or naval forces are employees of the government, and that the reference in the act to "acting within the scope of his office or employment" triggering liability, when applied to the military, means "acting in the line of duty."[176] The award, if any, is for compensatory damages only, despite the availability of exemplary damages under the state law, which is preempted.[177] All FTCA claims are bench trials.[178] As noted in the preceding section, medical malpractice actions for these veterans would fall under the FTCA scheme. A serious complication is presented, however, in the "exceptions" for the waiver of immunity, which includes a bar against "[a]ny claims arising out of the combatant activities of the military or naval forces, or the Coast Guard, during time of war."[179] As stated above, procedural prerequisite to filing under the FTCA in the district court is the presentation of the claim to the appropriate federal agency

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[172] 28 U.S.C. §§ 1346(b), 2671 *et seq.*
[173] 28 U.S.C. §§ 1346(b), 28 U.S.C. § 2879
[174] 28 U.S.C. §§ 2671-2680.
[175] 28 U.S.C. § 1346(b)(1).
[176] 28 U.S.C. § 2671.
[177] 28 U.S.C. § 2674.
[178] 28 U.S.C. § 2402. (Tax cases are available for jury trial on request).
[179] 28 U.S.C. § 2860(j).

for disposition, with a six-month deadline for disposition by the agency prior to the filing.[180]

B. Statutory Construction

Adequate compensation for OIF TBI veterans, as evidenced by the statutory scheme discussed *supra*, can be addressed under various statutes, depending on the particular facts of the claim presented. A proper analysis of the claim requires not only identification of the applicable statute or statutes, but also of the intended purpose of the statute and its effect on the claim. The exclusive remedy status of the FTCA, for other than "ratings" compensation under the veterans benefits statute, forces a focused look at its language, together with the judicial interpretation of that language.[181]

Statutory construction is the province of the judiciary, and possible avenues for additional OIF veteran relief lie within the weaving of the holdings on the FTCA by the judiciary. The development of an effective presentation of claims under a particular statute involves a review of previous opinions, particularly those issued by the United States Supreme Court for the federal statutes discussed herein, specifically the Court's interpretation of the statutory language in cases based on the FTCA.

In a decision involving claims in excess of $200 million due to the explosion of a ship loaded with fertilizer at the behest of the government for aid to foreign nations post-World War II, the Court examined the legislative history of the FTCA in detail.[182] The Court tracked the increase of the private claim bills,[183] the historical grant of jurisdiction from the Court of Claims to the district courts, together with the realization by the Seventy-Seventh Congress that during the preceding eighty-five years, a total lack of coverage for "common law" type of torts resulted from the wrongful actions of government officers or employees.[184] The statute included exceptions, now §§ 2860(a) through (n) as amended over time. The Court noted that the exceptions clarified the legislative intent and therefore should be carefully

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[180] 28 U.S.C. § 2675. For these claims, the initial tort claim would be filed with the Department of Veterans Affairs.
[181] 28 U.S.C. § 2679(b)(1).
[182] Dalehite et al. v. U.S., 346 U.S. 15 (1953).
[183] Prior to the FTCA, claims against the U.S. had to be presented for approval to the Congress under the "private bills' process, due to sovereign immunity.
[184] *Dalehite*, at 24-25.

regarded: "[i]n interpreting the exceptions to the generality of the grant, courts include only those circumstances which are within the words and reasons of the exception."[185] The Court further noted that:

> So, our decisions have interpreted the Act to require clear relinquishment of sovereign immunity to give jurisdiction for tort actions. n25 Where jurisdiction was clear, though, we have allowed recovery despite arguable procedural objections.[186]

The footnote in the quoted section included a distinction between the Court's previous holdings in *Feres*, which involved injuries to servicemembers "while on active duty," and the holding in *Brooks*, which was for "non-service disabilities."[187] This distinction is significant herein, because the OIF TBI veterans, who have been processed through two or three previous triage stations before arriving at WRMC, cannot be held to be "on active duty," which has been the bright-line demarcation by the Court under the *Feres* Doctrine.

In a later opinion, which included references to the FTCA construction under *Dalehite* and *Feres*, the Court stated:

> The broad and just purpose which the statute was designed to effect was to compensate victims of negligence in the conduct of governmental activities in circumstances like unto those in which a private person would be liable and not to leave just treatment to the caprice and legislative

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[185] *Id.* at 30-31.

[186] *Id.* at 31-32. The footnote states:

> In *Feres* v. *United States*, 340 U.S. 135, this Court held that the Act did not waive immunity for tort actions against the United States for injuries to three members of the Armed Forces while on active duty. The injuries were allegedly caused by negligence of employees of the United States. The existence of a uniform compensation system for injuries to those belonging to the armed services led us to conclude that Congress had not intended to depart from this system and allow recovery by a tort action dependent on state law. Recovery was permitted by a service man for nonservice disabilities in *Brooks* v. *United States*, 337 U.S. 49. In *United States* v. *Spelar*, 338 U.S. 217, we held that our courts did not have jurisdiction to try a tort action for injury by a federal employee to a complainant because of an accident at our air base in Newfoundland. This conclusion was reached because of the exception, § 2680(k), of "Any claim arising in a foreign country." The sovereignty of the United States did not extend over the base.

