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**The Needle and the Damage Done
Vaccinating America's Soldiers**

BY RICHARD CURREY

Army medic Michael Berger was told he would be at Walter Reed National Army Medical Center “for a couple weeks, for a check-up and a few tests. And then,” he said, “they told me I’d be on my way home.”

Berger reported to Walter Reed on February 17, 2004—and he has been there ever since.

One year earlier, in February 2003, Berger reported for active duty after being called up from his home in Marquette, Michigan. A 50-year-old staff sergeant with 20 continuous years of service in National Guard units and the Army Reserve, Berger was assigned to the 452nd Combat Support Hospital out of Milwaukee and sent to Ft. McCoy, Wisconsin, where he launched into “SRP,” the Soldier Readiness Program.

“We were headed overseas,” Berger said, “into the sand.” Although he wondered how he might fare serving next to soldiers in their twenties, Berger was fit, a runner, and a senior NCO with years of experience in medical care. He was fully prepared to do his part. An enthusiastic participant in the mobilization process, Berger volunteered for instructional duties. He met the other soldiers in the unit, including a lively young specialist named Rachel Lacy.

In short order, the soldiers of the 452nd underwent a day of paperwork, including a detailed medical history. With a strong family history of cardiovascular disease, including the loss of his mother to a heart attack at age 43 and a brother who suffered a stroke in his early forties, Berger underwent a heart catheterization procedure in 1996. “My doctor thought I should have the test because of my family history,” he said. “And the results were negative. I wrote it all down on my medical history form at Ft. McCoy. But if anybody took note of that history or thought it represented any sort of concern or risk, I never heard about it.”

A month after arriving at Ft. McCoy, in March 2003, Berger received the standard battery of inoculations administered to soldiers preparing for overseas deployment. The battery included vaccines for anthrax and smallpox, as well as several other infectious diseases.

Within 48 hours, Berger was feeling “lousy.” It was as if, he said, “I was working on a case of the flu. Along with that, I was experiencing some shortness of breath and a heaviness in my chest. I figured it was the vaccinations, but just in case, I checked in for sick call at the TMC—the troop medical center.” Doctors gave Berger a “cold pack” (a standard collection of medications to relieve symptoms of colds and flu), and he returned to duty.

Another week passed with no significant improvement in his condition. If anything, he was worse. In addition to chest heaviness and breathing difficulties, Berger said he “felt constantly exhausted.” He returned to the TMC but was merely advised to “let the medications work.”

The symptoms persisted over the next two weeks, but Berger dismissed his discomfort as the physical stress of keeping up with younger soldiers. On April 1 he was in the field, in the midst of a training exercise and about to conduct a class on intravenous fluid administration. Inside the tent where he was slated to teach the class, his symptoms suddenly worsened. “I just couldn’t catch my breath. I was feeling weak, light-headed, and dizzy.” Within another few minutes “things

got a little hazy,” and Berger said he “went down on one knee. I told the guys around me, ‘I think I’m in trouble.’ And sure enough I was. All of a sudden it was as if I had a thousand pounds on my chest. It was the textbook version of a heart attack.”

Berger was evacuated to a hospital in nearby La Crosse, Wisconsin, where the heart attack diagnosis was confirmed. He was placed in the hospital’s coronary care unit. Tests done the following day revealed that Berger had almost complete obstruction of a major artery supplying his heart. A stent was placed in the clogged artery, and the attending cardiologist contacted Ft. McCoy regarding Berger’s disposition.

The cardiologist was told that appropriate cardiac rehabilitation services were available at Ft. McCoy, and he released Berger back to the Army’s care. But when Berger returned to Ft. McCoy on April 4, he quickly learned there was, in fact, no cardiac rehab program of any sort on the base. The point quickly became moot, since Berger was placed on convalescent leave the following day. He was instructed to call his family and “get someone to come down and pick you up.”

Berger realized there was no treatment plan, no doctor, and no rehab in store for him. “They had no idea what to do with me,” he said. “I guess it was easier for the Army to put me on medical leave and get me out of there. Then my health problems were my own.”

