Chapter 16

THE US ARMY PHYSICAL DISABILITY SYSTEM

CHARLES A. PECK, JR, M.D.*

Medical Advisor, United States Army Physical Disability Agency, Walter Reed Army Medical Center, Washington, DC 20307-5001

INTRODUCTION

When rehabilitation of a soldier is not completely successful after injury or illness, it may be necessary to consider separation or retirement for reasons of permanent medical disability. Historical data indicate that 10% to 15% of surviving combat casualties undergo disability separation.[1-4] In addition, separation or retirement due to permanent medical disability may be necessary for soldiers who are injured by the rigors of training in preparation for combat, or as the result of accidents or illnesses.

The disabled soldier must be remembered. He deserves and must receive acknowledgment of hardships endured and perils he has survived. His spirit is never *hors de combat* and to cast him aside will ensure that few kindred spirits will follow him into a life dedicated to the defense of his nation. Since the beginning of military history, many rulers and governments have understood this principle. Historically, they either established pension systems or demanded that those who were responsible for furnishing troops also provided a system of fair, equitable compensation.[5] The army physical disability system has been established to compensate soldiers who have injuries or disease that have terminated their military careers. The purpose of this chapter is to describe, first, how the United States Army disability program is organized and performs its mandated functions, and second, some of its more recent accomplishments.

HISTORY

Early Development

Many ancient civilizations had compensation systems. The law of Ur-Nammu, King of Ur in Sumer circa 2050 BC, was believed to be the first of such laws.[6] This law was closely followed by the code of Hammurabi.[7] In 1592, the British Parliament provided yearly pensions limited to £10 for privates and £20 for lieutenants. Pensions were for those who "have adventured their lives and lost their limbs or disabled their bodies, to the end that they may reap the good fruit of their deserving, and others may be encouraged to perform like endeavors."[8] This is also an early example of soft-sell recruiting. Some 90 years later, England established a standing army and instituted a system of soldiers' homes to care for superannuated enlisted men. Officers mustered out of the service were to be carried at half pay status and remain liable for service in the event of war. The British system provided the foundation for the military retirement system of the United States of America.[5]

The first national pension law in the United States was enacted by the Continental Congress on 26 August 1776,[9] just 7 weeks after the Declaration of Independence had been signed. It provided half pay for life for all ranks of disabled veterans. Because many officers were not able to perform their duties due to old age and chronic illness, a law was enacted in 1855 that was initially applicable only to navy officers[10] and which permitted retirement after 40 years of service upon application to the President. A similar law, applicable to the army, was enacted in 1861.[11] This same law allowed those officers who became physically incapable of performing duty to be placed on the Reserved List. Retired pay was 75% of active duty pay. In 1862, a law similar to the current law was enacted[12]; it applied to both Army and Navy and provided pensions according to rank for all who were totally disabled. Partially disabled soldiers received proportionate amounts; widows; children under 16 years of age; dependent mothers; and orphaned, dependent sisters could receive total disability pension.

20th Century

Over the years, the pension laws were broadened to extend coverages, but the next major advance in military compensation would have to await the flood of disabled soldiers and sailors caused by World War I and World War II. In 1928, after World War I, a law was enacted that applied to all officers of World War I.[13] Soldiers who had more than 30% disability were placed on the Emergency Officers Retired List at 75% of the active duty pay to which they were entitled. Those with less than 30% disability were also placed on an Emergency Officer Retired List, but without pay. All were entitled to other benefits and privileges of retired officers.

The Veterans Bureau was established in 1921.[14] Its task was to administer benefits for non-Regular Army officers. In 1939, this law, as it applied to non-Regular Army officers, changed. If non-Regular Army officers were called to active duty in excess

of 30 days and suffered disability or death in the line of duty, they were entitled to the same benefits as Regular Army officers.[15]

The law, however, was not applicable to enlisted soldiers. This oversight was corrected in 1941 by legislation affecting Regular Army enlisted soldiers with more than 20 years of service and with permanent disability.[16] They became eligible for placement on the Disability Retired List and were to receive 75% of the average of their last 6-month's pay just prior to becoming disabled.

When the United States entered World War II, no disability retirement law was in place to cover the more than 10 million soldiers who would participate in this great war. The Career Compensation Act of 1949,[17] specifically Title IV, provided a law uniformly applicable to the three military services. This was later codified in Chapter 61, Title 10, of the United States Code (U.S.C.). It established rules of entitlement for members of the three services who were unfit for duty because of a disability incurred while on duty for more than 30 days, and a separate set of rules for those called to active duty for less than 30 days. This law provided benefits for Regular and Reserve officers and enlisted personnel, if the disability was due to injuries in the line of duty (LOD). The Act also provided severance pay to soldiers whose disabilities were not of sufficient degree to qualify them for retirement but did interrupt their careers.

A new addition provided to the 1949 Act[18] allowed placement of the soldiers on the Temporary Disability Retired List (TDRL). In the strictest application of this provision only soldiers who had medical conditions that might resolve and thus permit a return to active duty were eligible to be placed on the TDRL. In 1951, the law was interpreted by the US Department of Defense (DoD) to include all soldiers whose medical conditions were unstable regardless of whether they might return to active duty.[19] Stability was defined as no change in rating over a 5-year period. There is a 5-year limit for time on the TDRL. After 5 years, or less if the soldier's condition appears to have stabilized, final disposition is to be made.

Under the Compensation Act,[18] the secretary of each service branch was responsible for implementing the disability compensation process. Prior to this, the Veterans Administration had made the disposition in cases of soldiers with disabling conditions. Initially, the army process was implemented at the medical treatment facilities (MTFs). Alleged inequities in the system led to a review by the Secretary of the Army in 1965 and resulted in the establishment of the United States Army Physical Disability Agency (USAPDA) to implement the US Army's compensation program. Implementation was accomplished in accordance with Title 10, United States Code, Sections 61, 133(b), 1201, 1203, 1210, 1216(d) and 3010[18]; as well as by the Department of Defense (DoD) Directive 1332.18[19]; and Army Regulation (AR) 635-40.[20(ch3,¶2b(1))] "Separation from the Military Service by Reason of Physical Disability," a revision of DoD Directive 1332.18[21] and additions to Army Regulation 635-40,[22] have provided additional policy guidance. The rationale behind the laws establishing USAPDA are to be found in the following quotations:

> The mission of the army physical disability system is to 'provide a full and fair hearing to determine soldiers physical fitness for continued military service, determine level and type of compensation, and take action to separate or retire soldiers when a career is interrupted by reason of physical disability.'[23]

> Disability compensation is not an entitlement acquired by reason of service-incurred illness or injury.[20,22]

> The mere presence of an impairment does not, of itself, justify a finding of unfitness because of physical disability.[20,22]

THE ARMY DISABILITY SYSTEM

The army physical disability system depends on the function of two distinct entities: (*a*) the Medical Evaluation Board (MEB), which is transient and is called into being when and where it is needed, and (*b*) the Physical Evaluation Board (PEB), which has a permanent existence. The orientation and the organizations of the MEB and the PEB together with the controlling hierarchy of the USAPDA differ. Although both boards evaluate a soldier's medical impairment, the MEB uses strictly medical standards and the PEB uses military performance standards (Figure 16-1). While the MEBs can be constituted at any MTF, the USAPDA began with six regional PEBs and a Central Army Physical Review Council composed of four physicians; two lawyers; two personnel management officers (PMOs); a director and a deputy director, with an administrative staff; and a Physical Disability Branch (PDB). Currently, due to the alteration in force structure (downsizing) of the army, the USAPDA has three

Fig. 16-1. The primary components of the Army Physical Disability System, the Medical Evaluation Board (MEB) and the Physical Evaluation Board (PEB), use different criteria to evaluate the potentially disabled soldier. The MEB uses medical standards, while the PEB uses the soldier's performance of his duties to determine fitness.

Fig. 16-2. The organizational aspects of the Army Physical Disability System. Note that the Medical Evaluation Boards (MEBs) report to the Physical Evaluation Boards (PEBs), with the Physical Evaluation Board Liaison Officer playing the essential role as intermediary. The PEBs, but not the MEBs, are components of the US Army Physical Disability Agency (USAPDA), which in turn, is part of Personnel Command (PERSCOM). The MEBs are part of the Medical Command (MEDCOM). At the highest level in the army, the Army Physical Disability Appeals Board (APDAB) exists to advise the Secretary of the Army on the appropriate disposition for the small fraction of cases that are not resolved at the USAPDA level.

