



# Medical Discharges and Retirement

By Kathleen Gilbert and Luke Hiken

Attorneys and counselors are seeing increasing numbers of soldiers and sailors with physical and emotional injuries and illnesses, many resulting from the wars in Iraq and Afghanistan. The military has shown a consistent tendency to downplay or disregard all but the most obvious medical problems, so that many servicemembers do not receive treatment, and many who need medical discharge or retirement are retained in the service. In addition, many who qualify for such discharge or retirement are discharged for other reasons—for lesser psychiatric or physical problems that do not warrant benefits or, worse, for misconduct based on the symptoms of illness. Counselors and attorneys can play an essential role in helping these servicemembers receive proper treatment and medical discharge or retirement when appropriate. Advocates can also ensure that members' rights are protected in this process, and that underdiagnosis or lack of diagnosis does not result in loss of military and veterans benefits.

## CRITERIA FOR DISCHARGE

### Medical Discharge or Retirement Predicated Largely on Inability to Perform Duties

Department of Defense ("DoD") instructions and service regulations list conditions which may warrant medical discharge or retirement. DoD Instruction 1332.38 is the controlling regulation. It lists, in Enclosure 4, medical conditions that generally warrant referral for medical proceedings. The service regulations include Army Regulation ("AR") 40-501, chapter 3; Secretary of the Navy Instruction ("SECNAVINST") 1850.4E, Enclosure 8, which covers Navy and Marine Corps personnel; and Air Force Instruction ("AFI") 36-2902. In the past, attorneys and counselors were often taught to rely on AR 40-501 regardless of the branch of service involved, since the standards differed very little between services. However, there now are enough small differences, and the services are so reliant on their own regulations, that it is best to work with the regulation for the client's service, with reference to the DoD Instruction for additional helpful language. Familiarity with the language of specific

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service regulations also increases advocates' credibility with military commands and physicians.

Most conditions listed in the regs are not automatically disqualifying. Rather, discharge or retirement depends on the conditions' severity, amenability to treatment and, in particular, interference with performance of duties. These factors are often stated in the medical standards. For example, tendon transplantation warrants referral for discharge proceedings "[i]f restoration of function is not sufficient to adequately perform the preponderance of duties required" (DoD 1332.38, Encl. 4.2.6). In general, "[a]ny condition that appears to significantly interfere with performance of duties appropriate to a servicemember's office, grade, rank or rating will be considered." (DoD 1332.38, Encl. 4.1.3)

Conditions need not be related to combat or incurred while performing regular military duties to warrant medical discharge or retirement and benefits. They are considered to have occurred "in the line of duty" if they arose (or were aggravated) after entry onto active



duty, were not the result of misconduct or willful negligence, and were not incurred during a period of unauthorized absence (UA or AWOL). Pre-existing conditions and other conditions found not to be in the line of duty result in medical discharge without benefits. Line of duty conditions considered less severe may receive no compensation or a lump-sum payment from the military, leaving the member free to seek compensation from the VA. Those considered more severe result in medical retirement with monthly disability pension payments and a choice of care and administration of benefits through the military or the VA, as well as other retirement benefits. Needless to say, these determinations may be critical for members whose illness or injuries may have long-term effects on their livelihood.

### **Less Serious Conditions May Result in Administrative Discharges**

Not all medical problems warrant medical discharge or retirement, but many less serious conditions may result in administrative discharge. A number of these are set out in DoD 1332.38, Encl. 5. The governing regulation on enlisted separations, DoD Directive 1332.14, Encl. 3, part E3.A1.1.3.4.8, lists some “other designated physical and mental conditions” which may warrant administrative discharge, but leaves the services free to expand the list. Applicable service regulations include AR 635-200, Chapter 5, sections 5-13 and 5-17; Naval Military Personnel Manual (MILPERSMAN) sections 1910-120 and 1910-122; and AFI 36-3208, section 5.11. Criteria for discharge vary from service to service in significant ways, though all branches include psychiatric conditions called personality disorders, and most include physical problems such as airsickness or seasickness, enuresis and the like. Some services have begun to add learning disorders and even adjustment disorders to these lists.

Medical conditions which appear in the first few months of active service are often assumed to be pre-existing (this co-exists with a medical presumption that members were in good health upon entry). Such early medical problems are usually referred to a medical evaluation board, but may then result in discharge for erroneous enlistment or in medical discharge without full proceedings to determine disability status.

