

ARMY PHYSICAL DISABILITY EVALUATION SYSTEM: TIME FOR AN OVERHAUL, NOT AN ANALYSIS

BY

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USAWC CIVILIAN RESEARCH PROJECT

**ARMY PHYSICAL DISABILITY EVALUATION SYSTEM:
TIME FOR AN OVERHAUL, NOT AN ANALYSIS**

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ABSTRACT

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TABLE OF CONTENTS

ABSTRACT

LIST OF ILLUSTRATIONS

AGENDA

- **INTRODUCTION**
 - a. Explanation of the Problem
 - b. Identifying the Strategic Issue
 - c. Status of the Reserve Forces
- **Review of Army PDES System**
 - a. Inequities of PDES System
 - b. Practical Effects of RC Mobilization
 - c. Inequities of Post-Deployment System
 - d. Practical Effect of CBWTUs and COAD
- **Recommendations/Conclusion**
 - a. MMRB for Everyone
 - b. LOD under Same Standard
 - c. COAD for Everyone

LIST OF ILLUSTRATIONS

FIGURE 1. Overview of the Physical Disability Evaluation System (PDES)	
 From Soup to Peanuts.....	5
FIGURE 2. US Army Warrior Transition Unit.....	11

ARMY PHYSICAL DISABILITY EVALUATION SYSTEM: TIME FOR AN OVERHAUL, NOT AN ANALYSIS

The current Army Physical Disability Evaluation System (PDES) that has been utilized since the Global War on Terror (GWOT) began has gone through numerous evaluations, task force reviews and legislative initiatives. The consensus in most every one of these reviews has been an inconsistent system of evaluation and a lack of continuum of care. There have been various policies and subsequent revisions of each year's National Defense Authorization Act to remedy the perceived flaws in the system. Regardless of these reviews and revisions, when viewed from the perspective of the Reserve Component Servicemember this process presents a system of inequity when compared to the treatment of his Active Component brethren. This article will briefly analyze the deficiencies of the current disability system as it pertains to Reserve Soldiers who are determined to be non-deployable or subsequently injured while on active duty. The article will then address the recent task force study completed by Gen. (Ret.) Tommy Franks coupled with the current statutory mandates in an attempt to offer a practical solution that decreases the reliance upon unqualified medical personnel and can be facilitated with current personnel rather than merely hiring and/or adding personnel to address a simple but costly dilemma of what the Army is to do with its wounded warriors within the Reserve components.

By all accounts during the last two years the number of soldiers within the Reserve Component, i.e. National Guard and U.S. Army Reserves that are unable to deploy due to disqualifying health conditions have increased and in some instances at alarming rates.¹ (reference?) Consequently, it should not be a surprise that many of the Guard and Reserve units throughout the country are not mission capable due to the number of non-deployable soldiers

within their ranks. As a result of this deficiency, upon learning of a deployment, many units are forced to cross-level or require Soldiers from other units to fill the gaps necessary to satisfy deployment requirements. This type of gap-filling only lessens the efficacy of the unit from which the Servicemember was transferred and ultimately the overall operational readiness of the Guard and Reserves. (reference?) While deployed, it is common for both Guard and Reserve units to not be utilized in their traditional operational roles. These modified units are mobilized under what is termed a Joint Manning Document and are being utilized for the most part as security forces and the training of civil-military security forces such as the Afghanistan National Army and therefore not requiring any degree of proficiency in any specific occupational specialty such as a tank crewman or an artillery munitions expert. However, it is very shortsighted to believe that the only role of the Reserve Components in the future will be to provide security or training of a security force in the Middle East and not as an operational force. As set forth in the 2006 Quadrennial Defense Review (QDR), measures must be taken to enhance the Reserves' readiness so that each unit can perform its intended mission to become more "operationalized" so that select Reservists and units are more accessible and more readily deployable than today.² The most recent QDR reiterates the Army's requirement to employ National Guard and Reserve forces as an operational reserve to fulfill requirements in the States and overseas.³ The current PDES has frustrated the ability of, if not made it totally impossible, for Reserve readiness to satisfy this operationalized. requirement.