AMC: Army Medical Center
MTF: medical treatment facility
PEBLO: Physical Evaluation Board Liaison Officer

MTF: military treatment facility
PEB: Physical Evaluation Board

Fig. 16-3. There are four ways a soldier can enter the Army Physical Disability System: (1) physician, (2) Military Medical Retention Board (MMRB), (3) commanding officer, and (4) higher command. Once in the system, procedures are structured to give the soldier the correct evaluations.

regional PEBs and a PDB. The USAPDA is presently located in Building 7 at Walter Reed Army Medical Center, Washington, DC. The PEBs are located at Walter Reed Army Medical Center, Washington, DC; Fort Sam Houston, San Antonio, Texas; and Fort Lewis, Washington. With continued restructuring of the army, this configuration is likely to change, but the basic relationships remain: a multitude of MEBs are forwarded to a limited number of PEBs (Figure 16-2). Finally, USAPDA with its PEBs, but not the MEBs, is part of the Total Army Personnel Command (PERSCOM).

Both of these boards are proponents for the soldier. It should be noted that it is an informal custom to refer to not only the physical entities of the MEB and the PEB, but to their deliberations and to the products of their deliberations, as "boards." Thus, the physical entity of, say, the MEB is the site of a MEB, which produces a MEB.

There are four ways a soldier can enter the army physical disability system (Figure 16-3): (1) The physician caring for the soldier may refer a soldier after determining that the soldier does not meet medical retention standards. Retention standards are those guidelines put forth in AR 40-501.[24(ch3)] These are medical conditions that may preclude retention in the army. (2) Soldiers who have a Permanent 3 or Permanent 4 profile are required to appear before the Military Occupational Specialty-Military Medical Retention Board (MOS/MMRB), which may recommend that the soldier enter the army physical disability system. (3) A commanding officer may request through the medical commander, that a soldier undergo a fitness-for-duty evaluation. (4) Entry is directed by higher command (eg, the Secretary of the Army or his designee requests a fitness-for-duty evaluation of the soldier). Approximately 85% to 90% of the MEBs are physician directed and 8% to10% are MMRB directed. Soldiers may not direct that a MEB be convened on their behalf.

Medical Evaluation Board

Soldiers, in the performance of their duties, may incur injuries with residuals that prevent them from adequately meeting retention standards.[24(ch3)] An injury may be an acute injury, chronic residuals of injury or illness, or chronic and recurring illness or injury that is repeatedly exacerbated by the nature of the soldier's duties. Diseases may also be acute and debilitating (eg, a myocardial infarction) or chronic and recurring (eg, asthma, arthritis, or diabetes). The soldier is treated at a military hospital for the acute episode, after which a period of convalescent leave may be granted. During this convalescent period the soldier is still considered a patient of the hospital and must return to the hospital on a periodic basis to be evaluated by a physician. The physician determines if he can return to full duty, partial or restricted duty, or should undergo an MEB. The soldier who can return to duty with restrictions, is given a physical profile. The physical

profile is a written communication between the soldier's physician and his commander that explains the soldier's medical condition and how the condition might affect duty performance.[24(ch7)]

Unfortunately, the physician all too often writes the physical profile in such a way that it remains unclear as to exactly what the soldier is or is not allowed to do when he returns to duty. The resultant miscommunication leads to inappropriate restrictions on the soldier. Conversely, sometimes the profile fails to reach the commander and demands are placed on the soldier that may be detrimental. Currently, these problems are being reassessed. A profile is either temporary, to be reevaluated at a given date, or permanent, to remain with the soldier for the rest of his career unless altered by the MTF profiling officer and an appropriate profile board according to AR 40-501.[24(ch7)]

In some cases, the soldier may not meet retention standards. If this decision is based on the observed outcome of a disease or an injury, an MEB must be convened. Once the physician and the soldier have agreed that an MEB should be conducted, the Physical Evaluation Board Liaison Officer (PEBLO) of the hospital is contacted. The PEBLO will counsel the soldier and the physician on MEB procedures and monitor the process, the product of which is the MEB Narrative Summary (NARSUM) (Figure 16-4).

According to AR 40-400[25(ch6,p60)] and AR 635-40,[22] MEBs can be established at any MTF and are convened to document a service member's medical status, to review possible duty limitations, and to determine whether a soldier meets medical retention standards. They do not determine fitness or unfitness for military service. The MEB is made up of two or more physician members. One of these must be a senior medical officer with detailed knowledge of (*a*) directives pertaining to standards of medical fitness and medical disposition of soldiers, and (*b*) disability separation processing and the Veterans Administration Schedule for Rating Disabilities (VASRD).

Where dental or psychiatric conditions are of major importance, a dental officer and/or a psychiatrist must be a member of that MEB. Where mental competence is in question, the MEB will consist of at least three members, one of whom is a psychiatrist. The completed evaluation, the MEB NARSUM, is referred to the approving authority, which may be the hospital commander, but is most likely to be the Deputy Commander for Clinical Services, who will review the board's findings for completeness, accuracy, and logic. It has been suggested that the MEB NARSUM have a standardized format for easier review. It is the responsibility of the referring physician to prepare the medical documentation that is to be presented to the MEB. A suggested format follows.

DCCS: Deputy Commander for Clinical Services
MEB NARSUM: Medical Evaluation Board Narrative Summary
PEBLO: Physical Evaluation Board Liaison Officer

Fig. 16-4. To determine if a soldier meets medical retention standards, the Medical Evaluation Board is made up of appropriate medical personnel.

MEB Narrative Summary

Military History

The physician opens the MEB NARSUM with a statement indicating why the review is being done, that is, it is physician directed, MMRB directed, or appropriate command authority directed. This is followed by information on the administrative status of the soldier (ie, active duty, reserve component, or National Guard), which establishes eligibility for board proceeding. This information and the soldier's pertinent military history will have been supplied to the physician by the PEBLO. Included here should be data concerning the soldier's current status, such as mandatory retirement, selective early retirement, bars to reenlistment, and any pending administrative actions.

If the soldier's medical condition is the result of injury or alleged injury, an LOD investigation report must be included, indicating whether the injury was incurred in the LOD or was due to the soldier's misconduct, willful neglect, or both and not in LOD.

It is imperative that this determination be made early. It in no way implies that the soldier will not receive medical care, but the lack of a LOD determination can delay processing and finalizing of the soldier's case. It is best to prepare the LOD investigation report early while facts are still clear in everyone's mind.

Soldier's Chief Complaint and History of Present Illness

Following the military history, the soldier's chief complaint is recorded in his own words. A detailed history of the present illness elaborating the chief complaint is next. If the illness is chronic, documentation of the chronological sequence is important to ascertain how the medical condition has affected the soldier, how military service has affected the condition, and what the impact has been on duty performance. A soldier who has had a chronic knee problem all his military career but has been able to do his duty up to retirement may be viewed differently than a soldier who has an acute knee injury requiring operative intervention. It is incumbent on the physician to document how a soldier's medical condition affects his duty performance.

Past Medical History

After compiling a concise chronological history of the present illness, an equally concise pertinent past medical history is important. Any illnesses that were present prior to service entry are noted. Of major importance would be any prior hospitalizations and operations. A good source for this information is the Induction Medical Form (Report of Medical History, Standard Form 93) shown in Figure 16-5. The past medical history is vital in many disease processes, especially when the soldier may have a psychiatric illness. The relevant family and social histories are also included in the past medical history.

Current Physical Examination

After the pertinent history, a complete physical examination is recorded. The examination should not be only qualitative as related to the soldier's chief complaint, but should also be quantitative whenever possible. A qualitative finding study is a subjective type of finding, which does not have support other than the physician's observation. A quantitative finding study contains not only the physician's opinion but also factual data (measurements) to support the opinion. Quantitative findings carry a greater weight in the final decision as opposed to qualitative findings. Pertinent consultative evaluations are obtained when necessary. These may be used in the physical examination or as addenda to the MEB NARSUM.