What Berger did not know was that Rachel Lacy, the young soldier he met when he first arrived at Ft. McCoy—and who received the same battery of vaccines—had died following the abrupt onset of debilitating respiratory symptoms. She was, like Berger, evacuated by ambulance to La Crosse where the first civilian physician to see her immediately suspected she was suffering from a vaccine reaction.

Berger, unaware of her death as he traveled north, found himself “lying on the backseat of the car, in pain, undermedicated, five days out from a major heart attack, on my way home to no specific care or doctor and unsure of my Army status.” He felt rejected by an institution he had served for 20 years, and he traveled with an anxious uncertainty about what might happen to him in the weeks to come.

There was still more Berger was unaware of at the time he huddled in the backseat of his family car on the long ride home. On March 18—two weeks after Berger was immunized at Ft. McCoy—an American Indian nurse named Deerheart Cornitcher received the smallpox vaccine at Peninsula Regional Medical Center in Salisbury, Maryland. That evening she felt nauseated and attributed it to a minor vaccine reaction or, possibly, a mild case of food poisoning. Five days later she was dead of a heart attack.

Cornitcher was among seven health professionals vaccinated as part of a civilian readiness program, all of whom developed post-vaccine problems. Another vaccine recipient suffered a heart attack but survived, two developed inflammation of the lining around the heart, and two developed angina, the type of chest pain associated with heart disease.

Three days after Cornitcher’s death, the Centers for Disease Control (CDC) issued a national health advisory regarding smallpox vaccine and the apparent risk of associated heart problems. The advisory recommended that “persons with known cardiac disease not be vaccinated.”

Civilian smallpox vaccination efforts were suspended throughout most of the country. On March 28, three days before Michael Berger suffered a heart attack, the CDC issued a formal report on adverse cardiac effects in association with the smallpox vaccine. On that same day, the Advisory Committee on Immunization Practices (ACIP)—the nation’s presiding arbiter for policies related to vaccine safety—held an emergency meeting. ACIP did not restrict its assessment to civilian

programs, noting that 10 cases of myopericarditis (heart inflammation) already had been reported among the 240,000 primary military vaccinees.

ACIP called the post-vaccine rate of illness in the military “substantially elevated,” and found “a causal relation between [heart inflammation] and smallpox vaccination. Persons receiving smallpox vaccine should be informed that [heart ailments] are a potential complication of smallpox vaccination and they should seek medical attention if they develop chest pain, shortness of breath, or other symptoms of cardiac disease within two weeks after vaccination.”

Meanwhile, the autopsy report on Rachel Lacy noted that her death was, in all probability, related to a severe vaccine reaction. Her death certificate cites “post- vaccination pericarditis” as an underlying cause of death. It also includes “recent smallpox and anthrax vaccinations” as a contributing factor.

At the time Michael Berger had a heart attack, a national smallpox vaccine advisory was in effect and the smallpox story had been carried by all wire services, CNN, and covered in hundreds of newspapers, as well as on many professional medical web sites. But if medical officers at Ft. McCoy knew anything about the controversy, the newly issued directives from both the CDC and ACIP, or the results of Rachel Lacy’s autopsy, Berger said he—a medic assigned to a combat support hospital—heard nothing about any of it.

While on convalescent leave, Berger received a call from Ft. McCoy advising him to be back by May 6, at which time he would be transferred to Ft. Knox, Kentucky, where, he was told, “they have the facilities to handle your kind of case.” A good thing, he thought, because he had visited the local ER with chest pain twice while he was home, afraid both times he was having another heart attack.

The ride from Ft. McCoy to Ft. Knox took nine hours on a rickety Army bus, which arrived at a barracks Berger characterized as “World War II vintage.” There wasn’t room enough in that building for the entire group, so Berger and a few other soldiers were taken to a second building which was padlocked—with a condemned sign nailed to the door. Finally, at a third building, Berger was billeted on the third floor where, despite his post-heart attack status, he had to struggle up three flights of stairs with his duffel bag.

