UNITED STATES AIR FORCE
BOARD FOR CORRECTION OF MILITARY RECORDS

RECORD OF PROCEEDINGS

IN THE MATTER OF: Work-Product

DOCKET NUMBER: BC-2022-02751

COUNSEL: NONE

HEARING REQUESTED: NO

APPLICANT'S REQUEST

His honorable discharge be changed to a medical retirement.

APPLICANT'S CONTENTIONS

He had medical documentation removed from his medical records for a retinal tear and heart attack which occurred during an Inactive Duty Training (IDT) weekend while performing his military duty. He was working in his office on a computer when the retinal tear occurred and he was in a chemical exercise when his heart attack began. His military medical unit would not see him on a weekend when he had his heart attack and directed him to see his personal primary health care provider. He was able to see his primary care doctor three weeks later and was referred to a heart specialist who found a 99 percent blockage causing his heart attack. He immediately underwent surgery and his military supervisor was notified. His military medical unit was not notified; therefore, he was not placed on line of duty orders. He gave his military medical unit all of his medical records after he was ordered back to military duty against his doctor's directions. He was not given any information from his unit on his medical options and went ahead and filed for retirement. His AF Form 469, *Duty Limiting Condition Report*, indicates a Medical Evaluation Board (MEB) was to be completed but this never happened.

The applicant's complete submission is at Exhibit A.

STATEMENT OF FACTS

The applicant is a former Air Force Reserve (AFR) senior master sergeant (E-8) awaiting retired pay at age 60.

Dated 11 Jan 20, AF Form 469, provided by the applicant, indicates he was found to have had a medical condition which did not meet the medical standards in AFI 48-123, *Medical Examination and Standards*. The applicant was placed on fitness and duty restrictions; it was noted he was placed on a code 37 profile while undergoing an MEB to determine medical fitness for continued worldwide duty and retention.

Dated 25 Mar 20, Reserve Order Work-Product indicates the applicant was assigned to the Retired Reserve and placed on the Retired Reserve List (RRL), effective 30 Jun 20.

On 29 Nov 21, ARPC/DPTT sent the applicant the standard Notification of Eligibility for retired pay (20-year letter) informing him he has completed the required years under the provisions of Title 10 United States Code, Section 12731 (10 U.S.C § 12731), and entitled to retired pay upon application prior to age 60.

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

AIR FORCE EVALUATION

ARPC/DPTT recommends denying the application finding no evidence of an error or injustice in the applicant's request for a voluntary transfer to the RRL. A review of the applicant's Military Personnel Record shows the applicant voluntarily submitted a retirement application on 26 Jul 19 with an effective date of 30 Jun 20 which was approved by his chain of command. The application was processed and retirement orders were published on 25 Mar 20. ARPC has no record of any further communication from the applicant requesting a change of date or withdrawal of his application. The applicant did not have an assignment availability code 37 (AAC 37) on file reflecting he was undergoing a MEB, which would have prohibited ARPC from processing the retirement. Per AFI 36-3203, *Service Retirements*, paragraph 3.1.1.2, enlisted members who are retirement eligible must apply for retirement. The applicant is eligible for Reserve retired pay at age 60 (or at an approved reduced retirement pay age date, if applicable).

The complete advisory opinion is at Exhibit C.

The AFBCMR Medical Advisor recommends denying the applicant's request for a medical retirement. The Medical Advisor cannot corroborate the implicit malicious removal of medical documentation from the applicant's health record. Nonetheless, to justify the medical retirement of a Reserve component member several factors must be collectively, or consecutively, taken into consideration. Most of all the condition(s) must be found In the Line of Duty (ILOD), either service-incurred or permanently aggravated by service. Specifically, per DoDI 1332.18, *Disability Evaluation*, if performing in a 30-day or less status, or IDT, as was the applicant's case, the condition must be the proximate result of performing military service. Additionally, aggravation must constitute the worsening of a pre-existing condition as a direct result of military duty and over and above the natural progression of the condition. Proximate is defined in the instruction as a permanent disability, the result of, arising from, or connected with active duty, annual training, active duty for training, or IDT, to include travel to and from such duty or remaining overnight between successive periods of IDT. Proximate result is a statutory criterion for entitlement to disability compensation under chapter 61 of Reference (c) applicable to Reserve Component (RC) members who incur or aggravate a disability while performing an ordered period of military duty of 30 days or less.