Quantitative evaluations of various systems include: (*a*) pulmonary function studies for respiratory disease or thoracic surgery cases, (*b*) stress tests and angiogram studies in cardiology cases, (*c*) early and late neuropsychiatric testing in head trauma cases, and (*d*) electromyographic and / or nerve conduction studies in cases involving neurology, neurosurgery, and physical medicine. In addition, careful physical examination with supporting radiographs (plain films, computed tomography [CT], magnetic resonance imaging [MRI] studies) and muscle and nerve conduction studies are incorporated into the overall assessment. It is mandatory in orthopedic cases that range-of-motion studies be recorded if joint involvement is a factor. If one of paired extremities is uninjured, this presents an excellent standard for comparison to the injured extremity for range-of-motion and function.

The physician, having obtained a thorough history of all relevant aspects of the patient's military experience and medical complaints, and a physical examination, then records laboratory data to support the diagnoses. In addition to the general studies obtained, special studies such as those mentioned above may be included here.

Soldier's Assignment

The soldier may or may not have been hospitalized for the board process. If he was hospitalized, a chronology of the hospital course should be entered. If he was not hospitalized, he may be assigned back to his parent unit or to the MTF's medical holding unit. All hospitalized, active-duty, uniformed patients within an MTF's geographical region are attached to the medical holding unit (each inpatient MTF must have such a unit[25(ch7,p67)]); this information about the soldier's assignment should be included as part of the MEB NARSUM. The soldier's duties and how well the duties were performed while he was assigned to his parent unit or the MTF medical holding unit are also noted.

When the patient completes the hospital course, the physician records the soldier's current status and prognosis for recovery or partial recovery from the medical condition. A cardiac patient recommended for a trial of duty should have this recom-

Fig. 16-5. The Induction Medical Form, (Report of Medical History, Standard Form 93), which is a good source for obtaining information on the soldier's medical problems prior to his entering the army.

Fig 16- 5. *continued*

mendation recorded in the hospital records. If the soldier was placed on convalescent leave, his progress during this leave should be documented.[26(ch5,§3,¶5,6)] AR 600-8-10 defines convalescent leave as a period of time, not chargeable to regular leave, given the soldier to recuperate, or convalesce due to injury or illness. Up to 2 weeks of convalescent leave may be granted by the unit commander. In most instances, however, the duration of leave is recommended by the soldier's physician. The soldier's physician may request up to 30 days of leave. Leave in excess of 30 days must be approved by the hospital commander or his representative. The soldier on convalescent leave is still considered a patient of that MTF.

Medical Diagnoses and Conclusions

All medical diagnoses should be listed, beginning with the most critical. If possible these should be correlated with the VASRD as closely as possible. If the disease is not present in the VASRD, current medical diagnoses should be used. The physician then records conclusions as an ending to the MEB NARSUM. Conclusions should state whether the soldier meets retention standards according to AR 40-501 chapter 3 and cite the appropriate paragraph. Using paragraph 41e does not provide adequate information for the PEB and is used only when the physician does not have an accepted medical condition to cite. AR 40-501 chapter 3 paragraph 41e refers to "miscellaneous conditions and defects: (1) conditions that result in interference with satisfactory performance of duty as substantiated by the individual's commander or supervisor; (2) the individual's health or well being would be compromised if he were to remain on active duty; (3) in view of the soldier's medical condition, his retention in the military service would prejudice the best interest of the Government."

Review of MEB NARSUM

The attending physician, having competed and reviewed the MEB NARSUM, signs it and meets with a senior medical officer for review and signature. As mentioned previously, if the board has been convened to review psychiatric impairment or mental competency, an additional physician—a psychiatrist—is required at this meeting to review, agree, and sign the MEB NARSUM prior to forwarding it to the approving authority. If dental impairments exist which preclude retention on active duty, a dental officer must sign the MEB NARSUM. Once the approving authority has signed the MEB NARSUM, the soldier is then counseled by the PEBLO regarding the board's results. The soldier has the options of agreeing with the board's results or disagreeing. If he does not agree, the soldier must submit within 3 working days the reason for his disagreement. This written statement is reviewed by the approving authority and the MEB NARSUM is either (*a*) returned to the physician for compliance with the soldier's request, (*b*) forwarded to the PEB with the disagreement statement noted by the approving authority, or (*c*) forwarded to the commander for review. If the commander is the approving authority, the MEB NARSUM may be forwarded to the next higher command for resolution.

The Physical Evaluation Board

The soldier, thus having completed the first major step in the army physical disability system, will have been (*a*) found to meet medical retention standards and returned to duty with profile as warranted, or (*b*) forwarded to the PEB through the PEBLO, because retention standards were not met. Soldiers who do not meet retention standards are not necessarily unfit.[22(ch3-1)] A fit or unfit determination is made by the PEB. It is important for the medical officer to understand that medical impairment is not necessarily synonymous with, or the cause of, physical disability. No two soldiers are identical and no two cases presented to the army physical disability system are the same. In cases of grave medical conditions, objective medical evidence is sought and is weighted more strongly in the evaluation done by the PEB. In cases of chronic, long-term medical conditions, more weight is given to subjective complaints, performance, and administrative data when determining whether a soldier is fit or unfit (Exhibit 16-1).

The PEB differs from the MEB in many aspects but primarily in the basis of its findings. A MEB determines if a soldier meets medical retention standards according to AR 40-501, chapter 3. The PEB determines whether a soldier is fit or unfit, taking into consideration the medical findings of the MEB, in conjunction with the soldier's office, grade, rank, rating, and performance as recorded by his commander on enlisted/officer evaluation reports and personnel statements of work performance. The PEB is composed of two line officers and a physician, whereas the MEB is composed of physicians. Legal counsel provided to the soldier is independent of the PEB.

Soldiers are referred to the PEB through the PEBLO. The PEBLO is the linchpin in the army

EXHIBIT 16-1

PHYSICAL EVALUATION BOARD: WEIGHING THE EVIDENCE

Objective	vs	Subjective
Acute	vs	Chronic/Long-term
Medical	vs	Performance
		Administrative

Acute or Grave	Chronic/Long-term
Medical data generally	Performance
More important	Administrative

MEB: Medical Evaluation Board
PDB: Physical Disability Board
PEB: Physical Evaluation Board

Fig. 16-6. The soldier can agree or disagree with the informal board determination of fitness. If he agrees, the board is sent to the Physical Disability Board (PDB) for administrative implementation. If he disagrees, a formal Physical Evaluation Board (PEB) is convened.

physical disability system—the point of contact for the MEB, the soldier, and the PEB. The PEBLO counsels the soldier regarding the results of the MEB NARSUM, assembles all pertinent records, and forwards the MEB NARSUM with appropriate records (the MEB packet) to the PEB in the most expeditious manner available. In the army, the PEBLO is appointed by and works for the MTF Commander. The duties of the PEBLO are set forth in AR 635-40.[22(AppC,§1,p67)]

The PEB Process

In the following discussion of the PEB process, a typical uncomplicated active duty soldier will be presented. Various alternative considerations will be presented later. At every step of the process the soldier is afforded due process and a full and fair hearing. The PEB is a proponent for the soldier as well as the government.

After it has been signed by the approving authority and the soldier, the MEB packet (the MEB NARSUM, pertinent records, and performance data) is sent from the PEBLO to the PEB. On receipt, it is logged in by a case analyst and rechecked to ensure that all necessary paperwork is present and in order. The case then undergoes an informal review that results in a finding of fit or unfit (Figure 16-6).

If determined to be fit, the soldier is returned to duty. If determined to be unfit, a disability percentage is assigned to the soldier on the basis of the VASRD. Because the VASRD was originally written in 1946, it does not include many current medical diagnoses, a problem that is presently being corrected by the preparation of a revised and more up-to-date version. When a diagnosis in the MEB NARSUM is not in the VASRD, the PEB must select a closely related listed illness and rate the soldier accordingly. This process is known as "rating by analogy" (Table 16-1 contains some examples of analogous ratings). The physician, by using the VASRD, affords the PEB the best chance of reaching the right rating regarding the soldier's illness. Examples of disability ratings are shown in Table 16-2.

