[redacted]

[redacted]

# UNITED STATES AIR FORCE
# BOARD FOR CORRECTION OF MILITARY RECORDS

## RECORD OF PROCEEDINGS

**IN THE MATTER OF:** [redacted]

**DOCKET NUMBER:** BC-2023-02206

**COUNSEL:** NONE

**HEARING REQUESTED:** YES

## APPLICANT'S REQUEST

1. He be given a medical retirement.

2. He be paid all compensation back pay from active duty and retirement to include cost of living adjustments.

3. He be given any promotions and decorations due to him (for the decorations portion, he was sent a failure to exhaust letter and directed to AFPC).

## APPLICANT'S CONTENTIONS

He has been diagnosed with eight tick borne diseases that were misdiagnosed since 1982 while he was on active duty in the United States Air Force. In 1982, he was bitten by ticks after his truck hit a deer which caused rashes all over his body, and he was misdiagnosed as folliculitis. Based upon a 2023 lab report, those rashes were actually Rocky Mountain Spotted Fever as the lab results confirmed Bartonella, Rickettsiosis, Tick Borne Relapsing Fever, Ehrlichiosis, and Anaplasmosis. These are all tick-borne illnesses which date back to 1982. Between 1982 and 1984, he was misdiagnosed as a hypochondriac and medically discharged and placed on the Temporary Disability Retired List (TDRL). He served over 14 years with an outstanding career and reputation but when he got sick, he was labeled as a hypochondriac stating his symptoms were multiple somatic complaints with no disease causing that many symptoms. Due to this, they tried to court-martial him and administratively discharge him. This took him to the brink of suicide, administrative punishment, courts martial, false discharge, homelessness, false imprisonment, blindness, unnecessary surgeries, obesity, prescribed Opioids addiction, and near-death experiences.

In 2016, he was diagnosed with late-stage Lyme disease and was diagnosed with Bartonella and Babesiosis in 2018. He was never evaluated for tick borne illnesses; however, his military records show rashes associated with multiple tick-borne diseases and multiple undiagnosed and untreated bacteria were found in a urine culture. In 1986, specialty biopsies revealed unknown muscle disease, chronic dermatitis, and peripheral neuropathy consistent with tick-borne diseases.

The applicant's complete submission is at Exhibit A.

**STATEMENT OF FACTS**

The applicant is a former Air Force master sergeant (E-7).

On 30 Apr 75, DD Form 214, *Report of Separation from Active Duty*, reflects the applicant was honorably discharged in the grade of staff sergeant (E-5) after serving 4 years, 5 months, and 15 days of active duty for this period. No authority or reason for discharge were annotated on the DD Form 214.

The applicant's Certification of Military Service Certificate indicates he served honorably in the Air Force from 1 May 75 to 18 Dec 80.

On 31 May 83, a letter from the applicant's commander indicates he was absent without leave (AWOL) from 8 through 11 Mar 83 and his unit was going to impose punishment under Article 15, nonjudicial punishment (NJP). Because of this, the applicant demanded a trial by court-martial. The applicant was evaluated by the mental health clinic on 12 May 83, and it was determined, the applicant was suffering from a severe stress reaction diagnosed as a transient psychogenic fugue disorder and was not responsible for his actions. Therefore, the charges against him were dismissed.

On 12 Jun 84, AF Form 618, *Medical Board Report*, indicates the applicant was referred to the Informal Physical Evaluation Board (IPEB) for hypochondriasis, psychogenic pain disorder, psychogenic fugue by history, scapulocostal syndrome, and mild degenerative joint disease secondary to trauma.

On 26 Jun 84, the applicant's medical board proceedings case was returned for completion of a line of duty (LOD) determination.

On 17 Sep 84, AF Form 348, *Line of Duty Determination*, indicates the applicant sustained several injuries due to an altercation when he was accosted on 1 Jan 83. He sustained abrasions to his left forearm, ankle, hip and wrist injuries, and back pain and it was noted, the injuries were likely to result in permanent disability. The appointing authority agreed, the injuries were in the line of duty (ILOD).