Although Berger had been advised that Ft. Knox was “where I would get the best care available,” he quickly learned there was no cardiologist assigned to the base, nor was there a cardiac rehab program. In fact, there were inadequate numbers of Army doctors in general, and a civilian contract physician handled Berger’s case.

Hired just days before Berger’s arrival, the doctor had received no orientation on Army medical policies. Although sympathetic to Berger’s predicament, he felt there was little he could do. A civilian cardiologist, however, visited the base, although he was a specialist in heart disease in children. Still, that doctor renewed Berger’s medications and prescribed an exercise regimen. As he performed his examination, the doctor happened to inquire if Berger had ever received either smallpox or anthrax vaccinations.

Berger said that he had.

“The doctor told me it looked like the vaccines that some of us soldiers got might not be all that safe,” Berger said. The doctor added that with Berger’s family history of heart disease, “he was surprised the Army gave me the shots at all.” Berger had heard something to this effect when he had follow-up care in La Crosse before shipping out to Ft. Knox, but this cardiologist seemed to speak with greater certainty. “I asked the doctor what was going on, and he told me there was

evidence of a strong correlation between a family history of heart problems and bad, even fatal, reactions to the smallpox vaccine.”

During Michael Berger’s frustrating summer in Kentucky, medical hold living conditions similar to those at Ft. Knox were revealed on other bases, and the military vaccine issue became more convoluted and contentious.

In addition to the connection between smallpox and heart disease, the anthrax vaccine was implicated in a parade of catastrophic health effects, including an abrupt and lethal pneumonia, heart failure, and blood disorders. In May, as Berger was en route to Ft. Knox, Judge Emmet G. Sullivan, a federal judge in Washington, D.C., ordered the Department of Defense to stop using anthrax vaccine on the grounds that it was an experimental drug.

The vaccine (the same one that was used in the first Gulf War) never cleared U.S. Food and Drug Administration (FDA) standards for human use before it was administered to thousands of military men and women. Those recipients were given the vaccine without their awareness or consent, a flagrant violation of federal guidelines regulating the use of experimental drugs or medicines in human subjects. The FDA, however, outflanked the court order on a bureaucratic technicality, solicited no public comment, and quietly reapproved the vaccine.

By late July, the military vaccine program had notched a trail of questionable deaths and chronic illnesses, along with the outrage of those who were finding themselves the targets of disciplinary proceedings, even courts-martial, for refusing smallpox or anthrax vaccines. As soldiers and their families began to alert congressmen and senators, Assistant Secretary of Defense William Winkenwerder, Jr., reported that the Army had identified 37 cases of heart inflammation in the wake of smallpox vaccination—but no deaths.

Rachel Lacy’s death, it seemed, was still categorized as “unexplained” by DoD. But in early August, Rachel’s father told a UPI reporter that he was convinced a proper investigation into the cause of his daughter’s death was being blocked by the Army. He believed his daughter died as a result of the smallpox vaccine, and the Army was stonewalling in an attempt to avoid the criticism such a revelation might bring.

Rachel Lacy’s father was seconded in this opinion by Dr. Jeffrey Sartin, a physician who cared for Rachel early in the course of her illness. Sartin, an infectious disease specialist based in La Crosse—at the same hospital where Michael Berger was taken after he collapsed at Ft. McCoy—said he believed that Rachel Lacy’s illness and death should be classified as vaccine related. “If she had been a civilian,” Sartin said, “the case would almost certainly have been reported as such.”

At the same time, conditions in medical hold facilities at several bases were reaching a breaking point. In the course of his stay at Ft. Knox, Berger recalled living in a decrepit barracks some 60 years old that featured a roof open to the elements. Buckets dotted the floor during thunderstorms. When base authorities failed to respond to complaints, two soldiers from the company—both on patient status—climbed onto the roof and positioned a tarp. “Before they put the tarp up,” Berger said, “you could see the stars at night through that hole.”