The current PDES has come under serious scrutiny by the Department of the Army. The deficiencies at Walter Reed concerning the level of care and the administrative review of injured Soldiers has led to many reviews, studies, hiring of consulting firms and testimony before congressional committees due to the deficiencies discovered by an independent panel that was

ordered to review the rehabilitative processes at Walter Reed and the National Naval Medical Center.⁴ While this study and others have identified a plethora of issues and subsequently an extraordinary amount of attention being given to this problem, there has been little to no improvement in the system. There is a pilot PDES system underway that has a basic premise of eliminating the dual adjudication of determining disability of an injured soldier by both the Veteran's Administration (VA) and each of the Armed Services. Until these recommendations are finalized and the DES pilot runs its course, the leading guideline appears to be the recommendations provided by a Task Force led by Retired General Tommy Franks.⁵ The findings from this task force have recently resulted in a directive to Army Commanders from the Chief of Staff to begin initiatives to comply with many of General Frank's recommendations as set forth in a recent ALARACT message.⁶ All of the recommendations were insightful but the answer to almost every problem was the hiring of more medical staff and Physical Evaluation Board Liaison Officers (PEBLOs) and providing additional incentives to medical personnel. This article contends the PDES system has become too cumbersome and additional money and personnel aren't necessarily the solution and that the military should consider looking to the civilian court system for guidance on this matter.

This current PDES system and the GWOT has magnified the lack of medical readiness of the Reserve Forces. The number of Reserve soldiers that are currently non-deployable continues to rise in a meteoric fashion. In fiscal year 2007 and 2008, the number and percentage of Reserve Soldiers who did not meet minimum physical profile standards required for deployment are as follows:

In FY08, 215,792 ARNG Soldiers underwent a screening. Of these personnel, 14,700 or 6.8 percent were identified for review due to a profile-limiting condition or failure to meet

retention standards. In FY07, 155,662 ARNG Soldiers underwent a physical. Of these personnel, 5,606 or 3.6 percent were identified for review due to a profile-limiting condition or failure to meet retention standards.⁷

In FY 08, 65,209 Army Reserve Soldiers underwent a screening. Of these personnel 3,572 or 5.4 percent were identified for review due to a profile-limiting condition or failure to meet retention standards. In FY07, 56,384 Army Reserve Soldiers underwent a physical. Of these personnel 9,073 or 16 percent were identified for review due to a profile limiting condition or failure to meet retention standards.⁸

Furthermore, the number and percentage of new Reserve Soldiers that were transferred from deployable to non-deployable status in fiscal year 08 are as follows:

In FY 08, 10,536 ARNG Soldiers were transferred from deployable to nondeployable status for failing to meet medical deployability standards.⁹

In FY08, 9,128 Army Reserve Soldiers were transferred from deployable to nondeployable for failing to meet medical deployability standards..¹⁰

The addition of approximately twenty thousand Reservists being added to the ranks of the nondeployable last year would not be that surprising they were being screened for their first round of deployments. However that was not the case and is problematic when we are nine years into a low intensity conflict and this number is added to the list of Servicemembers that are unable to fight. To put this in perspective, this increase of nondeployable personnel in 2008, coupled with the number of Reservists that were discovered with profiles that prevented them from deploying in 2007 and 2008, is the equivalent of fifty percent of our troop commitment in Afghanistan after President Obama committed an extra 30,000 troops. Many of the Soldiers that were determined to be non-deployable had medical issues that were not considered combat-

related injuries. As stated above many Soldiers merely failed to deploy as a result of pre-deployment screening at the mobilization station. These soldiers normally don't ever follow through on the proper process (for numerous reasons to be discussed) after they are determined to be non-deployable and released from active duty. This will remain the Servicemember's status until he is separated due to an Expiration of Term of Service (ETS), retires or is processed for a subsequent deployment where increased scrutiny of the Reservist's medical condition again determines that he is non-deployable. While this system appears the most equitable for the Reservist it is crippling the readiness of the Reserve forces should the Reserves continue to be needed as an operational force.

The following diagram sets forth the current flow of an RC and AC Servicemember that presents at a mobilization site with an injury/condition.

