

Witness statement of Chief Warrant Officer 4 James Stephen Keeton, Target Acquisition Officer, Headquarters & Headquarters Battery, 1st Battalion, 206th Field Artillery.

No one knows for certain what happened the night of 29 June, 2004—Al Taji, Iraq. Some say I was injured through inhalation of toxic rocket propellant from the crater analysis I was performing. Others say it was an illness precipitated by a combination of stressors. Still, others say it was overmedication for a thyroid condition. Whatever the reason, it changed the course of my life in a single moment. And, it allowed me the opportunity to see a side of the military few really want to know first hand—the system of caring for the wounded and injured from point-to-point

Initial evacuation from theater to Landstuhl, Germany: 06 2236 hours July 2004

From Al-Taji, Iraq through the 31st CSH in Baghdad and Balad, to Landstuhl Regional Medical Center in Germany, I witnessed great acts of caring and compassion. Professionalism could never be higher in any organization, for example, nurse Cpt. Jennifer Campbell, who supervised me for 14 hours while in Baghdad and carefully prepared IV ports in both arms, recording her name and the date and time on securing tape; medics on the flight crews; and flight nurse 1Lt. Paul Hodge, who rode with me all the way from Baghdad to Balad in blackout conditions as the Blackhawk flew nap of the earth to avoid the possibility of anti-aircraft fire. These personnel and others put their lives on the line hour after hour shuttling wounded or ill troops from medical facilities to ports of departure. Doctors, nurses, and technicians fly from Landstuhl to Iraq and back, only to rest a few hours and do it again continually care for those that cannot care for themselves.

Certainly, there were glitches in the system, typical things that go wrong no matter where. For instance, military personnel filmed actual in-flight medical emergencies without consideration of litter-bound patients. Also, there was the problem of becoming separated from much-needed baggage, only to have it disappear forever.

Landstuhl, Germany: 08 0900 hours, July 2004

Little needs to be added or critically evaluated about my stay there. By the time we landed, my heart had converted to normal rhythm, and I was freed from the litter to be treated as an outpatient. Landstuhl is a regional medical center, equipped and staffed as a triage hospital for casualties along with their local mission. Landstuhl's goal is to treat and stabilize soldiers for return to theater or stateside. Those awaiting transport or receiving care are housed in a World War II remodeled barrack—Kleber Hall. Administrative care after I was boarded at Kleber Hall was impressive. I was given additional military clothing and a stipend to purchase civilian clothing and was allowed recreational time.

It was during my two-week stay in this facility as I underwent diagnostics and chucked for transport stateside that I noticed the system unraveling somewhat. Mostly, it was difficult for the young, inexperienced service member. Why? Let's look backward at their assignment in Iraq. Good leaders continually assess their troops, looking for signs of stress, tension—small shifts from normal that signal coming troubles. Good leaders then take steps to correct those minute shifts before the mission is endangered. When a

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service member is removed from that environment, it is stressful, more so if the soldier is injured or ill. Those men and women no longer have a support group of peers; instead they are thrown into a system focused only on stabilizing and treating—not long-term care. The nature of that environment spells trouble for youthful service members who don't have the experience to understand and navigate the system to find answers to their questions or support for their emotional concerns. Once I remember stopping in the canteen at the medical center after a diagnostic test. I encountered two very young soldiers that were pretty well beaten up. One was in a wheel chair and the other, although bandaged from head to toe, was pushing the wheel chair. They were in line behind me before I noticed. When I noticed them, I asked what they wanted; they were looking for ice cream. Once their order was filled, I said I would buy, which they didn't want because they didn't want pity. "Look at the uniform, guys; I was there with you. We probably shared the same dirt. I have some money to spare before I'm transported, so the treat is on me—my pleasure, guys," I said. When they realized it wasn't pity that I was giving them but respect because of our common frame of reference, they began to share stories and their frustrations about not getting answers to questions and not getting responses to queries about their future, although they had nothing negative to say about the level of care from the facility. Let it be said at this time, I didn't worry about my care. I am a senior officer with 38 years of experience. Queries are not likely to be rejected. When I ask questions, I'm not given "I don't know" or "It's not my lane" answers to my questions. Unfortunately, I encountered more than one frustrated, angry young man or woman. Most of their plights were because of insensitive leaders in rear detachment units. It was here I found out my family had never been notified, which wasn't a particularly pleasant experience since my call caught everyone by surprise.

Landstuhl, Germany to Ft. Hood, Texas 17 0700 hours, July 2004

Emotions run high for soldiers in the complexities of this system. Service members coped with their medical problems, with worries from home, and with administrative functions too numerous to mention. Youthful service members seemed to have problems making autonomous decisions because a formal structure was missing. Medical care on the trip home was exemplary, something I had begun to take for granted. However, there was something wrong. That something turned out to be a system problem where young people were victims in a structure they didn't understand. I'll explain. Very little training goes into casualty evacuation except for personnel assigned to units treating or transporting casualties; therefore, many simply don't know what to expect. Decisions must be made concerning health, family, military matters, and personal matters—often in a vacuum because an experiential base isn't there and subject matter experts usually aren't on these flights or in triage facilities.