Michael Berger’s living conditions at Ft. Knox proved to be symptomatic of overwhelmed Army medical facilities in general, a system that seemed to be grossly unprepared for the many wounded and ill soldiers who would inevitably be returning from a combat theater—or whose illnesses, like Berger’s, would keep them from deployment. UPI reporter Mark Benjamin, in a series of articles that brought him a prestigious journalism prize, detailed med-hold barracks in such poor repair that they were in danger of collapse, and waits for doctor appointments and therapy stretching out four to six months and longer. Benjamin wrote that “in nearly two dozen

interviews” soldiers consistently “described substandard living conditions” and interminable waits for any kind of medical attention.

After being at Ft. Knox for nearly eight months (during which time all his heart care was delivered by contract civilian doctors), a medical board found Mike Berger unfit for duty. He was offered a ten percent disability. Berger objected, noting that “a ten percent disability wouldn’t even cover the cost of medications I have to take for the rest of my life. Plus ten percent doesn’t entitle me to full VA care.” Berger thought that, since he had suffered his illness in the line of duty—and very possibly in direct connection with vaccines the Army had ordered him to take—he deserved more support in managing the results.

“But,” Berger said, “the med board told me, in so many words, that this wasn’t their problem.”

Berger fought the decision, but the board refused to budge. By this time he had been officially classified as a “vaccine reactor,” and while the board acknowledged his heart problems “could have been caused by the smallpox vaccine,” there was clearly no chance of improving their offer. Berger reluctantly accepted the package and returned to Ft. McCoy for his discharge.

Just two days before Berger was to pick up his discharge papers, he had a phone call from Janette Williams, a case manager at Walter Reed’s National Vaccine Healthcare Center. “She knew a lot about me,” Berger said. “But I’d never met her or spoken to her. She told me that from my records it looked like I was a possible positive smallpox reactor and the Army would like to bring me up to Reed for a few days of study.”

Although Williams told Berger he was free to decline her offer, she also advised him that his DD-214 “was unavailable” and his medical board decision had been rescinded. Which meant that, despite the suggestion that Berger had a choice in the matter, he had no real option except to report to Walter Reed. Still, Berger recalled, “Ms. Williams said I’d only be here for a couple of weeks to a month. Just a few tests, and I’d be on my way.”

Around this time the Army issued a statement that vaccines “might have led to the death of Rachel Lacy,” and Sen. Jeff Bingaman (D-N.M.) introduced a Senate resolution calling on Secretary of Defense Donald Rumsfeld to “review the military vaccine program amid growing reports of serious side effects.”

Michael Berger enjoyed the holiday season at home with his family in Michigan, and reported as ordered to Walter Reed on February 17, 2004, where his “two-week stay” now approaches a year.

And in that time his heart condition continued to deteriorate.

Berger has characterized his care at Walter Reed as “first rate,” even as his medical condition worsens. Now struggling with leakage in two heart valves and the re-closing of the artery that was stented after his heart attack, he takes several medications and has been told by his doctor that adhering to this regimen will give him “a normal lifestyle for three to five years.”

Mike Berger has entered the medical territory where doctors can watch, monitor, and intervene when necessary—but do little or nothing to turn back the course of disease.

And just when he thought he understood the medical verdict and the challenges ahead, Berger was dealt another blow. In view of his declining health, Berger requested a reevaluation of his earlier medical board decision. “My condition is worse than it was at Ft. Knox,” Berger said. “Nobody denies anymore that my problems are related to the smallpox—and possibly the anthrax—vaccines. My doctor tells me that I can anticipate a so-called normal life for only three to five more years.”

It seemed reasonable to revisit the disability question, and a hearing was scheduled for November 23. But there was never any actual hearing. Berger was never given the opportunity to offer testimony. He was never even called into the hearing room. After Berger waited in a corridor for seven hours, his attorney finally spoke, alone, to the hearing officer. "My lawyer told me that my disability was sticking at ten percent, and that if I argued about it, the board would rescind the offer and put me back on active duty."