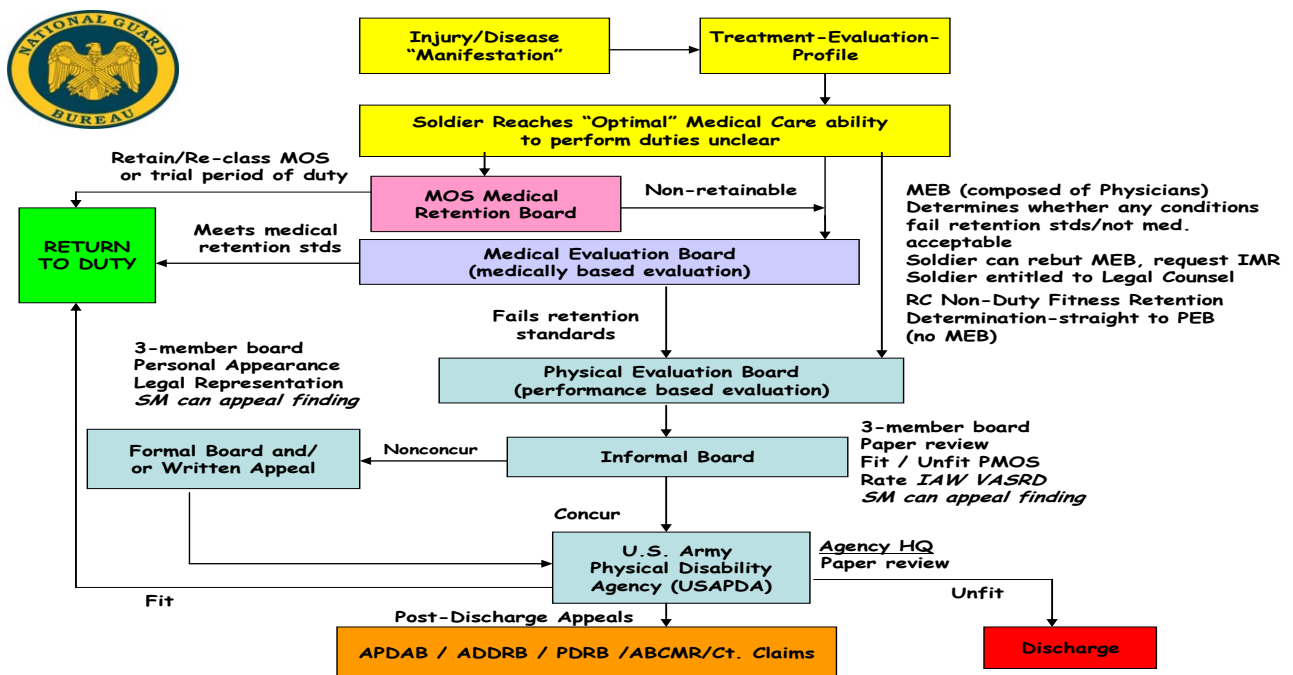


Figure 1¹¹

As the diagram depicts, there is a distinct difference in the deployment processing of Reserve Component Soldier when a condition or injury is discovered during the Soldier Readiness Processing for a combat deployment when compared to the treatment of an Active Component Soldier. In many instances where it is determined that a Reservist's injury or condition existed prior to entry into service (EPTS), he is released from active duty with a requirement to attend a Physical evaluation board. This is not only an injustice to the Reserves and National Guard but the processing of a Reserve Soldier through the process in Figure 1 is either not occurring or is taking an unacceptable amount of time to complete which is crippling the readiness of the Reserve Component.

The Active Component servicemember that enters through the same mobilization station is provided with the benefit of a regulation that grants the him/her a presumption of fitness or in other words, a presumption the injury occurred in the Line of Duty (LOD).¹² Active Component soldiers whose medical conditions prevent them from deploying at the Mobilization site are given the opportunity to complete a Military Occupational Specialty (MOS) (spell out with first time usage) medical retention board (MMRB). This is the most significant difference between the Reserve and Active Component as evinced by the increasing numbers of non-deployables from the aforementioned Army Posture Statements. The practical effect of this regulation requires every deploying Reservist to go through a cursory medical examination to determine fitness and, if they are determined to be unfit, they are released from active duty within 30 days to ensure the Reservist's injury is not considered to be within the LOD.

From a fiscal standpoint, it is understood that neither the Army nor any of the rest of the Armed Forces can assume liability for every injury incurred by a Reservist when the injury was not in the line of duty. Fiscal avoidance of a pre-existing injury appears to be the basis for

releasing Soldiers from Active Duty from active duty in the first 30 days of deployment when the Reservist is diagnosed with an injury that lacked the requisite documentation that the injury was incurred or was exacerbated in the line of duty. However, under the current regulation Active Component Servicemember's injuries are almost always within the line of duty when they are injured in their nonmilitary related activities such as skiing or four-wheeling as long as it is determined that there is not willful misconduct such as excessive alcohol use. Due to the extensive use of the Reserve forces in the current operational tempo and the large number of Soldiers that are being considered non-deployable it could be argued from a strategic requirement that the same expansive interpretation afforded Active Component Servicemembers should be utilized when adjudicating a line of duty on an injury to a Reservist. Should the Army continue with this practice, the practical result will be that many qualified Reservists will continue to not meet deployment standards while being qualified to serve and deploy in an alternate MOS.

