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Individual readiness and deployability have always been important factors in determining unit and overall Army readiness. As the Army downsizes, and the Operational Tempo and Personnel Tempo remain high or increases, individual readiness and deployability may become more critical to Army readiness. Maintaining a healthy and deployable force are critical components of ensuring a combat ready force. Consequently, all soldiers must be ready to deploy quickly. If the Army has a significant pool of soldiers who are medically nondeployable, it will not have the resources to continue to support operational missions. This study evaluated the effects on Army readiness of active component personnel with permanent nondeployable medical profiles (e.g., diabetes and cancer). The study assessed the efficacy of current Army policies. It also evaluated the readiness and medical reporting systems to determine the true impact of permanent nondeployable soldiers on readiness. This study concluded that profiles do not have a notable impact on Army readiness. However, the study found that the Army's readiness and medical reporting systems were unreliable and they may significantly obscure the magnitude of the nondeployable problem. In addition, Department of Defense and the Army policies do not efficiently promote a healthy and deployable force.

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fulfillment of the requirements for the
degree

MASTER OF MILITARY ART AND SCIENCE

by

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The opinions and conclusion expressed herein are those of the student author and do not necessarily represent the views of the U.S. Army Command and General Staff college or any other governmental agency. (References to this study should include the foregoing statement.)

ABSTRACT

THE IMPACT OF SOLDIERS WITH PERMANENT MEDICAL PROFILES ON
ARMY OPERATIONAL READINESS by MAJ Harold W. Reeves, Jr., USA, 97 pages.

Individual readiness and deployability have always been important factors in determining unit and overall Army readiness. As the Army downsizes, and the Army Operational Tempo and Personnel Tempo remain high or increases, individual readiness and deployability may become more critical to Army readiness. Maintaining a healthy and deployable force are critical components of ensuring a combat ready force.

Consequently, all soldiers must be ready to deploy quickly. If the Army has a significant pool of soldiers who are medically nondeployable, it will not have the resources to continue to support operational missions.

This study evaluated the effects on Army readiness of active component personnel with permanent nondeployable medical profiles (e.g., diabetes, and cancer). The study assessed the efficacy of current Army policies. It also evaluated the readiness and medical reporting systems to determine the true impact of permanent nondeployable soldiers on readiness.

This study concluded that profiles do not have a notable impact on Army readiness. However, the study found that the Army's readiness and medical reporting systems were unreliable and they may significantly obscure the magnitude of the nondeployable problem. In addition, Department of Defense and the Army policies do not efficiently promote a healthy and deployable force.

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LIST OF ABBREVIATIONS

AIT	Advanced Individual Training
ARI	Army Research Institute
BT	Basic Training
CJCS	Chairman of the Joint Chiefs of Staff
DA	Department of Army
DCSPER	Deputy Chief of Staff for Personnel
DES	Disability Evaluation System
DOD	Department of Defense
DoDD	Department of Defense Directive
GAO	Government Accounting Office
HIV-1	Human Immunodeficiency Virus Positive
P-U-H-L-E-S	Physical Capacity or Stamina, Upper Extremities, Lower Extremities, Hearing and Ears, Eyes, Psychiatric
MOOTW	Military Operations Other Than War
MEB	Medical Evaluation Board
MMRB	Military Occupational Specialty/Medical Retention Board
MTOE/TOE	Modified Table of Organization and Equipment or Table of Organization and Equipment
OPTEMPO	Operational Tempo
PEB	Physical Evaluation Board
PERSTEMPO	Personnel Tempo

PMND	Permanent Medical Nondeployable
PPES	Physical Performance Evaluation System
PMOS	Primary Military Occupational Specialty
SIDPERS	Standard Installation/Division Personnel System
SORTS	Status of Resource and Training Systems
SROC	Senior Readiness Oversight Council
TDA	Table of Distribution and Allowance
TTHS	Trainees, Transients, Holdees, and Students
USAPDA	United States Physical Disability Agency
USR	Unit Status Report
USAEUR	US Army Europe

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CHAPTER 1

INTRODUCTION

General Thesis Statement

Individual readiness and deployability have always been important factors in determining unit and overall Army operational readiness. As the Army downsizes and its operational tempo (OPTEMPO) and personnel tempo (PERSTEMPO) remain high or increase, individual readiness and deployability may become even more critical to unit and Army readiness. Additionally, policies and regulations that govern nondeployable soldiers should not exacerbate the deployability problem.

Department of Defense (DOD) and Army policies and regulations should promote a healthy and deployable force. Units may have little or no room to adjust to deployment demands with a decreasing force structure. If the Army has a sizable pool of soldiers who are medically nondeployable, it will not have the resources to continue to support operational missions. This nondeployable pool will require the Army to deploy continuously a smaller group of soldiers. Eventually, these over-deployed soldiers may fatigue, challenge, or resent the fairness of policies that requires some soldiers to deploy, but permits others who are medically not qualified to deploy remain in the Army and never deploy. Consequently, with a smaller, but more deployed Army, all soldiers must be ready to deploy anywhere with little or no notice.

Recognizing the importance of deployability and readiness, political leaders in recent years have debated the status of operational readiness with senior military leaders. Soldiers, both active and reserve, must continue to maintain individual readiness to be deployable. To qualify as deployable, the Army requires soldiers to be physically fit. At

a minimum, all soldiers must meet height and weight standards and other physical standards including maintaining immunizations and dental work as documented by a current physical examination. Other specialties may have physical requirements that are even more stringent (within five years).

When soldiers deviate, whether intentionally or unintentionally, from these requirements and become medically nondeployable, the Army, namely the soldier's unit, must fix or replace the soldier to maintain readiness. In the case of soldiers with permanent medical profiles, such as being Human Immunodeficiency Virus-1 (HIV) positive, neither the unit nor the Army can fix them. Therefore, unit readiness could suffer significantly. Whether a unit or the Army "fixes," replaces, or discharges the soldier who is not physically fit, impacts operational readiness since deployability is a factor in unit readiness. Accordingly, the Army should know how soldiers with permanent medical profiles influence unit readiness, deployability, and hence Army operational readiness.

Background

It is a common and often repeated adage during the recent downsizing within the military that "the Army can do more with less." Policymakers use this trite statement to make personnel cuts more palatable, while simultaneously increasing military commitments. Eventually the military demands could overwhelm soldiers' capabilities to accomplish the mission. The realistic probability is that the Army probably will do less with less and will not have the capability to continue increased OPTEMPO requirements given the continued reductions in force structure.

Having a capable and deployable force is at the heart of the readiness issue. The base force, in a downsized Army with increasing OPTEMPO demands, may not be able to support increased contingency and deployment requirements. In order to ensure that the Army can effectively support its ever-increasing worldwide operational requirements, the pool of deployable soldiers must be able and broad enough to support new demands. Those soldiers who are nondeployable, whether temporarily or permanently, directly influence the Army's ability to perform its mission.

The Army also is different from the civilian sector in that it can and must discriminate when hiring. The Army discriminates based on age, gender, and physical/mental abilities. Individuals over thirty-four years of age cannot enlist,¹ and the Army will not commission individuals under twenty-one, nor over twenty-seven years of age as officers.² The Army will not permit women to join the infantry or armor branches and will not commission or enlist individuals with physical or mental disabilities. Few civilian organizations can or need to discriminate in these ways because these physical/mental limitations do not prevent, in most instances, accomplishment of their job functions. For units and the Army to be operationally ready, all soldiers must be able to perform their functions to standard, which requires physical and mental capabilities that are related to physical/mental abilities, age, and in some instances, gender.

This downsizing experience is not unique to the Army, yet deployability generally is a specific military requirement. However, downsizing presents different challenges for the Army. For example, civilian organizations generally must provide some reasonable accommodation for their employees when downsizing, but the Army does not. In addition, civilian organizations must ensure that personnel reductions do not violate civil

rights laws. Finally, and most importantly, most civilian organizations do not have physical fitness or deployment requirements, although firefighters and law-enforcement officers must maintain individual fitness and readiness and may deploy to a hostile environment which threatens life and limb. Soldiers, on the other hand, must be able to perform to standard, often under adverse conditions.

As a unique institution within the US society, the military is not obligated to provide due process when separating service members for medical reasons. The courts and society, understanding the unique war orientation of the military, have granted the services significant latitude in the legal arena. Soldiers have sued DOD because they believed that the military violated their right to due process under the law. The federal courts have decided the lawsuits in favor of the DOD. For example, Master Chief Petty Officer (E9) Angelo Brigante of the US Navy was medically retired after twenty years of service. He fought the process and eventually sued to have his forced retirement overturned. The federal court ruled “federal courts have no authority to challenge the discretion of Navy officials, and that Brigante’s discharge process was fair.”³ Although the Brigante case does not address permanent medical deployability, it does demonstrate the uniqueness of the military and its legal necessity to discriminate on much broader terms than civilian organizations.

Scope

This study will concentrate on soldiers who have a permanent medical permanent nondeployable profile, whom the Army has determined are nondeployable. The intent of this thesis is to evaluate the effect that soldiers who are permanently nondeployable due to medical conditions have on Army operational readiness in the Army as a whole, in the

Modified Table of Organization and Equipment or Table of Organization and Equipment (MTOE/TOE) Army, and the Table of Distribution and Allowance (TDA) Army. In addition, the study will address permanent nondeployable soldiers who are HIV positive. This study analyzes deployability data for the last ten years. The Army, now the smallest since the 1930s, has experienced notable downsizing since 1987. The study also included comparisons of the other services in order to evaluate Army policies and practices and to look for optimal solutions if available.

Importance

The Army mission demands deployability. Nondeployable soldiers limit the ability of the Army to perform its mission. If nondeployable soldiers are a problem, than the Army must address them. The importance of this study lies in the fact that soldiers and all military personnel are increasingly overused, required to deploy more often, and for longer periods. With more deployment requirements and fewer soldiers, it will be difficult to maintain Army operational readiness. Nondeployable soldiers should not reduce Army readiness.

Research Questions

The primary research question is: How do nondeployable soldiers with permanent medical profiles affect Army readiness in the active component? The following subordinate questions assist in answering the primary research question:

1. What is the extent of the nondeployable soldier problem in the Army?
2. How do nondeployable soldiers with permanent medical profiles affect readiness in the MTOE Army?

3. How do nondeployable soldiers with permanent medical profiles affect readiness in the TDA Army?

4. How effective are DOD and Army policies and regulations in assisting the Army leadership to manage the impact of soldiers with permanent medical profiles on readiness?

Assumptions

1. Army operational readiness is the responsibility of the National Command Authority (NCA), which is the President and the Secretary of Defense.

2. Unit readiness and deployability are the responsibility of the commander and the individual soldier.

3. Each soldier is responsible for his own individual readiness and deployability.

4. Any soldier, who is nondeployable, for whatever reason, degrades readiness at the unit level, and since operationally ready units are essential to Army readiness, this degrades Army operational readiness.

5. Armies and soldiers exist to serve America's national interest, which generally requires conducting operational missions or functions that often require deployment of soldiers.

6. If soldiers do not maintain their deployable status, the Army has to fix, separate, or retire them.

7. The Army provides the policies and resources to assist commanders in maintaining unit readiness and deployability.

8. Given endstrength limitations, if the Army does not separate or retire soldiers who cannot or will not maintain their individual readiness and deployability, some other

soldier will have to fill in for these nondeployable soldiers. The Army cannot recruit new, deployable soldiers to replace nondeployable soldiers who are retained.

Definition of Terms

Deployability. Is a soldier's "ability to depart his or her military homestation to engage in military operations abroad, including combat if so required."⁴

Deployment. When the Army sends a soldier or a unit away from homestation. Each military service uses a different definition to define how long a soldier is away from homestation before the military considers service members deployed.

Medically Nondeployable. A soldier, because of a temporary or permanent profile, cannot deploy in support of an operational requirement abroad or in combat.

Military Occupational Specialty/Medical Retention Board (MMRB). The PPES requires soldiers with "permanent medical conditions or impairments" to be evaluated by a Military Occupational Specialty/Medical Retention Board (MMRB). The MMRB determines if soldiers can perform in their designated Military Occupational Specialty (MOS) under worldwide conditions.⁵ (See Appendices 3 and 5 for more detailed discussion on.)

Modified Table of Organization and Equipment or Table of Organization and Equipment (MTOE/TOE) Units. Army units that are operationally deployable and tactical in nature. Corps, divisions, brigades, and battalions are MTOE/TOE organizations. MTOE/TOE units are those that conduct operational missions in support of US policy. The 82nd Airborne Division is an example of an MTOE unit that contains combat (infantry), combat support (Military Intelligence), and combat service support (Quartermaster) units.

Nondeployable. A soldier who cannot deploy to support operational missions. A soldier may be nondeployable because of impending separation, retirement, legal, or medical reasons.

Operational Readiness. The Army or units ability to deploy and perform its operational mission, particularly its wartime tasks.

Operational Tempo (OPTEMPO). The rate and time the military employs or deploys units and equipment away from homestation to conduct its mission. This may include training missions, war, and Military Operations Other Than War (MOOTW). In addition, if a unit has a high OPTEMPO, that means it has deployed often and for long periods.

Permanent Profile. A soldier with a permanent medical condition that permanently restricts his or her physical activities. A soldier with a permanent back condition that prevents him from carrying a Army rucksack or running is an example of a permanent profile. However, this soldier may still be deployable depending on his or her job specialty. HIV and some forms of cancer are examples of illnesses that make soldiers permanently nondeployable. (See appendix A for more detailed discussion on permanent profiles.)

Personnel Tempo (PERSTEMPO). The rate and time the military employs or deploys its soldiers away from homestation to conduct its mission. Quite often, many use OPTEMPO and PERSTEMPO interchangeably and in conjunction with some type of deployment, but they are not the same.

Physical Disability. "Any impairment due to disease or injury, regardless of degree, which reduces or precludes an individual's actual or presumed ability to engage

in gainful or normal activity.” This definition includes mental disease, but does not include personality and behavioral disorders or a mental deficiency.⁶

Physical Performance Evaluation System (PPES). The PPES is the Army’s medical system that establishes the procedures for managing soldiers with permanent medical conditions that may require separation or retirement.

Primary Military Occupational Specialty (PMOS). Upon completion of basic training the Army assigns each soldier a PMOS that identifies the job specialty the soldier will work. Each PMOS generally has certain requirements, whether physical or mental, that soldiers must meet in order to receive that specialty. For those assigned as linguists, they must demonstrate a certain aptitude for languages and score at least an eighty on the Defense Language Aptitude Battery exam. Implicit in nearly all PMOS is the requirement to deploy worldwide.