In addition, discharge is permitted in the first few months for conditions which do not warrant medical dis-

charge, but would have prevented enlistment under the less stringent enlistment medical standards. These are found in Department of Defense Directive 6130.3, “Physical Standards for Appointment, Enlistment and Induction,” and in AR 40-501, chapter 2, which provides guidance for pre-enlistment physical examinations for all of the services. Erroneous enlistment proceedings or abbreviated medical proceedings may be used for these conditions. See, for example, AR 635-200, Section 5-11, “Separation of persons who did not meet procurement medical fitness standards.”

Finally, medical problems arising during the first 180 days of active service may lead to administrative discharge for Entry Level Performance and Conduct, with simplified administrative procedures and no requirement of a medical evaluation board. The discharge is based instead on a command determination that the member is not qualified for further military service by reason of unsatisfactory performance or conduct.

## **BENEFITS OF MEDICAL DISCHARGE OR RETIREMENT**

### **The Military and DVA May Rate Similar Disabilities Differently**

Medical discharge and retirement can mean important medical and financial benefits for veterans. Some of these parallel VA medical benefits, although medical retirement offers a wider range of benefits and, for those who have some time in the service, higher disability compensation. For some veterans, the ability to choose between military medical care and VA medical care, and the various benefits of retirement status (family medical care, use of base commissaries and the like) may be important considerations as well.

Although the military uses its own medical standards to determine whether members should be medically discharged or retired, it relies on the Department of Veteran’s Affairs (“DVA”) Schedule for Rating Disabilities (38 Code of Federal Regulations, Part 4) to determine the degree of disability and accompanying compensation. The military and the DVA are not bound by each other’s determinations under the rating schedule, and may rate similar disabilities differently. DoD Instruction 1332.39 discusses use of the rating schedule in military determinations.



The services' Physical Evaluation Board Liaison Officers may be very helpful in calculating financial and other benefits of medical discharge or retirement, and comparing these with VA benefits. Rod Powers' article on medical discharge and retirement, available at <http://usmilitary.about.com>, contains an excellent summary of disability payment on which this section is based.

### **Medical discharge without benefits: Pre-Existing Condition Limitation Not Applied to Members With More Than Eight Years of Active Service**

The military normally provides no benefits for those found medically unfit from conditions which existed prior to their entry onto active duty and were not aggravated in the service. However, this rule is not applied to members with more than eight years of active service, who should receive severance pay or disability retirement pay as if their conditions were incurred on active duty. Again, those whose illness or injury occurred during unauthorized absences (AWOLs or UAs), or as the result of their own misconduct or willful negligence receive no compensation. These conditions are described as "not in the line of duty."

Ineligible veterans may ask the Veterans Administration to make its own determination about eligibility for VA benefits. Military medical determinations are given considerable weight by the VA, but the VA should consider its own evaluations and any additional evidence provided by veterans. In addition, the VA will sometimes provide benefits for those whose illnesses or injuries are not deemed "service connected" under VA standards.

### **Members Discharged With Severance Pay May Apply to VA for Disability Compensation**

Members who are found medically unfit from conditions incurred in the line of duty will receive medical discharge with a lump-sum severance payment if their disability rating is determined to be less than 30%, and they have not served for 20 years. Severance pay is calculated at two months basic pay times their years of military service (not to exceed 24 months basic pay).

On discharge, these individuals can apply to the VA for medical care and disability compensation. Again, the VA relies heavily on military medical findings but makes its own determination. The amount of money received in severance pay is deducted from compensation

from the VA.

### **Disability Rating of 30% or More Results in Retirement**

Soldiers and sailors with conditions incurred in the line of duty who receive military disability ratings of 30% or more are retired from the service. Depending on the stability of their condition, they may be placed on the Permanent Disability Retirement List (PDL) or the Temporary Disability Retirement List (TDRL). Medical retirees in the latter category are reevaluated at 18-month intervals for five years. If their conditions do not change within that period, they are then transferred to the PDL. If any of the reevaluations show significant improvement, they may be discharged or (rarely) returned to military service; if reevaluations show stability, they may be moved to the PDL at that time.