Disability equates to economic loss, for which the individual is compensated. Ideally, the compensation should reflect the average loss of the soldier's earning capacity as a civilian. However, the army compensates the soldier for only the medical condition or conditions that make him unfit for military duty. The Veterans Administration compensates the soldier for all service-connected medical conditions that would have an impact on civilian employment. This is the basis for the percentage ratings contained in the VASRD. If the disability rating is less than 30%, the soldier is separated with severance pay. If the disability rating is greater than 30% and the disease process is stable, permanent disability retirement is awarded.

The informal review can also come to the conclusion that the disease process is not stabilized to the point where permanent disposition can be made. Accordingly, the soldier may be placed on the TDRL. The requirements for placement on the TDRL are the same as for permanent retirement for medical disability. The soldier must be unfit, must

TABLE 16-1

ANALOGOUS RATINGS*

Illness	VASRD Code	Analogous Illness
Rhabdomyolysis	5099-5021	Myositis
A-C Separation	5299-5003	Arthritis (pain)
Carpal, Bone Injury	5299-5212	Impairment of radius
Anterior Compartment Syndrome	5299-5312-8723	Muscle injury/Deep peroneal nerve
Pilonidal Cyst	7899-7806	Eczema
Thoracic Outlet Syndrome	8599-8513	All radicular nerve
Tension Headaches, Psychogenic	9499-9423	Undifferentiated somatoform disorder
Hypercoagulable States Rate residuals	7199-7120-7121	Varicose veins/Phlebitis
Ileostomy/Colostomy	7399-7330	Intestinal fistula
Hematological Malignancies	7799-7700	Anemia, pernicious
Stroke	9399-9300	Organic mental disorder plus residuals
Hemiplegia	8599-8520 8513	Sciatic nerve All radicular groups, one side
Paraplegia	8599-8520	Sciatic nerve, bilateral factor
Quadriplegia	8599-8520 8513	Sciatic nerve All radicular groups, bilateral factor

VASRD: Veterans Administration Schedule for Rating Disabilities
*Consult Army Regulation 635-40, Appendix B for other guidance

have a disability rating of at least 30%, or must have at least 20 years of service and be eligible for retirement. The medical condition must be temporary or unstable. A soldier who is determined to be fit will not be placed on the TDRL. By law a soldier may not remain on TDRL for more than 5 years. Termination of TDRL status may occur at any time prior to the 5-year maximum. At the end of 5 years, one of the following determinations must be made. The soldier is (1) retired permanently, (2) separated with severance pay, or (3) found fit. TDRL pay and entitlements automatically stop after 5 years unless the case had been finalized by one of the three prior findings, or variations thereof.

When the soldier is informed of the PEB's findings by the PEBLO, he has 10 days to agree or to disagree with the informal findings. If the soldier agrees and is fit, he is returned to duty. If he agrees and is found unfit, he is processed for separation or retirement. The informal board resolves about 75% of the PEB's cases. If the soldier disagrees with the findings of the informal board, he may request (1) a formal hearing with or without a personal appearance or (2) waiver of a formal hearing with or without a written rebuttal. The soldier may request representation by appointed military legal counsel or by civilian counsel at his own expense. An appointed military lawyer representing a soldier does so with the best interest of the soldier foremost. A soldier who is found fit cannot request a formal board but may file a written rebuttal.

A formal board is convened when (*a*) the soldier or next of kin/guardian requests a formal board or (*b*) the PEB president decides it is in the best interest of the soldier and the army.[22(ch4,¶21a,p15)]

Although a formal board has the same composition as an informal board, the specific members may differ (Figure 16-7). The president of the PEB will establish the date, time, and place of the hearing, providing the soldier with a minimum of 3 working days in which to prepare his/her case.[22(ch4,¶21d)] The PEB will notify the soldier of the

TABLE 16-2

VETERANS ADMINISTRATION SCHEDULE FOR RATING DISABILITIES (VASRD)

Code	Medical Impairment and Rating	%
5292	Spine, limitation of motion of, lumbar:	
	Severe	40
	Moderate	20
	Slight	10
5293	Intervertebral disc syndrome:	
	Pronounced; with persistent symptoms compatible with sciatic neuropathy with characteristic pain and demonstrable muscle spasm, absent ankle jerk, or other neurological findings appropriate to side to diseased disc, little intermittent relief	60
	Severe; recurring attacks, with intermittent relief	40
	Moderate; recurring attacks	20
	Mild; recurring attacks	10
	Postoperative, cured	0
5294	Sacroiliac injury and weakness	
5295	Lumbosacral strain:	
	Severe; with listing of whole spine to opposite side, positive Goldthwaite's sign, marked limitation of forward bending in standing position, loss of lateral motion with osteoarthritic changes, or narrowing or irregularity of joint space, on some of the above with abnormal mobility on forced motion	40
	With muscle spasm on extreme forward bending, loss of lateral spine motion; unilateral, in standing position	20
	With characteristic pain on motion	10
	With slight subjective symptoms only	0

scheduled hearing, notify board members and support staff, arrange for attendance of all military witnesses or obtain depositions, ensure that the soldier's records are furnished to medical witnesses for review before the hearing, and present available witnesses and evidence to the board.[22(ch4,¶d5)] At the formal board the soldier has legal representation, (military, civilian) or self-representation. The appointed military counsel will remain at the hearing and act as co-counsel unless excused by the soldier.[22(ch4.¶e–h)] The duties of the counsel are to safeguard the legal rights of the soldier, prepare the soldier's case for presentation to the board, request that the PEB arrange for witnesses or depositions, examine and cross-examine witnesses, and submit oral and written arguments. The soldier has the right to testify as a witness under oath but also has the right to remain silent.

The proceedings of the PEB are administrative and not judicial in nature; therefore, the board is not bound by rules of evidence prescribed for trials by courts-martial or for court proceedings in general.[22(ch4,¶m.(1))]

The usual formal board begins with the three-member board seated in the hearing room. The soldier, with counsel, reports to the president of the PEB. The president convenes the board and asks the soldier if there has been adequate time for the preparation his case.

Following an affirmative reply, the recorder announces the names and ranks of the board members. At this point the soldier may present any challenges as to board membership and composition. If the soldier challenges a member of the board, and the challenge is upheld by the president of the PEB, that member is excused and replaced by another member who is qualified to sit on the board. If there are no challenges, the president will inquire of the members of the board if they have reviewed the records of the case and whether counsel has any new documentary evidence to present. Having reviewed the new evidence, the president will ask the

NG: National Guard
PDB: Physical Disability Branch
USAPDA: United States Army Physical Disability Agency

Fig. 16-7. The structure of the formal Physical Evaluation Board (PEB) hearing process.

soldier again if he has had adequate time to prepare for the case and if elected counsel is still the soldier's choice. If the response is affirmative, counsel will be asked to present the case. The soldier and any witnesses may be sworn in after initial presentation by counsel or they may elect not to be sworn. Following the swearing in the board members may question the soldier and witnesses. The counsel then presents a summation. Following summation the hearing is closed for deliberation. The meeting is then reopened, the findings and recommendations are presented to the soldier, and the hearing is closed. Following the hearing, counsel discusses the findings with the soldier. The soldier is given a copy of the findings and may elect to make a selection at that time or take up to 10 days to submit a formal rebuttal. On request, counsel will assist in the rebuttal. A formal rebuttal must be based on

1. the decision of the PEB was based on fraud, collusion, or mistake of law;
2. the soldier did not receive a full or fair hearing; and/or
3. substantial new evidence has been obtained that could not be presented prior to disposition by the PEB.[22(ch4,¶21t.(1))]

The evidence on which the rebuttal is based must accompany the rebuttal. Having received a timely rebuttal, the PEB will normally respond within 3 days. The PEB can inform the soldier that (*a*) the rebuttal has been received and has not influenced the outcome of the case but that it will be reviewed by the USAPDA, or (*b*) the PEB has determined that the new information may influence the case. If the latter is true, a formal reconsideration is undertaken, the case is recalled, and the soldier is informed of the outcome of the reconsideration. The soldier has the right to rebut the new findings. The case, along with any rebuttal, will be reviewed by the USAPDA.

The decision options of the formal board are the same as those previously mentioned for the informal board (fit; unfit separated with severence pay [SWSP]; permanent retired [TDRL]). In addition to these most frequently arrived at findings, there are less frequent findings that either the informal or formal board might render.