Id. at 31, fn 25.

[187] *Id.*

> burden of individual private laws. Of course, when dealing with a statute subjecting the Government to liability for potentially great sums of money, this Court must not promote profligacy by careless construction. Neither should it as a self-constituted guardian of the Treasury import immunity back into a statute designed to limit it.[188]

The Court found that the Government had induced public reliance on its maintenance of the light in the lighthouse, and that its negligent care resulted in liability to those who had relied on its proper operation and had suffered harm.[189] Therefore, under "hornbook tort law," the statutory "under like circumstances" required that since the Government undertook the duty to warn the public, inducing reliance, it must perform the "'good Samaritan' task in a careful manner."[190] In a very recent FTCA case, the Court affirmed the *Indian Towing* "private person" standard and also included the very same reference to "hornbook tort law" that the inducement of reliance requires careful performance of the action undertaken.[191] It cannot be disputed that the OIF TBI veterans placed total reliance on the VA physicians to provide diagnosis and treatment that adequately correlates to the standard of care required of private physicians, and if these veterans have been denied such standard of care medical treatment, these authorities strongly support veteran claims under the FTCA for such medical malpractice under the *Indian Towing* "private person" standard.

C. Legislative Intent

The Court has held that the waiver to sovereign immunity under the FTCA should not be extended by the Court beyond the Congressional intent in the statute, and further, that the Court should not "assume the authority to narrow the waiver that Congress intended."[192] After *Kubrick,* the Court held that absolute immunity did

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[188] Indian Towing Co., v. United States, 350 U.S. 61, 68-69 (1955)(holding FTCA covered damages resulting from improper maintenance of lighthouse light by Coast Guard).

[189] *Id.* at 69.

[190] *Id.* at 64-65.

[191] United States v. Olson, 546 U.S. 43, 46-47, (2005).

[192] U.S. v. Kubrick, 444 U.S. 111, 117-18 (1979) (stating accrual under 28 U.S.C. § 2401(b) of medical malpractice benefits claim under 38 U.S.C. § 351) (citing Soriano v. U.S., 352 U.S. 270, 276 (1957); Indian Towing v. Untied States, 350 U.S. 61, 68-69 (1955)).

not shield official functions from state law tort liability unless the actions were within the official's duties and were discretionary in nature, and further, that the extent to which federal employees have official immunity is "to be formulated by the courts in the absence of legislative action by Congress."[193] Congress lost no time in responding to the Court's declaration, and enacted the Federal Employees Liability Reform and Tort Compensation Act of 1988, popularly named the Westfall Act.

> (b) Purpose. It is the purpose of this Act [amending generally 28 U.S.C. §§ 2671 *et seq.*. . .] to protect Federal employees from personal liability for common law torts committed within the scope of their employment, while providing persons injured by the common law torts of Federal employees with an appropriate remedy against the United States.[194]

Not only did Congress clarify its statutory intent by removing the *Westfall* "discretionary" requirement, it increased the scope of the FTCA to apply to employees of the legislative and judicial branches, in addition to the previously covered executive branch employees. Government employee status for regular medical personnel of the Veterans Administration hospitals is well established; government employee status is also applied where physicians hold hospital positions with the VA's consent, creating reliance by the patients that VA agents are the care providers.[195] Under the authorities cited in the preceding section, the legislative intent should be construed to require FTCA coverage for OIF TBI veterans such as Cpl. Poole (standard of care requires on-going, lifetime rehabilitative care) and Spc. Wilson (standard of care requires timely, accurate diagnosis).

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[193] Westfall v. Erwin, 484 U.S. 292, 295 (1988).

[194] Federal Employees Liability Reform and Tort Compensation Act of 1988, Pub.L. No. 100-694, § 2, 102 Stat. 4563 (1988).

[195] Rufino v. United States, 126 F. Supp. 132 (S.D.N.Y. 1954); Gamble v. Untied States, 648 F. Supp. 438 (N.D. Ohio, 1986); Dishman v. United States, 93 F. Supp. 567 (D. Md. 1950).

D. Physician Employment Status

The status of the tortfeasor as a federal employee is critical under the "Purpose" language of the statute, since the intent was to cover torts by federal employees.[196] The Court has held that the issue of whether a VA physician should be considered an employee or contractor is based on the "strict control test," which turns on the principal's contractual authority "to control the physical conduct of the [alleged employee] in [the] performance of the contract."[197] However, the control test is inappropriate when the facts include the negligent acts of a physician under 38 U.S.C. §§ 4114, 4116. The requirement of strict control is untenable because the nature of the physician's work, involving medical judgment and medical ethics standards, would severely curtail the statutory immunity for both temporary (§ 4114) and permanent (§ 4116) VA physicians, in contravention of the statutory intent to provide all VA physicians personal immunity under the FTCA.[198] In addition, the source of physician compensation may not be controlling, such as residents practicing in the VA centers.[199] Therefore, for these OIF veterans, the issue of employment status of the VA physicians is inapplicable and should not act as a bar to their claims under the FTCA.[200]

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[196] Olson, 546 U.S. at 47.