Calculations of disability retirement pay are based on "retired base pay." For those who entered military service after September 8, 1980, retired base pay is the average of the highest 36 months of basic pay during their service. For those who entered before that date, retired base pay is the highest basic pay they received while in the service. Disability payment is then determined from the higher of two computations: the disability rating times the retired pay base, or 2.5 times years of service times the retired pay base. TDRL members will not receive less than 50% of retired base pay. (Separate calculations are used for reservists.)

## **COUNSELING CONSIDERATIONS**

### **Exploring Medical Discharge or Retirement Worthwhile in Any Initial Discharge Discussion**

Many medical discharge cases begin when clients first come to counselors or attorneys with questions about medical discharges or discharges in general. In initial counseling for those seeking any discharge, it is wise to explore the possibility of medical discharge or retirement. All too often soldiers live with medical conditions that qualify for discharge because they have given up trying to get help or believe that pointing out medical problems would be considered admission of weakness and subject them to ridicule. Psychiatric problems, in particular, are often left unmentioned. Counselors and attorneys can ask clients to read through the list of

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medical conditions warranting discharge or ask them generally about all of their medical problems and compare those to the medical standards.

Nothing in the regulations prevents servicemembers from pursuing medical discharge and other discharges at the same time. Medical discharges and, for example, hardship or homosexual conduct (statements) discharges may easily be raised simultaneously. Many counselors and attorneys make an exception for conscientious objection discharge, where regulations urge commands to look for ulterior motives or other reasons the CO applicant might seek discharge. Some also warn clients about combining discharges when the members' honesty about symptoms may be critical to diagnosis and the other discharge rests on the members' subjective statements and honesty as well.

### **Medical Processing Prioritized Over Most Administrative Discharges**

Medical separation takes priority over most administrative discharges. Hardship or homosexual statements cases should be halted if medical problems are referred to disability proceedings. Soldiers diagnosed with personality disorders warranting administrative discharge and with severe depression or PTSD warranting medical retirement should be medically processed. Unfortunately, there are many recent cases in which medical evaluations have been abandoned in favor of personality disorder discharges, with physicians and commands ignoring the requirements of the regulations.

However, medical separation does not take priority over discharges which warrant other than honorable characterization or over disciplinary action and punitive discharge. Before deciding on a medical discharge, counselors or attorneys should inquire about pending involuntary discharges, investigations or disciplinary actions. Discharges in which an other than honorable discharge may be authorized (even if not recommended in the individual case) take precedence over medical proceedings (DoD 1332.38, Encl. 3.2.4.3). Similarly, pending approved unsuspended punitive discharges or dismissals preempt medical proceedings. (DoD 1332.38, Encl. 3.2.4.2) Medical discharge processing is normally suspended pending such administrative discharge proceedings or disciplinary proceedings, then dropped altogether if the other proceedings result in discharge. Some service medical regulations allow for medical discharge or retire-

ment, notwithstanding pending other-than-honorable discharge proceedings, if military headquarters determines that it appropriate. And, of course, medical problems may be raised in mitigation in discharge or court-martial proceedings to avoid other than honorable or punitive discharges. Such mitigation may result in retention in the service, leaving the way open for later medical discharge, or may result in a general or honorable discharge permitting VA medical care and benefits.

Many servicemembers who had medical problems or received medical treatment prior to enlistment and were encouraged by their recruiters to lie about the conditions. In other cases, the recruits themselves may have denied health problems to ensure enlistment. Pre-service problems may come up in discussion with military doctors or may provide important documentation for members whose medical problems are otherwise difficult to prove. Members alleged to have concealed medical information may face administrative discharge for fraudulent enlistment or erroneous enlistment. Under current discharge regs, these discharges must be honorable, general under honorable conditions, or entry level (uncharacterized); they cannot be characterized as other than honorable. Occasionally servicemembers are threatened prosecution for fraudulent enlistment; neither author of this article has ever seen such a prosecution, but the mere threat can be intimidating. These issues should be discussed with clients, so that they are not caught unaware by threats and can make an educated decision about the small possibility of discharge documents showing discharge for fraudulent enlistment.

## **DOCUMENTATION**

### **Report From Civilian Doctor May Persuade Military Physicians**

Servicemembers may consult attorneys or counselors after diagnoses of their problems by military or civilian doctors. More often, medical problems have not been diagnosed, or members feel they have been misdiagnosed by military doctors. In these cases, it is extremely helpful to begin by sending clients to civilian physicians - specialists if possible. While the military is not bound by civilian medical reports, they can be persuasive. Submission of civilian reports giving specific diagnoses and descriptions of severity can help clients gain access to military doctors and can help those doctors in coming to correct conclusions.