Soldiers may have medical conditions that existed prior to entry on active duty.[22(ch4,¶19e)] These may present a decided risk to the soldier and to the army. In such cases, if the condition is detected within 6 months of initial entry, and it has been determined that there has been no permanent service aggravation, the soldier may be discharged as personnel who did not meet procurement medical fitness standards.[27(ch2,¶5-11)] In these cases, accession standards,[24(ch12)] rather than retention standards,[24(ch3)] will be applied.

In a similar manner, a soldier with a preexisting disease, usually congenital or hereditary, may be found unfit and separated without benefits (SWOB) if the progression of the disease process is well documented in medical literature and the condition was not permanently service aggravated above and beyond natural progression.

Certain presumptions apply to the physical disability evaluation.[22(ch3,¶2a)] A soldier is presumed to be of sound physical and mental health except for conditions, other than congenital or hereditary, that were noted on the induction physical examination. Any disease or injury discovered subsequently, not due to the soldier's intentional misconduct or willful neglect, is presumed to be service incurred or service aggravated, unless the preponderance of evidence (not merely personal opinion, speculation, or conjuncture) demonstrates otherwise. If a soldier is being processed for separation or retirement for reasons other than physical disability, continued performance of duty commensurate with office, rank, grade, or rating up until the soldier is to be separated or retired, creates a presumption of fitness. This presumption may be overcome if the

medical condition actually rendered the soldier unable to adequately perform duties of office, rank, grade, or rating, or if an acute, grave illness occurred immediately prior to or coincident with separation or retirement.[22(ch3,¶2b)]

In certain instances where injury occurred due to the soldier's own misconduct or willful neglect (ie, not in LOD), the soldier is not eligible for benefits.[22(ch4,¶19g)] Thus, it is important that an LOD investigation report accompany the MEB packet when it is submitted to the PEB. Delay in submission of the LOD investigation report may be the single most important factor in delaying the processing of boards.

In cases of Army Reserve soldiers who are on continuous active duty for more than 30 days, the same rules apply as those for active duty soldiers. For Reserve soldiers who are on active duty less than 30 days, proximate result must be shown. That is, causal relationship must be established between the disability and the required military duty. An LOD determination must be accomplished for those cases. Regulations regarding Reserve Component soldiers are contained in AR 40-501[24(ch9,p66)] and AR 635-40[22(ch8,p43)]

If the PEB finds a soldier unfit, the percentage of disability determines whether the soldier is separated with severance pay; permanently retired; or, if the condition is unstable, temporarily retired. However, the PEB may find that although the soldier is unfit, he should be separated without benefits because (*a*) of LOD findings; (*b*) of existence of disease prior to service that was not permanently service aggravated; or (*c*) proximate cause was not established. The soldier has the right to agree or disagree with the findings. All disagreements are forwarded to USAPDA for review (Figure 16-8).

Review by the USAPDA

In addition to cases in which the soldier disagrees with the findings of the PEB, the USAPDA reviews cases (*a*) of all general officers and medical corps officers, (*b*) in which a voting member of the PEB submits a minority report, (*c*) that have previously been forwarded to the USAPDA and that were returned to the PEB for reconsideration, (*d*) designated by the Commanding General, (*e*) of soldiers assigned to the Disability System (PEB or USAPDA), (*f*) of special interest, and (*g*) selected for quality review.[22(ch4,§V,¶22)]

The USAPDA review is confined to the case records, proceedings, and related evidence. Oversight responsibility lies with the USAPDA to ensure that (*a*) the soldier received a full and fair hearing; (*b*) the proceedings of the MEB and PEB were conducted according to governing regulations; (*c*) the findings and recommendations of the MEB and PEB were just, equitable, consistent with facts, and in keeping with provisions of law and regulations; (*d*) due consideration was given to rebuttals submitted to the PEB; and (*e*) records of the case are accurate and complete.

A case analyst logs in each case on receipt at the USAPDA and distributes it to the agency physician, who reviews the case for medical completeness and agrees or disagrees with the PEB findings. If the physician agrees, the case is forwarded to the Personnel Management Officer (PMO); if the physician, however, disagrees, he prepares a proposed Modification (MOD) to the findings and calls the PEB to discuss the case with the PEB physician. This discussion is annotated, and if there is no mitigating evidence for the findings by the PEB, the proposed MOD is forwarded to the PMO.

The PMO reviews the case with special emphasis on how the medical condition relates to the soldier's assigned duties, office, rank, evaluation reports, and commander's statement of performance. Personnel records are again screened to ensure that administrative or judicial actions have not been taken by the soldier's unit or the Department of the Army. Reserve and National Guard cases are reviewed to ensure that they are eligible for disability processing. The PMO is usually a Reserve or National Guard member.

If the PMO determines that there is a discrepancy on any of these issues, a MOD may be generated by the PMO. The PMO also reviews any MOD generated by the physician and agrees or disagrees with the MOD. If there is disagreement, the PMO discusses the case with the physician and consensus is reached. The case is then reviewed by the Operations, Evaluations, and Analysis Officer (OEA). The OEA reviews all cases previously listed plus any MODs, and prepares the cases for signing by the Deputy Commander. All cases with potential legal ramifications are reviewed by USAPDA legal counsel.

Final Outcome of the Review by USAPDA

Any case in which USAPDA agrees with the PEB is forwarded to the PDB for the issuance of orders. Any case with a MOD is returned to the PEB for information. The soldier is informed of that MOD by the USAPDA. The soldier may submit a written rebuttal if he disagrees with the MOD; if he does,

MEB: Medical Evaluation Board
MOD: modification
PDB: Physical Disability Branch
PEB: Physical Evaluation Board

Fig. 16-8. The overall structure of the complete US Army physical disability process.

the case is again reviewed with the rebuttal. USAPDA informs the soldier whether the rebuttal was upheld (agreed with) and the findings changed, or whether the findings were unchanged. If the rebuttal is not upheld, the case is forwarded to the Army Physical Disability Appeals Board (APDAB) for review. APDAB is one of three independent boards of review that advise the Secretary of the Army; it is not part of USAPDA. If APDAB agrees with USAPDA, the case is finalized and the soldier is either discharged, separated, or returned to duty. If APDAB disagrees, the case is reviewed again by the USAPDA and the appropriate action taken as recommended by APDAB.

In summary, the USAPDA may (*a*) agree with the findings of the PEB; (*b*) return the case to the PEB

TABLE 16-3

KEY STATUTORY PROVISIONS OF THE CAREER COMPENSATION ACT OF 1949, U.S.C. 63 STAT. 802 AS AMENDED 10 U.S.C. 1201 ET SEQ

Disposition	LOD	Entitled To Basic Pay	Proximate Result*	Severity > 30%	Severity < 30%
Permanent Disability Retired List	Yes	Yes	Yes	Yes†	No
Temporary Disability Retired List‡	Yes	Yes	Yes	Yes†	No
Separate With Severance Pay	Yes	Yes	Yes	NA	Yes
Separate Without Benefits	No	No	No	NA	NA

LOD: line of duty
*Reserve component soldiers who have served 30 days or less on active duty
†If otherwise retirement eligible, any percentage
‡5-year limit by law

for reconsideration when case records indicate that such reconsideration is in the best interest of the soldier and the government; or (*c*) issue revised findings, that is, modify the disposition or rating of the soldier. In such cases, a detailed explanation will accompany the change. The final appeal determination that USAPDA can grant is referral of the case to APDAB.

When findings are revised, USAPDA will (*a*) furnish the soldier a copy of the revised findings with information copies to the PEBLO and the soldier's counsel; (*b*) advise the soldier he has 10 days to accept or rebut the revision in writing; or (*c*) if the soldier has not had a formal hearing, return the case to the PEB, recommending a formal hearing.

