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CHEMICAL AND BIOLOGICAL DEFENSE

DOD Should Clarify Expectations for Medical Readiness

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Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to contribute to your hearing on medical preparations for chemical and biological defense. As the war on terrorism proceeds at home and abroad, the need for attention to these matters has become more urgent. My testimony today is based on our report on DOD's preparations for medical support for chemical and biological casualties.¹ In the report, which is being released today, we responded to your request that we determine how DOD had adapted its medical personnel to emerging chemical and biological threats. Specifically, we looked at how DOD and the services had addressed chemical and biological threats in the distribution of medical personnel across specialties. We also looked at the extent of training for medical personnel in the treatment of chemical and biological casualties.

Background

In June 1995, a Presidential Decision Directive declared that the United States would give the highest priority to developing effective capabilities to detect, prevent, defeat, and manage the consequences of terrorists' use of nuclear, biological, or chemical materials or weapons. In addition, the former Secretary of Defense emphasized, at his confirmation hearing in January 1997, that U.S. forces abroad face the threat of chemical and biological weapons. According to both DOD officials and U.S. government reports, chemical and biological warfare must be considered a potential threat in future conflicts.

The Office of the Secretary of Defense, the joint staff, and the armed services play distinct but interrelated roles in ensuring medical readiness. Defense planning is led by the Office of the Secretary of Defense. This office sets policy and develops Defense Planning Guidance. Based on this formal guidance, the Joint Chiefs issue a biannual Joint Strategic Capabilities Plan (JSCAP) that gives missions to the nation's unified combat commands. These commands have operational control of U.S. combat forces and are responsible for fighting and winning the nation's wars within a particular area of responsibility, usually defined by geographical boundaries. The commanders-in-chief develop war plans and requirements that specify the combat troops and support that will be needed to meet the threat and mission assigned by the Capabilities Plan.

¹ *Chemical and Biological Defense: DOD Needs to Clarify Expectations for Medical Readiness* (GAO-02-38, Oct. 19, 2001).

The services, in turn, train and equip the forces, including medical personnel, necessary to meet the needs of the commanders-in-chief. The tools available to the services for this purpose include various types of training and exercises.

DOD and the Services' Efforts to Incorporate CB Threats in Medical Personnel Planning Not Systematic

We found that neither DOD nor the services had systematically examined the current distribution of medical personnel across specialties with respect to adequacy for chemical and biological defense. This was so despite public assessments by defense officials that have emphasized the seriousness of the military threat from chemical and biological weapons. Although the services had begun to review the staffing of deployable medical units for chemical warfare scenarios, they had not done so for biological warfare scenarios. In general, DOD has not successfully adapted its conventional medical planning to chemical and biological warfare. For example, in medical planning, DOD has used software, evaluations, and review processes that address conventional threats, but that have not fully incorporated chemical and biological threats. In addition, medical planners have lacked the information on casualty rates or qualified medical personnel required to address the appropriateness of the current distribution of medical personnel across specialties. As recommended by DOD studies, joint protocols for treating chemical and biological casualties have recently been completed. But agreement has not been reached among the services on which medical personnel are appropriate to provide treatment for different casualties caused by chemical or biological agents.

DOD officials attributed the lack of systematic efforts to several factors. These included failure to establish chemical and biological readiness as a medical priority in Defense Planning Guidance (particularly for biological warfare), complex assumptions required to predict casualties, poor availability of data on the effects of particular agents, disagreements among the services about how quickly troops could actually be evacuated, and pessimism that medical personnel could effectively treat substantial numbers of chemical and biological casualties. Medical planners for the joint staff, unified commands, and the services—who are charged with addressing these issues—all expressed frustration with inaction on the part of others. For example, citing lack of input from the services, the medical planners for the unified commands had reluctantly, they said, adopted a rough method of estimating the medical support required for chemical and biological scenarios. Specifically, they had simply multiplied the medical support required for conventional scenarios by a fixed factor.

This method presumes that the individual medical units currently possess the appropriate distribution of medical personnel across specialties.

