RECORD OF PROCEEDINGS

IN THE MATTER OF: XXXXXXXXXXXX

DOCKET NUMBER: BC-2021-03528

COUNSEL: NONE

HEARING REQUESTED: YES

APPLICANT'S REQUEST

He requests the following based on an allegation of reprisal pursuant to DODD 7050.06, *Military Whistleblower Protection*, and 10 U.S.C. § 1034.

1. His letter of reprimand (LOR) dated 28 Oct 14 be removed from his master personnel record group (MPerGp) and his officer selection record (OSR).

2. His unfavorable information file (UIF) dated 9 Feb 15 be removed from his MPerGp and OSR.

3. His referral officer performance report (OPR) for the reporting period ending 2 Apr 15 be removed from his MPerGp and OSR.

4. He be considered for promotion to the rank of colonel (O-6) by a special selection board (SSB).

APPLICANT'S CONTENTIONS

His reticence to engage in high risk care under an unapproved plan was not a disregard for good order and discipline but an attempt to ensure appropriate standard of care. Shortly after his arrival on station, his medical group commander (MDG/CC) and the executive leadership promoted a cardiology expansion in the military treatment facility (MTF) as if the plan was approved and funded by the Air Force Medical Operations Agency (AFMOA). The MDG/CC instructed him to not document any serious concerns via email and to clear up any safety or resource concerns verbally with him. The MDG/CC presented plans in a commander's call outlining how the MTF would bring in millions of Veterans Affairs (VA) dollars by expanding cardiac care. He was faced with the legal responsibilities to provide safe and compliant patient care or follow the MDG/CC's orders. His advocacy for the professional, ethical and safe practice of medicine was perceived by the MDG/CC and the executive leadership team as conduct unbecoming an officer.

On 9 Jul 14, the squadron commander (SQ/CC) initiated a commander directed investigation (CDI) to look into the allegations brought against him by the MDG/CC and two others over a three year period. The SQ/CC informed him she was closing the CDI following the investigating officer's (IO) recommendation to not substantiate the allegations. By the end of the week, she was relieved of command, and this prevented her from closing the CDI.

In Aug 14, the new SQ/CC, at the discretion of the MDG/CC, did not approve the CDI and was instructed to broaden the scope. The witness list relied heavily on non-practioner executives for negative accounts of interactions with him, which ultimately influenced substantiating one allegation. It became clear the CDI was reopened to mask reprisal actions. He sought assistance from the area defense counsel (ADC) who advised him to accept an early reassignment and that he should stop defending himself at his current assignment for fear of further reprisal.

On 28 Oct 14, he received a LOR for obstructing the MDG/CC's leadership by undermining the unapproved cardiology expansion plan and questioning the commander's clinical qualifications. This allegation arose from his effort to ensure compliance of the Air Force Surgeon General (AF/SG) and AFMOA. His rebuttal to the LOR was not provided to the numbered air force commander (NAF/CC) as required, nor was it included in his UIF or OSR, precluding his due process.

On 17 Sep 15, he received a referral OPR. The OPR stated he demonstrated insubordination and unprofessional behavior and received an LOR. The OPR stated comments on the OPR were requested from him and not provided; however, he was in the process of moving and was unaware of the referral OPR. An attempt to seek resolution with the inspector general (IG) resulted in discovering the IG failed to recognize the relevant issues. The cardiology consultant, as well as clinical cardiology peers determined his actions as a privileged provider were in line with his assigned duties. The lack of an impartial IG and safety staff at the small MTF fueled an environment which allowed the MDG/CC and staff to transfer clinical risk to patients by silencing clinicians with threat of career suicide for upholding the standard of care. He received an LOR, UIF and referral OPR for reporting safety concerns to his squadron and group leadership. It was an environment of distrust and retaliation.

In 2015, upon arrival at his new MTF, the leadership took direct action to remove the UIF, LOR and referral OPR from his records. In 2016, he was informed his record was corrected and he believed he was a nonselect for promotion because he was not competitive. This action was stated as complete and verified by the military personnel flight (MPF). However, subsequent reviews revealed the adverse records were not completely expunged. As a result, he was not promoted. Subsequent deployments and high demand operational tempos in support of Operation Iraq Freedom, Operation Enduring Freedom and COVID-19 as Chief of Cardiology, Medical Director and Deputy Chief of Medical Staff for the large MTF resulted in several promotion cycles being missed due to not being aware of the existing adverse records. He provides letters of support.

The applicant's complete submission is at Exhibit A.

STATEMENT OF FACTS

The applicant is a lieutenant colonel (O-5) in the Air Force.