Profile. A designation that a qualified medical representative gives to a soldier because of a medical condition. The profile generally restricts or limits a soldier’s activities either temporarily or permanently. Some, but not all, medical temporary and permanent profiles disqualify soldiers from deploying.

Standard Installation/Division Personnel System (SIDPERS). An Army software program MTOE units use to “transmit strength accounting data and by-name personnel accounting information.”⁷

Status of Resource and Training System (SORTS). An Army reporting system that tabulates monthly aggregate deployable strength. The Headquarters, Department of the Army, monitors these reports closely in order to evaluate Army readiness.

Table of Distribution and Allowance (TDA) Units. Army organizations or units, sometimes called nominative, which are not tactical, and by design are not normally deployable, and more importantly, are not designed to deploy and fight. However, unit members are required to maintain individual readiness such as maintain their physical fitness. The Department of Army and the Joint Staff are examples of TDA units or nominative assignments.

Temporary Profile. A soldier with a temporary medical condition that restricts a soldier's physical activities temporarily. Pregnancy or broken bones are examples of temporary profiles. Both medical conditions prevent soldiers from deploying to an operational mission. Once a female soldier becomes pregnant, she automatically becomes nondeployable until at least four weeks after the birth of her child.

An approved medical technician must assign the soldier the temporary or permanent profile status. Soldiers possessing temporary or permanent profiles are not necessarily nondeployable. For example, a soldier may have a permanent hearing profile and still be deployable. (See appendix A for more detailed discussion on temporary profiles.)

Unit Status Report (USR). A monthly readiness report that MTOE units submit that evaluate and discuss the overall readiness of the unit in terms of soldiers, training, equipment, and resources. By regulation unit commanders assign a readiness rating between C1-C5 (C1 being the best).

Limitations and Delimitations

This study was limited due to time, money, availability of information, and accessibility of data. The author used existing data, not new data specifically collected

for this study. The study was not fully able to evaluate the data collected on readiness, deployability, and permanent profiles because of inconsistencies within the Army and between DOD in defining and measuring these terms. Even within the Army, this is a problem. In addition, because of the classified nature of some of the data contained in such reports as the USR and because of the privacy act limitation, it was difficult to access and analyze some information.

Study Organization

Chapter 1 includes the general background of the problem, the study scope, the importance of the problem studied, the main and subordinate research questions, and study assumptions. In addition, chapter 1 defines key terms used throughout the study and it explains the study's limitations and delimitations.

Chapter 2 describes the significant literature relating to soldiers with permanent medical profiles. The important sections of the chapter are: Readiness in Perspective; DOD and Army Readiness Reporting Systems; Soldier Fitness and Physical Readiness Regulations and Policies; Readiness Indicators; Profiles in the Army; and HIV Positive Personnel.

Chapter 3 relates the subordinate questions to evaluation criteria for the collected data; describes the data sources and collection methods used for the study; and summarizes the limitations and conclusions generated by the study's methodology.

Chapter 4 analyzes and evaluates collected data by using the evaluation criteria from chapter 3 and provides key judgments related to the primary and subordinate research questions.

Chapter 5 provides a conclusion to the thesis, offers recommendations to the researched problem, and suggests areas for further study.

¹ Department of the Army, Army Regulation (AR) 601-210, *Regular Army and Army Reserve Enlistment Program* (Washington, DC: Government Printing Office, 28 February 1995), 3.

² Department of the Army, AR 601-100, *Personnel Procurement, Appointment of Commissioned and Warrant Officers in the Regular Army* (Washington, DC: Government Printing Office, 15 August 1981), 1-6.

³ Nick Adde, "Challenging a separation: Easier said than done," *Army Times*, 15 July 96, 18.

⁴ LeRoy B. Outlaw, Edmund F. Muendel, and David A. Smith. *Policy for DoD Management of Permanent Medical nondeployable Personnel* (McLean, VA: Logistics Management Institute, March 1997), iii.

⁵ Department of Army, AR 600-60, *Physical Performance Evaluation System* (Washington, DC: Government Printing Office, 31 October 1985), 3.

⁶ Department of Defense, DoDD 1332.18, *Separation or Retirement for Physical Disability* (Washington, DC: Government Printing Office, 25 February 1986), 2-1.

⁷ Department of Army, *FM 63-3 Corps Support Command* (Washington, DC: Government Printing Office, 30 September 1993), 2-24.

CHAPTER 2

LITERATURE REVIEW

This study describes the impact of nondeployable soldiers with permanent medical profiles on Army readiness. In addition, the study will address permanent nondeployable soldiers who are HIV positive.

Readiness in Perspective

In order to understand the impact of soldiers with permanent medical profiles on operational readiness, one must first understand the operational readiness of the US military. The Government Accounting Office (GAO) has conducted a series of studies on readiness, which describe and analyze readiness and deployability, as well as OPTEMPO and PERSTEMPO. The reports also describe and analyze Army reporting systems, such as the USR, SIDPERS, and SORTS.

A 1996 study entitled *Military Readiness: A Clear Policy Is Needed to Guide Management of Frequently Deployed Units* provides an excellent analysis of deployability. This study describes and explains how the services the MTOE type of units in deployments. It discusses changes in deployments over the last ten years. GAO reported that "DOD is examining the need to increase the number of some high-deploying units" (Special Forces/Rangers, general support quartermaster, field services, and general supply, air defense artillery/Patriot batteries, military police, mechanized infantry).¹

Another GAO report *Peace Operations: Heavy Use of Key Capabilities May Affect Response to Regional Conflicts* primarily emphasized the effect of peace operations on the Army, particularly on combat support forces (e.g., military police

personnel) and combat service support units (e.g., fuel handlers and quartermaster personnel). It describes in detail the Army practice of cross-leveling soldiers, especially service-support soldiers, in order to meet operational requirements because of increased peace operations. Peace operations have required the Army to continue extensive cross-leveling, especially in the support branches. The Army maintains these units at 10 to 20 percent below authorized levels and than cross-levels during contingency operations. GAO recommended that the Army reconsider the practice.²

In *Military Readiness: A Clear Policy Is Needed to Guide Management of Frequently Deployed Units*, GAO describes the change in military missions as a result of the end of the Cold War and the impact on military readiness. The study pointed out that, not only were units in general deploying more often, but also the deployment burden fell on some types of units more than others did.³ As *Military Readiness, A Clear Policy Is Needed to Guide Management of Frequently Deployed Units* states, units began deploying more often because the US has increased its peacekeeping or military operations other than war (MOOTW) significantly since 1982. For example, in 1982, the US first sent soldiers to observe and enforce the peace in Sinai, Egypt.⁴

DOD and Army Readiness Reporting System

DOD establishes the framework in which the Army manages its soldiers. A major component of evaluating the impact of soldiers with permanent medical profiles requires one to examine the effectiveness of the readiness reporting system. Several studies and reports suggest that the military's readiness reporting system distorts or underrepresents readiness and the number of soldiers with medical profiles. Consequentially, any official figures DOD or the Army provides on permanent medical nondeployable soldiers may be

inaccurate. There are five significant points relating to the readiness reporting system that, in a complimentary manner, negatively influence readiness and deployability. This negative influence occurs because DOD and Army systems permit and encourage ambiguity in assessing soldiers not usually medically capable of performing their PMOS for retention. These system inadequacies are:

1. DOD and the Army medical systems grant too much discretion to local commanders for military medical separation and retention boards.
2. There is no uniform definition of deployability in DOD or the Army, which denies policymakers clarity in understanding the system.
3. There is no requirement to use deployability as determination of fitness criteria. The system does not mandate that medical boards consider deployability as criteria for retention or even consideration. In addition, the system does not provide for a uniform definition of what constitutes permanent medically nondeployable soldiers.
4. DOD, and consequently the Army, is inconsistent in its treatment of soldiers. DOD provides extra guarantees for HIV positive soldiers not accorded to others, although DoDD 6485.9 *Human Immunodeficiency Virus-1 (HIV-1)*⁵ automatically classifies HIV positive soldiers as nondeployable. The inconsistent treatment automatically creates unequal treatment.
5. The Army does not centrally manage the medical board system, therefore this produces notable inconsistencies in retention and separation board results for similar disabilities.

This discretion causes DOD, and consequently the Army, inconsistently to medically process and retain disabled soldiers. Before the drawdown, when the Army

had eighteen divisions rather than ten, and the OPTEMPO and PERSTEMPO rates were nearly half what they are today, this latitude was not as detrimental to readiness as it is today.

Lieutenant Colonel Allen M. Gildersleeve's "Mountains or Molehills--Permanent Physical Profiles in the Army Reserve"⁶ raises the issue of the reliability and accuracy of the Army readiness reporting system. For example, it reported that three different readiness reporting systems produced vastly different results. He compared results from USR, SIDPERS, and an Army Research Institute (ARI) study.

GAO also investigated DOD's readiness systems, its reliability, and then reported its findings. *Military Readiness DOD Needs to Develop a More Comprehensive Measurement System* found that DOD's SORTS program was inadequate for predicting readiness and that during DESERT STORM Army readiness reports, for both active and reserve forces, were "often inflated or unreliable." It did however recognize that the Army implemented a program that "allows the Army to project for two years the status of elements reported under SORTS." However, the report did not indicate whether the system could contend with personnel shortfalls.⁷ It also identifies as a problem the inconsistency of the military's personnel reporting systems, such as SORTS, particularly in terms of deployment.⁸

OPERATION DESERT STORM: War Highlights Need to Address Problem of Nondeployable Personnel reported that one of GAO's most consistent findings over the last seven years has been the unreliability of DOD's readiness reporting systems.⁹ The report questioned DOD's readiness systems and provided an accurate picture of readiness implying that the system masked readiness problems.

Military Readiness: Current Indicators to Be Expanded for a More

Comprehensive Assessment discusses DOD's SORTS system and reviews its strengths and weaknesses in terms of reporting readiness, the impact of cross-leveling personnel on readiness, the fears of an impending hollow Army, and the personnel shortages of different Primary Military Occupational Specialty (PMOS). The report's ultimate objective was to compare the current state of Army readiness in light of its PERSTEMPO and OPTEMPO demands and its personnel shortages.¹⁰

Disease, not injury, is the primary reason for soldiers to become permanent medical nondeployable. Soldiers that the Army retains generally must remain stateside because of the better medical resources. This means that other soldiers must deploy for them. Also, all services state that a "fit determination does not necessarily mean that a service member is deployable; however, the relative weight of a Physical Evaluation Boards (PEB) gives deployability in the fitness determination bears on the outcome." The Navy and the Marine Corps placed the strongest emphases on deployability, while the Army and the Air Force require no formal consideration of deployability.¹¹

The Army uses permanent profiles without associated deployability identification. The unit commander decides the deployability assessment, which will produce inconsistent results in the Army. One commander may subjectively think a soldier is deployable when another does not. This allows the commanders potentially to employ subjective irrational evaluation measurements. This creates an incongruity where some PEBs assess soldiers as fit within the limits of the profile, but the unit may still consider the soldier nondeployable!¹²

These anomalies occur because services do not consistently interpret DOD guidance and policies as they relate to Disability Evaluation System (DES). This leads to the following conflict, "Deployability is not uniformly addressed in all fitness determinations. A finding of fit does not necessarily mean that a service member is deployable in all instances. However, when a member is identified as unfit because of physical disability, he or she generally is seen as nondeployable."¹³ This transpires because there is no uniform definition of deployability in DOD and the Army. This lack of emphasis is probably an archaic byproduct of the Cold War when military personnel, particularly Army and Air Force, were forward deployed with their primary emphasis based on deterring the attack of the former Soviet Union. Unlike today, there was no need to emphasize power projection or deployability because the force structure was much larger, more static, and forward deployed.

Since the end of the Cold War, the US military has undergone a radical transformation. The US military is now primarily a power projection force that must deploy rapidly. After the transition to a much more mobile military, these archaic rules may inhibit readiness. Previously, most stateside units were on a thirty, sixty, or ninety day deployment cycle. Units, with the exception of the 18th Airborne Corps (e.g., 82nd Air Borne Division), had this much time to prepare because the US believed it possessed sufficient forces forward deployed and the force structure was much larger. In addition, the military now prepositions much of its equipment in theater, thus negating the need to move all stateside units' major equipment.

Soldier Fitness and Physical Readiness Regulations and Policies

A major component of evaluating the impact of soldiers with permanent medical profiles requires one to examine the effectiveness of policies and regulations associated with the process. This section will discuss whether the DOD and Army policies and regulations adversely influence readiness by permitting the Army to retain soldiers who cannot deploy on active duty. The Army is subordinate to DOD and therefore its policies must compliment, not contradict them.

The principal regulations governing medical fitness for DOD are DoDD 1332.18¹⁴ and 6485.1 *Immunodeficiency Virus-1 (HIV)*.¹⁵ For the Army, the principal regulations are Army Regulation (AR) 600-60, *Physical Performance Evaluation System*,¹⁶ AR 635-40, *Physical Evaluation for Retention, or Retirement*,¹⁷ or *Separation*, and AR 40-501, *Standards of Medical Fitness*.¹⁸ Except for DoDD 6485.1, which deals only with HIV, the regulations and directives address the entire spectrum of soldier fitness and physical readiness.

DoDD 1332.18, *Separation or Retirement for Physical Disability* is the source document for each military service detailing management of personnel with disabilities. DoDD 1332.18 creates a broad framework for the services to operate under when managing their soldiers with disabilities. DoDD 1332.18 establishes the necessary individual protections and safeguards, as well as the minimum standards for military medical retention.¹⁹ DoDD 1332.18 establishes the management of medically disabled soldiers while protecting the soldiers' interests and welfare. This regulation directly influences Army medical policies and procedures. Section D.2 states the, "Inability to perform the duties of his or her office, grade, rank, or rating in every geographic location

and under every conceivable circumstance will not be the sole basis for a finding of unfitness. Where feasible, consideration should be given to reclassifying the service member to an office or military specialty for which he or she would be fit before disability separation or retirement is accomplished.”²⁰

The regulation establishes the DOD DES and requires the services to hold Physical Evaluation Boards (PEB) to determine medical fitness. A PEB determination of “fit” usually returns a service member to duty. Conversely, a PEB determination of “unfit” usually results in a member’s separation or retirement from service.²¹

DoDD 1332.18, Section 3 lists seven criteria and standards that services cannot use to separate soldiers. The services interpret this statement differently and a “fit determination does not mean that a person is deployable.”²² DoDD 1332.18 also grants the services significant autonomy and discretion in how, or whether services separate medically unfit soldiers. The service regulations permit them to retain soldiers “irrespective of deployability considerations.”²³ However, the Army and the Air Force do not routinely exercise this authority.²⁴ AR 635-40, *Physical Evaluation for Retention, or Retirement, or Separation* mirrors the DOD directive. It states, “The mere presence of an impairment does not itself justify a finding of unfitness because of physical disability. In each case, it is necessary to compare the nature and degree of physical disability present with the requirements of the duties the soldier reasonably may be expected to perform because of his or her office, grade, rank, or rating.”²⁵ These characteristics influence the entire disability evaluation system.