Extent of Medical Personnel Training Limited for the Treatment of CB Casualties

Following the Gulf War, both GAO and the DOD inspector general identified a number of shortcomings in DOD's capacity to provide medical treatment for the numbers of chemical and biological casualties that were predicted. In 1996, GAO observed that many of the problems identified in these reports persisted. In the review we report on today, we found that the extent of training, as well as testing and exercises, for medical management of chemical and biological casualties remains limited. Rather than adjusting the distribution of medical specialists, the services officials for medical planning maintain that specialized training in the military is the appropriate way to address any need for additional medical skills. However, while progress has been made since the Gulf War in increasing the availability of such specialized training, these courses are essentially voluntary. While training requirements for medical personnel generally incorporate instruction in such matters as donning chemical protective gear, only the Army includes an introduction to chemical and biological casualty management in training required of medical personnel. On the basis of the number of students who have taken the various specialized courses, we found that no more than a fifth of uniformed medical personnel had completed any specialized military medical training for chemical and biological casualties. Even medical personnel who had been trained could not be readily identified in the event of an emergency. This is because either the tracking systems do not exist or are not currently functioning. Except for the Army's Medic 2000 study—which found that the lowest proficiency scores among medics were for nuclear, biological, and chemical skills—the services have not defined standards for treatment of chemical and biological casualties nor tested the proficiency of medical personnel. The Army study and other indirect evidence indicate that the likelihood of chemical and biological casualties receiving proficient medical care remains low, due in part to weak or absent requirements for training, as well as testing and certification, of medical staff.

Medical planners from each of the five regional unified commands told us that, to their knowledge, no realistic field exercise of chemical or biological defense had been conducted. But the surgeons general from the services have begun integrating chemical and a few biological scenarios into their medical exercises. Additional data provided by DOD show that only two joint military exercises planned since 1993 had included both medical support activities and chemical or biological warfare. Similarly, key evaluations used to advise the President on readiness to implement

the national security strategy had never set a scenario for the unified commanders requiring medical personnel to respond to the effects of weapons of mass destruction. Officials told us that exercises involving medical support for chemical and biological casualties were rare because of conflicting priorities encountered by both warfighters and medical personnel and because of difficulty and expense.

Conclusions and Recommendations

In the years since Desert Storm, DOD and the services have not fully addressed weaknesses and gaps in planning, training, tracking systems, or tests of proficiency for the treatment of chemical and biological casualties. The resulting organization of medical personnel has not been rigorously tested for the capacity to deliver the required support. As a consequence, medical readiness for chemical and biological scenarios cannot be ensured.

Although we found efforts to plan and train for these threats, there is a wide and longstanding gap between DOD's appraisal of chemical and biological threats and DOD's medical preparedness to meet them.

We recommend that the Secretary of Defense address the gap between the stated chemical and biological threat and the current level of medical readiness by, first, clarifying DOD's expectations concerning medical preparation for chemical and biological contingencies and, second, as appropriate, incorporating biological medical readiness in Defense Planning Guidance. To the degree that DOD views chemical or biological contingencies as a serious threat and expects medical personnel to prepare for them, we also recommend additional actions:

First, the services and joint staff should conclude an agreement about which medical personnel are qualified to provide specific treatments. Without such an agreement, each service's medical model will continue to be based on different assumptions concerning which personnel are qualified to administer treatments. The results will therefore be neither comparable among the services nor readily defensible. This database should eventually be validated by proficiency testing of the identified personnel to help further refine requirements for training and distribution of medical personnel across specialties.

Second, the services should develop medical training requirements for chemical and biological contingencies, assess the effectiveness of the training with rigorous proficiency standards and tests, and track individual training and proficiency.

Third, the joint staff, commanders-in-chief, and the services should increase chemical and biological exercises involving medical personnel to an extent commensurate with current chemical and biological threat assessments. Given the threat of mass casualties, exercises should explore the extent of medical capabilities and the full consequences of scenarios that overwhelm them.

An additional recommendation and further information are included in our report.

Mr. Chairman, this concludes my statement. I will be happy to answer any questions you or Members of this Subcommittee may have.

Contacts and Acknowledgments

For further questions about this testimony, please contact Nancy Kingsbury, at (202) 512-2700. Other individuals making key contributions to this testimony include Betty Ward-Zukerman, Daniel Rodriguez, and Laurel Rabin.