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If the clients already have diagnoses and are confident of their accuracy, existing records may suffice, though even here civilian reports may lend additional emphasis. In either case, it is useful to obtain copies of all military medical records, and any relevant civilian medical records, at the beginning of a case. It is worth noting that clients are not always aware of helpful or harmful entries in their military medical records, including diagnoses other than those mentioned to patients. Soldiers who have heard “you’re depressed” from their doctors may find that they have been diagnosed with adjustment disorders and/or personality disorders rather than depression.

The diagnoses can be compared with the conditions in the service regulation. In many cases the specific condition will be listed; if not, a civilian health care expert can look for the presence of similar conditions with similar effects, severity and prognosis. The DVA rating schedule can be used to determine symptoms or standards used to measure severity.

## **INITIATING MEDICAL PROCEEDINGS**

### **Outside Assistance at the Outset Often Is Advantageous**

In some cases, the existence of a condition by itself is enough to lead commands to refer members to sick call and cause military doctors to initiate medical discharge proceedings of their own accord. Here it may be sufficient for clients to present themselves for evaluation. In many cases, however, commands or other medical personnel (usually medics or corpsmen) make it difficult to see military physicians. And military doctors may fail to recognize problems, may delay in making diagnoses, or may make efforts at treatment before deciding whether conditions require discharge. In these cases, outside assistance may be important at the outset, and service differences are significant.

In the army, unlike the other services, disability proceedings often begin with a referral by the commanding officer, specifically asking that a medical evaluation board be conducted. The other services generally rely on physicians to take this first step, and may be less concerned about referrals by commands. In all services, heads of medical treatment facilities may request medical evaluation boards (“MEBs”), as may the service’s medical

headquarters. Thus, if doctors fail to act on their own, counsel in Army cases may wish to address a letter to the command, providing medical documentation of the condition and requesting medical discharge. In other services, this request is better addressed to the treating doctor, the head of the treating facility, or headquarters.

The role of Army commands in medical processing is also made confusing by the Army’s heavy reliance on its separate medical “profiling” system. Here doctors are asked to evaluate members’ availability for full duty, deployment, etc., and commanders have sole jurisdiction to decide how or whether to act on the profile presented by doctors. But while Army commanders may decide not to act on a “P4” profile for PTSD, which should normally preclude deployment, the question of medical discharge for PTSD remains in the hands of the medical structure. Unfortunately, many commands, soldiers and even Army doctors tend to assume that commands have greater authority than the regulations allow, and civilian advocates may need to remind both commands and doctors of the requirements of the regs.

### **Soldiers Frequently Lack Access to Counsel Until Late in the Process, If at All**

Members with medical problems have little or no access to legal help through the military at the outset of their cases. Military counsel is not normally available to soldiers who are having problems gaining access to doctors, feel they have been badly treated in the medical system, or believe that medical evaluation boards should have been prepared long ago. Frequently the first opportunity to learn about rights and options in medical proceedings comes after medical evaluation board reports have been prepared and presented to members for signature and possible rebuttal. At that point, non-attorney benefits counselors, called physical evaluation board liaison officers, meet with servicemembers to explain the discharge/retirement process and the members’ rights. Military attorneys are not made available unless and until formal hearings before physical evaluation boards are scheduled. While those attorneys may also assist the members after the hearing in further written challenges or appeals, such assistance is not consistent.

For this reason, military counselors or attorneys can play an essential role in the early stages of cases. Members are generally not familiar with the medical standards governing discharge, and may be misled by over-

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worked corpsmen, medics or doctors, as well as unsympathetic commands. Few have any idea of the criteria which might make the difference between a medical discharge without disability benefits for a pre-existing condition or medical retirement with disability benefits. Full discussion of grounds for discharge and disability evaluation procedures can provide critical assistance.