On 23 Oct 84, AF Form 618, *Medical Board Report*, indicates the applicant was referred to the IPEB for hypochondriasis, psychogenic pain disorder, psychogenic fugue by history, scapulocostal syndrome, and mild degenerative joint disease secondary to trauma. On 24 Oct 84, the applicant acknowledged the Medical Evaluation Board (MEB) findings and submitted a letter of exception. In this letter, the applicant stated the doctor showed little concern for his condition and repeated lied about his pain and the extent of his relief. He further disagreed with the psychological diagnosis on the report claiming the doctors were seeking vengeance for their own ignorance of

his condition and purposely, for their own vindication, their inability to comprehend and treat his condition.

On 30 Oct 84, AF Form 356, *Informal Findings and Recommended Disposition of USAF Physical Evaluation Board*, indicates the applicant was found unfit due to his medical conditions of hypochondriasis associated with psychogenic pain disorder and psychogenic fugue by history with severe industrial impairment, associated with scapulocostal syndrome, moderate, and mild degenerative joint disease secondary to trauma with a disability compensation rating of 50 percent with a recommendation of "Temporary Retirement." His other condition, history of peptic ulcer disease, was found not unfitting and his probable mixed personality disorder with passive-aggressive and histrionic features was considered but not ratable.

On 8 Nov 84, AF Form 1180, *Action on Physical Evaluation Board Findings and Recommended Disposition*, indicates the applicant agreed with the findings and recommended disposition of the Physical Evaluation Board (PEB).

Dated 4 Nov 84, Special Order [redacted], indicates the applicant was relieved from active duty and placed on the TDRL in the grade of master sergeant with a compensable percentage for physical disability of 50 percent, effective 29 Nov 84.

On 28 Nov 84, DD Form 214 reflects the applicant was honorably discharged in the grade of master sergeant (E-7) after serving 14 years and 13 days of active duty. He was discharged with a narrative reason for separation of "Placed on Temporary Disability Retired List."

On 31 Oct 86, AF Form 356 indicates the applicant was found unfit due to his medical conditions of psychogenic pain disorder with pain the predominant symptom, not explainable by any organic pathology; history of psychogenic amnesia; with moderate social and industrial impairment, rated at 10 percent and history of peptic ulcer disease, rated at 0 percent with a combined disability compensation rating of 10 percent with a recommendation of "Discharge with Severance Pay." His other condition, histrionic and passive-aggressive and histrionic traits, possible mild peripheral neuropathy by electromyography/maximum voluntary contraction (EMG/MCV) but not demonstrated on physical exam was considered but not ratable.

On 24 Nov 86, the applicant disagreed with the findings and requested an appearance before the Formal Physical Evaluation Board (FPEB).

On 13 Jan 87, AF Form 356, *Formal Findings and Recommended Disposition of USAF Physical Evaluation Board,* indicates the applicant was found unfit due to his medical conditions of multiple variable and atypical pains of unknown etiology probably due to psychogenic pain disorder, not explainable by any organic pathology; history of psychogenic amnesia; with moderate social and industrial impairment, rated at 10 percent and history of peptic ulcer disease, rated at 0 percent with a combined disability compensation rating of 10 percent with a recommendation of "Discharge with Severance Pay." His other condition, histrionic and passive-aggressive and

histrionic traits, possible mild peripheral neuropathy by EMG/MCV but not demonstrated on physical exam was considered but not ratable.

On 13 Jan 87, AF Form 1180 indicates the applicant disagreed with the findings and recommended disposition of the PEB formal hearing and desired to submit a rebuttal.

On 24 Mar 87, the Secretary of the Air Force (SAF) Physical Review Council reviewed the applicant's case and concurred the previous board's decision.

On 1 Apr 87, the SAF directed the applicant be discharge with severance pay with a disability rating of 10 percent.