[197] Logue v. United States, 412 U.S. 521, 528 (1973); United States v. Orleans, 425 U.S. 807 (1976).

[198] Quilico v. Kaplan, 749 F.2d 480, 482-487 (7th Cir. 1984); *Cf.* Lily v. Fieldstone, 876 F.2d 857, 859 (10th Cir. 1989) (status depends on intent of the parties, compensation arrangements, selection of patients, determination of schedule, and administrative support by agency).

[199] 38 U.S.C. § 7406 (2002); Ezekiel v. Michel, 66 F.3d 894 (7th Cir, 1995).

[200] Claims for medical negligence of VA physicians are subject to the FTCA under 38 U.S.C. §§ 7316 (2002) [Note: 38 U.S.C. § 4116 was repealed and § 7316 replaced it], and for medical negligence by physicians under the DOD, the referral to the FTCA lies under 10 U.S.C. § 1089 (1998).

VII. THE *FERES* LABYRINTH

A. *Brooks*

The FTCA was enacted to cut a big swath into sovereign immunity in all federal agency activity.[201] The statute includes an exception from compensation for "[a]ny claims arising out of the combatant activities of the military or naval forces, or the Coast Guard, during time of war," which is pertinent to this analysis.[202] After the passage of the FTCA, the Court granted the petition for writ of *certiorari* so that it could present the statutory interpretation for the exception from coverage granted to military activities.[203] The case involved three members of the Brooks family who were involved in a major collision with an army truck; one brother was killed, and the other brother and father were seriously injured.[204] The government was excepting to the claims by the brothers, as they were service members on furlough and therefore the accident claims were "incident to service," but the Court held that the claims were proper because the injuries were caused by an accident, which had no connection with the Brooks' army careers and was "not caused by their service except in the sense that all human events depend upon what has already transpired."[205] Touching on what would become a rationale in *Feres*, the Court held that the statutes that allowed service members to receive disability payments and survivor payments for their family did not indicate a purpose to thereby forbid FTCA claims.[206] The Court also held that the FTCA did not include a provision for election of remedies, but that it was meant as an additional remedy, with a set-off for other benefits received.[207] Despite the fact that the *Brooks* brothers were military and on leave, their claims were allowed because the injury was not a result of "combatant activities," since neither that exception nor

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[201] "As used in this chapter and sections 1346(b) and 2401(b) of this title, the term 'Federal agency' includes the executive departments, the military departments, independent establishments of the United States, and corporations primarily acting as instrumentalities or agencies of the United States, but does not include any contractor with the United States." 28 U.S.C. § 2671 (2002).
[202] 28 U.S.C. § 2680(j)(2006).
[203] Brooks v. United States, 337 U.S. 49 (1949).
[204] *Id.* at 50.
[205] *Id.* at 52.
[206] *Id.* at 53.
[207] *Id.* at 53-54.

the foreign situs exception applied.[208] The Court also noted that it was clear that the FTCA was intended to cover service member claims, as far as the "any claim" language, particularly because of the specific exception limitation for "combatant activities of the military or naval forces" and those "arising in a foreign country."[209] The Court has not overruled *Brooks*, despite the numerous opportunities to do so.

B. *Feres*

The year following *Brooks,* noting a split in the Second, Fourth, and Tenth Circuits, the Court refined that holding by disallowing the claims of three service men who were injured while on active duty, not on furlough, by other service members.[210] The *Feres* claim was a wrongful death due to quartering in faulty barracks that caught on fire; the *Jefferson* claim was based on medical negligence where a subsequent surgery, done after eight months, revealed that a prior surgery had left a towel 30 inches long by 18 inches wide, marked "Medical Department U.S. Army" inside the stomach; and the *Griggs* was a medical malpractice claim due to death during surgery.[211] The Court noted that each of the three cases involved service members on "active duty and not on furlough," and that the injuries resulted from actions of other service members.[212] These claims presented the "'wholly different case' reserved from our decision in *Brooks v. United States*, 337 U.S. 49, 52," thus effectively affirming *Brooks*' coverage for injuries incurred while on leave, and for activity not "incident to service."[213]

The Court presented two rationales for disallowing the three claims: (1) the 'distinctively federal character' of the relationship between the Government, the need for uniform compensation outside the differences in state tort laws, and the military and the lack of federal authority for claims "incident to service;"[214] and (2) the availability of other military compensation statutes, together with the lack of FTCA language allowing for a set-off adjustment. In addition, despite noting that the exceptions language included "combatant activities," "during

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[208] *Id.* at 51-52.
[209] *Id.*
[210] Feres v. United States, 340 U.S. 135 (1950).
[211] *Id.* at 136-137.
[212] *Id.* at 138.
[213] *Id.*
[214] *Id.* at 143-44.