In the case under review, on 2 Oct 19, the consulting cardiologist noted the applicant's history of chest pain with minimal exertion, but also noted he had no history of myocardial infarction (MI). Although the applicant had presented with a history of exertional angina, given the pathophysiology of coronary artery disease and the degree of obstruction of the applicant's left anterior descending (LAD) coronary vessel, and the absence of objective evidence of a de novo or worsened cardiac injury or infarction resulting from chemical, biological, radiological, nuclear, or

explosive (CBRNE) training, and without speculation or conjecture, the Medical Advisor determined, by a preponderance of evidence and medical principles, the applicant's coronary artery disease did not meet eligibility for entering the Integrated Disability Evaluation System (IDES) as a compensable medical condition. Instead, as a non-duty related medical condition, the applicant would have been eligible to appeal to the IDES for his fitness only, if found medically disqualified. Thus, while it is possible, or likely, the applicant may have experienced a physiologic burden upon the heart during CBRNE training, the supplied evidence and history does not support a permanent cardiac injury, or infarction, nor worsening of his coronary artery disease because of his training experience.

With respect to the applicant's claimed retinal detachment, given the documented long-standing history of retinal lattice and vitreous degeneration, previous retinopexy procedures, and the documented attendant "strong risk" for future retinal detachment (RD), although allegedly occurred while utilizing the computer on duty, the Medical Advisor has determined, by a preponderance of evidence, the applicant's retinal detachment was an expected natural progression of his underlying pre-exiting retinal and vitreous disease processes and, bore no causal relationship with his IDT experiences. Moreover, even if the applicant's claimed retinal detachment was deemed the result of working at his computer, there is no evidence presented the event resulted in either a deficiency of visual acuity or visual field, pain, rest requirements, or episodic incapacity sufficient to warrant a medical retirement, under the Veterans Affairs Schedule for Rating Disabilities (VASRD) code 6008. Neither did the applicant qualify for retirement as a compensable medical condition under other laws and policies, e.g., "8-Year Rule," which requires disqualification or determination of unfitness, while serving in 31 days or more status, and at least 8 years creditable years of active service. Nor did the applicant qualify for medical retirement under the Prior Service Condition policy in DoDI 1332.18, as there is no evidence of an ILOD determination for coronary artery disease during a prior period of service.

The complete advisory opinion is at Exhibit D.

APPLICANT'S REVIEW OF AIR FORCE EVALUATION

The Board sent a copy of the advisory opinion to the applicant on 18 May 23 for comment (Exhibit E), and the applicant replied on 12 Jun 23. In his response, the applicant contends no action was taken by his leadership to notify his medical unit once he received medical attention from his civilian health provider. His records were not coded correctly nor was a MEB completed as indicated on his AF Form 469. Due to these actions not being completed, this prevented his ILOD determination from being accomplished which would have resulted in a medical retirement. His military medical unit will not see anyone with any kind of medical issue while on duty and advise all personnel to seek medical attention through their civilian provider. Because of this, it took him several days to schedule an appointment after the incident. During IDT, he exerted himself during the CBRNE training in extreme temperatures and experienced a strain on his heart, which was the beginning of his chest and arm pains which eventually led to his emergency heart surgery. He was never told by a civilian or military health provider of having a pre-existing condition and was always told his blood work was normal. Elevated levels of cholesterol were noted as far back as 2004, but no plan or action was taken or discussed with him to resolve this issue. If he had been

given the information regarding his elevated cholesterol levels, he could have addressed the issue beforehand, thus preventing his heart bypass surgery. Additionally, because he was not coded properly in the system, ARPC did not stop his retirement from being processed and he was physically unable to stop the process that was started prior to his heart surgery. To support his contentions, he submits additional medical documentation.

The applicant's complete response is at Exhibit F.