As noted above, many soldiers and sailors find it difficult to gain access to military doctors, who are frequently overworked and sometimes more sympathetic to command needs than their patients' medical problems. In many areas, non-physicians serve as gatekeepers; they and medical officers serving in the field may be the most likely to under-diagnose medical and psychiatric problems that should warrant referral to a specialist or even emergency treatment. Advocates can help members move through this sometimes unfriendly system by bringing pressure on commands, medical treatment facilities or medical headquarters, or by enlisting the assistance of civilian physicians to document problems and urge evaluation and treatment. The right to medical evaluation and care is not discussed much in military regulations, though it is assumed to be a basic right. Some help can be found in DoD 6000.14, enacted in keeping with the civilian concept of patients' bill of rights. While aimed at military treatment facilities rather than commands, it discusses the general right to treatment, as well as the right of beneficiaries to "a fair and efficient process for resolving differences with their healthcare providers...including a rigorous system of internal review and an independent system of external review." (DoD 6000.14, Section 4.7)

With problems that are difficult to measure, including some psychiatric conditions and physical conditions which manifest in such elusive symptoms as back pain or headaches, civilian documentation and pressure from advocates may be important in ensuring that problems are taken seriously. Here, reports from civilian doctors may be particularly helpful, making it difficult for commands and military doctors to ignore the condition, and providing documentation for complaints if they do so.

Part of this process involves helping soldiers or sailors to be effective patients. Many servicemembers downplay medical problems to avoid ridicule or harassment. They should receive an explanation of the value of full reporting of problems and of repeated visits to sick

call or their individual doctor whenever symptoms arise. Most counselors and attorneys encourage their clients not to present as members wanting their rights or members wanting discharge, but rather as patients wanting help with problems. Doctors are often happier if they are the first to conclude that medical discharge is warranted.

### **Military Medical Records Are Not Confidential and Are Often Withheld**

Members also need to be warned that military medical records are not confidential, and that information they provide to military doctors or mental health professionals can and will be repeated to their commands. Information about illegal drug use or about sexual conduct which violates military policy, for example, may lead to involuntary administrative discharge or disciplinary action, in some case resulting in loss of medical benefits.

If access to records is denied, sometimes informal appeal to the commanding officer by members or their advocates will make access easier. Formal letters from counsel requesting medical evaluation sometimes provide the necessary impetus. In other cases, formal complaints under UCMJ Article 138 are necessary. If denied at the initial levels, these complaints can be pursued up to the level of the secretary of the service involved. Parallel letters and complaints can be made to the commander of the military treatment facility involved and to the surgeon general of the service.

### **The Standard for Exhaustion of In-Service Administrative Remedies**

The regulations offer little guidance on time frames for medical evaluation and treatment, or from diagnosis to initiation of medical evaluation board proceedings. When cases stall, counselors or attorneys may need to recommend a reasonable time and demand that the service justify any delay beyond that point. The issue of how long the service can take before responding to certain requests should be judged under a reasonableness standard.

Where members have given the military the opportunity to grant the relief requested or to rectify any unwarranted denial of a request for relief, and have submitted such appeals to the secretary of the service, administrative remedies have been exhausted for purposes of federal court intervention. The military

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should not be able to avoid the consequences of unreasonable delays by transferring members to a war zone and away from the assistance of their attorneys.

When in-service remedies have been exhausted, attorneys may go into federal district court to challenge any denial deemed arbitrary and capricious or without basis in fact. GIs may prevail on a writ of habeas corpus or writ of mandamus in such a forum if they have provided a *prima facie* case warranting medical discharge or retirement, and the military has failed to disprove the existence of the medical condition identified in the *prima facie* case.

## DISABILITY EVALUATION SYSTEM

The disability evaluation system and the process for medical discharge and retirement are governed by statute. (10 USC 1201-1221) Procedures and standards are discussed in DoD Instruction 1332.38 and DoD Directive 1332.18, as well as SECNAVINST 1850.4E (the Navy Manual of the Medical Department, or MEDMAN, is also helpful), AR 635-40, and AFI 36-3212. There are variations between services, so that it is important to work with individual service regulations as well as the DoD Instruction. In addition, there is a significant body of case law on the disability system and the rights of those considered for medical discharge or retirement; unfortunately, almost all of the cases, like the regulations, deal with individuals who have already entered the system through a medical evaluation board.

### Medical Evaluation Board Reports Are Subject to Detailed Regulations But Offer Members No Opportunity to Present Evidence

Cases begin formally when a treating physician, usually a specialist, and two other medical personnel prepare a MEB report (sometimes called a “medical board” in the Navy and Marine Corps). MEBs do not formally convene, and they offer members no formal opportunity to testify or present evidence. Rather, their reports are based on the observations and opinions of the board member(s) seeing the patient, and on the medical record. The regulations set detailed requirements for MEB reports, including types of testing required for some specific medical conditions. The reports include diagnoses, origin and history of the conditions and descriptions of treatment. The reports state whether the conditions are

cause for referral into the disability evaluation system, but should not offer opinions on whether or not members are medically fit or unfit for duty. These boards do not make recommendations for discharge or retirement, or suggest any percentage of disability.