AR 40-501, *Standards of Medical Fitness*²⁶ explains the Army’s medical board process, defines permanent and temporary medical profiles, and prescribes how the Army

will designate medical fitness using the P-U-L-H-E-S SYSTEM. Furthermore, the Physical Performance Evaluation System (PPES) described in AR 40-501 authorizes the Army to evaluate soldiers using a Military Occupational Specialty/Medical Retention Board (MMRB).²⁷

The Army's physical profile serial system covers the function of the body as it relates to military duties. The profile system assigns profiles to soldiers based on the six factors of "P-U-L-H-E-S." The system provides a numerical index to a soldier between one to four.²⁸ For example, if a soldier has a medical problem, whether temporary or permanent, a medical representative assigns the soldier one of its six profile serial system "P-U-L-H-E-S" number such as "3" on a physical profile form (DA Form 3349). An H2 (Hearing and ears) would mean that under "any or all factor indicates that an individual possesses some medical condition or physical defect which may require some activity limitations."²⁹ (See appendices A and B for detailed discussion of P-U-L-H-E-S).

AR 600-60, *Physical Performance Evaluation System* is the most exhaustive and thorough of the Army's three principal medical regulations and complements AR 40-501.³⁰ This regulation details the various and sundry medical disabilities that can affect a soldier, and relates them to profile assessment and identifies how the medical boards should evaluate these conditions in relation to the soldier. (See appendices B, C, and E for more detailed discussion.)

AR 600-60³¹ discusses the procedures and policies that govern the Military Occupational Specialty (MOS) MMRB. The MMRB is the Army's first formal medical board for a soldier with a medical disability. The regulation establishes the parameters for MMRB members when evaluating soldiers and explains soldiers' rights and options.

Through AR 600-60, the Army prescribes how it wants soldiers with disabilities viewed and managed:

- A soldier is presumed physically fit when commissioned, appointed, enlisted, or entered on active duty. This presumption continues throughout the soldier's career unless an injury or disease is incurred that prevents satisfactory performance of duty. If the soldier remains on active duty until his or her scheduled nondisability separation or retirement, he or she is presumed to be physically fit at the time of separation or retirement.
- A soldier with a medical condition that prevents the full accomplishment of the duties required by the soldier's MOS or specialty code should not be transferred to a less demanding duty position or allowed to perform only a part of the required duties in order to allow the soldier to continue to serve on active duty. Such medical conditions also should not be minimized during periodic physical examinations. Referral to an MMRB or to the Army's physical disability system is necessary to ensure that a soldier can perform satisfactorily the duties of his or her MOS or specialty worldwide under field conditions. This referral will also ensure that a soldier who may be eligible for disability benefits or severance pay is not precluded from such entitlements by the presumption of fitness that applies at the time of nondisability separation or retirement.³²
- After a Medical Evaluation Board (MEB) is held in accordance with AR 40-3, a Physical Evaluation board (PEB) holds an informal hearing to determine if the soldier is physically fit to continue to perform the duties of his or her office, grade, rank, or rating in a worldwide field environment. The soldier may concur or nonconcur with the findings and may demand a formal PEB. A formal PEB determines if the soldier is physically fit and may revise its initial determination based upon any nonoccurrence or rebuttal provided by the soldier. On completion of the PEB process, the soldier's case is forwarded to the United States Army Physical Disability Agency (USAPDA) for review.
- On receipt of the soldier's case by USAPDA, the Disability Review Council (DRC) reviews the case to ensure compliance with AR 635-40. If USAPDA approves the PEB findings and recommendation, the case is forwarded to MILPERCEN for appropriate disposition. If USAPDA modifies the findings and recommendations, the soldier is provided the opportunity to concur, request a formal PEB if not previously demanded, or rebut the modification. The Physical Disability Appeals Board resolves cases involving modified findings and recommendations when the soldier disagrees with such action, and the case is forwarded to MILPERCEN for appropriate action.³³

The MMRB is "unique to the Army." AR 600-60 authorizes commanders to conduct the MMRB at installation level and determine if soldiers can perform to their

PMOS requirements and deploy worldwide. The board convening authority can make one of the following decisions:

- Retain the soldier in his or her PMOS or specialty code.
- Place the soldier in a probationary status for up to six months for assessment.
- Recommend the soldier for reclassification to a new PMOS or for a change of specialty code.
- Refer the soldier to the Army's DES.³⁴

AR 635-40, *Physical Evaluation for Retention, Retirement, or Separation*,³⁵ like AR 600-60 addresses the medical board process and also prescribes procedures and policies for managing soldiers with medical conditions. AR 635-40 further explains the PEB system that actually evaluates soldiers with physical disabilities for retention, retirement, or separation. In addition, AR 635-40 specifies and establishes the standards for retaining soldiers on active duty, the duties and responsibilities for the PEB officials and the procedures for the medical examination of soldiers processed by the Army.

AR 635-40 requires boards to evaluate the "overall effect of disabilities." The board must determine if the disability affects the soldier's performance or dictates that the Army must impose a restriction on duty assignment for the soldier. The board should also look out for the welfare of the soldier and protect him or her for future assignments.³⁶

*Reserve Forces: DOD Policies Do Not Ensure That Personnel Meet Medical and Physical Fitness Standards*³⁷ highlights the negative impact of nondeployable soldiers in the Army reserve component. Though this study does not generally address the reserve component, some of GAO's findings and recommendations concerning the impact of soldiers with profiles on readiness apply to the active component.

Medical Board Evaluation Inconsistencies

The Army established medical retention standards outlined in chapter 3 of AR 40-501 to ensure that the Army possessed medically fit soldiers. The Army implemented the regulation and guidelines “to achieve uniform disposition of cases arising under the law.”³⁸ However, this may not be the case. If a soldier has one or more medical conditions or disabilities, it does not mean that the soldier is automatically referred to a medical board or considered medically unfit. Therefore, the Army must separate or retire the soldiers. This practice may prevent lack of uniformity by creating wide-ranging medical board results for similar disabilities.

The board must consider all pertinent information concerning the disability and fitness of the soldier. The board can consider recommendations, efficiency reports, and letters of recommendations by the soldier’s superiors testifying that the soldier performed his or her duties despite the disability. As stated in AR 635-40, the board may weigh these more heavily than a clinical estimate of the soldier’s doctor. In fact “if the evidence establishes the fact that the soldier adequately performed the normal duties of his or her office, grade, rank, or rating until the time of referral for physical evaluation, the soldier might be considered fit for duty. This is true even though medical evidence indicates the soldier’s physical ability to perform such duties may be questionable.”³⁹

Reflecting this sentiment, then Secretary of Defense and the Chairman of the Joint Chiefs of Staff (CJCS), William J. Perry and General John M. Shalikashvili, in a joint statement on 9 February 96 said, “Service members suffer from diseases that make them nondeployable, but who are permitted to serve their country so long as they meet uniform

retention standards. Decisions on their retention are made on an individual basis in accordance with current regulations.”⁴⁰

The “questionable” ability of soldiers to perform their duties undermines the necessary capability for mission accomplishment. This Army practice promotes a lack of uniform standards for evaluating medical fitness and compels local commanders to make the best decision without clear and objective fitness criteria.

Understandably, it can be extremely difficult, when faced with the requirement to separate or retire a disabled soldier. This becomes more difficult when the person has an outstanding record; who acquired their disability while in the line of duty (e.g., back injury while jumping out of an airplane); or if a soldier wants to remain in the military. The Army, which is substantially more people dependant than the other services, may not want to signal to its work force that it is disloyal and “throw soldiers away” after becoming disabled. Expanding options for medical retirement or providing more generous disability payments for disabled soldiers may ease the responsibility for board members to medically separate or retire disabled soldiers.

Profiles in the Army

Several documents provided an excellent overview on soldiers with profiles and effectively presented the issue in context. The weightiest article was *Policy for DoD Management of Permanent Medical Nondeployable Personnel* (Outlaw et al). It was an extensive DOD study on nondeployable personnel with permanent medical disabilities within DOD. Outlaw reviewed the services’ policies and practices in managing nondeployable personnel. The study provided extensive data and analysis on DOD’s conflicting policies in managing HIV positive personnel, how DOD and other policies

influence retention, and provided recommendations to correct the identified problems.⁴¹ However, it does not relate or compare the impact of personnel on readiness, or more important, link it to downsizing and increased OPTEMPO and PERSTEMPO, as does this study. Nonetheless, this thesis relied heavily on many of Outlaw's findings.

GAO's Operation Desert Storm: War Highlights Need to Address Problem of Nondeployable Personnel provided a very comprehensive review of the nondeployable profile problem during DESERT SHIELD/DESERT STORM.⁴² This report described the impact of nondeployable personnel on operations and how all the services managed the problem. Its findings are still relevant to the Army today. In addition, Lieutenant Colonel Allen M. Gildersleeve's "Mountains or Molehills--Permanent Physical Profiles in the Army Reserve"⁴³ discusses the impact of soldiers with permanent profiles in the Army reserve component. However, he provided relevant insights on nondeployability within the active component.

In the 1990s, the news media has written extensively on the impact of nondeployability on readiness. Rick Maze's "If you can't deploy . . . Discharge is not mandatory, House [US House of Representatives] says"⁴⁴ discusses the political sensitivity of the nondeployable issue within the US Congress and how the Congress continues to assert its voice on this issue. G.E. Willis' "Nondeployables a workable issue for aviation regiment"⁴⁵ provides a review of how an Army aviation regiment managed its operational obligations given a pool of nondeployable soldiers. He discusses the challenges and solutions of how Army units contend with this problem. Willis, in "Profiles: Who gets them, what they mean"⁴⁶ thoroughly discusses the various types of nondeployable factors (e.g., HIV, Sole Surviving Son or Daughter, dental problems)

within the Army system and how the Army defines them. Furthermore, these articles discuss the impact of nondeployables on readiness, how widespread the problem is in the military, and different perceptions of soldiers and leaders. These articles demonstrate the timeliness and potential value for this study.

HIV Policies and Issues

By regulation, DOD automatically rates soldiers who are HIV positive as permanently nondeployable. However, DOD and the Army track HIV positive personnel separately from permanent medically nondeployable personnel. DOD provides specialized policies and guidance regarding soldiers who are HIV positive. DoDD 6485.1, *Human Immunodeficiency Virus-1 (HIV-1)*⁴⁷ is the DOD policy that dictates how each service must manage and treat personnel who are HIV positive and the HIV education program each service must provide. The directive also outlines the limitations of the services in attempting to separate personnel with HIV. DoDD 6485.1 is the only DOD medical policy that specifically addresses a single, specific medical condition.

However, unlike other illness or diseases, the HIV-1 policy adds extra protections for HIV positive personnel. Only HIV-1 has its "own stand-alone DoD directive."⁴⁸ The policy "restricts the referral of asymptomatic HIV+ personnel to the DES--avoiding an adjudication of their fitness to serve." Everyone else who has permanent medical conditions or defects are subject to immediate DES. The policy does not mandate the separation, but it permits it or creates the framework for it except in the case of HIV-1 positive service members.⁴⁹

The regulation does not require the military to refer HIV positive soldiers to the DES, but they must be MEB referred. Services may restrict HIV personnel to

nondeployable units. The military cannot deploy or assign them to units outside of the US.⁵⁰ That is, “DOD’s HIV policy requires that HIV positive (permanent)--members whose blood test positive for the HIV-1 virus, which causes AIDS ‘shall be assigned within the United states, including Alaska, Hawaii and Puerto Rico, due to the high priority assigned to the continued evaluation of medical personnel.’ For reasons of readiness, such people may be restricted to nondeployable units or positions.”⁵¹ Even if the Army places HIV positive personnel in a deployable unit or position, they cannot deploy.

The military does not enter the fact that someone is HIV positive on a service member’s record, but if the board finds HIV positive active-duty soldiers unfit for duty, the military must separate or retire them. The protection of the military blood supply is of the utmost importance. War and major battles require large quantities of blood and “battlefield transfusions” may be required.⁵²

No other disability receives such protection. Furthermore:

Active-duty personnel with evidence of HIV-1 infection who are found otherwise fit for duty in accordance with military medical standards are eligible for continued service in the armed forces. In this respect, such individuals are treated the same as others with evidence of other progressive illnesses (such as cancer that is in remission and does not inhibit or restrict the service member from performing his or her normal military duties). Personnel with evidence of HIV-1 infection without evidence of physical or neurological impairment will not be separated from the service solely on the basis of such evidence of HIV-1 infection.⁵³

David F. Burrelli’s “HIV-1/AIDS and US Military Manpower Policy” discusses the impact on military readiness of personnel who are HIV positive. Burrelli explains the effects of DOD’s policy on the military services and how they manage the HIV issue. He also crisply reviews what the services can and cannot do while managing HIV positive

personnel. He describes policy, but does not evaluate the effectiveness or correctness of DOD and Army HIV policies.⁵⁴

Burrelli stated that DOD prohibits the use of information regarding HIV positive status in court martials; line of duty determinations; involuntary separations (other than for medical reasons); administrative or punitive reductions in grade; denials of promotion; unfavorable entries in a personnel record; bars to reenlistment; and, any other actions considered by the Secretary concerned as an adverse personnel action.⁵⁵ However, services can use the fact that personnel are HIV positive in the following areas: reassignment; disqualification from a reliability program; denial, suspension or revocation of a security clearance or access to classified information; and removal from duties requiring a high degree of stability or alertness such as explosive ordinance disposal.⁵⁶

The major issue is that anyone who is HIV positive can never deploy and must remain stateside for treatment. In addition, the Army may have to transfer an HIV positive soldier; i.e., an HIV positive infantryman may need to be transferred to the Signal Corps for the Army to retain him. For other disabilities, the Army cannot transfer a soldier to a less demanding PMOS.