The applicant provides a redacted CDI Report of Investigation (ROI) dated 25 Aug 14. On 9 Jul 14, an IO was appointed concerning the work environment at the squadron. The ROI includes the following allegations:

Allegation A: Between on or about 1 Jan 13 to 1 Feb 14 he was cruel toward [redacted] by insulting his intelligence and belittling him. **(NOT SUBSTANTIATED).**

Allegation B: Between 1 Jan 14 to 28 Feb 14 he unlawfully poked [redacted] in the chest. **(NOT SUBSTANTIATED).**

Allegation C: Between 1 Dec 11 to 31 Mar 14 he wrongfully obstructed [redacted's] leadership by undermining [redacted's] backup plan and questioning his qualifications, constituting conduct unbecoming an officer and a gentleman. **(SUBSTANTIATED).** The IO concluded while he denied the negative conduct, multiple witnesses testified to the contrary. The preponderance of the evidence demonstrated that he likely used defamatory language about staff members both in their presence and to other staff members, and that his documented history of indecorum in the workplace was below the necessary standard for good order and discipline to occur.

Allegation D: On or about 19 Feb 13 he made a derogatory statement to [redacted] and that under the circumstances, the conduct was to the prejudice to good order and discipline. **(NOT SUBSTANTIATED).**

On 28 Oct 14, the applicant received a LOR for the substantiated allegation in the CDI. The SQ/CC stated after reviewing the facts in the CDI, the recommendations of the IO and consulting with the staff judge advocate (SJA), he concluded the applicant did in fact demonstrate behavior that was unbecoming an officer and a gentleman on multiple occasions with and/or in front of many different peers and subordinates. He made disparaging statements that his commander and the MDG leadership were not qualified as credentialed providers or had the knowledge necessary to direct policy or direction of care within the facility. It was also witnessed on multiple occasions that he made inappropriate statements or used unprofessional language with subordinates demonstrating a lack of proper officer decorum. The LOR stated his behavior created an environment of distrust and fear of retaliation in the form of public embarrassment. It also resulted in the unwillingness by others to work directly with him in the delivery of patient care.

On 24 Nov 14, the applicant responded to the LOR. He stated the primary issues were staffing and resources. Efforts to provide alternative help were ineffective. He was repeatedly denied leave because of productivity goals, and he was a one-man shop. His mindset was to keep his nose to the grindstone with patient care. He was remorseful he did not recognize his exhaustion in his pursuit of productivity. As the sole staff cardiologist for inpatient service, his primary concern was patient safety. This was shared by others, and he provides statements from the physicians. He cannot recall when he discussed the behavior of the MDG leadership other than what he believed to be on a need-to-know basis, such as patient safety meetings, credentialing meetings, staff meetings or other meetings related to patient safety. He was told the LOR was about his officership and there were no concerns about his skills as a cardiologist. He asked where the shared responsibility for the unique circumstance where everyone knew cardiology was understaffed and lacked resources, but he was allowed to work himself to exhaustion. Not until the LOR was issued were changes made by the new flight commander to shift towards realistic work hours for him.

On 5 Dec 14, the wing judge advocate (WG/JA) determined the action to file the LOR in the OSR was legally sufficient.

On 22 Dec 14, after reviewing the applicant's written response and the commander's recommendation, the NAF/CC determined the LOR would be filed in his OSR.

The applicant received a referral OPR for the reporting period ending 2 Apr 15. The OPR stated he demonstrated insubordination and unprofessional behavior for which he received an LOR on 28 Oct 14.

On 11 Aug 15, the WG/IG informed him they completed an analysis of his complaint submitted on 7 Jul 15 that his SQ/CC reprised against him when he accepted the findings of the CDI initiated by the previous commander and then issued a LOR in response to the substantiated finding. The IG informed the applicant the allegation could not be framed because no standard was violated. By definition, for there to be reprisal, protected communication must have taken place. A review of the facts determined there was no protected communication related to the allegation. Abuse of authority was also considered. While the actions taken could adversely affect the applicant, the actions were within the authority of his commander and were the result of the CDI findings. The applicant's allegation was dismissed.

On 16 Oct 19, the applicant's commander recommended retroactive removal of the LOR stating his past advocacy to modify cardiovascular policy, now considered the standard, at his previous assignment was appropriate and within the responsibilities of an appointed medical director. It

was the applicant's foresight and courage to point out critical changes were essential to optimal patient safety.

On 9 Jun 20, the Cardiology Consultant to the AF/SG requested the applicant's OSR be restored to the pre-issuance of the LOR. He stated the applicant's decisions were medically consistent with the best scientific evidence and other Air Force MTFs' clinical plans at the time. Further, any local MTF decision involving asking a provider to potentially practice outside of the scope of guidelines and community standards should have been accomplished transparently and in writing through the local chief of medical staff to the cardiology consultant, the AFMS Medical Corps Chief and/or the AF/SG.