If the soldier agrees with the revision, it will be approved for the Secretary of the Army and forwarded to the PDB for orders. If the soldier disagrees with the review and submits a statement of rebuttal, and if consideration of the rebuttal does not result in any change, a letter will be forwarded to the soldier indicating that no change was made and the case will then be forwarded to APDAB for review. This review will be the final review and the recommendation by APDAB will be returned to the USAPDA who, after making the recommended changes, will forward the case to the Total Army PERSCOM for final disposition. PERSCOM makes final disposition of the cases based on the final decision of USAPDA or APDAB. Orders vary with the final outcome of the case: (*a*) permanent retirement for physical disability (10 U.S.C. 1201 or 1204); (*b*) placement on the TDRL (10 U.S.C. 1202 or 1205); (*c*) separate for physical disability with severance pay (10 U.S.C. 1202 or 1206); (*d*) separate for physical disability without severance pay (sections 630, 1162(a), 1165, or 1169, Title 10 United States Code; (*e*) transfer of soldier who had 20 qualifying years in the reserve to inactive reserve on soldier's request (10 U.S.C. 1209); (*f*) release from active duty and return to retired status for retired soldier serving on active duty who was found to be physically unfit; or (*g*) return to duty of soldiers found fit. This process is summarized in Table 16-3. If the soldier still does not agree with the disposition, he may petition the Army Board for Correction of Military Records requesting review and change when he is no longer in the military.

Statistics Illustrating the Function of the Army Physical Disability System

The following statistical data are presented to illustrate the volume and variety of dispositions made by the army physical disability system. The overall workload of the USAPDA since 1987 has been relatively constant except for the peaks in the years 1991 and 1992 that reflect the effect of the army mobilization during the Persian Gulf War (Figure 16-9). During the period FY 1987 through FY 1997, on average, about 88% of the new cases were active duty soldiers and 12% reserve component. During the first half of this period there were four PEBs (the Georgia PEB closed in 1993). The partition of the caseload among the three existing PEBs was relatively similar during FY 1994 through FY 1997: Walter Reed Army Medical Center processed 35% of the cases, Fort Sam Houston 36%, and Fort Lewis the other 29% (Table 16-4). It should be noted that at this time, there is not an exact parallel configuration between the largest 15 MTFs and the three PEBs (Table 16-5).

TABLE 16-4

PHYSICAL EVALUATION BOARDS CASE DISTRIBUTION: TOTAL CASES RECEIVED

Fiscal Year	Walter Reed Army Medical Center Washington, DC	Fort Gordon Georgia*	Fort Sam Houston Texas	Fort Lewis Washington
1989	2,536	2,150	2,592	2,567
1990	2,592	2,725	3,258	2,732
1991	3,348	2,876	3,578	2,896
1992	2,540	3,373	3,776	2,933
1993	1,986	1,458	1,761	1,388
1994	2,562		2,774	2,266
1995	2,542		2,582	2,249
1996	2,979		2,601	2,408
1997	2,660		3,296	2,164
TOTALS	23,745	12,582	26,218	21,603

*Georgia Physical Evaluation Board closed in 1993

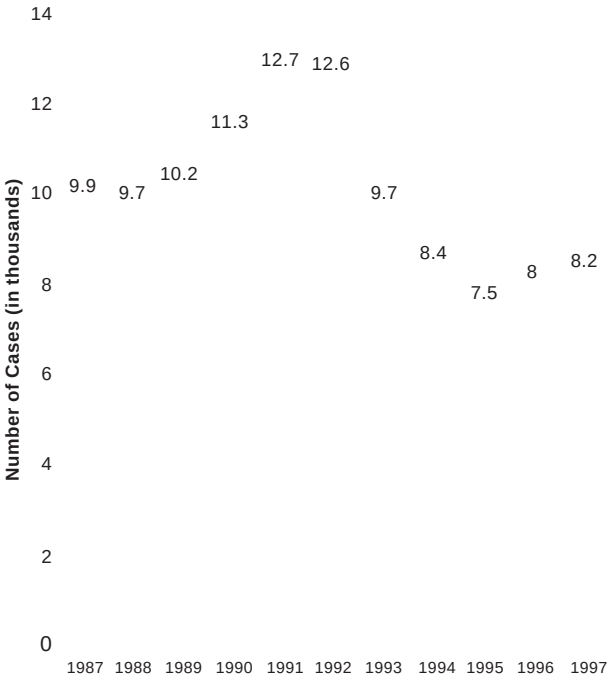


Fig. 16-9. US Army physical disability system, overall work load completed for fiscal years 1987 through 1997.

TABLE 16-5

TOP 15 POSTS SENDING CASES TO THE DC, TEXAS, AND WASHINGTON PEBs (Total Combined Cases Sent: 5,066)

MTF	Cases	PEB Processing Cases
Walter Reed AMC	618	WRAMC, Washington, DC
Fort Campbell	432	Fort Sam Houston, Texas
Fort Hood	411	Fort Sam Houston, Texas
Fort Knox	387	Fort Sam Houston, Texas
Fort Sam Houston	340	Fort Sam Houston, Texas
Fort Gordon	340	Fort Sam Houston, Texas
Fort Bragg	338	WRAMC, Washington, DC
Tripler AMC	309	Fort Lewis, Washington
Fort Benning	300	Fort Sam Houston, Texas
Fort Stewart	292	Fort Sam Houston, Texas
Madigan AMC	289	Fort Lewis, Washington
Fort Leonard Wood	280	Fort Lewis, Washington
Fort Polk	252	Fort Lewis, Washington
Fort Carson	247	Fort Lewis, Washington
Fitzsimons AMC	231	Fort Lewis, Washington

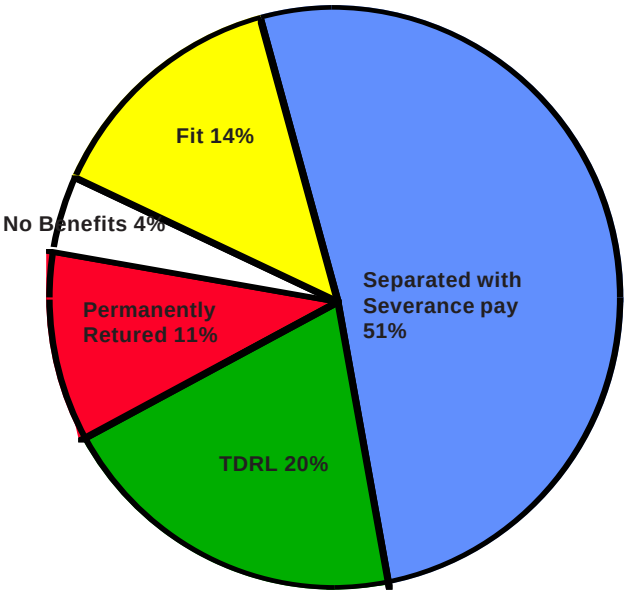
AMC: Army Medical Center
MTF: Medical Treatment Facility
PEB: Physical Evaluation Board
WRAMC: Walter Reed Army Medical Center

TABLE 16-6

MOST FREQUENTLY USED VASRD CODES

VASRD	Cases	Total Cases %
5003	Arthritis (degenerative)	11.9
5295	Back (physical)	8.3
5257	Knee	6.0
5293	Back (neurologic)	2.9
5010	Arthritis (traumatic)	2.3
6351	HIV	2.2
9208	Bipolar Disorder	2.2
9207	Major Depression	2.2
8045	Brain Disease	1.5
6602	Asthma	1.4
5255	Femur	1.3
5024	Tenosynovitis	1.2
9210	Psychosis	1.2
9304	Dementia	1.2
5276	Flat Feet	1.2

HIV: human immunodeficiency virus
VASRD: Veterans Administration Schedule for Rating Disabilities

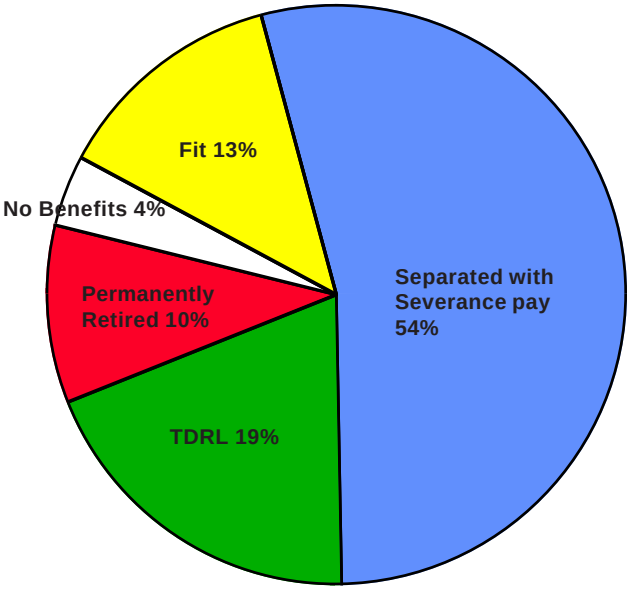


TDRL: Temporary Disability Retired List

Fig. 16-10. Total Physical Evaluation Board case dispositions for fiscal years 1987 through 1997, by outcome (108,200).