During the 1990s there has been a strong movement led by members of Congress to automatically separate military personnel who become HIV positive. Though these efforts have failed, the news media have covered this issue extensively. For example, Rick Maze in "Divisions are showing--Some Republicans oppose proposed separation policy for HIV-positive in military," reviews the attempts by legislators, primarily Republican House of Representative members, unsuccessful attempts to require the

automatic separation of HIV positive personnel from the military.⁵⁷ Andrew Compart in "Restrictions other than HIV may be ignored," like Maze, covered the congressional hearings, legislative proposals, interest group lobbying, and the cost to treat HIV positive personnel.⁵⁸ To date, Congress has passed no legislation that would dictate that the services automatically separate HIV positive personnel.

Some of the objections to the legislation were that it only singled out HIV positive personnel while allowing other nondeployable personnel to remain in the military. If such legislation passed, the next step could be to automatically separate all soldiers who are permanent medically nondeployable. In addition, DOD opposed the legislation to automatically separate HIV positive soldiers.

In Soraya S. Nelson's, *AIDS Likely to Cost the Military \$3 Billion*, he estimated HIV treatment cost for DOD is \$3 billion between 1990 and 2000.⁵⁹ That is \$300 million a year to treat a handful of HIV positive soldiers left on active duty. Nevertheless, it is difficult to determine of this total, how much it specifically cost the Army to treat HIV positive soldiers. Medical personnel do not document treatment expenses for every soldier-related illness. The investigator could not find a DOD or centralized database containing medical costs for other medical disability treatments.

One Congressman wondered how the Army could rationalize discharging 1,700 soldiers a week, while retaining HIV positive soldiers on active duty⁶⁰ who will cost the military \$3 billion or more by the year 2,000.⁶¹ In a well-documented era of ever-decreasing military budgets, retaining permanently nondeployable soldiers not only has the potential to degrade operational readiness, but it has a significant budgetary affect also.

Summary

Permanent medical profiles influence Army readiness, but no one has described how they affect Army operational readiness. The impact, either positive or negative, is difficult to measure. In order to evaluate readiness, one must understand how the Army defines and measures readiness. As in any measurement, one must be cognizant of the reliability and validity of the measurement system and the consistency with which the measurement system is used.

The purpose of this study is to describe the impact of nondeployable soldiers with permanent medical profiles on Army readiness by answering the primary research question: How do nondeployable soldiers with permanent medical profiles affect Army readiness in the active component? The subordinate questions, which this study must first answer in order to answer the basic research questions, are:

1. What is the extent of the nondeployable soldier problem in the Army?
2. How do nondeployable soldiers with permanent medical profiles affect readiness in the MTOE Army?
3. How do nondeployable soldiers with permanent medical profiles affect readiness in the TDA Army?
4. How effective are DOD and Army policies and regulations in assisting the Army leadership to manage the impact of soldiers with permanent medical profiles on readiness?

¹ Government Accounting Office, *Military Readiness: A Clear Policy Is Needed to Guide Management of Frequently Deployed Units* (Washington, DC: Government Printing Office, April 1996), 24.

² Government Accounting Office, *Peace Operations: Heavy Use of Key Capabilities may Affect Response to Regional Conflicts* (Washington, DC: Government Printing Office, March 1995), 4.

³ Government Accounting Office, *Military Readiness: A Clear Policy Is Needed to Guide,*" 1-3.

⁴ Ibid., 24.

⁵ DOD 6485.1 *Human Immunodeficiency Virus-1 (HIV-1)*,) (Washington, DC: Government Printing Office, 19 March 1991).

⁶ Lieutenant Colonel Allen M.G. Gildersleeve, "Mountains or Molehills, Permanent Physical Profiles in the Army Reserve" (Medford, Mass: Fletcher School of Law and Diplomacy, 6 May 1997), 2.

⁷ Government Accounting Office, *Military Readiness DOD Needs to Develop a More Comprehensive Measurement System* (Washington, DC: Government Printing Office, October 1994), 4-5.

⁸ Government Accounting Office, *Military Readiness: A Clear Policy Is Needed to Guide,*" 1-3.

⁹ Government Accounting Office, *OPERATION DESERT STORM: War Highlights Need to Address Problem of Nondeployable Personnel* (Washington, DC: Government Printing Office, August 1992).

¹⁰ Government Accounting Office, *Military Readiness: Current Indicators to Be Expanded for a More Comprehensive Assessment*. Statement of Neal P. Cutrin (Washington, DC: Government Printing Office, 1994), 1-2.

¹¹ LeRoy B. Outlaw, Edmund F. Muendel, David A. Smith. *Policy for DoD Management of Permanent Medical nondeployable Personnel* (McLean, VA: Logistics Management Institute, March 1997), 36.

¹² Ibid., 3-8.

¹³ Ibid., iv.

¹⁴ DoDD 1332.18, *Separation or Retirement for Physical Disability* (Washington DC: Government Printing Office, 4 November 1996).

¹⁵ DoDD 6485.1, *Human Immunodeficiency Virus-1 (HIV-1)*.

¹⁶ AR 600-60, *Physical Performance Evaluation System* (Washington DC: Government Printing Office, 1985).

¹⁷ AR 635-40, *Physical Evaluation for Retention, Retirement, or Separation* (Washington DC: Government Printing Office, 1990).

¹⁸ AR 40-501, *Standards of Medical Fitness* (Washington DC: Government Printing Office, 1995).

¹⁹ DoDD 1332.18, *Separation or Retirement for Physical Disability*.

²⁰ Outlaw, 5-7.

²¹ Ibid., iii.

²² Outlaw, 2-6.

²³ Ibid.

²⁴ Ibid.

²⁵ AR 635-40, 4.

²⁶ AR 40-501, *Standards of Medical Fitness*.

²⁷ Ibid.

²⁸ Ibid.

²⁹ Ibid.

³⁰ AR 600-60, *Physical Performance Evaluation System*.

³¹ Ibid.

³² Ibid. 8.

³³ Ibid.

³⁴ Outlaw, C-2.

³⁵ AR 635-40, *Physical Evaluation for Retention, Retirement, or Separation*.

³⁶ Ibid.

³⁷ Government Accounting Office, *Reserve Forces: DOD Policies Do Not Ensure That Personnel Meet Medical and Physical Fitness Standards* (Washington, DC: Government Printing Office, March 1994)

³⁸ AR 635-40, 4.

³⁹ Ibid.

⁴⁰ Outlaw, 6-1.

⁴¹ Ibid.

⁴² Government Accounting Office, *OPERATION DESERT STORM: War Highlights Need to Address Problem of Nondeployable Personnel*.

⁴³ Gildersleeve.

⁴⁴ Rick Maze. "If you can't deploy . . . Discharge is not mandatory, House says," *Air Force Times*, 27 June 1994.

⁴⁵ Willis, G.E. "Nondeployables a workable issue for aviation regiment," *Army Times*, 8 July 1996.

⁴⁶ Willis, G.E. "Profiles: Who gets them, what they mean," *Army Times*, 8 July 1996.

⁴⁷ DoDD 6485.1, *Human Immunodeficiency Virus-1 (HIV-1)*.

⁴⁸ Outlaw, 6-2-6-3.

⁴⁹ Outlaw, v.

⁵⁰ Ibid., 6-2-6-3.

⁵¹ G.E. Willis, "Profiles: Who gets them, what they mean," *Army Times*, 8 Jul 1996, 14.

⁵² Ibid., 458.

⁵³ Burrelli, 457.

⁵⁴ David F. Burrelli, "HIV-1/AIDS and U.S. Military Manpower Policy," *Armed Forces & Society*, (Vol. 18, No. 4, Summer 1992).

⁵⁵ Ibid., 459.

⁵⁶ Ibid., 459-460.

⁵⁷ Rick Maze. "Divisions are showing – Some Republicans oppose proposed separation policy for HIV-positive in military," *Air Force Times*, 8 January 1996.

⁵⁸ Andrew Compart. "Restrictions other than HIV may be ignored," *Air Force Times*, 28 March 1994.

⁵⁹ Soraya S. Nelson, "AIDS Likely to Cost Military \$3 Billion," *Air force Times*, March 19, 1990, 10.

⁶⁰ Rick Maze, "If You Can't Deploy . . . Discharge is not Mandatory, House Says," *Air Force Times*, June 27, 1994, 10.

⁶¹ Nelson, 10.

CHAPTER 3

RESEARCH METHODOLOGY

Introduction

This study describes the impact of nondeployable soldiers with permanent medical profiles on Army readiness by answering the primary research question. How do nondeployable soldiers with permanent medical profiles affect Army readiness in the active component? The subordinate questions, which this study must first answer in order to answer the basic research questions, are:

1. What is the extent of the nondeployable soldier problem in the Army?
2. How do nondeployable soldiers with permanent medical profiles affect readiness in the MTOE Army?
3. How do nondeployable soldiers with permanent medical profiles affect readiness in the TDA Army?
4. How effective are DOD and Army policies and regulations practices in assisting the Army leadership to manage the impact of soldiers with permanent medical profiles on readiness?

Subordinate Questions and Evaluation Criteria

1. What is the extent of the nondeployable soldier problem in the Army?

Criteria:

- 1.1. How many nondeployable soldiers with permanent medical profiles are in the Army?
- 1.2. What are the ranks, gender, and PMOS of nondeployable soldiers with permanent medical profiles?

2. How do nondeployable soldiers with permanent medical profiles affect readiness in the MTOE Army?

Criteria:

- 2.1. How many soldiers by rank and gender are in the MTOE Army?
- 2.2. How many nondeployable soldiers with permanent medical profiles are in the MTOE Army?
- 2.3. What are the ranks, gender, and PMOS of nondeployable soldiers with permanent medical profiles in the MTOE Army?

3. How do nondeployable soldiers with permanent medical profiles affect readiness in the TDA Army?

Criteria:

- 3.1. How many soldiers by rank and gender are in the TDA Army?
- 3.2. How many nondeployable soldiers with permanent medical profiles are in the TDA Army?
- 3.3. What are the ranks, gender, and PMOS of nondeployable soldiers with permanent medical profiles in the TDA Army?

4. How effective are DOD and Army policies and regulations in assisting the Army leadership to manage the impact of soldiers with permanent medical profiles on readiness?

Criteria:

- 4.1. How many soldiers does the Army process for medical separation, retention, or retirement?

4.2. Is deployability an important component of the medical board process?

Reliability of DOD's Readiness Reporting Systems

The reliability of DOD readiness reporting systems make it difficult to fully and accurately assess the extent of the nondeployable problem. DOD and Army's medical and readiness reporting systems are unreliable and they tend to obscure the extent of the nondeployability problem. These unreliable and inaccurate reporting systems make it difficult thoroughly to evaluate readiness, deployability, and profiles. Furthermore, the Army does not centrally track or manage the nondeployability of soldiers with P3 or P4 profiles; nor does it have an automated information system in place that will enable centralized reporting of nondeployable soldiers. The Army personnel system does maintain P-U-H-L-E-S information on all service members in its central soldier's data file. However, "the PULHES numerical designator by itself is not an indicator of deployability or assignment restrictions (AR 40-501, p. 45). Status of Resource and Training System (SORTS) reporting units report monthly aggregate deployable strength, which is monitored by Headquarters, Department of the Army."¹

Another on-going problem for the Army is the practice of cross leveling soldiers to meet operational requirements. During DESERT STORM, the Army estimated that it had to cross-level 50,000 soldiers during the war to meet operational requirements because of nondeployable soldiers.² GAO cited a December 1990 Center for Army Lessons Learned publication in which one unit had a 60 percent turnover rate among officers including a company commander. It also stated that many units received large quantities of replacements just before deployment.³

The Center for Army Lessons Learned report did not differentiate between permanent and temporary profiles. The Army can expect some turnover, but can a unit effectively sustain a 60 percent turnover rate among its officers because of nondeployable officers? As early as 1992, GAO assessed that cross leveling masked the Army's nondeployable soldier problem. Army officials told GAO that this type of cross leveling, "First, if only part of the reporting unit is deployed, certain resources available to the unit are depleted, thereby degrading readiness in such areas as personnel and equipment on hand. Second, if a unit is engaged in one role, such as peacekeeping or security operations, it may be unable to train personnel in the full range of military skills or to maintain its equipment in mission-ready condition."⁴

For the 1993 Somalia operation, deployed Army units borrowed soldiers from other units to meet their operational obligation.⁵ Now that the Army has downsized to ten divisions and experienced increased OPTEMPO and PERSTEMPO, the risks of deploying with replacement soldiers may be too great. The military must acknowledge and contend with the problems of nondeployable soldiers (both permanent and temporary).⁶

Clearly, unit readiness decreases when units deploy without important leaders such as commanders, first sergeants, or executive officers. Losing junior soldiers also negatively influences unit readiness. How can units quickly adapt to these changes? Of course, part of the normal challenges of the military, particularly in wartime, is to adjust to the loss of soldiers. Wartime losses are to be expected. Nevertheless, is it fair and appropriate to handicap units before deployment or before the war starts? The loss of soldiers, especially essential soldiers, can be difficult to quantify in specific terms.

However, experience and study suggest that retaining permanent nondeployable soldiers damage Army combat readiness.

Each service defines deployment differently as Table 1 demonstrates. The Army does not count field time, such as a three-to-four-week rotation through the Combat Training Centers as a deployment. It follows that the Army, much less than DOD, will not be able fully to evaluate how long it deploys its soldiers.

Table 1. Service Deployment Measurement Systems

Measurement	Army	Navy	Air Force	Marine Corps
Definition of deployment	7 days or more	56 days or more	1 day or more	10 days or more away from home station
Policy or regulation limiting deployments	No policy, but goal of no single deployment over 179 days	Yes, policy limits deployments to 180 days/6 months	No policy, but maximum desired level of 120 days per year	No policy, but goal of no single deployment over 6 months
System tracking capabilities	Unit and individual	Unit only	Major weapon systems and individual	Unit only

Source: Government Accounting Office, *MILITARY READINESS, A Clear Policy Is Needed to Guide Management of Frequently Deployed Units* (Washington, DC: Government Printing Office, April 1996), 3.

Figure 1 demonstrates that the deployment rates, in terms of the percentage of soldiers gone at one time, increased for the Army (5 to 9 percent) and the Air Force (2 to 6 percent) between 1987 and 1995.