time of war," and "arising in a foreign country," it disallowed any argument that such language would imply coverage for claims "arising from noncombatant activities in peace."[215] Even though it noted that "[t]he primary purpose of the Act was to extend a remedy to those who had been without," and that it was based on claims proper against a "private individual" that were "under like circumstances," it disavowed claims by a soldier for negligence because "no private individual has power to conscript or mobilize a private army," resulting in "no analogous private liability," which is an illogical argument given the legislative intent of the statute to waive immunity for federal activities.[216] Nevertheless, based on the foregoing, all three claims for injuries while on active duty were held barred; this is what is known as the *Feres* doctrine. As will be noted below, the two rationales ("incident to service" and "other compensation available") in *Feres* were augmented by a third rationale ("military discipline") in *Brown.*

C. *Brown*

Four years after *Feres*, the Court revisited this issue in a medical malpractice claim under the FTCA presented by a veteran.[217] The veteran had been injured while on active duty, requiring surgery on his left knee, but the knee continued to dislocate; subsequent repair surgery involved the use of a defective tourniquet, which resulted in permanent nerve injury and disability to the leg.[218] The Court distinguished the holding in this case from the *Feres* decision, because those claimants were all on active duty when the injury occurred, each of which was caused by other members of the military.[219] In addition, the Court cited to *Feres* for the proposition that:

> The peculiar and special relationship of the soldier to his superiors, the effects of the maintenance of such suits on discipline, and the extreme results that might obtain if suits under the Tort Claims Act were allowed for negligent orders given or negligent acts committed in the course of military duty, led the Court to read that Act as excluding claims of that character. *Id.*, at 141-143.[220]

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[215] *Id.* at 138.
[216] 340 U.S. at 140-142.
[217] United States v. Brown, 348 U.S. 110 (1954).
[218] *Id.* at 110-11.
[219] *Id.* at 111-112.
[220] *Id.* at 112 (citing *Feres* 340 U.S. at 141-43).

The Court held that *Brown* was governed by the holding in *Brooks*, not *Feres*, since despite the fact that the knee was initially injured while on active duty, the surgery causing the disabled leg occurred "after his discharge," when the claimant was not "on active duty or subject to military discipline.[221] The Court also noted that although Brown's medical treatment by the VA was "in the service," such a claim "is not foreign to the broad pattern of liability which the United States undertook by the Tort Claims Act."[222] Under the facts in *Brown* (medical negligence on a veteran by the VA physicians), the "negligent act giving rise to the injury in the present case was *not* incident to the military service, the *Brooks* case governs and the judgment must be *Affirmed.*"[223] Three justices dissented in this case, because of an oblique argument based on Equal Protection:

> To permit a veteran to recover damages from the Government in circumstances under which a soldier on active duty cannot recover seems like an unjustifiable discrimination, which the Act does not require.[224]

The statutory construction, legislative intent, and equitable underpinnings of the *Brooks* and *Brown* decisions would reappear in Justice Scalia's scathing dissent in *Johnson*, *infra* and provide significant support for claims under the FTCA by the OIF TBI veterans for medical negligence by the VA.

D. *Shearer*

Thirty-one years after the holding in *Brown,* the Court expounded on the rationale which it cited as included in *Feres*, but which was clearly stated in *Brown*: the "military discipline" rationale.[225] *Shearer* did not involve medical malpractice on a veteran, as in two of the *Feres* cases and as in *Brown*, rather, it involved a claim for negligent supervision by the Army for the death of Pvt. Shearer, who was kidnapped and killed by another Army private who had just been released to Fort Bliss from a German prison for manslaughter.[226]

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[221] *Id.*
[222] *Id.*
[223] United States v. Brown, 348 U.S. at 113 (emphasis in original).
[224] *Id.* at 114 (Black, J. dissenting).
[225] United States v. Shearer, 473 U.S. 52 (1985).
[226] *Id.* at 54.

The Court relied on the statutory exception to the FTCA for claims "arising out of assault or battery."[227] In *Shearer,* the Court noted the "peculiar and special relationship of the soldier to his superiors," citing to the *Feres* reference in *Muniz* and to *Brown.*[228] The Court disavowed any "bright-line rules," and required that each case "must be examined in light of the statute as it has been construed in *Feres* and subsequent cases."[229] Citing to its previous holdings in *Stencel* and *Chappell,* the controlling factors are: (1) whether the court will have to "second-guess military decisions," and (2) whether the claim "might impair essential military discipline," regardless of the location of the injury and off-duty status.[230] The Court also based its denial of the claim on the allegations as to military conduct, which were "essentially military judgments" that included "complex, subtle, and professional decisions as to the composition, training. . . and control of a military force."[231] The focus in *Shearer* was on the "military discipline" rationale. Medical negligence at VA medical centers on OIF TBI veterans is the result of negligent medical judgment and care, not military judgment, and therefore such rationale presents no bar to their FTCA claims.

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[227] *Id.* at 54-55 (citing 28 U.S.C. § 2860(h) (2006)).

[228] *Id.* at 57 (citing United States v. Muniz, 374 U.S. 150 (1963), quoting United States v. Brown, 348 U.S. 110, 112). (FTCA was available for negligent acts injuring federal inmates, including medical malpractice and negligent supervision).

