This appendix contains a comprehensive list of issues associated with the Disability Evaluation System. We identified these issues—which address instances of variability in policy application across or within the military departments, as well as some specific problems associated with the DES—during interviews with numerous and diverse primary participants, and in the course of attending the military departments’ major training events. These issues serve as the basis for the goal fabric analysis and the resulting actions in the ten categories of interventions discussed in Chapter 4.

1. Medical Evaluation Boards convened too early (for example, shortly before surgery or immediately after post-injury/illness period).

2. The services employ different philosophies for referring service members for Medical Evaluation Boards. For example, the majority of Army service members who receive Medical Evaluation Boards are referred to the PEB and the majority of those are found unfit, whereas the majority of Air Force service members who receive Medical Evaluation Boards have a high probability of returning to duty.

3. DoDD 1332.18 holds the Secretaries of the military departments responsible for ensuring that physicians who serve on Medical Evaluation Boards are trained in the preparation of medical boards for physical disability evaluation. No institutional mechanism exists in any of the military departments to do this. The Departments of the Navy and the Air Force claim to be in the process of updating instructions (published official governing documents) that describe how to conduct Medical Evaluation Boards.

4. In the Department of the Navy, the Medical Evaluation Board fairly frequently (in 5 to 10 percent of the cases) refers medical boards that do not qualify for the DES to the PEB because the referring physicians and commanders do not communicate with each other and the physicians play a strong patient advocate role.

5. No written retention standards exist (except for the Army) and the services use different retention standards. For example, the Army refers service members with asthma to the Medical Evaluation Boards.

6. Confusion exists among members of the Disability Advisory Council and members of the PEBs regarding reasons for nondeployability and use of nondeployability in determinations of fitness.
7. Different military departments’ informal PEBs receive different information upon which to make judgments.

8. The military departments allow service members different lengths of time (3, 10, or 15 days) to make an election of informal PEB and formal PEB findings, which impacts service members’ perceptions of due process.

9. No reliable information system exists to present performance data to MTF commanders and the Surgeons Generals.

10. Some medical boards are not processed in a timely manner; they linger in the system and are then referred to the PEB after the narrative summary and/or the specialty consults are more than 90 days old.

11. DoD Directive 1332.18 holds Secretaries of the military departments responsible for ensuring that physicians who serve on Medical Evaluation Boards are trained in the preparation of medical boards for physical disability evaluation; however, no institutional mechanism exists in any of the military departments to ensure that this happens. Across the military departments, doctors typically receive no standardized training in writing medical boards (narrative summaries) or specialty consults. Some new doctors may receive a “crash course” on writing narrative summaries, but nothing standardized or consistently used exists within or across the military departments.

12. Many doctors have no understanding of the DES, or they lack knowledge about the information the PEB needs to make appropriate assessments. Many do not fully understand some basic concepts of the DES, such as “service aggravation,” “presumption of fitness,” or “fit/unfit.”

13. An adversarial relationship exists between referring physicians and the Department of the Navy PEB. Doctors spend 16 months (Limited Duty maximum time) treating a service member’s medical condition and when they cannot resolve the condition during that time, they refer the service member to the PEB with the expectation that the PEB will find the member “unfit.” In cases such as these, some doctors tend to regard a “fit” call by the PEB as a personal affront to their medical expertise. Referring physicians oftentimes do not understand that a PEB determination of “fit for duty” is not equivalent to “fit for full deployment.”

14. Nondeployable service members are a particular problem in the Department of the Navy because the Navy does not have many shore billets. Most Department of the Navy assignments require four years of shore duty, then three years of sea duty. Because of this rotation policy, some line officers, physicians, medical policymakers, and assignments personnel in the Department of the Navy would like to see the fit call and suitability standards more closely aligned. Likewise, some operational leaders, physical disability evaluation policymakers, and assignments personnel in the Army also would like to see the deployability and fit calls more closely aligned.

15. The Department of the Navy PEB is finding an increasing number of service members “fit.” The fit calls have roughly doubled over the past few years; about
30 percent of the PEB adjudications result in fit calls. Is the increase caused by a change in the PEB philosophy, or a change in the quality of the Medical Evaluation Board or Physical Evaluation Board? The PEBs first got access to the commanders’ nonmilitary assessment following publication of the new Secretary of the Navy Instruction 1850.4D in December 1998, and the fit calls subsequently went up (reportedly because the PEBs now had access to the commander’s input).

16. DoD Directive 1332.18 and the new SECNAVINST 1850.4D contain examples of a good medical board. Copies reportedly are rarely made available to doctors, and most doctors do not use them even when they are available.

17. Physicians across the military departments who write specialty consults (from orthopedics, pulmonary, cardiac, and other specialty areas) need to be informed about the five specific points they must address when writing their consults in order for the PEBs to adjudicate the cases (for example, sufficiently documenting specific range-of-motion ratings). Cardiac cases most often lack the sufficiently detailed information.

18. Commanders typically do not understand the role or purpose of the DES, or their role within the system. In particular, they do not seem to understand the “tail” (that is, the vast amount of resources) that follows referrals to the Medical Evaluation Board.

19. In the Army, no one physician is responsible for moving a patient’s case through the health-care system to a Medical Evaluation Board. As a result, the patient gets passed on for specialty consults and the case can get lost in the process. In the Air Force, the initial contact physician for the specialty ensures that the appropriate consults are done, the narrative summary is dictated, and the medical board is consistent and complete, and the medical board together with the outpatient records is delivered to the Medical Evaluation Board. In the Air Force, the MTF commander ensures that the attending physician notifies the PEBLOs as soon as it appears likely that a service member will require evaluation to determine physical fitness for retention in a duty status (U.S. Department of the Air Force, Physical Disability Division, 1999).