Furthermore, the Army and the Air Force do not individually track OPTEMPO or PERSTEMPO rates.⁷ With insufficient data, it is difficult for DOD, much less the Army and the Air Force, to determine what the positive and negative influences are on soldiers and readiness. This denies DOD and the Army the capability objectively to evaluate the deployability of their service members. The Army also suffers from this predicament

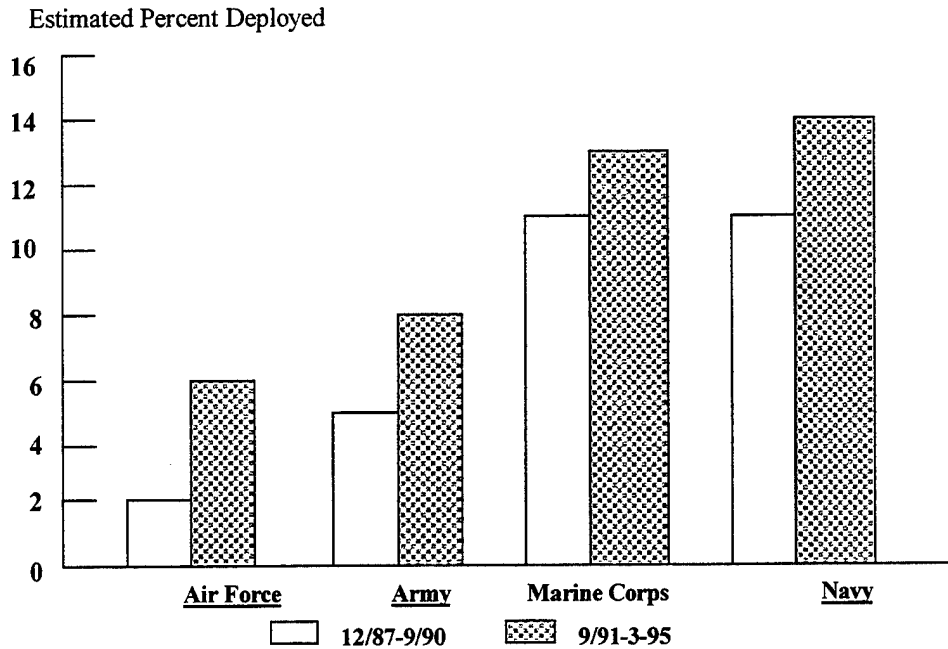


Figure 1: Estimated Percentage of Services Deployed (1987-95). *Source:* Jack Weible. "Pentagon to Measure Deployment Tempo: Defense Officials Say it's Long Overdue for the Army and Air Force," *Army Times*, 19 January 1998, 4.

Note: GAO excluded data from July 1990 through August 1991 to eliminate effects of the Gulf War. The report excluded Marine Corps data for September 1991 through March 1992 due to inaccurate reporting of family separation allowances.

since it does not count field time as deployed. Nonetheless, soldiers today spend about five months or 150 days a year deployed.⁸ Services interpret the regulations so differently that DoDD 1332.18⁹ is more of a hindrance than an aid to the services.

DOD readiness reporting systems present validity as well as reliability issues. The senior Army leadership bases much of their readiness assessments on USR and SIDPERS reports. General Shelton, the Chairman of the Joint Chiefs of Staff, referring to declining readiness and fears of a hollow military, said that, "There is a world of difference between where we were then and where we are now. We have a tremendously talented bunch of young men and women."¹⁰ However, the same report cited a recent

classified memorandum that assessed the military could not maintain “current levels of overseas presence” because of negative effects on “maintenance, personnel, and training readiness.”¹¹

A Senate Budget committee analyst in December 1997 said there were “extremely serious Army-wide personnel and training (i.e., readiness) problems,” like infantrymen, mechanics, and such only filled to 50 percent capacity. The study suggested that the situation could get worse because of future problems.¹² Furthermore, the Army, which is generally more sensitive to and potentially weakened by personnel problems, suffers more from personnel shortfalls than other services. For example, the Army had to piecemeal soldiers together to support operations such as those in Bosnia due to shortages of mid-grade officers, infantrymen, and mechanics.

In the investigator’s own Bosnia deployment with first Infantry Division from March to May 1997 the same phenomena occurred. There were officers from TDA, units such as the Artillery School, and the Reserve Officer Training Corps instructor filling tactical MTOE positions. The 1st ID did not have soldiers to place in those positions because of split-based operations (managing units in Germany and Bosnia) and other operational missions such as Macedonia. This cross leveling breaks up unit esprit and training.¹³ *US News & World Report* reported that the an Army colonel said that the “readiness rates are false . . . There is a lot of pressure from higher-ups to inflate them. It’s like all the students are getting A’s, then flunking the final exam.”¹⁴

At least since the early 1990s, many have questioned the reliability and validity of DOD and Army’s readiness reporting systems. Several independent studies, GAO investigations, and the news media have documented this problem. For DESERT

SHIELD/DESERT STORM GAO determined that there was a “lack of complete and comparable data . . . [that made] it impossible to develop a reliable estimate of the total number of nondeployable personnel. Moreover, any numbers cited would not reflect the potential for additional nondeployables that were minimized or masked by varying degrees of prescreening to avoid such problems, and the special packaging of forces by the services” for the war. Nonetheless, GAO said that the services were able to meet the personnel requirements for the operations and that DOD did not consider it a serious problem.¹⁵

Peacekeeping operations have dramatically increased the deployment requirements for Army units. While analyzing readiness, GAO was not able to “develop detailed statistics on the amount of time these services spent for peace operations because detailed records were not available to isolate time spent on one activity versus another during scheduled deployments.”¹⁶

DOD recently directed the Army and the Air Force, for the first time, to track OPTEMPO and PERSTEMPO, which they will report to the Senior Readiness Oversight Council quarterly. The Senior Readiness Oversight Council is a DOD level committee that provides oversight to personnel and equipment matters for the Defense Department.¹⁷

Lou Finch, the Deputy Undersecretary of Defense for Readiness, said that tracking PERSTEMPO and OPTEMPO “hadn’t even been an issue.” The new policy requires the Army to monitor active duty, Reserve, and National Guard components. Finch wants to limit Army deployments to 120 days a year per unit and those units that exceed 180 days placed on a “watch list.”¹⁸ The system should assist DOD, the Army,

and Air Force, in better managing OPTEMPO and PERSTEMPO. However, it may not change the PERSTEMPO rate that mirrors the OPTEMPO rate.

In 1994, GAO raised concerns about the SORTS system and the services' inability to develop a system that was predictive about a unit's future readiness. The following were GAO's significant points:

- DOD's systems provide useful information, but are not predictive in nature of "impending change in readiness."
- DOD's system measures what resources units need to meet their wartime needs and they assess their C-ratings status per USR regulations.
- SORTS data is not comprehensive and only provides a "snapshot in time" month to month in terms of readiness, personnel, and training.
- SORTS does not measure PERSTEMPO, OPTEMPO, mobility, morale or leadership all of which are critical readiness factors.
- C-ratings are subjective based on the commanders' assessment that may or may not reflect accurate evaluation criteria to measure readiness.
- As early as 1991, GAO felt that much of the SORTS readiness data was "of limited value because the assessments were" based on unit training at home station and that the units may not have fully considered loss of key personnel on their readiness.¹⁹

GAO also found that:

DOD systems are inadequate to assess the full impact of high PERSTEMPO on readiness. Although unit readiness reports indicated a stable level of readiness during the 1990s, the high-deploying units we visited voiced pronounced concern that some personnel have been stressed to their saturation point, with attendant concerns about difficulties in family life and lowered retention rates. The SORTS reports do not capture all the factors that DOD considers critical to a comprehensive readiness analysis, and indicators of personnel readiness--such as retention rates--are generally not available in the form needed to analyze stress on individual units.²⁰

However, GAO responded that data suggested that the nondeployable numbers were significant. The inadequate screening program for active and reserve components and the readiness reporting during peacetime intensified and masked the seriousness of the nondeployable problem. GAO said that "action is needed to minimize future

recurrences, particularly when there will be fewer active and reserve forces from which to tailor and substitute personnel to meet force requirements.” Though GAO identified these problems in 1994, the Army and DOD have not yet fixed them. An increased OPTEMPO coupled with the drawdown aggravate the problems.²¹

Fortunately during DESERT SHIELD, Iraq mitigated the potential problems caused by the unreliability of the readiness reporting system. It allowed the US six months to build up and work through these problems. The next time the US may not be as lucky. In addition, in 1992 GAO recognizes that the New World environment has changed. Today’s military must be “deployable virtually worldwide.”²²

The Army has implemented a program that allows it “to project for two years the status of elements reported under SORTS,” although, the system may not contend with personnel shortfalls.²³ GAO, after working with other services, briefly discussed different critical indicators it felt necessary for the services to track and report to the highest levels in order to assist in predicting readiness. The first indicator listed “personnel deployability status,” showed the “numbers of personnel by grades that are not deployable due to medical or dental problems, personal hardship, or lack of essential training.”²⁴

Outlaw, in reviewing DOD’s reporting system, made the following observation regarding readiness and nondeployable soldiers by stating that, “Some of the variation is due to different methods for classifying soldiers with permanent medical conditions. For example, the Army number for permanent medical nondeployables (other than HIV+) includes soldiers who are in the disability evaluation system-awaiting disposition of their case. The other services do not include this population in this report category.”²⁵

Consequently, DOD's policies deny itself the true knowledge of the extent of the nondeployable issue.

These statistics, despite the questionable reliability and validity, receive significant visibility. The Secretary of Defense annually reports to Congress on the numbers and rates of soldiers who are temporarily and permanently nondeployable as required by the National Defense Authorization Act of FY95. This Congressional interest is a direct result of HIV-1 controversies of the 1990s.²⁶

Data Sources and Collection Methods

1. Due to time and resource constraints, the investigator relied upon secondary data to answer the research questions. GAO published reports that contained much of the information and statistics to which the investigator applied the criteria:

- a. *DOD Reserve Components: Issues Pertaining to Readiness.*²⁷
- b. *Military Readiness: A Clear Policy Is Needed to Guide Management of Frequently Deployed Units.*²⁸
- c. *Military Readiness: Current Indicators to Be Expanded for a More Comprehensive Assessment.*²⁹
- d. *Military Readiness Data and Trends for January 1990 to March 1995.*³⁰
- e. *Military Readiness DOD Needs to Develop a More Comprehensive Measurement System.*³¹
- f. *OPERATION DESERT STORM: War Highlights Need to Address Problem of Nondeployable Personnel.*³²
- g. *Peace Operations: Heavy Use of Key Capabilities may Affect Response to Regional Conflicts.*³³

h. *Reserve Forces: DOD Policies Do Not Ensure That Personnel Meet Medical and Physical Fitness Standards.*³⁴

2. In addition, the Office of Army Deputy Chief of Staff for Personnel (DCSPER) and the Army Physical disability Agency were significant sources of information on personnel with permanent medical profiles.

3. Finally, several other publications provided descriptions and analysis of readiness, regulations and policies, profiles, and HIV issues. These publications included:

- a. AR 40-501, *Standards of Medical Fitness.*³⁵
- b. AR 600-60, *Physical Performance Evaluation System.*³⁶
- c. AR 635-40, *Physical Evaluation for Retention, Retirement, or Separation.*³⁷
- d. DoDD 1332.18, *Separation or Retirement for Physical Disability.*³⁸
- e. DoDD 6485.1, *Human Immunodeficiency Virus-1 (HIV-1).*³⁹
- f. "Mountains or Molehills – Permanent Physical Profiles in the Army Reserve."⁴⁰
- g. "Policy for DoD Management of Permanent Medical Nondeployable Personnel."⁴¹
- h. "HIV-1/AIDS and US Military Manpower Policy."⁴²

4. The data collected through the reporting system for this study was current, relevant, and representative of Army personnel. The collected data included all ranks, MTOE and TDA units, and gender. The collected data was sufficient to conduct analysis and adequately and logically address the research question and subordinate questions.

5. After obtaining the information, the investigator organized it to coincide with the research questions and used the criteria to answer the questions.

Limitations Generated by Methodology

1. The investigator did not have the opportunity to analyze data on medical ailments that make soldiers permanently nondeployable because of lack of access to specific or consolidated Army data.

2. It was difficult to analyze readiness data concisely because of the inconsistent method that the Army and other services use to collect and define deployability and the unreliability of military readiness data.

3. The investigator was not able to analyze data in terms of PMOS and disability because it was not available to him.

¹ LeRoy B. Outlaw, Muendel, Edmund F., and Smith, David A. "Policy for DoD Management of Permanent Medical Nondeployable Personnel" (McLean, VA: Logistics Management Institute., March 1997), C-3.

² LTC Allen M. Gildersleeve. "Mountains or Molehills – Permanent Physical Profiles in the Army Reserve" (Medford, MA.: Fletcher School of Law and Diplomacy, 6 May 1997), 20.

³ Ibid.

⁴ Ibid.

⁵ G.E. Willis, "Nondeployables a workable issue for aviation regiment," *Army Times*, 8 Jul 1996, 14.

⁶ Ibid., 14.

⁷ Jack Weible. "Pentagon to Measure Deployment Tempo: Defense Officials Say It's Long Overdue for the Army and Air Force," *Army Times*, 19 January 1998, 4.

⁸ "High OPTEMPO has Corrosive effect," *Army Times*, 17 November 1997, 35.

⁹ Department of Army, AR 635-40, *Physical Evaluation for Retention, Retirement, or Separation* (Washington, DC: Government Printing Office, 1990).

¹⁰ Richard J. Newman. "Can Peacekeepers Make War: America's Warriors Have Many Jobs Today--Raising Fears That They are Less Prepared for Real Combat," *US News & World Report*, 19 January 1998, 43.

¹¹ Ibid., 42.

¹² Ibid., 39.

¹³ Ibid., 43.

¹⁴ Ibid., 42.

¹⁵ Government Accounting Office, *OPERATION DESERT STORM: War Highlights Need to Address Problem of Nondeployable Personnel* (Washington, DC: Government Printing Office, August 1992), 1-2.

¹⁶ GAO, *MILITARY READINESS, A Clear Policy Is Needed*, 7.

¹⁷ Weible, 4.

¹⁸ Ibid.

¹⁹ Government Accounting Office, *Military Readiness: Current Indicators to Be Expanded for a More Comprehensive Assessment*. Statement of Neal P. Cutrin (Washington, DC: Government Printing Office, 1994), 1-2.

²⁰ Ibid., 11.

²¹ Government Accounting Office, *OPERATION DESERT STORM: War Highlights Need*, 1-2.

²² Ibid., 6.

²³ Government Accounting Office, *Military Readiness DOD Needs to Develop a More Comprehensive Measurement System* (Washington, DC: Government Printing Office, October 1994), 4-5.