The pre-deployment examinations that conclude the Reservist was not injured in the LOD are creating an administrative stovepipe that the Reserves and National Guard are unable to manage. Sending a part time or M-day Reservist to an appointment at a remote Military Treatment Facility (MTF) for a PEB when that Reservist has civilian responsibilities and is keenly aware that he will most likely lose his drill check based on the results of the appointment is problematic at best. Where Soldiers are willing to appear at these hearings, the lack of physicians conducting these hearing and the logistics problem of actually placing a Reservist back on orders to go through the PEB process appears to be a bridge too far. Upon interviewing an unnamed personnel director in the National Guard it was stated the Active Component system that actually conducts the PEB has inadequate resources to conduct these review boards

for the Reserve Forces until the backlog of MEBs are completed for the active component. This MEB has been a constant source of non-compliance within the Army as it is unable to meet neither the 90 day DoD standard nor its own 30 day time standard as documented in various inspections by the Army Inspector General.¹³ This waiting period leaves the Reserves with an individual that is unable to be deployed and in many cases is slotted in a critical specialty. The common answer for many Reserve units across the nation to this dilemma is to place the non-deployable Reservist in an MOS that doesn't normally deploy such as a personnel specialist. Currently the transfer of a Reservist to a non-deployable MOS isn't that big of a problem because another Reservist can be plucked from another unit in the Reserves to train security forces, provide security for convoys or detainees in the current mode that Reserve Forces are being utilized in our current war on terror. However when the conflict elevates to a degree that demands technical expertise exceeding the need to provide convoy security, recognize improvised explosive devices and suicide bombers then suddenly the unit's effectiveness as a whole such as an artillery battery will sorely miss these non-deployable personnel. These technical skills will be difficult to quickly duplicate in order to wage any type of an offensive by an operational force.

The above process is the proximate cause for the lack of personnel readiness in the Reserve component. When medical personnel determine that a Reservist is non-deployable, that Reservist should be sent through a MOS medical retention board (MMRB) process immediately rather than sent back to their rural hometown to wait for their ETS date or to being barred from reenlistment due to a medical disqualification. Otherwise, if the system functions as it should the Reservist is to attend what, in most cases, will be a career ending Physical Evaluation Board should that process ever actually occur. The primary strategic factor to be considered in this

process is that a Reserve Component Commander will not deploy with individuals that he does not consider critical to his mission or capable of performing the tasks set forth on the Joint Manning Document. In many instances the disqualifying profile or medical condition found was unknown to the Servicemember and he was performing his assigned duties without any sort of limitation. Ironically, when he is summoned to be deployed the Reservists is told his only recourse is to have a board determine whether he is physically qualified to perform his MOS which he was probably not going to perform while being deployed. The vast financial investment placed in the Servicemember and the obvious amount of faith placed in the Servicemember by his unit to be taken on a combat deployment is systematically vanquished by a medical condition that can be as innocuous as lack of knee flexion.¹⁴

While the pre-deployment process and the inequity of not being allowed to timely reclassify a Reserve Servicemember in an alternate MOS for deployment is troublesome, the post deployment process only magnifies the lack of readiness of both the Reserve and Active Duty. It is a general assumption in military personnel circles that an injured Servicemember injured in the line of duty should receive a disability from the VA in all cases and other entitlements depending on his term of service should he not be able to return to duty. This sounds like a very easy equation and should be very easy to manage. However, due to the many programs available to assist a wounded Servicemember in the healing process this simple classification system has been swallowed by the exceptions. While these exceptions are providing many options for Reservists and Active duty Servicemembers, these same exceptions are crippling the readiness of our forces. These exceptions and the time frame to adjudicate a case through the current PDES are also failing the needs of Reservists. Upon return from a deployment every Servicemember is required to undergo a Post Deployment Health Care Summary that details any of the soldiers

ailments/injuries that may have occurred or exacerbated during the Servicemember's deployment. The Servicemember who doesn't wish to remain at the mobilization station on some sort of active duty status will often always choose to conceal or minimize their injury to see their family. There are programs to bring the Reservist back on active duty to address the injuries but the onus of proving the injury was incurred in the LOD is on the Reservist.

Where there has been doubt or confusion concerning a Servicemember's medical status the default measure was to place the Servicemember in a hospital type unit labeled a Warrior Transition Unit (WTU). This unit is more of a military unit where the soldiers are assigned to platoons without any specificity as what injuries qualified for entry into the WTU. This lack of specificity opened the floodgates for those questionable cases and seriously burdened the Army's medical community. Any medical facility would most certainly be overwhelmed financially and logistically should it be required to maintain a room and a bed for patients that only required monitoring for a broken leg, mild forms of depression, or any other injuries that merely require time as a primary healing factor. The Army has recently recognized this issue and modified WTU entry and exit criteria requiring active duty Servicemember's without significant injuries to be returned to their units allowing the closure of certain WTUs. According to a GAO study released April 2009, these revised criteria do not apply to the Reserve and National Guard Servicemembers and these Soldiers remain in the WTU until their condition is resolved or the Servicemember completes the PDES process.¹⁵ The report stated the Army was to release a revised policy for the National Guard and Reservists in March 2009 and indeed guidance was issued in late March but specific criteria was not established.¹⁶ In an effort to be more receptive to National Guard Soldiers the Army has opened Community Based Warrior Transition Units

(CBWTU). This new criteria and the new CBWTUs have reduced the strain on WTUs enabling the Army to close several of these WTUs.