Dated 8 Apr 87, Special Order [redacted] indicates the applicant was removed from the TDRL and discharged with entitlement to severance pay, effective 18 Apr 87.

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

**APPLICABLE AUTHORITY/GUIDANCE**

AFR 35-4, *Physical Evaluation for Retention, Retirement and Separation*, paragraph 3-59, *Grade Determination*, members are usually retired or discharged by reason of physical disability in the grade in which they are serving on active duty. If they have satisfactorily served in a higher grade, or are regular Air Force enlisted members, or Reserve component officers holding a valid appointment in a higher non-regular (USAF Reserve) commissioned grade, they may be eligible for retirement or disability severance pay in the higher grade. This determination is made within the Office of the SAF and announced in retirement orders or discharge instructions.

**AIR FORCE EVALUATION**

The AFBCMR Medical Advisor recommends denying the application finding insufficient evidence to support the applicant's contentions and his request. The burden of proof is placed on the applicant to submit evidence to support his contentions/request. The evidence he did submit was assessed to not support his request for a change in his military records to include a medical retirement and or historical financial compensation.

In this discussion, the Medical Advisor will address specific points as written by the applicant on his application to the Board. First, the applicant describes striking a deer with his automobile and lifted the deer off the road in 1982. As this was self-reported, there was no evidence found in the records to definitively reflect the presence of ticks or the human attachment of the same. Additionally, the applicant stated, in Sep 82 he had rashes over his entire body. However, the encounter on 1 Sep 82 noted folliculitis rash only on his face and arms and he has had the same thing in the past. Lastly, the applicant maintains, for over three decades he was misdiagnosed because his real belief was that his so-called folliculitis rash in 1982 was really that of various tick

diseases. His proof of that belief was by providing a single sheet laboratory report obtained 40 years after his reported deer incident which revealed the following results: Bartonella genus 'positive' (defined as: detected 2 or more Bartonella species-specific antibody); Bartonella species positive; Rickettsiosis rickettsii IgG (serum) = 40 (<40 is negative); and Rickettsiosis typhi (IgG) serum = 40 (<40 is negative).

Much is known about serum testing parameters for tick-borne diseases when specimens are obtained early, within a few weeks in the disease process. However, antibodies created by our immune system, in all cases so distant to a possible inciting event, can only indicate a past exposure to the various bacteria that can cause a tick-borne related illness, even if the infection is no longer active; this is because antibodies produced by the body can remain detectable in the blood for many years after treatment or even if the infection resolved on its own, making it difficult to distinguish between current and past infection solely based on a positive test result. Ideally, these tests called Immunofluorescence antibodies (IFA) assays are highly sensitive at detecting antibody two to three weeks after illness onset, and assay results are best interpreted if serum samples are collected in both the acute and convalescent phases of illness and tested in tandem. Clinical observations have suggested very early therapy with a tetracycline-class drug can sometimes diminish or delay the development of antibodies in Rocky Mountain Spotted Fever (RMSF); however, this should not dissuade appropriate serologic testing. Such drug therapy is extremely important in this case because, when diagnosed with folliculitis on 1 Sep 82 (the date and time the applicant claims his presentation was indeed Lyme disease), ironically, he was treated with the very same antibiotic that is the indicated treatment for an actual diagnosis of Lyme disease. Rickettsial diseases are caused by closely related bacteria typically spread to people from infected fleas, ticks, and mites. Various laboratory methods exist for the diagnosis of rickettsial diseases. Methods differ in availability, type and timing of specimen collection, and interpretation of results. Molecular methods, such as polymerase chain reaction (PCR) tests, and serologic techniques, such as the IFA assay, are the most commonly available testing methods for rickettsial diseases. For serologic confirmation of rickettsioses, ehrlichioses, or anaplasmosis, IgG IFA testing of at least two serum samples collected, ideally, two to four weeks apart, during acute and convalescent phases of illness, is recommended. A diagnosis of tick-borne rickettsial disease is confirmed with a fourfold or greater increase in antibody titer in samples collected at appropriately timed intervals in patients with a clinically compatible acute illness. A diagnosis of tick-borne rickettsial disease is supported but not confirmed by one or more samples with an IgG antibody reciprocal titer ≥64 in patients with a clinically compatible acute illness. The bartonella species that show positive in 2023 only reflects past exposure to bacteria and not to a specific time frame of the onset to any tick-borne related condition. The duration antibodies persist after recovery from the infection varies and depends on the pathogen and host factors. The serologic diagnosis of rickettsioses is often confounded by the occurrence of preexisting antibodies that are reactive with a particular pathogen although unrelated entirely to the disease under investigation. According to the Center for Disease Control (CDC), misinterpretation of serologic data based on single or inappropriately timed samples is problematic and should be avoided, particularly when no other diagnostic techniques are included in patient assessments.