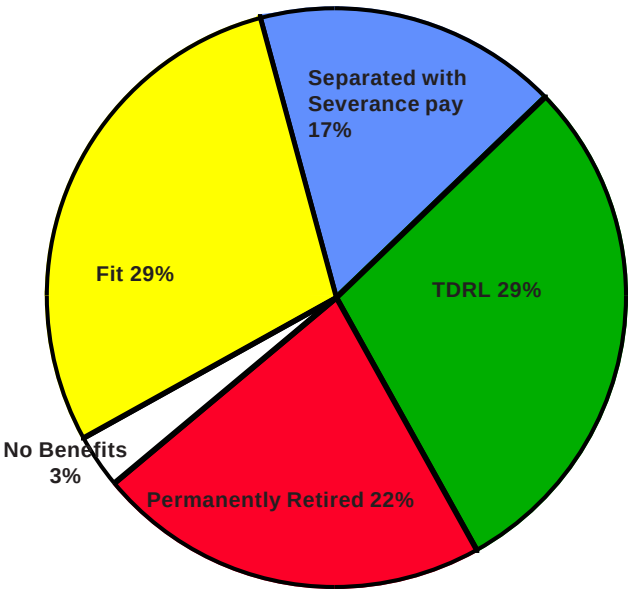
Soldiers entering the army physical disability program are found to have a large variety of medical conditions, with most occurring with low frequency. The 15 most common medical conditions coded by the VASRD account for only 47% of the total number of cases (Table 16-6). These codes will change because of recent policy changes; many of the 5003 codes for arthritis are being moved to the exact anatomical location, most commonly 5295 (back) or 5257 (knee). In addition, all human immunodeficiency virus (HIV) cases are being coded as 6351. Prior to 1991, codes 6351, 6352, and 6353 were all used for HIV.

The disposition outcomes of cases by PEBs fall into five categories: (1) separation with severance pay, (2) placement on the temporary disability retired list, (3) permanently retired, (4) separated without benefits, and (5) found fit. When all dispositions are considered for the period FY 1987 through FY 1997, the most common outcome was separation with severance pay (51%) (Figure 16-10). Almost one-fifth of cases saw no award of money because most soldiers in this category were either found fit or separated without benefits. The disposition for enlisted men is shown in Figure 16-11; the



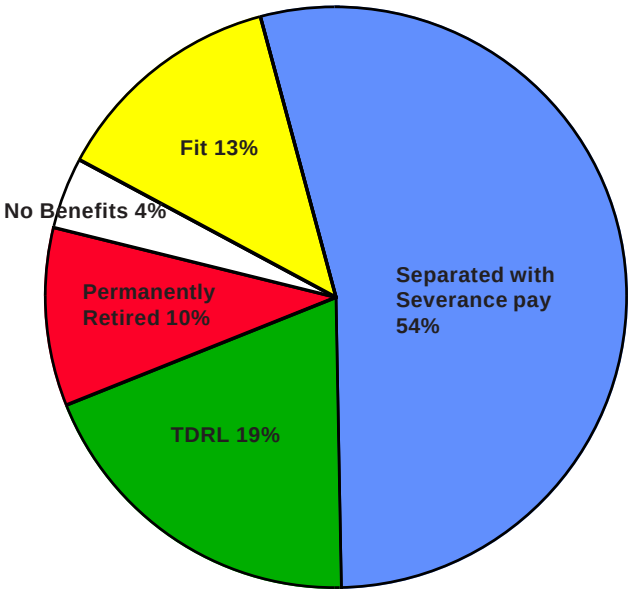
TDRL: Temporary Disability Retired List

Fig. 16-11. Total Physical Evaluation Board case dispositions of enlisted personnel for fiscal years 1987 through 1997, by outcome (99,544).



TDRL: Temporary Disability Retired List

Fig. 16-12. Total Physical Evaluation Board case dispositions of officers for fiscal years 1987 through 1997, by outcome (8,656).

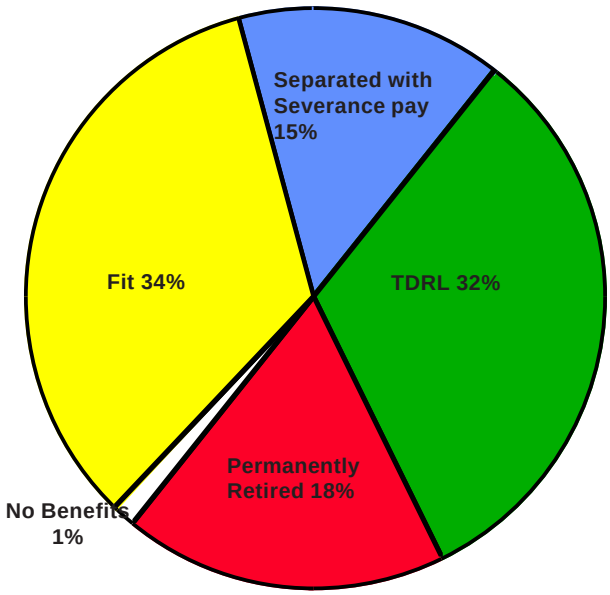


TDRL: Temporary Disability Retired List

Fig. 16-13. Total Physical Evaluation Board Regular Army case dispositions for fiscal years 1987 through 1997, by outcome (95,216).

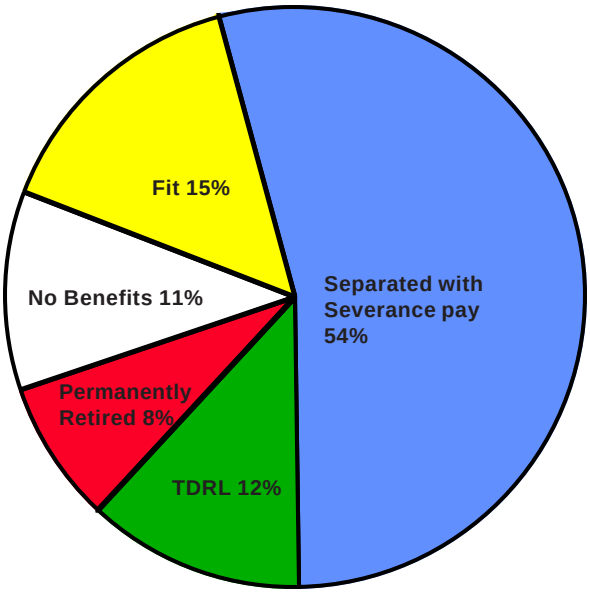
disposition for officers is shown in Figure 16-12. Compared to enlisted personnel, officers were more than twice as likely either to be found fit or to be permanently retired. Conversely, it was uncommon for officers to be separated with severance pay. In considering these data it should be borne in mind that the officers were older and were more likely to have multiple diagnoses that were of a chronic nature. Enlisted soldiers had more acute injury residuals and were younger, usually being healthy otherwise. It is to be expected that the increased number of diagnoses and the increased severity of the disease in officers resulted in a higher overall disability rating reflected in the higher percentage permanently retired.

At any given time, members of the Total Army consist of three components: Active Army, the Army National Guard (ANG), and the Army Reserve (USAR). The Active Army, the principle source of cases for the army physical disability system, consists of the Regular Army, soldiers of the National Guard on active duty, and activated members of the Reserve. The PEB disposition of Regular Army and Active Guard Reserve (AGR) soldiers on active duty might be expected to differ from soldiers who have been temporarily activated (Figures 16-13, 16-14, and 16-15). Regular Army and AGR soldiers have a similar distribution of dispositions, but compared to temporarily activated soldiers seen by the PEBs, have a much lower probability of being found fit



TDRL: Temporary Disability Retired List

Fig. 16-14. Total Physical Evaluation Board Army National Guard case dispositions for fiscal years 1987 through 1997, by outcome (5,410).