²⁴ Ibid., 5-6.

²⁵ Outlaw, 1-3-1-4.

²⁶ Ibid., (iii).

²⁷ Government Accounting Office, *DOD Reserve Components: Issues Pertaining to Readiness* (Washington, DC: Government Printing Office, March 21, 1996).

²⁸ Government Accounting Office, *Military Readiness: A Clear Policy Is Needed to Guide Management of Frequently Deployed Units*.

²⁹ Government Accounting Office, *Military Readiness DOD Needs to Develop a More Comprehensive Measurement System*.

³⁰ Government Accounting Office, *Military Readiness Data and Trends for January 1990 to March 1995* (Washington, DC: Government Printing Office, March 1996).

³¹ Government Accounting Office, *Military Readiness DOD Needs to Develop a More Comprehensive Measurement System*.

³² Government Accounting Office, *OPERATION DESERT STORM: War Highlights Need to Address Problem of Nondeployable Personnel*.

³³ Government Accounting Office, *Peace Operations: Heavy Use of Key Capabilities may Affect Response to Regional Conflicts* (Washington, DC: Government Printing Office, March 1995).

³⁴ Government Accounting Office, *Reserve Forces: DOD Policies Do Not Ensure That Personnel Meet Medical and Physical Fitness Standards* (Washington, DC: Government Printing Office, March 1994).

³⁵ Department of Army, AR 40-501, *Standards of Medical Fitness* (Washington, DC: Government Printing Office, 1995).

³⁶ Department of Army, AR 600-60, *Physical Performance Evaluation System*. (Washington, DC: Government Printing Office, 1985).

³⁷ Department of Army, AR 635-40, *Physical Evaluation for Retention, Retirement, or Separation*.

³⁸ Department of Defense, DoDD 1332.18, *Separation or Retirement for Physical Disability* (Washington, DC: Government Printing Office, 4 November 1996).

³⁹ Department of Defense, DoDD 6485.1, *Human Immunodeficiency Virus-1 (HIV-1)* (Washington, DC: Government Printing Office, 19 March 1991).

⁴⁰ Gildersleeve.

⁴¹ Outlaw.

⁴² David F. Burrelli. "HIV-1/AIDS and US Military Manpower Policy." *Armed Forces & Society* (Vol. 18, No 4, Summer 1992).

CHAPTER 4

DATA ANALYSIS

Introduction

This study describes the impact of nondeployable soldiers with permanent medical profiles on Army readiness by answering the primary research question. How do nondeployable soldiers with permanent medical profiles affect Army readiness in the active component? The subordinate questions, which this study must first answer in order to answer the basic research questions, are:

1. What is the extent of the nondeployable soldier problem in the Army?
2. How do nondeployable soldiers with permanent medical profiles affect readiness in the MTOE Army?
3. How do nondeployable soldiers with permanent medical profiles affect readiness in the TDA Army?
4. How effective are DOD and Army policies and regulations in assisting the Army leadership to manage the impact of soldiers with permanent medical profiles on readiness?

Research Results

Subordinate Question 1. What is the extent of the nondeployable soldier problem in the Army?

Criteria: 1.1 How many nondeployable soldiers with permanent medical profiles are in the Army?

Soldiers with permanent nondeployable medical profiles (e.g., HIV, cancer, etc.) officially constitute only about one percent of Army endstrength (see table 2). G.E. Willis

paraphrased a DA personnel spokesman as defining the problem as a “drop in the bucket” when comparing the 5,000 nondeployable soldiers to the 70,000 to 90,000 new troops each year.¹ Table 2 depicts how many soldiers have nondeployable permanent medical profiles.

Table 2. Total Permanent Nondeployables for September 1997

Item	Total Personnel in US Army	Personnel with Permanent Medical Profiles	HIV Positive Personnel & Personnel with Permanent Profiles*
Raw #	487,6420	3252	3503
% of Army	100%	0.67%	0.72%

*The Army tracks HIV separately from permanent profiles. Consequently, this study followed this practice throughout. Source: Major Steve Grimes, Email message to Major Harold Reeves, Department of Army Statistics on the Personnel on the Medical Profile status for the Army, Deputy Chief of Staff for Personnel (DCSPER), (703)697-2403, 4 September 1997.

The problem may be more complicated than it appears. G.E. Willis commented, “The Army may be deploying more frequently since the end of the Cold War, but barely half its 495,000 troops are able to go anywhere. A close look at the composition of the active force shows 40 percent is tied down in garrisons, depots, training units and other nondeploying assignments. Yet, even in the “deployable” 60 percent of the Army, thousands of soldiers on any given day cannot really deploy.”²

In other words, the Army is not as deployable as it might appear. Willis provides the breakdown of all nondeployable profile types (temporary and permanent). They are:

- Trainees, hospitals, prisons, students 12 percent.
- Permanent nondeployable 1 percent.
- Temporary nondeployable, short of 12 weeks training 7 percent.
- Dental, temporary nondeployable 1 percent.
- Temporary nondeployable, no HIV test, pregnant 1 percent.
- Other temporary nondeployable, AWOL, no family care plan, seven days to ETS, legal, hospital/convalescent leaves 1 percent.

- Normal leave 2 percent.
- Deployable 50 percent.
- TDA (technically nondeployable by job/assignment, though they often deploy) 25 percent.³

If necessary, the Army can quickly correct the leaves and the dental work and obtain the HIV test. Nevertheless, the other areas could be difficult for the Army to correct and manage in an expeditious manner. Temporary nondeployable profiles of all types total 10 percent (50,000) of the Army population, many of which are trainees. Major Army Commands report that 10 percent of their forces (5 percent trainees) are nondeployable.⁴ A ten-percent nondeployable rate is rather significant when one considers that a large percentage of the force is not even in the MTOE Army. Nonetheless, permanent medical nondeployable profiles are only one percent of the total force. Evaluating the issue in terms of a smaller Army with significantly increased mission requirements, the problem should become more apparent.

The military's inability to determine exactly how many personnel are nondeployable, and therefore how to identify precisely how many personnel have with permanent medical profiles, is not a recent phenomenon. During DESERT STORM the "number of nondeployable soldiers reported by the Army represented a moving average rather than a total, and was significantly lower than the total reported at one point by the Army's Forces Command."⁵ This problem was not the Army's alone. The Air Force had 15,000 nondeployable airmen during DESERT STORM. GAO had very little confidence in the accuracy of the readiness reporting system. The Air Force apparently "masked the potential for nondeployable soldiers by designating primary and alternate personnel for each position"⁶ thus understating the problem. The Marine Corps had 8,000

nondeployable Marines during the conflict. GAO did not distinguish between permanent and temporary profiles.⁷

During DESERT SHIELD commanders interpreted deployability versus nondeployability in different ways. Conflicting guidance and policies within units or sheer inconvenience produced variations of deployability results. There was no Army or DOD peacetime reporting system for the active and reserve components.⁸ DOD could not adequately assess the total number of nondeployable soldiers with this incomplete and non-systematic reporting. Units frequently had to deploy with new soldiers which often adversely affected unit morale, cohesiveness, and perhaps most important, combat readiness.⁹

An ARI 1995 Army study, directed by the Army Deputy Chief of Staff for Personnel (DCSPER), questioned the accuracy of the reporting of nondeployable soldiers. Three separate sources (USR, SIDPERS, and ARI Study) produced three different results. The ARI study, which produced the most dramatically different results, evaluated how accurate the Army reporting systems were in identifying nondeployable soldiers.¹⁰ The Army had "four to five times more soldiers with permanent profiles, a percentage of whom would be determined to be non-deployable, than were being captured by USR or SIDPERS personnel system."¹¹ If accurate, this would mean the Army permanent profile rate was 4 or 5 percent rather than the 1 percent reported. That would mean there are potentially 16,000-20,000 soldiers with permanent medical profiles in the Army--the equivalent of one MTOE division! It would be difficult to determine how many of these 16,000-20,000 soldiers are nondeployable.

Figure 2 displays the differences between USR, SIDPERS, and the ARI survey. The differences probably result from what Gildersleeve called the “hip-pocket profile shadow world.”¹² That is, soldiers, although they have permanent profiles (both deployable and nondeployable), are able to conceal (either intentionally or unintentionally) their profile from the military medical system or the Army medical system fails to track or document the profile. Some soldiers may maintain their profile in

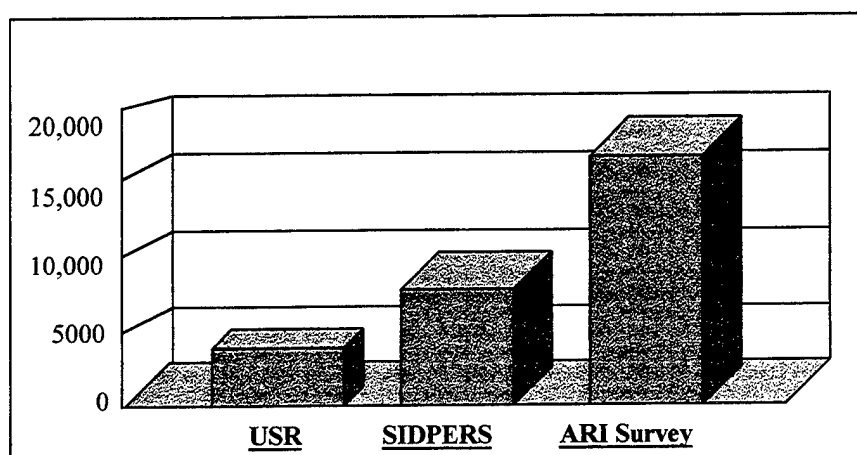


Figure 2. Comparison of Numbers of Active Army Permanent Profiles. *Source:* Lieutenant Colonel Allen M. G. Gildersleeve, “Mountains or Molehills, Permanent Physical Profiles in the Army Reserve” (Medford, Mass: Fletcher School of Law and Diplomacy, 6 May 1997), 2.
Note: Identified by USR, SIDPERS, and ARI Study.

their hip-pocket only to use it to avoid separation or to get out of deployments. Officials often fail to document these hip pocket profiles on the soldier’s personnel and medical records. For example, a soldier may have a back injury that prevents him or her from doing sit-ups, but is able to hide it from the chain of command until convenient.

Table 3 provides notable comparisons between the services on nondeployable soldiers with permanent medical profiles for 1995. As table 3 reveals, the Army in 1995

had the largest number of permanent nondeployable soldiers (3,773) of the services-- slightly over 57 percent of DOD's total, but still less than 1 percent of Army personnel.

Table 3. Nondeployable Soldiers with Permanent Medical Conditions Reported to Office of Secretary of Defense for FY95

Service	Nondeployable Category				Total nondeployables with permanent medical conditions	
	Permanent Medical conditions (other then HIV +).		HIV			
	No.	% of total strength	No.	% of total strength	No.	% of total strength
Army	3,447	0.68	326	0.06	3,773	0.74
Navy	163	0.04	491	0.11	654	0.15
Marines Corps	34	0.02	55	0.03	89	0.05
Air Force	1,966	0.50	91	0.02	2,057	0.52
Total DOD	5,610	0.37	963	0.06	6,573	0.43

Source: LeRoy B. Outlaw, Edmund F. Muendel, and David A. Smith. *Policy for DoD Management of Permanent Medical Nondeployable Personnel* (McLean, VA: Logistics Management Institute, March 1997), 1-3.

In addition, though technically deployable, soldiers in the Exceptional Family Member Program (EFMP), while not counted as nondeployable, are not, as a rule deployed. The Army enrolls a soldier in EMFP if a dependant requires specialized medical treatment at an advanced hospital. Lieutenant Colonel (Retired) Edward Greene asked, "What happens when a person's got an exceptional family member and can only go to places with big hospitals? [or says] Capt. Smith is a good guy, so we kind of keep the guy around. But after a few years, [it means] someone [else] has taken a turn [at deployment]."¹³ However, these soldiers are deployable, but the Army generally assigns them to a nondeployable position. They can leave family members and deploy if necessary.

Criteria: 1.2. What are the ranks, gender, and PMOS of nondeployable soldiers with permanent medical profiles ?

Policy for DoD Management of Permanent Medical Nondeployable Personnel

reports that “there is a correlation between grade and fitness determinations. Senior personnel are retained as fit at higher rates than junior-grade personnel.” There is a disparity between the services on how they process personnel for the permanent medical nondeployable (PMND) status. The Navy and Marines emphasize deployability more than the Army and Air Force. The Army’s system is more similar to the Marines and Navy in how it processes soldiers with physical disabilities, but it provides more leeway to personnel with asthma and diabetes. The Army, Navy, and Marines have higher rates of injuries than the Air Force. This probably occurs by virtue of the greater physical demands of a ground or sea-based service.

Table 4 provides the Army personnel summary by gender for September 1997.

Table 4. Army Personnel Summary by Gender for September 1997

Gender	Raw Numbers	% Total Army
Males	415,413	85%
Females	72,229	15%
Total	487,642	100%

Source: Major Steve Grimes, Email message to Major Harold Reeves, Department of Army Statistics on the Personnel on the Medical Profile status for the Army, Deputy chief of Staff for Personnel (DCSPER), (703)697-2403, 4 September 1997.

Table 5 displays the gender of nondeployable personnel with permanent medical profiles and those who are HIV positive. All tables in this section separate data on soldiers who are HIV positive because the Army manages and tracks theses separately.

Table 5: Nondeployable Soldiers with Permanent Medical Profiles and HIV Positive Soldiers for September 97

Gender	Permanent Medical Profiles			HIV Positive Soldiers			Permanent Medical Profiles & HIV Positive Soldiers		
	Raw No.	% of Army	% of Profiles	Raw No.	% of Army	% of Profiles	Raw No.	% of Army	% of Profiles
Males	2570	0.50%	79%	236	0.0%	7.0%	2796	0.6%	80%
Females	682	0.10%	21%	25	0.0%	0.7%	707	0.1%	20%
Total	3252	0.67%	100%	261	0.0%	9.0%	3503	0.72%	100%

The data in table 5 indicate that:

1. Males had a higher number of soldiers nondeployable due to permanent medical profiles (2570--males vs. 682--females) in the Army. The rates are representative of the male versus female composition: Eighty-five percent of the Army (male) has 79 percent of the personnel who are nondeployable due to permanent medical profiles. The other 15 percent of the Army (female) has the 21 percent of the personnel who are permanently nondeployable due to permanent medical profiles.

2. HIV positive soldiers in raw numbers (261) and as a percentage of the total Army (0 percent) are measurable. However, they represent 9 percent of the total profiles.