Figure 2¹⁷

However this doesn't close the loop for the National Guard or Reserve Servicemember as most of these treatment facilities or CBWTUs aren't anywhere near rural America and some of the homes of the Reserve and National Guard soldier. While the active duty Servicemember returns to his unit, a military hospital, home and family, the Reservist stays at a WTU or, if he qualifies, i.e. is responsible, has transportation, etc., is assigned to a CBWTU and sent home. The nine CBWTUs that have been opened by DoD are set forth in figure 2. While these CBWTUs relieved the strain on Active Duty Military Treatment Facilities, no one seems to notice that injured Reservists are being forced to drive past active duty installations to report to a more remote CBWTU.

Gen Franks' study clearly identified many of the issues that were presented and offered real world solutions. The study did not specifically focus on Reserve specific issues but was very objective and recognized the majority of the failings of the PDES system. The majority of these recommendations were focused on doing away with the dual adjudication of disabilities as this process is seriously delaying the PDES system. This dual adjudication shouldn't have been an issue but the NDAA 08 set forth the directive that only one standard of adjudicating disabilities would be used on future cases. However, a glaring recommendation from the perspective of a Reservist was the recommendation to permit reservists who incurred combat related injuries the right to request continuation on Active Duty. The current process simply allows a Reserve Servicemember that was deployed and was seriously injured while on Active duty back in his reserve status should the Servicemember choose to apply for continuation on a Reserve status.¹⁸ It is incomprehensible that all applications made by Active Component soldiers that have disqualifying injuries are given liberal permission to apply for continuation on active duty and Reservists are not. The Reservist will not have a military treatment facility in his back yard, the support of a full time military network and will most likely be out of a job as soon as the employer can legally terminate the Servicemember's employment. The Reservists protection under **Uniformed Services Employment and Reemployment Rights Act** of 1994, (USERRA), the federal law which protects the Servicemember's employment rights to reemployment and protection against discrimination by the employer due to the Servicemember's military service, only lasts for one year after the Servicemember's redeployment and the Servicemember will return to an "at will" employee in most states.¹⁹ A seriously injured Servicemember would have protections under the Americans with Disabilities Act (ADA) provided the employer employs 15 or more people. However, for the vast number of

Reservists that work in machine shops, garages, farm labor etc., who do not employ the requisite number of employees for coverage under the ADA there will not be any legal protection. These “at will” States will leave the injured Veteran without any recourse as small employers will be unable to afford to continue to employ someone who has a serious handicap or ailment that was incurred during the Reservist’s military service. Even in cases where the Reservist has protections under USSERA or the ADA, the Government Accounting Office recently reported Reservists actually waited an average of 619 days from the time they first filed their initial formal complaints with Department of Labor (DOL) (spell out) until the time the complaints were fully addressed by DOL, Department of Justice (DOJ), or Office of Special Counsel (OSC).²⁰ When considering these minimal protections for Reservists it really isn’t that shocking when press releases report that 25 percent of this nation’s homeless are Veterans whose VA disability check won’t cover the bills after they lose their civilian employment.²¹

Most Reservists understand that the VA determines disability and provides compensation based on their loss of earning capacity due to LOD related injuries. What is not understood is that many of the injured are also entitled to combat-related severance payments that the NDAA 08 drastically increased. Furthermore if a Reservist has a requisite number of active duty years he is entitled to monthly disability payments. In many instances the Reservist who has an injury that would qualify as a combat related LOD is being separated under his unit’s ETS or length of service procedures without any of these entitlements due to never being processed through the PEB process. The primary reason for this lack of equal treatment is the same issue that arose in the pre-deployment scenario. The units and individual soldiers have difficulty in facilitating a formal PEB to determine if they qualify for a severance payment or monthly disability. The Servicemember can ill afford to take time off from his civilian job and the Active Component is

quite busy with doing medical boards for active duty soldiers. The path of least resistance is to get a VA rating and begin to draw the VA disability check and remain in the Reserves until the Servicemember is separated from the Service or prevented from reenlisting due to being medically disqualified. While this is a financial injustice to the Servicemember, the reality behind this problem from a purely strategic perspective is again, non-deployable soldiers are being kept in the Reserves until their ETS date or length of service retirement and are medically disqualified to serve if and when they are called upon to deploy.