Under current regulations, medical boards must be accompanied by non-medical assessments prepared by the members’ command, discussing the effects of conditions on performance of duties. This is the only formal role commands have once the disability proceedings have been initiated. These assessments are quite significant, however, since the impact of conditions on members’ ability to perform duties is an important factor in determining unfitness and disability percentage. This makes it essential that soldiers and sailors communicate symptoms and their impact to the command while seeking medical attention.

Line of duty investigations may also be required in cases of accident or where there is any concern that conditions may have resulted from members’ misconduct or willful negligence. (DoD 1332.38, Encl. 3.4.4) These are not prepared by commands, but by appointed investigating officers, frequently military attorneys. Command members may be interviewed as part of the investigation, and command attitudes may thus affect a basic determinant of eligibility for benefits.

### Members May Submit Rebuttal, But Time Period Is Limited

Members must be given a copy of the medical board report and may submit a rebuttal if they disagree with it as a whole or in part. It is at this point that most members first speak with physical evaluation board liaison officers and are given a general idea of the proceedings and their rights. In some cases, these personnel will pressure members to sign the board and waive the right to rebuttal on the spot. However, it is always wisest to have attorneys or counselors review reports and discuss them with clients before deciding on the value of a rebuttal; even small errors regarding symptoms, severity, origin or effect on duties may affect the outcome. If rebuttal is appropriate, it offers an opportunity to provide additional documentation of the medical condition discussed in the report, or other medical conditions omitted from the report. There is only limited time to submit rebuttals, unless extensions of time are granted, so that it is important to review medical records in advance and consider



documentation concerning any adverse or incorrect information in the records before the MEB report is completed.

### **Informal Physical Evaluation Board Makes Findings on Fitness for Discharge or Retirement**

The medical board report, any rebuttal, underlying medical records, the non-medical assessment and the line of duty investigation report, if any, are then forwarded to the service's Central Physical Evaluation Board ("CPEB") for non-hearing consideration by the informal Physical Evaluation Board ("IPEB"). The PEB will sometimes return reports to the medical treatment facility if medical evaluation was too remote in time, appropriate testing was not conducted, or documents such as the non-medical assessment were not included. In addition, the medical evaluation board will sometimes submit an addendum if significant changes occurred since the initial medical board report was prepared.

IPEBs make findings and recommendations as to whether conditions result in medical unfitness, whether discharge or retirement is warranted, and whether conditions existed prior to entry or were the result of misconduct. If applicable, they also recommend specific disability ratings, using the DVA rating schedule. Their findings and recommendations are terse, often presented without real explanation or rationale.

IPEB reports are then returned to the medical treatment facility and provided to the servicemembers, along with further information about their rights from the PEB liaison officers. Findings and recommendations are considered final if members accept them at this point.

### **Formal Physical Evaluation Boards Provide Only Opportunity for a Hearing**

Members who disagree with a recommendation for discharge or retirement, or with the disability rating, may make a written request for reconsideration to the PEB. (DoD 1332.38, Encl. 3.3.3.4) If these requests are unsuccessful, they have the further right to a hearing before a formal physical evaluation board ("FPEB"). (DoD 1332.38, Encl. 3.1.3.3.1.1)

Unfortunately, those found medically fit by IPEBs have no right to a FPEB (Encl. 3.1.3.3.1.2) or the remainder of the PEB process, though nothing prevents them

from rebutting the IPEB or making a request for a FPEB. For these individuals, further medical evaluation and a new attempt at a medical evaluation board are often necessary, unless their cases show obvious abuse of discretion or lack any basis in fact, in which case resort to federal *habeas corpus* would be appropriate.

FPEBs provide the first and only opportunity for a hearing in the disability process. Traditionally held at major military hospitals, the Navy now holds its FPEBs in Washington, D.C. Members may be represented by attorney or non-attorney counsel, testify and present witnesses and documentary evidence. Hearings are informal, but board members may be vigorous in questioning members. FPEBs are required to provide some justification of their decisions.