ADDITIONAL AIR FORCE EVALUATION

The AFBCMR Medical Advisor recommends denying the applicant's request for a medical retirement. The applicant responded to the Medical Advisory with numerous observations/occurrences. Among the most contentious of over 20 issues raised, included his elevated lipid profile, dating to 2004, which was not allegedly acted upon, and resulted in development of coronary artery disease, the fact he was referred to his primary care manager (PCM) for follow-up evaluation, which took several days to accomplish, the fact he was ultimately assigned an AF Form 469, designating the requirement for MEB/PEB processing; but which never took place, in part due to difficulty contacting and obtaining responses from medical personnel to initiate the appropriate actions.

Had the applicant initially presented with a complaint of chest and/or arm pain during, or immediately following the CBRNE exercise, the most appropriate action would have been to conduct or arrange an urgent or emergent evaluation, requiring transport, same day/same hour, to rule out acute coronary syndrome, to preserve salvageable cardiac muscle or, best, to interrupt an impending myocardial infarction, through emergency interventions (medications, coronary artery catheterization, and surgical intervention via stenting vs bypass grafting), if necessary. Without laboratory testing results and electrocardiography conducted nearest the time of occurrence, the AFBCMR Medical Advisor can only speculate whether the applicant had reached any level of threat of myocardial infarction or suffered any cardiac injury. However, what is indisputable is the 99 percent arterial occlusion of his left anterior descending artery, which was not amenable to stenting and required bypass grafting, which placed him a great risk of experiencing a serious myocardial infarction (irreversible, non-viable heart muscle due inadequate blood supply or tissue perfusion on demand). The applicant's coronary artery disease would have likely resulted in medical disqualification.

So, where does the expression existed prior to service (EPTS) fit into the discussion? Based upon the level of occlusion of the applicant's LAD artery, this did not occur because of performing military IDT duties, while serving a period of 30 days or less. Thus, a preponderance of evidence indicates the applicant's near occluded LAD was not duty-related. The Board must then decide whether the applicant's participation in CBRNE training caused an injury, e.g., myocardial infarction which can be attributed to the activity and environmental conditions at the time. Again, without actual clinical studies conducted at or about the time of alleged "heart attack" there is no objective evidence of such an injury occurrence. Chest pain, or angina, does not equal myocardial infarction, but is a clear warning that such an occurrence may be imminent or in the future if unresolved; by restoration/improvement of adequate myocardial perfusion, e.g., use of vasodilators and beta blockers. None of this emergency treatment was provided to the applicant.

However, the applicant was finally able to obtain a cardiology evaluation and ultimately receive the definitive work-up and treatment he needed.

With respect to the AF Form 469, the Medical Advisor concedes such a document is designated when MEB/PEB processing is required for a given duty or mobility limiting medical condition. However, while the applicant may have experienced angina or other subclinical signs of acute coronary syndrome, requiring coronary artery bypass grafting, the Medical Advisor opines his experiences reported on 8 Sep 19, were not proof of permanent or irreversible cardiac injury at the time. Therefore, based upon a preponderance of evidence, he would have been eligible for processing through the Disability Evaluation System, as a nonduty-related medical condition, eligible for appeal of "fitness only."

With respect to the applicant's historical elevated lipid profile, given the absence of other risk factors, the Medical Advisor cannot ignore this as a probable contributory factor in the evolution of his coronary artery disease. However, without an investigation, which is beyond the scope of the AFBCMR activity, the Medical Advisor could not establish source or validate any alleged failure to notify applicant of the results of lipid testing, and whether this deficiency reoccurred over the several year period from 2004 to the time of discovery of his occluded LAD in 2019-2020. The Medical Advisor also acknowledged the medical information, received from reputable sources, addressing the effect of environmental factors, e.g., excessive heat exposure, upon cardiopulmonary functioning and the variety of possible presentations by individuals experiencing acute coronary syndrome, some with little or no symptoms, to symptoms suggestive of a problem with other organ systems, e.g., esophageal, gastrointestinal source. Therefore, with or without chest pain, the marked occlusion of the applicant's left anterior descending artery is only proof he was vulnerable to a major cardiac event, but not proof he experienced a major cardiac event on 8 Sep 19. Specifically, the Medical Advisor is of the opinion the applicant experienced what is referred to as angina pectoris (chest pain), with exertion, which occurs when not enough oxygenated blood is delivered to cardiac muscle with exertion. However, with immediate cessation of the exertional activity and/or introduction of a vasodilator, e.g., nitroglycerin, the angina may be relieved. Angina onset without exertion or unrelieved by rest, referred to a Prinzmetal angina, is due to coronary artery vasospasm.