3. There are more HIV positive male soldiers (236) than HIV positive female soldiers (25). However, neither represents a significant number compared to total males and total females in the Army. Males are 7 percent of the HIV positive soldiers and females 0.7 percent of the HIV positive soldiers in the Army. When added to numbers with permanent profiles, results increase the percentage (79 percent to 80 percent) for males and decrease the percentage (21 percentage to 20 percent) for females.

Table 6 displays the Army personnel summary by rank for September 1997.

Table 6. Army Personnel Summary by Rank for September 1997

Item	Raw #	% Total Army
Total Officers in the Army (O1-O10)	67,555	14.0%
Total Warrant Officers in the Army (W1-W5)	11,750	2.0%
Total NCOs in the Army (E5-E9)	188,646	39.0%
Total Junior Enlisted in the Army (E1-E4)	219,691	45.0%
Total	487,642	100.0%

Table 7 displays rank, permanent profiles, and HIV positive status for the Army for September 1997. (See appendix D for complete permanent nondeployable statistics.)

Table 7: Ranks of Nondeployable Soldiers with Permanent Profiles and HIV Positive Status for September, 1997

Gender	Permanent Medical Profiles			HIV Positive Soldiers			Permanent Medical Profiles & HIV Positive Soldiers		
	Raw No.	% of Army	% of Profiles	Raw No.	% of Army	% of Profiles	Raw No.	% of Army	% of Profiles
Officers	233	0.0%	7.0%	17	0.0%	0.5%	250	0.0%	7.0%
Warrants	70	0.0%	2.0%	4	0.0%	0.1%	74	0.0%	2.0%
NCOs	1653	0.3%	51.0%	189	0.0%	5.0%	1842	0.4%	53.0%
Jr. Enlist.	1296	0.3%	40.0%	51	0.0%	1.0%	1368	0.0%	39.0%
Total	3252	0.6%	100%	261	0.0%	6.7%	3503	0.4%	100.0%

The data in tables 6 and 7 indicate:

1. Officers, who comprise 14 percent of the Army, had the lowest rate of permanent nondeployability (7 percent).
2. NCOs, who comprise 39 percent of the Army, had the highest rate of permanent nondeployability (51 percent).
3. NCOs and junior enlisted soldiers had the highest rates of HIV positive status, without a permanent medical profile, 5 percent and 1 percent respectively.

4. When combining numbers of permanently nondeployable soldiers with HIV positive status, NCOs, who comprise 39 percent of the Army, had the highest rates of permanent nondeployability (55 percent).

5. When combining HIV with permanent profiles, officers, who comprise 14 percent of the Army, had the lowest rates of permanent nondeployability (7 percent).

Table 8 displays the summary of Army personnel by rank and gender for September 1997.

Table 8: Army Personnel Summary by Rank and Gender for September 1997

Item	Raw #	% Total Army
Male Officers	57913	12.0%
Female Officers	9642	13.1%
Male Warrant Officers	11012	2.0%
Female Warrant Officers	738	6.0%
Male NCOs	165229	34.0%
Female NCOs	23417	5.0%
Junior Male Enlisted	181259	37.0%
Junior Female Enlisted	38432	8.0%
Total	487,642	100.0%

The investigator was not able to obtain data on PMOS and nondeployable soldiers with permanent medical profiles, therefore the summary table (table 9) compares permanent profiles, HIV, rank, and gender, but not PMOS. (See appendix D for complete permanent nondeployable statistics.)

Table 9 displays the rank and gender of nondeployable soldiers with permanent medical profiles and HIV positive status for September 1997. The data in table 9 indicate that:

1. Commissioned and warrant officers, both male and female, had the lowest rates of permanent nondeployability (8.3 percent not considering HIV positive status, 11 percent including those with HIV positive status).

Table 9: Rank and Gender of Nondeployable Soldiers with Permanent Medical Profiles and HIV Positive Status for September 1997.

Gender	Permanent Medical Profiles			HIV Positive Soldiers			Permanent Medical Profiles & HIV Positive Soldiers		
	Raw No.	% of Army	% of Profiles	Raw No.	% of Army	% of Profiles	Raw No.	% of Army	% of Profiles
Male Officers	152	0.0%	5.0%	16	0.0%	0.1%	168	0.0%	5.0%
Female Officers	81	0.0%	2.0%	1	0.0%	0.0%	82	0.0%	2.0%
Male Warrant Officers	59	0.0%	1.0%	4	0.0%	0.0%	63	0.0%	2.0%
Female Warrant Officers	11	0.0%	0.3%	1	0.0%	2.0%	70	0.0%	2.0%
Male NCOs	1373	0.2%	42.0%	174	0.0%	5.0%	1547	0.3%	44.0%
Female NCOs	280	0.0%	8.6%	15	0.0%	0.4%	295	0.0%	8.0%
Junior Male Enlisted	986	0.2%	30.0%	42	0.0%	1.0%	1028	0.2%	30.0%
Junior Female Enlisted	310	0.0%	10.0%	9	0.0%	0.2%	319	0.0%	9.0%
Total	3252	0.6%	100.0%	261	0.0%	8.7%	3503	0.5%	100.0%

2. The highest rates of nondeployability due to permanent medical profiles with HIV positive status was among male NCOs (42 percent) who represent 39 percent of the Army and male junior enlisted soldiers (30 percent) who represent 37 percent of the Army.

3. The rates of nondeployability due to permanent medical profiles without HIV positive status was 8.6 percent for female NCO's, although they represent only 5 percent of the Army. For junior enlisted females, who represent 8 percent of the Army, the rate was 10 percent.

4. When combining HIV positive status with permanent medical profiles, male NCOs who represent 34 percent of the Army had higher rates of nondeployability (44 percent) than any other group. The next highest rate was for junior male enlisted (30 percent). All other groups were less than 10 percent.

Subordinate Question 2: How do nondeployable soldiers with permanent medical profiles affect readiness in the MTOE Army?

Criteria: 2.1. How many soldiers by rank, and gender are in the MTOE A

Table 10 displays the number of soldiers in the MTOE Army by rank and gender:

Table 10: MTOE Personnel Summary by Rank and Gender for September 1997

Item	Raw #	% of MTOE Army	% Total Army
Male Officers	22807	7.6%	4.4%
Female Officers	2776	0.9%	0.5%
Male Warrant Officers	7153	2.4%	1.5%
Female Warrant Officers	443	0.0%	0.0%
Male Enlisted	233930	77.5%	48.0%
Female Enlisted	34757	11.5%	7.1%
Total Officers	25583	8.5%	5.2%
Total Warrant Officers	7596	2.5%	1.6%
Total Enlisted	268687	89.0%	55.1%
Total Male Population	263890	87.4%	54.1%
Total Female Population	37976	12.6%	7.8%
Total	301866	N/A	N/A

Source: Major Steve Grimes, Email message to Major Harold Reeves, Department of Army Statistics on the Personnel on the Medical Profile status for the Army, Deputy chief of Staff for Personnel (DCSPER), (703)697-2403, 4 September 1997.

These numbers represent the Army's daily operating strength--the available soldiers to put in authorized positions. They do not include trainees, transients, holdees, and students (TTHS) not in authorized positions (65,037 soldiers). The Army operating strength (MTOE and TDA--422,605) plus the TTHS (65,037) equal the Army's endstrength. The majority of the TTHS soldiers are in basic training (BT), Advanced Individual Training (AIT), officer basic and advanced courses, moving, or even prison. The MTOE Army in September 1997 was 71 percent of the Army's operating strength or 62 percent of the Army's endstrength. The MTOE Army, on average, comprises between

75-80 percent of the Army's operating strength and about 65 percent of the Army's endstrength.¹⁴

Criteria: 2.2. How many nondeployable soldiers with permanent medical profiles are in the MTOE Army?

This information was not available to the investigator. Though the Army officially reported its permanent nondeployable rate at 1 percent, the information available to the investigator did not break down the data by MTOE or TDA. In addition, the investigator did not find any studies or reports that specifically address the MTOE Army in terms of readiness impact of nondeployable soldiers with permanent medical profiles. Nonetheless, if all of these nondeployable soldiers were in the MTOE Army—that is the permanent medically nondeployable (3252) and the HIV positive (261), which is still only 1 percent (3503) of the Army¹⁵--it should be a manageable problem.

Criteria: 2.3. What are the ranks, gender, and PMOS of nondeployable soldiers with permanent medical profiles in the MTOE Army?

This information was not available to the investigator.

Subordinate Question 3: How do nondeployable soldiers with permanent medical profiles affect readiness in the TDA Army?

Criteria: 3.1. How many soldiers by rank and gender are there in the TDA Army?

Table 11 displays the summary for soldiers by rank and gender in the TDA Army. The TDA Army in September 1997 was 29 percent of the Army's operating strength or 25 percent of the Army's endstrength. The TDA Army, on average, comprises between 30 percent of the Army's operating strength and about 25-30 percent of the Army's endstrength.¹⁶

Table 11. TDA Personnel Summary by Rank and Gender for September 1997

Item	Raw #	% of TDA Army	% Total Army
Male Officers	25549	21.2%	5.2%
Female Officers	5345	0.04%	1.0%
Male Warrant Officers	2828	2.3%	0.6%
Female Warrant Officers	214	0.2%	0.0%
Male Enlisted	69615	57.7%	14.3%
Female Enlisted	17188	14.2%	3.5%
Total Officers	30894	25.6%	6.3%
Total Warrant Officers	3042	2.5%	0.6%
Total Enlisted	86803	72.0%	17.8%
Total Male Population	97992	81.2%	20.0%
Total Female Population	22747	18.8%	4.7%
Total	120739	N/A	N/A

Criteria: 3.2. How many nondeployable soldiers with permanent medical profiles are there in the TDA Army?

This information, like that for the MTOE Army, was not available to the investigator.

Criteria: 3.3. What are the ranks, gender, and PMOS of nondeployable soldiers with permanent medical profiles in the TDA Army?

This information, like that for the MTOE Army, was not available to the investigator. Though the Army officially reported its permanent nondeployable rate at 1 percent, the information available to the author did not break down by TDA or MTOE. In addition, the investigator did not find any studies or reports that specifically address the TDA Army in terms of impact of nondeployable soldiers with permanent medical profiles readiness. Nonetheless, if all of these nondeployable soldiers were in the TDA Army—that is the permanent medically nondeployable (3,252) and the HIV positive (261), which is still only 1 percent (3,503) of the Army¹⁷—it should be a manageable problem.

Subordinate Question 4: How effective are DOD and Army policies and regulations in assisting the Army leadership to manage the impact of soldiers with permanent medical profiles on readiness?

Criteria: 4.1. How many soldiers does the Army process for medical separation, retention, or retirement?

Table 12 displays the comparison of medical separation and retention rates among the services by grade and group for 1995. (This information was not available for 1996 or 1997.) As table 12 indicates, the Army boarded almost twice the personnel as the other services. The Army separated over 89 percent of those boarded (the Army boarded 4,672 but only retained 523 soldiers). Table 12 indicates that the Army separated or retired more enlisted soldiers (3,908) than officers (241) and more junior enlisted (2,284) than senior enlisted (1,624). The Army assessed 4,149 soldiers as unfit for duty and separated or retired them.

The data demonstrates that officers (both warrant and commissioned officers) have higher retention rates than enlisted soldiers (89 percent for officers vs. 11 percent for enlisted) and, that more senior personnel, officer and enlisted, have higher retention rates. For majors through brigadier generals the retention rate was 39 percent versus 15 percent for lieutenants through captains and for sergeants through sergeants majors the retention rate was 17 percent versus 4 percent for private through specialist.

Table 12. Comparison of Fit/Unfit Determinations, by Grade, Group, and by Service for FY95

Disposition	Grade group	Army		Navy		Marine Corps		Air Force		ALC-C No.
		No	%	No	%	No	%	No	%	
Fit, return to duty	E1-E4	105	4	146	11	56	5	52	18	20
	E5-E9	335	17	232	19	79	18	826	53	437
	WO	22	35	3	30	2	22	N/A	--	N/A
	01-03	24	15	13	19	5	33	83	51	44
	04-07	37	39	25	41	8	47	126	74	57
Subtotal	--	523	--	419	--	150	1,087	--	--	558
Unfit, separate or retire (permanent & temporary)	E1-E4	2,284	96	1,231	89	1,113	95	241	82	--
	E5-E9	1,624	83	1,006	81	352	82	731	47	--
	WO	41	65	7	70	7	78	N/A	--	--
	01-03	141	85	54	81	10	66	81	49	--
	04-07	59	61	36	59	9	53	45	26	--
Subtotal	--	4,149	--	2,334	--	1,491	--	1,098	--	--
Total cases	--	4,672	2,753	--	1,641	--	2,185	--	--	--

Source: LeRoy B. Outlaw, Muendel, Edmund F., and Smith, David A. "Policy for DoD Management of Permanent Medical Nondeployable Personnel" (McLean, VA: Logistics Management Institute., March 1997), iii.

The top 10 disability categories for which the Army separated or retired for fiscal years 1996 were (in order): knee impairment, lumbosacral strain (back), degenerative arthritis, intervertebral disc syndrome (back), bronchial asthma, dysthynic disorder (psychiatric depression), limited motion (ankle), HIV-related illness, psychotic order, and brain disease due to trauma. For 1997 the top 10 disability categories for which the Army separated or retired were (in order): degenerative arthritis, bronchial asthma, lumbosacral strain, knee impair impairment, intervertebral disc syndrome, HIV-related illness, post-traumatic stress disorder, migraine, dysthynic disorder, and diabetes.

Figures 3 and 4 display the number of soldiers the Army separated or medically retired for fiscal years 1996 and 1997. There were 4,500 Army personnel separated or medically retired in FY96 and FY97. Among the twenty most frequent disabilities resulting in separation or medical retirement, thirteen were identical in both years. Seven conditions recurred for both years (knee impairment, lumbosacral strain, degenerative arthritis, dysthymic disorder, intervertebral disc syndrome, HIV-related

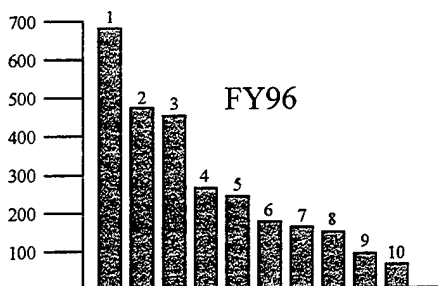


Figure 3. Number of Army Personnel Separated or Medically Retired by Top Ten Disability Categories in FY96 (Total = 2,820)

Source: Author received the information from the Army Physical Disability Agency on 3 March 1998, 8120 Woodmont Ave, Bethesda, MD 20814-2743, and COMM (301) 295-1042/1038.