Specifically, the lab report that was provided with the application, being decades after the applicant's reported originating deer incident was indeed inappropriately timed to provide any diagnostic finding other than the applicant has, at some time, been exposed. About the applicant's physician authored statement dated 11 Jun 23; it was reviewed and found to be lacking in facts and predicated only in remote historic recall. Additional statements regarding historical diagnoses and misdiagnoses were without evidentiary proof from decades prior. Without excerpting various comments from this physicians' letter as examples, the Medical Advisor would simply like to note the applicant's physician witness statement closing comment, "now that [the applicant] diagnosis of tick-borne illness is proven by labs and symptoms and military doctors that confirmed but didn't treat…" As previously stated, the lab values only proved of an exposure to various bacteria. The Medical Advisor opines the validity of this bottom-line statement is completely without merit and blatantly false in many ways. For example, the provider denoted the applicant developed an erythema migrans rash (classic) target-like Lyme disease rash. However, that was never revealed in the medical records nor in any of his submitted 81 pictures of skin areas. Additionally, there was a statement noting he tragically was misdiagnosed by several doctors on several Air Force bases. Again, the Medical Advisor questions as to the evidence on hand and or submitted as to make such a statement four decades later.

Medical education has always emphasized a diagnosis should be based upon a complete medical history and physical examinations (PE) and not based solely on pictures; however, in the specialty of dermatology, pictures have a much greater value as an adjunct in rendering a proper diagnosis. In this case, it is in the Medical Advisor's professional opinion all the 81 pictures of the applicant's skin strongly revealed nothing other than the appearance of folliculitis which was his ongoing diagnosis and reportedly with a history of the same. The inconsistent reporting of the classic skin manifestation was nowhere to be found in evidence. Despite comments from the applicant's physician in 2023 regarding a direct nexus to a single, self-reported [non-verifiable] event some 40 years prior completely negates all other lifetime exposures (positive exposure to bacteria) that could / may have occurred after the reported event.

Lastly, the applicant did note his collecting DVA disability as relating to service connection and therefore, it remains paramount to brief the difference between the military and DVA disability evaluation. For awareness sake, the military's Disability Evaluation System (DES), established to maintain a fit and vital fighting force, can by law, under Title 10, U.S.C., only offer compensation for those service incurred diseases or injuries which specifically rendered a member unfit for continued active service and were the cause for career termination; and then only for the degree of impairment present at or near the time of separation and not based on future progression of injury or illness. On the other hand, operating under a different set of laws (Title 38, U.S.C.), with a different purpose, the DVA is authorized to offer compensation for any medical condition determined service incurred, without regard to and independent of its demonstrated or proven impact upon a service member's retainability, fitness to serve, or the length of time since date of discharge.

The complete advisory opinion is at Exhibit C.