CONCLUSION/RECOMMENDATIONS. Many things must be addressed in order to stabilize the Reserve Component system as an operational asset. The first thing that should be addressed is that upon deployment, when a medical condition is discovered that disqualifies the Servicemember from performing his MOS, the Servicemember should be administratively dealt with at that time. To release the Servicemember from active duty back to his Guard or Reserve unit only exacerbates the problem due to the lack of physicians that can form a board to truly determine whether the Servicemember should be separated. From interviews with an active duty physician and his mobilization staff it was abundantly clear the Army does not have adequate physicians or time to conduct these boards.²² The next problem that should be addressed is why physicians are conducting the boards and determining legal standards in the first place. In the civilian world doctors do not legally determine whether someone is entitled to a worker's compensation or is permanently disabled. Furthermore, civilians that are injured can look to precedents from previous court decisions to determine whether their claim has merits. The same should hold true for all soldiers to include Reservists in the military. The injured Servicemember subjected to the MMRB/PDES system in its current state encounters at a minimum four doctors at different stages with one opportunity of refuting the process with an independent medical

review at the MEB. Should the Armed Forces choose to rely more heavily on its legal resources, the number of doctors could be reduced to zero in those cases where retention is not contested.

In cases of a waiver only one doctor would be necessary during the PEB process.

The current PDES system set forth in figure 1 should be reduced to an MMRB for all soldiers when they are determined to have a disqualifying profile or referred to the PDES system for any reason. It is obvious that active duty doctors do not have time to do the necessary MMRBs upon deployment but a yearly health assessment that mirrors the deployment physical would identify these issues and would eliminate the lengthy medical screening that must be done upon every deployment. This current system where active duty doctors are being tasked to not only deploy and serve in their medical MOS but also serve on MMRBs, MEBS and PEBs has seriously burdened the PDES system and its ability to administratively separate Reserve soldiers and ensure they receive their entitlements. The Servicemember should be appointed counsel for the initial MMRB with the hearing held on an active duty installation. In the alternative and most logistically feasible, a Senior Army Advisor should be appointed to a local board to avoid paternalism within Reserve units. The boards in this case would be done locally in instances where an injury or condition is found through the recommended annual screenings. Each Servicemember should be given the opportunity to present his argument for retention regardless of whether the injury was in the line of duty. There is a sizeable investment in all of our military personnel and to not explore every option as to whether a Servicemember can be deployed as soon as possible before subjecting the Servicemember to this lengthy and sometimes futile separation process is a waste of assets. It has been opined that the base costs to train a Servicemember on the most basic tasks exceeds fifty-thousand dollars and this amount is far exceed for specialized tasks.²³ Based on the vast expense of recruiting and training today, the

benefits derived by allowing Reservists to be reclassified and not hinging their continued service upon a documented LOD injury should clearly outweigh the costs or concerns for continued medical care.

Should it be determined at a local MMRB that the Servicemember is not suitable for retention in any MOS the case should then proceed directly to a physical evaluation board. In many instances the Servicemember will not wish to contest retention via the MMRB in cases of terminal disease or traumatic injury where there is no chance of retention which saves time and would permit the case to proceed to a PEB to determine whether the disability was compensable and if so to what extent. If this waiver was done with the assistance of counsel it should not require any review under the MEB. An expedited MEB process was considered by Gen. Franks' in these obvious cases but the MEB as it is currently being utilized does very little to protect an injured Servicemember's rights to disability entitlements.

The informal and formal MEB should be eliminated as it merely reviews the record of the MMRB that was conducted at the Servicemember's unit. Furthermore, it is only after a decision has been made by a panel of doctors at MMRB that the Servicemember is entitled to counsel and an independent medical examination to rebut the previous decision. The need for guidance in this process has been addressed by NDAA 08 and implementing policy has been set forth with a right to an independent medical evaluation such as the Servicemember's primary care manager who is not involved in the MEB process to possibly refute the MEB summary.²⁴ As stated earlier the Army is having difficulty meeting time constraints on this process and the additional procedural rights set forth under the NDAA will only lengthen the process. The MEB should be eliminated with increased procedural safeguards made available at the initial MMRB as the evidence at the MMRB influences or taints the entire remaining process.

In a perfect world all the procedural safeguards should be made available to the Servicemember at an MMRB but it is unlikely for this to occur due to the spontaneous nature of these hearings that are normally done on a Reservist's drill weekend. In the alternative, a standing Physical Evaluation Board located within each State should do nothing but conduct a full hearing with *de novo* reviews of all contested MMRB cases where the Servicemember has been deemed non-retainable. Every case where there is controversy should be considered by the PEB board regardless of whether or not the Reservist requests review. The Servicemember should be transferred into a separate PEB chain of command with General Court Martial Convening Authority that would be responsible for expeditiously moving cases so that the Servicemember is either returned to duty or separated with the appropriate amount benefits. This allows the line unit to begin filling critical MOS positions and combat readiness is not adversely affected while awaiting the results of the Board. The PEB panel should not be able to have a cursory review of the case prior to a contested hearing that could and in most cases would sway the opinions of the Servicemember's status. Should the Servicemember waive consideration for retention in an alternate MOS or lose on the merits of a contested case, this board should mirror the procedure set forth in a civilian worker's compensation court that determines whether an injury was in the course and scope of employment with consistent standards for both Active Component and Reservists.