TDRL: Temporary Disability Retired List

Fig. 16-15. Total Physical Evaluation Board Army Reserve case dispositions for fiscal years 1987 through 1997, by outcome (7,574).

or being placed on the TDRL. Conversely, Reserve and National Guard soldiers on temporary active duty are less likely to be separated with severance pay. One way of interpreting the finding is that a larger percentage of activated National Guard and Reserve component soldiers are being found fit because these soldiers wanted to be found fit, a conclusion supported by their performance data, including their commanders' statements and evaluation reports. Analysis of the increased percentage of SWOBs for the Reserve Component indicated a direct correlation with the proximate result findings (ie, a direct result of performing military duty). In the majority of these cases the medical impairment was not the direct result of performance of military duty. The PEB is a performance based system and the Commander knows best how his soldiers can perform assigned tasks.

Benefits paid by the USAPDS for FY 1987 through 1989 averaged $477 million per fiscal year. This amount has been fairly constant year by year except for FY 1990 through FY 1992, which reflects the Persian Gulf War years. Data for FY 1997 indicate that $344.5 million was paid out in benefits; 76% went to soldiers who were permanently retired; 18.8% went to soldiers who were separated with severance pay; and 5% of the money went to soldiers who were placed on the TDRL, even though 20% of total dispositions in FY 1987 through FY 1997 were TDRL. Thus, it was more cost-effective from the government's standpoint to place soldiers on TDRL rather than to permanently retire them when their disease/condition first manifests itself.

THE US NAVY AND AIR FORCE DISABILITY SYSTEMS

The following is a brief review of the US Navy and Air Force disability systems and a comparison of disability dispositions for the three services for FY 1997 (Table 16-7). There is no separate marine disability system; the navy disability system is also responsible for the marines.

US Navy

The naval disability system is a component of the Naval Council of Personnel Boards and is directly under the Assistant Secretary of the Navy for Manpower and Reserve Affairs. The navy has one informal PEB and two formal PEBs. The formal boards are located in San Diego, California, and at the National Naval Medical Center, in Bethesda, Maryland. Although different individuals sit on the informal and formal boards, each of the boards is composed of one navy line officer, one marine line officer, and one navy physician.

In FY 1997 the navy processed 10,196 cases; 1,057 (10%) sailors and marines were found fit; and 9,139

TABLE 16-7

TRISERVICE COMPARISON STATISTICS FY 1997

Element	Air Force	Army	Navy
Total New Cases*	4,045	8,038	10,196
Fit	1,776	1,162	1,057
Unfit	2,269	6,876	9,139
SWSP	867	4,109	5,258
PERM	648	850	1,071
TDRL	655	1,584	2,045
SWOB	99	333	765

PERM: Permanent Disability Retired List
SWOB: separated without benefits
SWSP: separated with severance pay
TDRL: Temporary Disability Retired List
*Old TDRL cases not counted

(90%) were found unfit. Of the unfit sailors and marines, 5,258 (58%) were separated with severance pay; 1,071 (12%) were permanently retired; 2,045 (22%) were placed on the TDRL; and 765 (8%) were separated without benefits.

US Air Force

The Air Force disability system has one informal board and one formal board. Both of these boards are part of the Air Force Personnel Center located at Randolph Air Force Base, Texas. The Informal Board is composed of two air force physicians and one air force line officer; the Formal Board has two air force line officers and one air force physician. The members sitting on the informal and formal boards are not the same individuals. In FY 1997 the air force processed 4,045 airmen, of whom 1,776 (44%) were found fit and 2,269 (56%) were found unfit. Of those airmen found unfit, 867 (38%) were separated with severance pay; 648 (29%) were permanently retired; 655 (29%) were placed on the TDRL; and 99 (4%) were separated without benefits.

Comments

As one can see, the Disability Boards of the three services are fairly consistent in the findings of service members appearing before them. This is to be expected because they are all governed by the same law (Chapter 61, Title 10 U.S.C.). The differences can be explained in the manner in which the service secretaries choose to implement the disability system within their service. The army has the same members sitting on their informal and formal boards. The air force and the navy have different members sitting on their informal and formal boards. The air force finds a greater percentage of airmen fit due to the fact that they have within each of their units a given number of nondeployable slots to which airmen may be assigned. With these slots being available, the air force board can find an airman fit and assign him to a nondeployable slot. As a group these individuals are classified as Code C. The army and navy do not have a comparable classification and, thus, have a lower percentage of fit findings.

CONCLUSION

The United States Army Physical Disability System is a segment of the army unknown to the majority of soldiers—those who have never had significant medical conditions. But to that minority whose military careers have been terminated by medical conditions, it becomes an advocate for transition of the disabled soldier into civilian life. The disability system assists the soldier at every stage with counseling to ensure that he receives a full and fair hearing and just compensation for a medical condition sustained while in service of his country.

For over 50 years, the present disability system has been helping soldiers. It is an integral part of the army in the maintenance of a full and fit force. For soldiers who cannot continue military service due to medical impairment, the army stands ready to provide for them through a "Quality Disability System Administered with Pride."

ACKNOWLEDGMENT

The author thanks his associate and fellow physician, Dr. Donald Howie, for his support and assistance, and for his historical contribution to the establishment of the USAPDA, without which we would probably not have the USAPDA as we know it today. The author thanks Roderick F. Faulkner, former Chief Graphics Illustrator with the USAPDA, for his invaluable assistance in preparation of the text and graphics.

REFERENCES

1. Love AG, ed. Medical and casualty statistics. Part 2. In: Statistics. Vol 15. In: *The Medical Department of the United States Army in the World War.* Washington, DC: US Government Printing Office; 1925: 1181–1183.

2. Reister FA. *Medical Statistics in World War II.* Washington, DC: Office of The Surgeon General, US Department of the Army; 1975: 13.

3. Reister FA. *Battle Casualties and Medical Statistics: US Army Experience in Korea.* Washington, DC: Office of The Surgeon General, US Department of the Army; 1973: 7;12-17.

4. Neel S. *Medical Support of the US Army in Vietnam 1965-1970.* Washington, DC: US Department of the Army; 1973: 52–53.

5. Howie D, Chair. Report of Study Group on the Disability Retirement System. Washington, DC: US Department of Defense. 17 January 1966.

6. Karamer SN. *History Begins at Sumer.* London, England: Thames and Hudson; 1959: 93.

7. Gurts A, Kaornblith B, Urmson J. *Compensation Bodily Harm.* Brussels: Fernand Nathan; 1977: 7–211.

8. 43 Elizabeth, Ch 3.

9. *Journals of the Continental Congress.* Vol 5; 702.

10. U.S.C. 10 Stat. 616.

11. U.S.C. 12 Stat. 289.

12. U.S.C. 12 Stat. 566.

13. U.S.C. 45 Stat. 735.

14. U.S.C. 40 Stat. 398.

15. U.S.C. 53 Stat. 557.

16. U.S.C. 55 Stat. 394.

17. Career Compensation Act of 1949. U.S.C. 63 Stat. 802.

18. Career Compensation Act of 1949. U.S.C. 63 Stat. 802, *as amended* 10 U.S.C. 1201 et seq.

19. US Department of Defense. *Uniform Interpretation of Laws Relative to Separation.* Washington, DC: DA; 1951. DoD Directive 1332.18.

20. US Department of the Army. *Physical Evaluation for Retention, Retirement, or Separation.* Washington, DC: DA; 1968. Army Regulation 635-40.

21. US Department of Defense. *Uniform Interpretation of Laws Relative to Separation.* Washington, DC: DA; 1996. DoD Directive 1332.38.

22. US Department of the Army. *Physical Evaluation for Retention, Retirement, or Separation.* Washington, DC: DA; 1990. Army Regulation 635-40.

23. Hickman, James, Lieutenant Colonel, Chief, Operations, Evaluation and Analysis Division; US Army Physical Disability Agency. Personal Communication.

24 US Department of the Army. *Standards of Medical Fitness.* Washington, DC: DA; 1995. Army Regulation 40-501.

25. US Department of the Army. Medical Services Patient Administration. Washington, DC: DA; 1990. Army Regulation 40-400.

26. US Department of the Army. *Personnel Absences: Leaves and Passes.* Washington, DC: DA; 1994. Army Regulation 600-8-10.

27. US Department of the Army. *Personnel Separations: Enlisted Personnel.* Washington, DC: DA; 1990. Army Regulation 635-200.