**APPLICANT'S REVIEW OF AIR FORCE EVALUATION**

The Board sent a copy of the advisory opinion to the applicant on 18 Feb 25 for comment (Exhibit D), and the applicant replied on 18 Mar 25. In his response, the applicant provides a lengthy explanation as to why he was misdiagnosed in the service and how he should have been found medically unfit due to Lyme disease to which guidelines and criteria established by the Center for Disease Control (CDC) were not available in the mid-1980s. If this criterion was known, the outcome of his separation and removal from the TDRL would not have been justified and he either would have been cured and continued to serve or he would have been permanently retired from military service. The advisory opinion should have examined his case to determine whether he met CDC guidelines and diagnostic criteria for Lyme disease today; however, the advisory opinion is silent on this point. Therefore, the Board should determine retroactively whether or not his medical records met the guidelines and diagnostic criteria for Lyme disease today; so, they can decide whether or not he had Lyme disease while he was on active duty and/or during his TDRL.

His 46-page rebuttal goes on to reference his misdiagnosis, errors in the advisory opinion and references the CDC guidelines. In his conclusion he states, for nearly, 40 years no doctor has been able to stabilize his illnesses except Work-Product, a tick-borne disease specialist. He is now being treated for tick-borne diseases and would like the stain of hypochondriasis and psychogenic pain removed from his military record because he was a proud, dedicated, and highly awarded senior non-commissioned office in record time and was prepared to become a commission officer until he was infected with Lyme disease which ended his career.

The applicant's complete response is at Exhibit E.

**FINDINGS AND CONCLUSION**

1. The application was not timely filed. The Board also notes the applicant did not file the application within three years of discovering the alleged error or injustice, as required by Section 1552 of Title 10, United States Code, and Department of the Air Force Instruction 36-2603, *Air Force Board for Correction of Military Records (AFBCMR)*.

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 applicant claims because he was diagnosed as a hypochondriac, the service tried to court-martial him and administratively discharge him. However, the Board finds no evidence of this and finds his discharge was consistent with the substantive requirements of the regulations in effect at the time. The records revealed he was AWOL to which his commander was going to issue an Article 15, NJP but found the applicant was not responsible for his actions and the matter was dropped. Furthermore, 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. Specifically, the Board finds no evidence to suggest the applicant was misdiagnosed or an error or injustice occurred during the disability evaluation process. The

applicant's lab results or the statement from his doctor forty years after an event with a deer was not convincing enough to grant the applicant's request. The Board finds no evidence to link the lab results to this self-reported event forty years later. The pictures he submitted were from the present and not from his medical records while he served in the military. Additionally, the applicant's medical records reveal he had a history of folliculitis rashes to his face and arms prior to the supposed event and the lab results from 19 Jul 85 when he was referred to dermatology by the DVA revealed laboratory analysis of both blood and urine were normal. The Board acknowledged the applicant's contention CDC standards should be applied to determine whether he had Lyme disease to which he is currently being treated for; however, the military's DES established to maintain a fit and vital fighting force, can by law, under Title 10, U.S.C., only offer compensation for those service incurred diseases or injuries, which specifically rendered a member unfit for continued active service and were the cause for career termination; and then only for the degree of impairment present at or near the time of separation and not based on post-service progression of disease or injury. Lastly, the applicant provides no further explanation or evidence to suggest the grade of master sergeant held at discharge was in error or that he should have been discharged at a higher grade when he separated from the service or when he was removed from the TDRL. The Board finds no evidence to suggest the applicant served in a higher grade for which he was entitled to. Additionally, for the applicant's request for decorations due to him, again, he provided no specifics and was sent a letter informing him this request was a failure to exhaust and directed him to AFPC. 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 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-2023-02206 in Executive Session on 19 Mar 25 and 24 Apr 25:

[redacted], Panel Chair
[redacted], Panel Member
[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 Jul 23.
Exhibit B: Documentary evidence, including relevant excerpts from official records.
Exhibit C: Advisory Opinion, AFBCMR Medical Advisor, dated 18 Feb 25.
Exhibit D: Notification of Advisory, SAF/MRBC to Applicant, dated 18 Feb 25.
Exhibit E: Applicant's Response, w/atchs, dated 18 Mar 25.

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.

4/29/2025

[redacted]

Board Operations Manager, AFBCMR
Signed by: USAF