On 3 Sep 20, the Chief of Medical Staff requested the wing commander (WG/CC) retroactively remove the LOR and UIF from the applicant's OSR. His actions demonstrated a clear alignment with the best principles of patient safety and the UIF and LOR were founded on a misinterpretation of his efforts. His intentions were to provide the safest, most effective, and best care available, although interpreted to be otherwise by his leadership at the time. His position, then and now, was fully endorsed by the consultant to the AF/SG for cardiology.

In an email dated 9 Apr 21, his force support squadron (FSS) informed the applicant they received an email from AFPC stating that the "reprimand" had been removed from the automated records management system (ARMS).

For more information, see the excerpt of the applicant's record at Exhibit B and the advisory opinions at Exhibits C and D.

APPLICABLE AUTHORITY/GUIDANCE

Per 10 U.S.C. § 1034 and AFI 90-301*, Inspector General Complaints Resolution*, reprisal against military members for making protected disclosures is prohibited.

DAFPM 2021-36-03*, Adverse Information for Total Force Officer Selection Boards*, dated 14 Jan 21and Section 502 of the National Defense Authorization Act (NDAA) for Fiscal Year 2020, signed on 20 Dec 19, as codified in 10 U.S.C. § 615(a)(3) requires all adverse information to be filed in an officer's master personnel records group (MPerGp) and OSR for consideration by promotion boards. The new policy removed the authority for WG/CCs or issuing authorities to direct removal of derogatory data from the OSR effective 1 Mar 20, as previously permissible in AFI 36-2907, *Adverse Administrative Actions*, and AFI 36-2608, *Military Personnel Records*. Adverse information requiring mandatory filing in the OSR and MPerGp includes but is not limited to LORs and any substantiated adverse finding or conclusion from an investigation or inquiry. Only the AFBCMR may remove the adverse information from the officer's record.

AIR FORCE EVALUATION

AFPC/DP2SSM recommends denial for removal of the LOR. The applicant's commander issued an LOR based on the preponderance of evidence in accordance with DAFI 36-2907, *Adverse Administrative Actions.* The applicant does not have a UIF in his records, so there is no action for the Board to take on the request for removal of the UIF.

The LOR meets the requirements in AFI 36-2907. In accordance with the NDAA, 10 U.S.C. § 615(a)(3), the LOR meets the requirements of adverse information and was filed in the applicant's MPerGp and his OSR. The retroactive LOR removal request dated 16 Oct 19 is also contained in the MPerGP.

The complete advisory opinion is at Exhibit C.

AFPC/DP2SP recommends denial for SSB. The evaluation of the applicant's request requires them to rely on the opinions of other Air Force experts. Based on the advisory from AFPC/DP2SSM and with no material error within the applicant's OSR, there is no basis to warrant an SSB. The applicant was non-selected for the rank of colonel by the CY15A (M0615A) Medical Corps Below-the-Promotion Zone (BPZ) and CY16A (M0616A) Medical Corps In-the-Promotion Zone (IPZ) Central Selection Boards (CSB) and all promotion boards thereafter.

The complete advisory is at Exhibit D.

APPLICANT'S REVIEW OF AIR FORCE EVALUATION

The Board sent copies of the advisory opinions to the applicant on 25 Oct 22 for comment (Exhibit E). In a response dated 22 Nov 22, the applicant contends the advisory opinions were limited to their review and recommendations to the administrative practices of the LOR and referral OPR. Although there were administrative issues, the errors and injustices begin with the misapplication of administrative actions for medical decision making governed by AFI 44-119, *Medical Quality Operations*. The injustice for which he requests relief is predicated on the failure of the legal team, command and the IO to identify the allegation in the CDI whether he between 1 Dec 11 and 31 Mar 14 wrongfully obstructed leadership by undermining his commander's backup plan and questioning his qualifications and that such acts constituted conduct unbecoming an officer in violation of Article 133, UCMJ, a consequence of the command team using administrative actions as an attempt to direct patient care.

He was the only fully qualified credentialed inpatient cardiologist who made daily rounds and wrote notes in the charts of patients. He was required to review and direct policy regarding patient care, quality and standards of care that affected the beneficiary population. The distinction of who is or who is not qualified to make the critical care decisions is based entirely on credentials, privileges, and daily practices, as established in the AFI. Statements that may have been interpreted in relationship to officership or leadership were mistaken. He asks the Board to consider that the CDI quality and integrity was inconsistent at the time of the events. He was subjected to a command that used fear and intimidation in attempts to direct patient care. He requests the Board evaluate the appropriateness of using the UCMJ administrative process to justify punishment for licensed clinical care determinations. The Air Force Cardiology Consultant to the AF/SG indicates in his letter that it is not. The Cardiology Consultant was not interviewed by the IO and the CDI process outlined in AFI 44-119 was circumvented.