In the last analysis, *Feres* seems best explained by the 'peculiar and special relationshjp of the soldier to his superiors, the effects of the maintenance of such suits on discipline, and the extreme results that might obtain if suits under the Tort Claims Act were allowed for negligent orders given or negligent acts committed in the course of military duty." [keep quotations as they were in the text]

Muniz, 374 U.S. at 162.

The *Muniz* Court also stated:

> "The Federal Tort Claims Act provides much-needed relief to those suffering injury from the negligence of government employees. We should not, at the same time that state courts are striving to mitigate the hardships caused by sovereign immunity, narrow the remedies provided by Congress. As we said in *Rayonier, Inc. v. U.S., supra, at 320,* 'There is no justification for this Court to read exemptions into the Act beyond those provided by Congress. If the Act is to be altered that is a function for the same body that adopted it."

Muniz, at 165-66.

[229] *Id.* at 57.

[230] *Id.*

[231] *Id.* at 58 (citing *Chappell v. Wallace* 462 U.S. 296, 302 (1983)) (quoting *Gilligan v. Morgan,* 413 U.S. 1, 10 (1973)).

E. *Johnson*

Two years after *Shearer*, in a case clearly distinguishable on its facts from the issue herein, the Court barred the claim of a widow for the death of her husband Coast Guard helicopter pilot, who was flown into a mountain while on a rescue mission, and while FAA controllers had positive radar control of the helicopter.[232] This decision is presented here because the Court reversed the *en banc* decision of the Eleventh Circuit that had affirmed the claim, and also re-visited the *Feres* doctrine. The Court presented a statement of the three *Feres* factors: (1) the federal relationship between the Government and the military; (2) the "no fault" compensation scheme under the Veterans Benefits statutes; and (3) the "military discipline" impact argument.[233] The Court stood firm on the *Feres* bar to injuries that "arise out of or are in the course of activity incident to service."[234] It denied that "military status" was crucial, but stated instead that the inquiry centered on "service-related injuries."[235] Of importance herein, the Court distinguished, but did not overrule *Brown*, thus validating it as precedent.[236] It also clearly shifted the *Feres* inquiry away from the first two rationales, noting "the effect of a suit on military discipline to be the doctrine's primary justification."[237] The Court noted that although *Feres* had been articulated for over forty years, Congress had never acted to remedy the possible "misinterpretations of its intent" in the *Feres* doctrine, although it did include a footnote cite to bills introduced to allow medical malpractice claims against the Government.[238]

This case is notable, since it is a 5-4 decision, with a stringent dissent by Justice Scalia, joined by Justices Brennan, Marshall, and Stevens. His dissent begins with the statement that the *Feres* rationales are judicial suggestions of "possible" valid exemptions for some military claims under FTCA, but that his reading of the statute results in an affirmative exclusion of any such exemption in the statute.[239] The

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[232] United States v. Johnson, 481 U.S. 681 (1987) (addressing the split in the circuits).
[233] *Id.* at 684 n2.
[234] *Id.* at 686 (citing *Feres*, 340 U.S., at 146).
[235] *Id.* at 686-688.
[236] *Id.* at 687 n7.
[237] *Id.* at 684.
[238] *Id.* at 686 (citing reference to H.R. 1161, 99th Cong. (1st Sess. 1985) and H.R. 1942, 98th Cong. (1st Sess. 1983).
[239] *Id.*, at 692 (Scalia, J., dissenting).

dissent analyzes *Feres* as presenting three rationales: (1) the lack of "parallel private liability;" (2) the discrepancy of state law controlling a "distinctively federal" relationship of the military to the government; and (3) the fact that Congress had already provided compensation and could not have intended additional recovery for injuries incident to service; in *Brown*, Justice Scalia noted that the Court added a fourth rationale: the interference with "military discipline."[240] In his view, none of the rationales justify the result under *Feres,* and only the first ("parallel private liability") had scant textual support in the statute, albeit that rationale was disavowed under *Rayonier* and *Indian Towing.*[241] The dissent stated that *Feres* is thus only sustained by "three disembodied estimations of what Congress *must* (despite what it enacted) have intended."[242] Justice Scalia cited repeatedly to *Brooks* and *Brown*, noting that they had never been expressly disapproved, as being in conflict with the holding in *Johnson* because those decisions recognized the validity of FTCA claims availability for the military, with the noted express exemption for "combat injuries."[243] In an oft-cited segment, Justice Scalia states:

> In sum, neither the three original *Feres* reasons nor the *post hoc* rationalization of 'military discipline' justifies our failure to apply the FTCA as written. *Feres* was wrongly decided and heartily deserves the 'widespread, almost universal criticism' it has received.[244]

Justice Scalia's eloquence cannot be improved upon, particularly given the factual circumstances of the OIF TBI veterans' potential FTCA claims and the unfairness of a *Feres* application to bar such claims under its extension in *Johnson.* But, as noted below, there are possible avenues, even under the *Feres* progeny.