The applicant states he is "attaching the form used for fitness testing, whereas we are directed to seek medical care from our personal primary care provider, if we are experiencing chest pain." The Medial Advisor has not been supplied the applicant's Fitness Assessment (FA) history (dates completed or scores), nor any exemptions or medical clearance documents to be completed prior to participation. Noting the level of occlusion, near 99 percent, of the applicant's LAD coronary artery, the Medical Advisor opines, unless exempted from the 1.5-mile run, he would have been vulnerable to become symptomatic with exertion, either during FA testing or training for the FA, as he now claims he experienced only during the CBRNE exercise.

The complete advisory opinion is at Exhibit G.

APPLICANT'S REVIEW OF ADDITIONAL AIR FORCE EVALUATION

The Board sent a copy of the advisory opinion to the applicant on 6 Jul 23 for comment (Exhibit H), and the applicant replied on 31 Jul 23. In his response, the applicant contends, contrary to the advisory opinion, there is evidence he was experiencing chest pain and has submitted copies of these letters from his treating physician and photographic evidence of before and after his chest pain symptoms occurred. He notified the proper individuals in his chain of command and sought medical treatment as quickly as he could. Additionally, he has shown how frivolously his unit treated his situation finding no one to assist him in taking the necessary steps to get the medical assistance he needed.

The applicant's complete response is at Exhibit I.

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 recommendation of the AFBCMR Medical Advisor and finds a preponderance of the evidence does not substantiate the applicant's contentions. The mere existence of a medical diagnosis does not automatically determine unfitness and eligibility for a medical separation or retirement. The applicant was in an IDT status when his chest pains occurred. In order to qualify for a duty-related compensable fitness determination, his condition must be the proximate result of performing his military duties and/or aggravation must constitute a worsening of a pre-existing condition above and beyond the natural progression of the disease. The Board finds the applicant's condition to be pre-existing without aggravation above and beyond due to the applicant's near occluded left anterior descending coronary vessel and finds his condition was not aggravated above and beyond natural progression due to his participation in the CBRNE exercise. Even if the applicant was found unfit for continued military service, the Board finds he would have been processed for a fitness determination only as there was no causal relationship with his IDT duties, his condition was of natural progression and not service aggravated. Additionally, the Board finds no evidence to support the applicant's claim a malicious removal of medical documentation occurred. Furthermore, as noted in the ARPC/DPTT advisory opinion, the Board finds the preponderance of evidence supports the applicant was correctly processed for retirement and transferred to the RRL. Therefore, the Board recommends against correcting the applicant's records.

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 Department of the Air Force Instruction (DAFI) 36-2603, *Air Force Board for Correction of Military Records (AFBCMR)*, paragraph 2.1, considered Docket Number BC-2022-02751 in Executive Session on 26 Jul 23 and 21 Aug 23:

[redacted], Panel Chair
[redacted], Panel Member
[redacted], Panel Member

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

Exhibit A: Application, DD Form 149, w/atchs, dated 17 Oct 22.
Exhibit B: Documentary evidence, including relevant excerpts from official records.
Exhibit C: Advisory Opinion, ARPC/DPTT, w/atchs, dated 21 Nov 22.
Exhibit D: Advisory Opinion, AFBCMR Medical Advisor, w/atch, dated 16 May 23.
Exhibit E: Notification of Advisory, SAF/MRBC to Applicant, dated 18 May 23.
Exhibit F: Applicant's Response, w/atchs, dated 12 Jun 23.
Exhibit G: Advisory Opinion, AFBCMR Medical Advisor, dated 5 Jul 23.
Exhibit H: Notification of Advisory, SAF/MRBC to Applicant, dated 6 Jul 23.
Exhibit I: Applicant's Response, w/atchs, dated 31 Jul 23.

Taken together with all Exhibits, this document constitutes the true and complete Record of Proceedings, as required by DAFI 36-2603, paragraph 4.12.9.

2/6/2024

[redacted]

Board Operations Manager, AFBCMR
Signed by: [redacted]