Berger asked his lawyer if he could accept but file an objection in writing. That counteroffer earned the same threat to rescind the disability and return Berger to active-duty status.

"I recognized this was probably an empty threat," Berger said, "but the fact that the Army thought intimidation was either needed or justified—I've kept the faith, followed orders, gone where they sent me, cooperated with all medical instructions, participated in the program here at Reed. I've given the Army its due at every step of the way. But enough is enough."

Berger signed off on the medical board's decision, "under duress," as he put it—but he also contacted the office of Sen. Debbie A. Stabenow (D-Mich.), who launched a formal inquiry into his case.

Michael Berger's continuing story is emblematic not only of an Army vaccine program gone awry, but the deeper confusions and missteps that plague the use of vaccines in the military at large. Service personnel are ordered to receive immunizations that are judged to be in their best interests—and also in the best interests of the service. This stance is rooted in the very essence of command, where the good of the many always supercedes the good of a few, and the primacy of the mission is all.

Yet the fact remains that, at least since the first Gulf War, vaccines have been administered to U.S. troops that were not approved for human use and carried significant questions about safety and even their ability to induce immunity. Any soldier might question the wisdom of receiving vaccines that never cleared standard FDA guidelines, or carry known health risks for a significant percentage of individuals, or have only marginal capacities to confer immunity to any biological agent that might conceivably be used in a combat scenario.

Michael Berger recalled what all of us who served in any branch of the military recall: there is no written or verbal "consent to treat" in military medical settings. There is no opportunity to discuss or opt out of "shot day" in recruit training or during mobilization. And if all recruits are men in their late teens or early twenties who are "vaccine-naïve" (as was often the case through the Vietnam era) many less-adverse reactions are seen.

But times have changed. Women serve. Older men serve. People who have received other vaccines earlier in their lives serve. And many of these servicemen and women may well have health histories—like Michael Berger—that preclude receiving certain vaccines. At the moment, servicemembers who refuse vaccination, even if on solid medical grounds, are usually punished, more than a hundred so far by court-martial.

On October 1, 2004, Rep. Christopher Shays (R-Conn.) proposed a bill that would exempt servicemembers from punishment for refusing to take smallpox or anthrax vaccines. An act of Congress may well be the only way to force the military to create and promulgate the regulations and training needed to improve this aspect of its vaccine program.

On October 28, 2004, Judge Emmet G. Sullivan (the judge who was foiled a year earlier when the FDA hurriedly approved the anthrax vaccine under dubious circumstances) ruled that the Department of Defense must cease anthrax vaccination immediately, noting that FDA "acted

improperly when it approved the experimental injections for general use,” and flatly called the military’s mandatory vaccination program (which has immunized more than a million troops in the last six years) “illegal.”

As for the dismal inadequacies at inferior and overcrowded medical holding facilities at Army bases, a cascade of complaints instigated a Senate investigation from the office of Sen. Kit Bond (D-Mo.). But it remains unclear if this Army-wide problem has been fully or adequately addressed.

“I’m not interested in playing the disgruntled soldier,” Berger said. “I’m not looking to hurt anybody or to get even with anybody or make a lot of noise for no reason. **From what I’ve been told the Army knew there was a category of people that should not receive the smallpox or anthrax vaccines, and I’m simply asking for accountability on the part of the service I’ve served proudly for 20 years.**”

Berger sees his situation as similar to an injury sustained in the line of duty. “I was ordered to get the vaccines. I did so. And doing so proved to be detrimental to my health. In what way am I personally responsible for that? If I were wounded in combat, there’d be no questions asked—I’d be cared for until I recovered, and if I were disabled, I’d receive a realistic disability pension. How is my situation different?”

Michael Berger is not sure what comes next. Sen. Stabenow’s investigation is underway, and the labyrinth of the VA medical system is waiting for him at home in Michigan. “It’s a step at a time,” he said. “Right now, I’m just looking forward to being back with my wife and kids.”