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[240] *Id.,* at 694.
[241] *Id.*, at 694-95.
[242] *Id.,* at 695.
[243] *Id.,* at 697-699.
[244] *Id.* at 700 (citing In re Agent Orange Product Liability Litigation, 580 F. Supp. 1242, 1246 (E.D. N.Y.), appeal dism'd, 745 F.2d 161 (2nd Cir. 1984) (interlocutory appeal on government's motion to dismiss under *Feres* and *Cohen* doctrines denied).

VIII. DISTINCTION IN THESE MEDICAL NEGLIGENCE CLAIMS

A. OIF TBI Veterans' Duty Status–"Incident to Service"

In the *Feres* issue of "incident to service," the relevant distinction is between "active duty" status and service members who have been discharged or furloughed.[245] This clarification is crucial herein because of the expansion of the *Feres* bar to include medical treatment received by a soldier on "active duty."[246] The Eleventh Circuit granted re-hearing *en banc* and affirmed the FTCA claim of a solder on leave as not "incident to service." That court held that three factors should be considered in analyzing the applicability of the "incident to service" bar: the duty status of the service member, the place of the injury, and the activity pursued when the injury occurred, and if the totality of the circumstances indicate that the activity was not "incident to service," then *Feres* does not bar recovery under the FTCA.[247] The claimant in *Elliott* was allowed his claim because the court held it would be consistent with the prior circuit holdings, and also the Court's holding in *Brooks* and *Brown,* since the injury occurred while the claimant was on leave, in his apartment, as distinguished from the *Feres* claimants, who were injured while they were on active duty.[248]

The Fifth Circuit similarly allowed a claim when the service member was on temporary disability retirement leave (TDRL), since the medical hold on discharge was solely to provide medical examinations. Therefore, the claimant was not on "active" duty service and his widow could maintain her FTCA medical negligence claim.[249] However, the Fourth and Eleventh Circuits have held that TDRL does

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[245] *See* United States v. Persons, 925 F.2d 292, 296 n.6 (9th Cir. 1991) (noting that negligent medical treatment while off-duty but active is barred under *Feres*).

[246] Skees v. United States, 107 F.3d 421, 424 (6th Cir. 1997).

[247] Elliott v. United States, 13 F.3d 1555, 1560-61 (11th Cir. 1994).

[248] *Id.* at 1561-63. *See also* Wojton v. United States, 199 F. Supp. 2d 722, 734-35 (W.D. Ohio 2002) (allowing medical negligence claims for PTSD misdiagnosis as separate from benefits determination under *Brown*, pending trial determination as to military status at the time of injury).

[249] Harvey v. United States, 884 F.2d 857 (5th Cir. 1989). *See also* Cortez v. United States 854 F.2d 723 (5th Cir. 1988) (*Feres* bar did not apply to service member on TDRL and FTCA was available for widow's claim).

not mean that medical malpractice is not "incident to service," since the service member may not be actually discharged.[250] The Fifth Circuit has also couched the relevant inquiry as: "we conclude that the controlling fact in the case at bar is whether Bankston had been discharged from the service at the time of the alleged negligence or that his status was tantamount to being discharged for the purpose of asserting this claim."[251] The issue of no *Feres* bar due to TDRL or permanent disabled retired list (PDRL) is fact-intensive and fact-determinative because of the applicability of *Brown* as controlling.[252] However, due to the nature of their injuries, OIF TBI veterans (even if not yet formally discharged), would be on TDRL, and therefore their injuries while on "leave" status would allow their claims, despite *Feres*.

B. Failure to Diagnose and Misdiagnosis as Actionable Misrepresentation

A medical "diagnosis" is the determination of the nature of the patient's disease, distinguishing it from other disease.[253] The statements by Dr. Warden of the DVBIC regarding the "walking wounded" OIF veterans with TBI, together with the May 2006 GAO report to Congress of inadequate diagnosis/assessment of PTSD in veterans, indicate a significant incidence of undiagnosed or misdiagnosed brain injury. Significant to this issue, in a case involving negligent diagnosis and treatment at an army hospital, the Fifth Circuit held that the FTCA § 2680(h) "misrepresentation" exception[254] did not apply because the government had a duty to render proper care and a proper diagnosis, and therefore the failure to provide proper diagnosis and treatment presented a viable FTCA claim.[255] Likewise, the FTCA's § 2680(h) "misrepresentation" bar to claims under the FTCA did not apply where the government is charged with the duty of ascertaining facts as to medical diagnosis, and an additional duty to perform proper treatment together with the disclosure of such medical facts, therefore negligent performance of the diagnosis results in a failure to perform the additional duty of proper treatment.[256] Statutes

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[250] Berry v. United States, 772 F.Supp. 563, 564-65 (D. Kan. 1991).
[251] Bankston v. United States, 480 F.2d 495, 497 (5th Cir. 1973).
[252] Crumpler v. United States, 495 F. Supp. 266, 270-71 (S.D. N.Y. 1980).
[253] *See*, DORLAND'S ILLUSTRATED MEDICAL DICTIONARY at 458 (28th ed. W. B. Saunders Co., 1988).
[254] *See* discussion of the MEDICAL CLAIMS ACT, *supra* note 39.
[255] Beech v. United States, 345 F.2d 872 (5th Cir. 1965).
[256] Hungerford v. United States, 307 F.2d 99 (9th Cir. 1962).