20. Most Department of the Navy service members are referred to Medical Evaluation Boards by the Limited Duty Boards because the service member has spent too much time in a “limited duty” status.1

21. PEBs return insufficient or incomplete medical boards to the referring MTF for the following reasons: no, or insufficient, nonmedical assessment or commander’s letter; missing LODD; missing appropriate specialty consult(s) or the consults lack sufficient detail to adjudicate a case, for example, no social and

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1In the Department of the Navy, a service member may receive up to 30 days of “light duty” while undergoing treatment for a medically diagnosed condition. If the member continues to need medical treatment at the end of the 30-day period, he or she may be referred to a Limited Duty Board or a Medical Evaluation Board for further evaluation. The Limited Duty Board may grant the member up to 16 months of Temporary Limited Duty (in up to eight-month increments) and the member may spend up to 30 days in Medical Hold pending completion of a Medical Evaluation Board referral to the PEB.
industrial impairment assessment on psychiatric cases; insufficient signatures (number and specialty of physicians, and the approving authority must be a medical officer); the narrative summary is more than 90 days old and therefore no longer reliable; incomplete narrative summaries that lack the level of detail needed to make a fit/unfit determination and apply the VASRD.

22. PEBLOs with greater tenure, program knowledge, and experience may be (1) more likely to provide service members with accurate expectations of the DES because they can better explain the VASRD rating and disability compensation; (2) more effective in soliciting commanders’ letters and LODDs; and (3) more comfortable and effective in using the chain of command to solve problems such as unit commander nonresponsiveness.

23. The members of the Disability Advisory Council and military department’s primary participants communicate with one another infrequently.

24. Although DoD Directive 1332.18 identifies medical evaluation as one of four elements of the DES, the medical community does not seem to accept ownership of this element given its apparent reluctance to (1) respond to requests from the PEB to train physicians who write narrative summaries and specialty consults to meet certain standards; (2) incorporate its governing documents into the overall DES documents; (3) strike the appropriate balance in terms of advocacy—physicians seem to emphasize their role of service member advocate over their equally important role of military department advocate.

25. Data with which to make an assessment are not generally provided to senior officials charged with quality assurance.

26. Secretaries of the military departments receive no information regarding how well the DES is working.

27. Human elements—such as emotions, personality issues, good soldier/bad soldier issues, and length of service (when close to 20 years)—hamper efforts to render fair and consistent decisions. PEB decisions change with new members’ personal philosophies.

28. The Department of the Navy reserves “Permanent Limited Duty” status for members who have a “significant number of years in service and want to retire,” who are very close to retirement when found unfit, or who have special expertise. This tendency seems to be consistent with DoD Directive 1332.18.3.12: “As an exception to general policy, the Secretary concerned, upon the request of the member or upon the exercise of discretion based on the needs of the Service, may continue in a permanent limited duty status either on active duty or in the Ready Reserve, a member determined unfit because of physical disability when the member’s Service obligation or special skill and experience justifies such continuation.”

29. Primary participants interpret DoD policy and apply it consistently to the best of their ability. However, primary participants do not converse with their counterparts from the other military departments or the OSD, so they have no way of
knowing if they are passing judgments that differ from those of their counterparts in the other military departments.

30. The Departments of the Navy and Army PEBs are physically located in different regions of the country and rarely communicate with one another.

31. DoD Directive 1332.18 holds the Secretaries of the military departments responsible for ensuring PEB members and applicable review authorities are trained and certified in physical disability evaluation. No institutional mechanism exists in any of the military departments to ensure that PEB members and applicable review authorities are “certified” in physical disability evaluation.

32. Physicians often write medical boards for service members from other military departments. The different military departments write medical boards in different ways. Some primary participants think that the ASD/HA should require a standard format for medical boards in all of the military departments.

33. O-6s who serve as PEB president in the Department of the Navy typically stay in the position for only about six months. This turnover, or lack of continuity, precludes those leaders from developing real commitment to the PEB mission and it is nearly impossible for them to champion needed change, such as streamlining operating procedures and revising policy documents, let alone the more difficult challenge of changing the PEB philosophy.

34. Many primary participants suggested that senior OSD leadership appears to take very little interest in the DES and exercises practically no authority in assuring that it operates as it should. They perceive that the only real DES oversight comes from the Director of Officer and Enlisted Personnel Management.

35. No DES process owner exists; none of the primary participants (except the PEBLOs in the Department of the Navy medical centers) in the medical evaluation phase of the DES work for the O-6 who oversees the PEB, who is also the PEB approving authority.

36. Service member patients perceive variability in the application of disability policy because both the DoD and VA rate a physician’s diagnosis using the VASRD, but DoD and VA actually evaluate different things for different purposes at different times.

37. Navy PEBLO positions are filled with service members from a variety of career fields with skill sets that are far removed from patient administration and counseling.

38. Military departments describe the purpose of DES differently.

39. Referrals to pre-separation counseling before a PEB decision of unfitness may lead to incorrect and premature expectations of the service member.

40. Military departments conduct Medical Evaluation Boards in different forms (convene or pass medical boards).

41. We observed junior noncommissioned officers and petty officers acting as PEBLOs and Department of the Navy disability evaluation counselors.
42. No institutional mechanism exists for quality assurance.

43. Fitness and rating calls for members with close to but less than 20 years of service are inconsistent because of the desire of some services and some PEBs to retire such individuals.