Over the days, I talked with many young troops, helping them deal with insensitive rear detachment personnel, telling them not to jump the gun on medical review boards, telling them to be patient with worried families, and simply dealing with, not only the normal, but the exaggerated stressors driven by the environment to which we were subject. We simply didn't have the coordination or support to prepare us for what to expect. One event, however, stood out more than the norm. It was a chaplain's visit while on a bus at

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Andrews AFB. This chaplain, a lieutenant colonel, boarded the bus and asked each soldier if he or she was guard or reserve. If a soldier was guard or reserve, he passed the soldier by and spent time with each active duty soldier. I know it sounds like a fabrication; it isn't; it was the most amazing display of insensitivity I've ever witnessed.

Ft. Hood, Texas 21 1445 hours July, 2004

For me, the system completely failed after touchdown at Ft. Hood. I was briefed upon arrival that I would be transported to cardiology by a young specialist for evaluation and determination of future care. I wasn't. I was to have a care manager assigned, per the briefing. I didn't. My unit was to have been briefed I was inbound. It wasn't. As a result, I was lost in the system for two days—a cardiac patient running around unescorted, on unmonitored blood thinner and rate control medication. After being completely supervised for the last two weeks, it was very disquieting. Call it divine intervention; call it luck; call it anything you want, but I found assistance through a young female specialist whom I had helped days before. She was sitting outside the hospital with her care manager when I walked by. She asked me how things were going and as I told her, her care manager took over the situation, and I was in the cardiologist's office within 30 minutes. Imagine, though, for a moment that you are 22 years old, of little rank and position, frustrated, stressed, a little frightened, and not knowing who to contact. Compound that with the lack of concern from leaders who are to guide you along the way. No small wonder there are complaints. Medical care probably doesn't deserve many of these complaints; it is the administrative side of the system along with poor leadership characteristics that has created most of the problems.

Transfer to Arkansas Community Based Health Care Organization, October, 2004

LTC Mary Borses, Chief of Cardiology, Darnall Army Hospital, Ft. Hood, Texas developed a plan of action—to return me to full duty probably around January, unless surgery was required. Unfortunately, I was forced into a transfer through the Ft. Hood medical hold system into the Community Based Health Care Organization (CBHCO) in Arkansas. This started the evaluation and treatment process all over again, with months of lost time and frustration. Civilian doctors don't fully understand the Army system of treatment and evaluation with intent to return to duty, much less medical review systems. “Forced” is a choice of words I use because I was told I had to transfer only to find out that simply wasn't true.

The CBHCO must utilize the TRICARE system for payment of medical services rendered unless the service member can get to a military installation having medical facilities. Doctors in many rural areas and some in urban areas don't honor TRICARE because of poor recompense for services. TRICARE requires a long interval for appointment approval. Finally, TRICARE may not pay for some services or procedures that take place in full military hospitals. For instance, Dr. Borses included in her plan for my treatment the possibility of surgery. Surgery is now required, but I'm being told now that there is concern that TRICARE may not approve the surgery or the payment. Why is

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there a difference? In fact, why should there even be a question? Isn't a mobilized guard officer entitled the same medical care as his active duty counterpart?

CBHCOs are doing everything they can in support of returning troops. They are starting to feel the frustrations, however. I'm aware of numerous cases where service members are being flushed from the system before their medical treatment is complete. I'm aware of the frustration my care manager feels because he is being pressured by 5th Army to flush his patients as quickly as he can—perhaps before they are ready. A wounded soldier in a clinic I attend is being forced off active duty because of this. He is still attending rehabilitation three days a week and is concerned about a civilian job. Another soldier, released from active duty but without having all his orthopedic surgeries complete, cannot find work and has no income. Military systems of treatment imply soldiers will be referred to various review boards when their care and rehabilitation reaches a point that nothing further can be done. In many cases this simply isn't happening. Often soldiers are being referred to review and evaluation boards before their treatment has reached that point where nothing more can be done or before their treatment is complete. When they are referred, some have a long wait. I've had a long wait. I came out of Iraq July 6; it is now the first week of March and I've not even been referred to a board, much less had critical surgery. I'm told I must attend a board. When will that happen? It is difficult to be held in limbo for a year or more as I will be. My unit will return and demobilize before I'm released. I cannot work at my civilian job or my military specialty. It is truly a difficult situation.

The critical issue to me seems to be the complexity of dealing with the sheer numbers of soldiers returning from Iraq with injuries or illnesses and the fact that there is no support system in place to deal adequately with the issues faced by these soldiers. For guard and reserve soldiers, the problem is made even more complicated by the fact that the active Army wishes to release them from active duty as soon as possible, but unfortunately, many will not be able to return to the civilian jobs they left due to permanent injuries. For these guard and reserve soldiers who were mobilized to serve their country, there is simply is no safety net unless some provisions are made to ensure an adequate transition period and services to assist them in a successful return to civilian life.