providing that FTCA is exclusive remedy for medical negligence specifically state that the 2680(h) exception is inapplicable, resulting in official immunity for the medical personnel, but liability for the government under the FTCA.[257] The FTCA as a remedy in medical negligence injuries has been recognized. Claims based on false information regarding medical condition of a child patient were not barred because waiver was inapplicable in medical malpractice cases.[258] Actionable misrepresentation under 2680(h) included negligent preparation of a psychiatrist's patient status report resulting in his release and murder of his wife, in effect a tortuous failure by a government agency to disclose pertinent information, a violation of a medical duty imposed by law.[259] The clear intent and language of the Medical Claims Act that makes medical negligence claims based on misrepresentation available, despite the FTCA exemption, together with the judicial allowance of such claims leaves a clear path for the OIF TBI veterans to file their claims.

See Sen. Rep. No. 94-1264, *reprinted* in 1976 U.S.C.C.A.N. 4443, 4451 (noting that the Legislative history of 10 U.S.C. § 1089 explains the purpose of § 1089(e) is to:

> . . . nullify a provision of the Federal Tort Claims Act which would otherwise exclude any action for assault and battery from the coverage of the Federal Tort Claims Act. In some jurisdictions it might be possible for a claimant to characterize negligence or a wrongful act as a tort of assault and battery. In this way, the claimant could sue the medical personnel in his individual capacity norwithstanding subsection (a) simply as a result of how he pleaded his case. In short, subsection (e) makes the Federal Tort Claims Act the exclusive remedy for any action, including assault and battery, that could be characterized as malpractice.)

Sen. Rep. No. 94-1264.

See also Lojuk v. Quandt, 706 F.2d 1456, 1463 (citing Sen. Rep. No. 94-1264 [Not sure if this site is necessary if directly citing to the Sen Rep.]) *See also* Wright v. Doe, 347 F. Supp. 833 (M.D. Fla. 1972) (holding that the government may be liable regardless of the immunizing exceptions that would otherwise apply under the FTCA). *See also* 38 U.S.C. § 4116 (stating 28 U.S.C. §§ 1346(b), 2672 as the exclusive remedy).

[258] *See* Hill v. United States, 751 F. Supp. 909 (D Colo. 1990) (holding, as many courts have held, that the misrepresentation exception to the United State's immunity is inapplicable in malpractice cases under the FTCA). (citing Keir v. United States, 853 F.2d 398, 410-11 (6th Cir. 1988); Ramirez v. United States, 567 F.2d 854, 856-57 (9th Cir. 1977); Phillips v. United States, 508 F. Supp. 544, 547-48 (D.S.C. 1981); *see also* Hicks v. United States, 511 F.2d 407, 413-14 (D.C. Cir. 1975); Betesh v. United States, 400 F. Supp. 238, 241 (D.D.C. 1974)).

[259] Hicks v. United States, 511 F.2d 407 (D.C. Cir. 1975).

C. Tolling of Limitations

Although statutory construction militates for firm time limitations on FTCA actions,[260] the courts have allowed tolling of the statute where the government's negligence has rendered the service member incapacitated. In a case of a Vietnam veteran who was diagnosed with severe psychiatric illness, but was not given a neurological workup despite several hospitalizations that included electroconvulsive therapy, and died due to a brain tumor-induced coma,[261] the court allowed the FTCA claims, despite the intermittent treatment and length of time from discovery of the tumor.[262] The *Dundon* court cited to authority from a different circuit, which held that:

> We do not consider the insanity rule discussed in *Casias*[263] to be applicable to the present case . . . We say also that brain damage or destruction is not to be classified in the same way as ordinary mental disease or insanity for the purpose of barring such an action; that the incapability of the plaintiff to comprehend the elements of possible malpractice, if such existed or exists, should not bar the plaintiff from ever pursuing a remedy for violation of his rights.[264]

In *Dundon,* the court allowed the claims of misdiagnosis and negligent medical care to proceed based on the distinction between mental incompetence as a result of mental disease and mental incapacity due to organic brain damage. In a similar case involving an anti-depressant

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[260] *See* 28 U.S.C. § 2401(b) (2006) (stating that the statute of limitations for a tort claim against the United States is two years after such claim accrues). *See also* United States v. Kubrick, 444 U.S. 111, 123-24 (1979) (holding that a claim accrues when claimant has discovered, or with reasonable diligence should have discovered, the existence, permanence and physical cause of the injury, despite his belief that it is actionable).

[261] The VA physicians were attempting to insert a shunt, but the tumor exploded during surgery, spilling the tumor into his tissues, which was followed by further botched invasive surgery, from which he never recovered and died at the age of thirty.

[262] Dundon v. United States, 559 F. Supp 469 (E.D. N.Y. 1983).