Those Soldiers entering the PEB system who were injured in combat or in the line of duty and given any type of medical benefit which entitles them to military pay while injured and are released to their home unit on a limited duty status should also be assigned to the PEB Command and be required to return to the PEB for review as the PEB Judge deems appropriate which again is akin to a worker's compensation court. This limited duty status should address the PEB

Command having authority to reduce pay or rank via an Article 15 for missing appointments so that Servicemembers aren't rewarded for malingering and to encourage attendance at therapy sessions to expedite recovery. As of October 2009, there were 32 WTUs and 9 CBWTUs with more than 3,800 permanent cadre and staff overseeing a current population of about 9,000 wounded, ill, and injured Soldiers.²⁵ These numbers don't even take into account the Surgeons and Specialists the military does not have within its staff that are necessary for the Servicemember's recovery. The current response to send injured Active Component Soldiers back to their units and Reservists to these CBWTUs will most likely result in specialized medical care being provided by Tricare providers. However, the addition of 3800 non-physician staff for the treatment of patients who only need time to recover appears to be bureaucracy in its finest hour. Furthermore, sending an injured Reservist home and having him report daily to his Reserve unit for accountability purposes while he can't perform his MOS and may never return to this unit is an insult to both individual and the unit that has to create work for an injured warrior. Furthermore, frustration within the unit is increased with this system as the injured soldier is holding a position that a Commander may need to fill for an upcoming deployment.

Upon the Servicemember reaching a specified number of weeks of disability while healing at their home or upon maximum medical improvement, the Servicemember would either be released from the PEB's jurisdiction to return to his unit as fully recovered or ordered to conduct an MMRB. Again, many seriously injured Servicemembers could waive the MMRB and could immediately begin the PEB hearing, be rated in accordance with the veteran's administration schedule for rating disabilities, and given the appropriate amount of compensation and/or disability retirement in accordance with those injuries that were duty related. This Servicemember would never have to bother with reporting to his WTU cadre or suffer the

indignity of reporting to his unit for the mere purpose of accountability. This process reduces many of the stovepipes, delays and inconsistent results that are occurring within the current system and gives all soldiers the same procedural due process while balancing the needs of the Army to quickly separate those soldiers that are unable to deploy. This process may increase the workload on some legal offices as it increases the need for legal advisors, recorders and respondent's counsel i.e. PEBLOS, but it drastically decreases the numbers of personnel that are currently being utilized in the CBWTUs. The NDAA 08 clearly set forth the need for increased involvement by the Judge Advocates General's Corps in this process.²⁶ In this process every Servicemember would be appointed a PEBLO upon being assigned to the PEB unit to maneuver through the system in the same fashion a Plaintiff navigates through a worker's compensation court. It doesn't take any type of research expert to determine by logging on to Google and typing in the search term "PEB" to discover that Reservists aren't frustrated with their care but have become infuriated with the PDES bureaucracy.²⁷ To not afford a Reservist the right to an adequate degree of due process when considering the termination of a military career due to combat related injuries should offend even the most conservative policymaker. But much more important than individual due process, we must have an Army that is ready and capable of going to war without reassessing the injuries of previous battles and having more cadre in the hospitals than we do on the front lines.

The remaining glaring inequity that should be addressed is that Reservists should not be considered in any different light than an Active Component Servicemember who is injured in combat when they are requesting to continue on active duty. This inequity was readily recognized by the Task Force conducted by retired Gen. Franks.²⁸ These Warriors that have lost a limb or other disqualifying injury are, based on their length of service, going to either receive

VA benefits disability payments for the rest of their lives or a one time severance payment . For these heroes that wish to continue to work, the chances of meaningful employment with a civilian employer are not likely based upon the limitations discussed under USERRA. The recommended fast tracked PDES system previously discussed would not address these issues and exceptions to the regulation would have to be made as injuries such as an amputation are by regulation a clear medical disqualification for continued service. These exceptions are currently being made for Active Component Soldiers but not Reserve Soldiers.²⁹ While our policymakers make some distinction for continuation benefits based on a Servicemember's military status, the improvised explosive device or sniper's round that severely limits a Reservist's quality of life fails to make that same distinction. This type of inequity only fractures any perception of fairness and equitable treatment felt by the Reserve force that is being required to serve on the same battlefield as the Active Component. A wounded hero from the Reserve Forces proclaiming this type of unfairness resonates through small communities and falls upon the receptive ears of relatives and potential recruits. This inequity should be addressed as soon as possible due by either equal treatment, expansive civilian job protection or an absolute preference in hiring for DoD civilian vacancies. Otherwise, in a sound economy the financial incentives for our Reserve Forces will have to be increased exponentially to convince a new generation to continue to serve in what appears to be an everlasting engagement with terrorism.