Military attorneys are appointed to represent members prior to FPEB hearings. Some members choose to be represented by counselors from veterans service organizations such as the Disabled American Veterans. Civilian attorneys and counselors may provide representation.

### **Military Counsel Frequently Lack Time to Prepare for Hearings**

In the Navy, at least, it is common for military attorneys to meet with their clients for the first time on the day before the hearings, severely limiting opportunity to prepare. Military counsel often have a good understanding of the decision-making patterns, biases and attitudes of board members. Perhaps as a result, some tend to think that particular ratings for particular conditions are a forgone conclusion. Few have extensive experience in developing and presenting detailed medical and lay evidence before these boards, and the lack of time for advance preparation further limits this work.

Civilian advocates can play a key role prior to hearings by preparing members to testify, preparing any witnesses and developing additional evidence of the extent or severity of medical conditions, their impact on performance of duties, etc. Testimony or statements from lay witnesses, including fellow servicemembers, friends and family members may be useful in arguing for increased disability ratings. Civilian medical evaluations can be used to challenge problems in MEB reports or IPEB findings. Formal hearings offer important opportunities to provide evidence concerning pre-existence of



medical conditions, service aggravation, and line of duty determinations. Well-prepared testimony from clients can have an important impact on the boards, as can the opportunity for board members to observe soldiers' or sailors' appearance or symptoms.

Attorneys or counselors can also provide important representation at the hearings. Although formal rules of evidence do not apply, advocates can challenge inappropriate or harassing questions and note for the record improper considerations, failure to obtain necessary medical evidence, and the like. If necessary, they can remind board members of specific standards and presumptions applicable to individual cases, and can assist clients in summarizing the real impact of illnesses or injuries on their lives.

Nothing prevents IPEBs on reconsideration, or FPEBs, from making findings less favorable to members than the prior findings and recommendations, so that members take some risks in pursuing their cases, and are well advised to have legal assistance. Navy PEB liaison officers have told one of this article's writers that the IPEB does not reduce findings on reconsideration. This may be common practice, but unfortunately is not stated in the regulations. FPEBs can and do reduce disability percentages or make other reduced findings and recommendations.

### **Further Appeal Taken to Board for Correction of Military/Naval Records**

Further written appeal through the disability evaluation system is available in all of the services, though the form varies considerably. While there are no further hearing rights, the member may still make written appeals to reviewers and, ultimately, the secretary of the service.

Members who do not feel their cases have been handled appropriately also have the option of petitioning the Board for Correction of Military/Naval Records ("BCMR"). Since this is a lengthy procedure, it does not provide much help for those whose immediate goal is discharge. But for those discharged without proper benefits, the BCMRs offer an important remedy. These boards can change the final determinations in medical disability cases, place medically discharged personnel on medical retirement, increase disability ratings, or change administrative or end-of-term-of-service discharges to

medical retirement. Application to the BCMRs must be made within three years of the error or injustice at issue, defined as the date of discharge. However, late applications are frequently accepted if the Board finds it in the interests of justice to do so. The BCMRs will review the propriety of the disability evaluation proceedings as well as factual matters. Failure to afford members their full rights in the disability proceedings will not warrant correction of the record unless the BCMRs also find the change to be medically warranted.

## **CONCLUSION**

The very conditions for which people seek discharge may affect their ability to achieve it. Accordingly, these proceedings, and medical discharges generally, are important areas for counseling and representation. Clients who have the assistance of advocates or simply have full explanations of the medical standards and their rights are likely to fare much better than others in the disability evaluation system. This is particularly true where the debilitating effects of combat may impair clients' ability to navigate the system when their symptoms are acute and the disability process itself causes additional stress. As the current wars progress and increasing numbers of soldiers attempt to cope with illness and injury, those who face doctors and disability proceedings alone often find their conditions undiagnosed or underdiagnosed and their rights neglected.

The Task Force encourages counselors and attorneys to educate themselves in this area and to include military disability cases in their work. The Central Committee for Conscientious Objector's (CCCCO's) excellent counseling manual, *Helping Out*, provides a good overview of medical discharges, though there have been some changes (particularly for the Air Force) since its publication. For cases involving psychiatric issues, we encourage readers to become familiar with the MLTF memo, "Military Psychiatric Policies," available at [www.nlgmltf.org](http://www.nlgmltf.org). We hope to develop other training materials in the coming months.

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