If the AFBCMR is unable to grant a complete correction, he requests the LOR and referral OPR be removed from his OSR, and he be granted SSB consideration for promotion. He provides a letter of support from MDG/CC requesting the Board review the documents to ensure that medical practice and administrative actions are appropriately considered. The perceived injustice in this case is the interpretation that differences in medical practice patterns between supervisor and subordinate resulted in UCMJ action. As a medical director, the applicant's practice could have been subject to an external staff assistance visit from other experts. The perceived insubordination could have been a professional disagreement on best available patient care, and subject to peer panel review; and the difference between peer practice patterns is not addressed in the administrative action. The Air Force Cardiology Consultant corroborates the applicant's judgment as best for patient care and safety. Utilization of a CDI as a vehicle to adjudicate differences in opinion regarding medical care is not commiserate with the practices defined in AFI 44-119.

The applicant's complete response is at Exhibit F.

FINDINGS AND CONCLUSION

1. The application was timely filed.

2. The applicant exhausted all available non-judicial relief before applying to the Board.

3. After reviewing all Exhibits, the Board concludes the applicant is not the victim of an error or injustice. The Board concurs with the rationale and recommendations of AFPC/DP2SSM and AFPC/DP2SP and finds a preponderance of the evidence does not substantiate the applicant's contentions. The applicant contends the CDI was in reprisal to mask allegations by non-physicians and he received a LOR, UIF and referral OPR for reporting patient safety concerns. The Board conducted its own independent review and finds no evidence the applicant was a victim of reprisal per DODD 7050.06, 10 U.S.C. § 1034 or AFI 90-301. Based on the evidence, there was no protected communication, and it appears the applicant filed his IG complaint of reprisal in response to the unfavorable personnel actions. The applicant also contends the IG was partial; however, he has provided insufficient evidence to substantiate his allegation. Therefore, the Board concurs with the IG's decision on 11 Aug 15 to dismiss the applicant's IG complaint of reprisal. The Board recognizes the applicant was the sole cardiologist on staff and he provides letters of support, to include from the Air Force Cardiology Consultant, stating his actions demonstrated the best principles of patient safety and the LOR, UIF and referral OPR were based on a misinterpretation of his efforts and difference in interpretation in medical practice patterns. However, the Board notes the CDI shows the substantiated allegation was not due to a disagreement regarding patient care or safety but was due to the applicant obstructing and questioning his leadership's qualifications. There were multiple witnesses and staff members who testified the applicant used defamatory language about staff members and that his history of indecorum in the workplace was below the necessary standard for good order and discipline. The Board finds the applicant's conduct was disruptive and his commander had sufficient reason to issue the LOR, which was within his authority and discretion. Moreover, the Board finds the 2 Apr 15 referral OPR documenting his insubordination and unprofessional behavior and receipt of an LOR was in accordance with Air Force regulations and the applicant has not provided any evidence to show the OPR is not accurate or correct as written. The Board notes the applicant states he was advised the adverse information was removed from his records; however, DAFPM 2021-36-03*, Adverse Information for Total Force Officer Selection Boards*, and Section 502 of the FY20 NDAA, as codified in 10 U.S.C. § 615(a)(3), requires all adverse information to be filed in an officer's MPerGp and OSR for consideration by promotion boards. Adverse information requiring mandatory filing includes LORs and any substantiated adverse finding or conclusion from an investigation or inquiry. Therefore, the Board recommends against correcting the applicant's records.

4. The applicant has not shown a personal appearance, with or without counsel, would materially add to the Board's understanding of the issues involved.

RECOMMENDATION

The Board recommends informing the applicant the evidence did not demonstrate material error or injustice, and the Board will reconsider the application only upon receipt of relevant evidence not already presented.

CERTIFICATION

The following quorum of the Board, as defined in Air Force Instruction (AFI) 36-2603, *Air Force Board for Correction of Military Records (AFBCMR)*, paragraph 1.5, considered Docket Number BC-2021-03528 in Executive Session on 22 Nov 22 and 6 Dec 22:

, Panel Chair

, Panel Member
, Panel Member

All members voted against correcting the record. The panel considered the following:

Exhibit A: Application, DD Form 149, w/atchs, dated 7 Oct 21.
Exhibit B: Documentary evidence, including relevant excerpts from official records.
Exhibit C: Advisory Opinion, AFPC/DP2SSM, w/atchs, dated 19 Apr 22.
Exhibit D: Advisory Opinion, AFPC/DP2SP, dated 14 Oct 22.
Exhibit E: Notification of Advisory, SAF/MRBC to Applicant, dated 25 Oct 22.
Exhibit F: Applicant's response, w/atchs, dated 22 Nov 22.

Taken together with all Exhibits, this document constitutes the true and complete Record of Proceedings, as required by AFI 36-2603, paragraph 4.11.9.