Endnotes:

¹ 2009 Army Posture Statement, Reserve Component Readiness, para 11(b). (May 7, 2009)

² Quadrennial Defense Review Report, Reconfiguring the Total Force , pg 76 (February 6, 2006)

³ Quadrennial Defense Review Report, Keeping Faith with the Reserve Components, pg 53 (February 1, 2010)

⁴ Rebuilding the Trust, Independent Review Group, Report on Rehabilitative Care and Administrative processes at Walter Reed Army Medical Center and National Naval Medical Center. (April 2007)

⁵ I Will Never Leave a Fallen Comrade, Final Task Force Recommendations to Better Fulfill the Army's Duty in MEB/PEB (29 April 2009)

⁶ ALARACT message, Chief of Staff of the Army, December 2009.

⁷ 2008 Army Posture Statement, Reserve Component Readiness, para 11(a). (February 26, 2008)

⁸ Ibid.

⁹ 2009 Army Posture Statement, Reserve Component Readiness, para 11(b). (May 7, 2009)

¹⁰ Ibid.

¹¹ LTC Paul Elkin, Overview of the Physical Disability Evaluation System (PDES) From Soup to Peanuts, Powerpoint Presentation at JAG All Hands Conference in Orlando, Florida. (January 2009)

¹² DEP'T OF ARMY, REG. 635-40, MEDICAL SERVICES: PHYSICAL EVALUATION FOR RETENTION, RETIREMENT, OR SEPARATION, para. 3-2 (a) (1) (8 February 2006)

¹³ DAIG Army Physical Disability Evaluation System Findings and Recommendations, Approved by the Vice Chief of Staff, Army (13 August 2008)

¹⁴ AR 40-501 Standards of Medical Fitness, para 3-13(d)(2). (14 December 2007)

¹⁵ GAO Report to Congressional requesters, Army Health Care, Progress Made in Staffing and Monitoring Units that Provide Outpatient Case Management, but Additional Steps Needed, (April 2009)

¹⁶ The Deputy Chief of Staff, G-1, Warrior Transition Unit Consolidated Guidance, (20 March 2009)

¹⁷ Military Health System, Webpage from Military .com, Declining Numbers prompt Army to restructure WTU (June 15, 2009).

¹⁸ Medical Policy Officer, HQDA , G-1 Continuation on Active Duty (COAD) Continuation on Active Reserve (COAR) (AR 635-400) Webpage slideshow (20090409).

¹⁹ 38 U.S.C. § 4316 : US Code Section 4316: Rights, benefits, and obligations of persons absent from employment for service in a uniformed service.

²⁰ GAO 06-60: Military Personnel, Federal Management of Servicemember Employment Rights Can be Further Improved, GAO Report to the Ranking Minority Member, Committee on Health, Education, Labor and Pensions, U.S. Senate, Page 6. (October 2005)

²¹ USA Today, Veteran's Make Up 1 in 4 homeless, November 11, 2007.

²² Richard Warren <Richard.j.warren@us.army.mil>, “electronic message with mobilization specialist on MMRB hearings” Electronic message to COL Steve Elliott, <steve.d.elliott@us.army.mil>, 18 December 2009.

²³ Lt. Col David C. Thomas II, The U.S. Army; A Business? Return on Investment? Weppage on Military.com http://www.military.com/NewContent/0,13190,120304_ArmyBusiness-P1,00.html. (Dec 3, 2004)

²⁴ Policy Memorandum on Implementing Disability-Related Provisions of the National Defense Authorization Act of 2008 (Pub 1. 110-181) Oct 14, 2008

²⁵ About WTU, Webpage from Warrior Transition Command, <http://wtc.armylive.dodlive.mil/about-wtu/>

²⁶ Ibid.

²⁷ Michael Parker’s DES Outrage of the Week, <http://www.pebforum.com/section/mike-parker-s-des-outrage-week-29/>

²⁸ General (Retired) Frederick M. Franks Jr., Memorandum for Chief of Staff, United States Army, Pentagon, Washington D.C. 20310. (28 October 2008).

²⁹ AR 635-40, Personnel Separations, Physical Evaluation for Retention, Retirement or Separation, par 6-4 b.(3)C, (8 February 2006)