[263] *See* Casias v. United States, 532 F.2d 1339, 1342 (10th Cir. 1976) (holding that mental incompetency does not toll limitations under 28 U.S.C. § 2401(b)).

[264] Ziedler v. United States, 601 F.2d 527, 531 (10th Cir. 1979) (noting that a VA patient with two lobotomy procedures was allowed to file claims through his conservator 29 years after the initial procedure).

overdose-induced coma, the court denied the limitations motion because the veteran was incapable of being aware of his potential claims.[265] Clearly, there is a recognition that VA patients, such as the OIF TBI veteran cohort herein, who have been either misdiagnosed, not diagnosed, or provided negligent medical care resulting in exacerbated organic brain damage, should be allowed special consideration under their specific circumstances upon filing of a FTCA claim.

XIII. POLICY IMPERATIVES

Policy, as embodied in our statutory scheme and the implementation through agencies and regulations, can only be reasonable if it is effective in addressing a social need. It is undeniable, from all of the first-hand reporting and statistics on OIF veteran TBI discussed above, that the situation of OIF veterans who are suffering from TBI is a significant public health issue and therefore, policy must be either adjusted from its current stance, or new policy must be implemented to ensure: (1) that every OIF veteran is appropriately screened for the injuries from TBI and PTSD, regardless of the physical presentation of their wound pattern, and (2) that every OIF veteran who is diagnosed with TBI is provided the adequate standard of medical care, including continued rehabilitation, social assistance, and home care assistance. Policy initiatives require dissemination of information so that the permanent disabilities of these American heroes are both acknowledged and addressed. There is an undercurrent of concern, beginning with the field surgeons who are performing the initial triage on these very young Americans, to the director of the DVBIC, Dr. Warden, for the "walking wounded." Americans must be made aware of what these thousands of families know—adequate care is required for the "walking wounded."

Two case studies have been previously presented, Cpl. Poole (OIF) and SubLt Zasetky. War stories are compelling, and the continued tracking of the wounded in the news is also compelling. Literature is often used to promote social change, and another notable work describes, with riveting detail, the incalculable cost and sacrifice of a permanently disabled veteran, this one from World War I.[266] The book is a novel, written in protest of the war and its casualties, and was such an effective anti-war piece that the author was one of the ten film

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[265] Clifford v. United States, 738 F.2d 977 (8th Cir. 1984) (noting that a VA physicians prescribed long-term Elavil without requisite re-evaluations).

[266] DALTON TRUMBO, JOHNNY GOT HIS GUN, (Bantam Books, 1989) (1939).

writers who was "blacklisted" during the McCarthy era. He was jailed, and then exiled in Mexico until Otto Preminger announced he had hired Mr. Trumbo to write the screenplay for *Exodus*. Much in the same way that *The Man With a Shattered World* is a first-person diary, *Johnny Got His Gun* is a first-person narrative. The protagonist, Joe, is a veteran who has been left with the inverse of these TBI veterans—he has no arms or legs, the front of his face is completely missing from his brow line to his trachea, and he cannot see, move, talk, swallow or care for himself in any way. However, his brain *does* function, and the book tracks his passage from initial recovery to utter desperation at the end of the novel.

As the narrative progresses, after years of mental exertion, he comes to the realization that the one way he can communicate is by nodding his head on the pillow, in Morse code. What he desperately wants is to communicate, to have the outside world realize that the costs of war are too great, and that there must be another way. When he is finally able to find someone to listen to him, he asks to be released to attempt to live his life as normal as possible with his family (they never appear at the hospital). He receives his answer tapped in Morse Code on his forehead: "What you ask is against the regulations."[267] In contrast, for the OIF TBI veterans, the statutory language clearly provides a FTCA remedy to this significant public health concern affecting thousands of families.

CONCLUSION

After the fiasco of the *Agent Orange* litigation that barred any additional compensation for the veterans under the *Feres* Doctrine, it is perceived that the pursuit of FTCA claims for these veterans would be futile. This author believes that the clear language of the statutes, together with the particular circumstances of the admittedly inadequate medical care provided to these thousands of young heroes and the various holdings, including *Brooks* and *Brown,* are sufficient to *compel* an attempt to process such claims and increase the compensation for their disabilities to a reasonable level, not one that is based solely on the VA ratings scales and their short term of active duty. At the very least, the filing of such claims will force the attention Americans-at-large on the problem, possibly requiring that the Traumatic Brain Injury Act be re-funded, and possibly compel Congressional action, such as

[267] *Id.* at 234-235.

was granted to the Gulf War veterans by special statute. It is difficult to improve on Justice Scalia's eloquence in addressing the lack of compensation for the family in *Johnson*:

> If our imposition of that sacrifice bore the legitimacy of having been prescribed by the people's elected representatives, it would (insofar as we are permitted to inquire into such things) be just. But it has not been, and it is not. I respectfully dissent.[268]

And, in the words of a physician-researcher:

"These men have given their best efforts for their country; we owe them nothing less."[269]

[268] *Johnson*, 481 U.S. at 703.
[269] Drazen, *supra* note 49 at 2121.