Iraq War TBI Veterans Funding Remains Unmet

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Corporal Jason Poole’s story is now oft-repeated: traumatic brain injury (TBI) from a roadside bomb in Iraq, back in the states, learning how to speak and to walk all over again.¹ He is a 23-year-old Marine who is now blind in his left eye, deaf in his left ear, weak on his right side, with a “fickle” memory, and able to read “barely 16 words a minute.”² Corporal Poole’s injuries required the reconstruction of the entire left side of his face with grafts, plates, and 75 to 100 titanium screws. Although he has no recollection of the blast, three others with him were killed when the bomb went off. His skull was fractured in multiple places, with every bone broken in his face and his jaw pulverized. When it happened, he was on his third tour and only 10 days from coming home. He was in a coma for one month and 23 days. Since then, he has had not only to recover from all of the reconstructive surgeries, but also to learn how to speak, how to walk, and how to go through the daily routines, including taking three buses to travel back and forth to his therapy sessions at a Veterans Affairs center.³ With the help of his physicians, therapists, and family, Cpl. Poole is hoping to move on to college preparatory skills training and eventually to volunteer in teaching art therapy, children’s theatre, or social work, get married, and have a family of his own. Given a tremendous investment of medical, social, emotional, family, and mind-boggling financial resources, his hopes are realistic in the current health care system.

The U.S. Department of Defense publishes an on-line tabulation of American war casualties from the Iraqi and Afghan fronts in Operation Iraqi Freedom and Operation Enduring Freedom.⁴ One physician has noted that the figures represent “the largest burden of casualties our military medical personnel have had to cope with since the Vietnam War.”⁵ Tracking mortality/survival rates since World War II, the statistics indicate that, although the potency of munitions has increased, lethality has decreased. For example, the World War II mortality rate was 30%, in Vietnam it was 24%, but in Iraq and Afghanistan it has been only 10%. As of February 10, 2006, 2,270 U.S. military personnel have been killed in action in Iraq and Afghanistan, but 16,653 have been wounded in action, with 7,706 wounded not returning to duty within 72 hours.⁶

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¹ Denise Grady, Struggling Back from War’s Once-Deadly Wounds, N.Y. TIMES, Jan. 22, 2006, at 1.
² Id.
³ The headquarters of the Defense & Veterans Head Injury Program (DVHIP) is at Walter Reed Medical Center, Washington, D.C., with other seven sites in San Diego, CA (Naval Medical Center), Lackland AFB/Fort Sam Houston, Texas (Wilford Hall Medical Center/Brooke Army Medical Center), Tampa, FL (James A. Haley Veterans Hospital), Minneapolis, MN (Minneapolis Veterans Affairs Medical Center), Palo Alto, CA (Veterans Affairs Palo Alto Health Care System), Richmond, VA (Hunter McGuire Veterans Affairs Medical Center), and Charlottesville, VA (Lakeview Virginia NeuroCare, Inc.). Satellite clinics are located at Fort Bragg, NC and Camp Pendleton, CA.
⁵ Id.
Because Walter Reed Medical Center in Washington, D.C., is the primary clearinghouse for injured soldiers coming back into the states, the Department of Defense has studied the rate of TBI among admitted patients from 2003 to 2005, mainly Iraqi veterans: 59% were diagnosed with TBI, 56% moderate or severe and 44% mild.\(^7\) “Mild” TBI generally means a brief change in mental status or consciousness, whereas “severe” TBI means an extended period of unconsciousness, amnesia, and problems with independent function. For soldiers treated at the Defense and Veterans Brain Injury Center (“DVBIC”), treatment modalities include: neurological, neuropsychological, psychological, laboratory, psychosocial, audiologic, EEG, psychiatric, therapeutic recreation, and occupational/physical/speech/cognitive therapies.\(^8\) This translates into staggering costs of trained providers, equipment, and patient/family commitment. The DVBIC is unlike traditional TBI centers in that its mission is to serve veterans. The financial costs are met through a variety of programs within the U.S. Department of Veterans Affairs and the TRICARE military healthcare program.\(^9\) Many disabled veterans also qualify for Medicare due to their disabled status, with TRICARE funding continuing medical care not covered by Medicare.

The strain on health care delivery to survivors of TBI should be addressed by Congress. In 1996, Public Law No. 104-166, The Traumatic Brain Injury Act, was enacted to authorize state surveillance of the incidence, prevalence, and associated disabilities of TBI by the U.S. Centers for Disease Control and Prevention (“CDC”). The CDC published its data in 2003, before the Iraq War casualties could be included, and even then the numbers were staggering – an estimated $37.8 billion in 1985 alone.\(^10\) With the newest technologies and escalated costs, the numbers must necessarily be much higher, yet appropriations for programs that assist with TBI have actually declined in recent years.\(^11\) This places an undue burden on state disability systems, including those critical social service delivery mechanisms vital to the needs of the long-term TBI disabled, including growing numbers of Iraq War veterans. Informed health care professionals in all sectors should be actively participating in the democratic process of writing to their representatives in both houses of Congress, urging attention to this unmet health care policy issue. If the veterans with TBI have placed themselves in the line of fire for us, the least we can do is place ourselves in the line of communication to Congress to fund their continuing health care needs.

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\(^7\) Susan Okie, *Traumatic Brain Injury in the War Zone*, 352 NEW ENG. J. MED. 2043 (May 19, 2005). *See also* Gregg Zoroya, *Key Iraq Wound: Brain Trauma*, USA Today, Mar. 4, 2005, at 1A.

\(^8\) See Defense and Veterans Brain Injury Center, at http://www.dvbic.org/ (last visited May 6, 2006).