Figure 4: Number of Army Personnel Separated or Medically Retired by Top Ten Disability Categories in FY97 (Total = 1,700)

Note: Investigator received Figures 3 and 4 as they appear with different scales on the vertical axis. Therefore, direct comparison between FY96 and FY97 are more difficult.

illness, and bronchial asthma). Three conditions did not recur (ankle (limited motion), psychotic order, and brain disease due to trauma). Three other conditions (post-traumatic stress disorder, migraines, and diabetes) replaced them.

Criteria: 4.2. Is deployability an important component of the medical board process?

Clearly summarizing the problem, General Crosbie Saint, the former commander of US Army Europe (USAEUR), said, "If you really need a deployable soldier, but the soldier is nondeployable, why have that soldier in the Army? And if you don't really need a soldier—someone capable of holding a rifle and crawling in the mud, wouldn't it be more appropriate to send a civilian?"¹⁸ The Army must have soldiers and units that are deployable. The military performs a valuable and unique mission that currently no other institution can perform.

Ultimately the medical board, as described in AR 635-40, determines the soldier's fitness for duty. As previously stated, disability does not instantly require separation or retirement. Neither will the Army necessarily medically separate soldiers who do not

possess a unique skill or a critical PMOS that is in short supply. "The ability of a soldier to reasonably perform his or her duties in all geographic locations under all conceivable circumstances is a key to maintaining an effective and fit force." However, AR 635-40 prohibits using worldwide deployability as the only factor in determining medical unfitness.¹⁹ The Army grants great discretion for medical boards in evaluating soldier's medical fitness. It is not a rigid, templated system. The PMND system, as currently structured, allows boards to use subjective judgment, which may result in inconsistent interpretation and application of standards across the Army.

It may not make sense for the Army to retain soldiers who cannot deploy worldwide. However, if a soldier can perform his PMOS, should the Army retain him? For example, if a soldier, whose PMOS is a drummer in an Army band, develops a nondeployable medical condition, but can perform his PMOS, it may make sense for the good of the Army to retain the soldier.

On the other hand, if the Army wants a soldier to be able to perform more than just their PMOS, or if the unit has a secondary mission that requires deployment, it may not be justifiable to retain the soldier. The USAREUR band deployed to Bosnia to execute its secondary mission, guarding the 1st Armored Division. Thus, deployability is a factor in today's high OPTEMPO/PERSTEMPO Army. Perhaps DOD and, therefore the Army, should adopt the definition of deployability suggested by Outlaw, "The absence of significant restrictions on a service member's ability to relocate from a CONUS or OCONUS home station, as an individual or as part of a unit, to perform the duties of his or her office, grade, rank, or rating in support of military operations inside and outside the borders of the United States and Puerto Rico—under conditions

reasonably foreseeable for a member of that office, grade, rank, or rating." This definition at least contains a recommendation to include worldwide deployability as a factor in retention.

¹ G. E. Willis, "From the Top: The Army Hopes New Policies Will Help Ease the Strain of Deployment," *Army Times*, 15 July, 1996, 12.

² G. E. Willis, "Soldiers: Some Troops Cannot Deploy. What does that do to the rest of the Army?," *Army Times*, 8 July 1996, 12-14.

³ *Ibid.*, 12.

⁴ Major Steve Grimes, email message to Major Harold Reeves, Department of Army Statistics on the Personnel on the Medical Profile status for the Army, Deputy Chief of Staff for Personnel (DCSPER), (703)697-2403, 4 September 1997.

⁵ Lieutenant Colonel Allen M.G. Gildersleeve, "Mountains or Molehills, Permanent Physical Profiles in the Army Reserve" (Medford, Mass: Fletcher School of Law and Diplomacy, 6 May 1997), 3.

⁶ *Ibid.*, 19.

⁷ *Ibid.*, 22.

⁸ Government Accounting Office, *OPERATION DESERT STORM: War Highlights Need to Address Problem of Nondeployable Personnel* (Washington, DC: Government Printing Office, August 1992), 1-2.

⁹ *Ibid.*, 2.

¹⁰ Gildersleeve, 2.

¹¹ *Ibid.*

¹² *Ibid.*, 5.

¹³ Willis, "Soldiers," 14.

¹⁴ Major Steve Grimes, email message to Major Harold Reeves, Department of Army Statistics on the Personnel on the Medical Profile status for the Army, Deputy Chief of Staff for Personnel (DCSPER), (703)697-2403, 3 March 1998.

¹⁵ Grimes, 4 September 1997.

¹⁶ Ibid.

¹⁷ Ibid.

¹⁸ Willis, "Soldiers," 12.

¹⁹ Ibid.

CHAPTER 5

RECOMMENDATIONS AND CONCLUSIONS

Introduction

The purpose of this study was to describe the impact of nondeployable soldiers with permanent medical profiles on Army readiness by answering the primary research question: How do nondeployable soldiers with permanent medical profiles affect Army readiness in the active component? In order to determine how nondeployable soldiers with permanent medical profiles affect Army readiness, the investigator addressed four subordinate questions.

1. What is the extent of the nondeployable soldier problem in the Army?

Permanent medical profiles ostensibly only have a minor impact on Army operational readiness. The total permanent profiles reported by the Army only constitute about 1 percent of the Army personnel endstrength.¹ However, in a downsized Army, it may not be logical to retain soldiers who are not deployable. There has been some debate within the Department of Army staff concerning the real impact of nondeployable soldiers. Furthermore, the Army readiness system may not accurately report the size of the nondeployable problem. The study was not able fully to evaluate data collected on readiness, deployability, and permanent profiles because of inconsistencies within the Army and DOD in defining and measuring these terms. Even within the Army, this is a problem.

Male NCOs and male junior enlisted soldiers had the highest rates of nondeployability due to permanent medical profiles. Officers (warrants and commissioned officers) overall, both male and female, had the lowest rate of

nondeployability due to permanent medical profiles. Males have higher numbers and higher proportion, but the male versus female proportion of profiles is roughly the same as their proportionate representation. In addition, the HIV positive status (for all ranks and genders) numbers and as a portion of the Army are barely measurable. The investigator could not obtain data on PMOS and profile linkage; therefore, he was not able to determine if there was a correlation between PMOS and profiles.

2. How do nondeployable soldiers with permanent medical profiles affect readiness in the MTOE Army? The investigator was not able to obtain information that separated profiles by MTOE units. Based on the small number of reported medical nondeployable profiles and HIV positive status (3,503 or 0.72 percent),² it does not appear that they have a significant impact on the MTOE Army.

If the reports are valid and reliable, the number of nondeployable soldiers with permanent medical profiles is small, representing a minor proportion of the MTOE Army. They should have only a marginal impact on the MTOE Army's readiness. The 3,503 soldiers with permanent medical profiles or HIV positive status who are permanently nondeployable are equivalent to an Army brigade.³ If the Army could assemble these nondeployable soldiers in one unit, they might be able to assist the Army in its operational deployments.

3. How do nondeployable soldiers with permanent medical profiles affect readiness in the TDA Army? The investigator was not able to obtain information that separated profiles by TDA. The reported number (3,503)⁴ is small and should have even less impact on the TDA Army's readiness, since whole units do not deploy unlike MOTE units.

4. How effective are DOD and Army policies and regulations in assisting the Army leadership to manage the impact of soldiers with permanent medical profiles on readiness? DOD and Army policies and regulations send mixed signals to the services and medical evaluation boards, at times producing inconsistent and inefficient results. These policies may in fact cause the Army unintentionally to obscure the magnitude of the nondeployable problem.

Boards can produce inconsistent results when evaluating disabled soldiers. They may retain soldiers who are not even deployable. This may occur because DOD and the Army do not mandate worldwide deployability as a precondition for retention, as demonstrated by the DOD policy to retain HIV positive personnel who are otherwise fit for duty and can perform their PMOS. AR 635-40 and AR 635-40 prohibits using worldwide deployability as the only factor in determining medical unfitness.⁵ The Army has the most liberal policy of all the services. This may not be prudent, since the Army is the most personnel intensive and dependent force.

In addition, to the effectiveness of the medical board processing system, one of the most important aspects of DOD and Army policies and regulations is the readiness reporting system. As previously discussed, the reliability and validity of the readiness reporting systems such as the USR and SORTS programs, is questionable. Both systems provide useful information, however, they may not accurately report the correct number of nondeployables, much less the Army readiness status. DOD and Army's medical and readiness reporting systems may in fact tend to obscure the extent of the nondeployability problem.

These questionable reporting systems made it difficult for the investigator thoroughly to analyze and evaluate readiness, deployability, and permanent medical profiles. Several studies challenged the effectiveness of DOD's readiness systems. For example, as early as 1991, GAO felt that much of the SORTS readiness data was "of limited value because the assessments were" based on unit training at home station. In addition, they found that the units may not have fully considered the impact of the loss of key personnel on their readiness.⁶

According to the data available, the investigator identified that 0.67 percent (without HIV positive personnel) to 0.72 percent (with HIV positive personnel) of the Army is nondeployable due to permanent medical profiles.⁷ However, Gildersleeve suggests that proportion may actually be as high as 5 percent. The 1995 ARI study Gildersleeve quoted found that Army had "4 to 5 times more soldiers with permanent profiles, a percentage of whom would be determined to be non-deployable, than were being captured by USR or the SIDPERS personnel system."⁸ The investigator could not determine how accurate the study was, but it, to include several GAO studies, did challenge the reliability of the military's readiness reporting system. The key issue is that neither DOD or the Army may know the true status of unit readiness or the number of soldiers with permanent medical profiles who are permanently nondeployable. Without this knowledge, DOD and the Army cannot make or adjust policies to efficiently promote and gain a healthy force.

Recommendations

1. Improve validity and reliability of the readiness reporting systems so that DOD and the Army know exactly how many soldiers are permanently nondeployable and

how long and how often the soldiers deploy. DOD should impose a standard definition for deployment that would enable them fully to measure some aspect of readiness such as deployment. For example, "one day away from the unit equals one day deployed."

There should be no difference between the services. Consequently, DOD and the Army will know exactly the PERSTEMPO/OPTEMPO status of its personnel and units. With this accurate information, the services will be able to make informed and intelligent decisions regarding military personnel.

2. Include cross leveling for operational requirements on their readiness reports so that the Army clearly knows the severity of its personnel shortfalls. This will also improve the validity and reliability of the readiness reporting system.

3. Revise the medical board process:

- a. Require worldwide deployability as a principal criterion for retention of soldiers processing through a medical retention board. Regulations and policies should explicitly state that deployability must be a factor in all medical fitness boards. Deployability and fitness should generally be synonymous in meaning.⁹ One possible exception may be for those soldiers in MOSs that does not require deployment.¹⁰ In order to maintain consistency, if the Army and DOD grant exceptions to this policy, it must clearly outline exceptions to the "deployability equals retention rule." Exceptions must be few in order to maintain a coherent system. However, given the recent phenomena of the Army tasking TDA personnel to conduct operational missions, providing exceptions may be impossible. Furthermore, if the Army downsizes significantly, but maintains a high OPTEMPO/PERSTEMPO rate, the exception criteria may not be prudent.

b. Centralize the medical board process and reduce the latitude that medical boards have when considering retention. Requiring worldwide deployability and the ability to perform ones PMOS will be helpful. In addition, perhaps providing for more liberal disability payments for soldiers disabled by Army related requirements, will make it psychologically easier for board members to retire or separate soldiers.

4. Retaining personnel who are HIV positive does not increase the proportion of personnel who are nondeployable due to permanent medical profiles; however, the perception that personnel who are HIV positive are retained at a higher rate than personnel who have other progressive diseases or PMND conditions is potentially divisive and detrimental to morale. Although we do not include morale assessments in readiness reports, it is generally accepted the morale impacts readiness--individual and unit. In addition DOD should consider accepting Outlaw's suggestion to align DoDD 6485.1 with DoDD 1332.18 so that service members who are HIV positive are treated no different than service members who have other progressive diseases or PMND conditions.¹¹

Suggestions For Further Research

1. Investigate how nondeployable soldiers with permanent and temporary medical profiles affect readiness in the Reserve Component. Reservists do not have the same opportunity afforded them to maintain their physical conditioning as do active component soldiers. The ability of reserve component leaders to screen their personnel may not be as robust as the active component. Maintaining a healthy force is just as important for the reserve component as it is for the active component. The active

component cannot operate without the reserve component and many reserve units have higher OPTEMPO and PERSTMPO rates than the active component.

2. Measure the effect of soldiers who are temporarily medically nondeployable (e.g., injuries, pregnancy) in the active and reserve components on Army operational readiness. As chapter 4, section 1.1 reported, temporary nondeployable soldiers are a sizeable percentage of the Army. For the same reason as reported in this study, the Army may need more closely to evaluate its medical policies to ensure a healthy and deployable force, especially with increased OPTEMPO and PERSTEMPO rates.

3. Analyze the influence of different political special interest on the Army, DOD, the legislative, and executive branches of the federal government concerning retention of soldiers with medical problems who cannot perform their PMOS or deploy.

4. Evaluate and determine if there are relationships between PMOS and the top ten conditions or other factors that make soldiers permanently nondeployable and then determine if the Army can develop specific policies that can prevent these conditions from occurring. If the Army can identify these factors, it could potentially reduce the disabilities and save resources. This should include evaluating if there is a link between PMOS permanent profiles (e.g., the incidence of cancer and a specific PMOS such as the Chemical Corps). The author was not able to evaluate or make any correlation between soldiers with permanent profiles and disabilities. The Veterans Administration could conduct this analysis since these soldiers would have service connected disabilities.

With dwindling resources, high OPTEMPO and PERSTEMPO, the Army must aggressively seek to preserve a healthy, deployable force. If the Army can prevent or reduce these disabilities, a healthy force will result with improved readiness.

Summary

Soldiers with permanent medical profiles who are permanently nondeployable as officially reported had a minor impact on overall Army, MTOE, and TDA readiness. The number of soldiers who are permanently nondeployable to include HIV positive status, constitute less than 1 percent of the Army, clearly a manageable problem. However, the DOD and Army readiness reporting system may be unreliable and may mask the true number of nondeployable soldiers with permanent medical profiles as suggested in this study. If in fact the readiness reporting system is unreliable and inaccurate, than the problem may in fact be more pronounced than reported, and may be more difficult to manage.

¹ Steve Grimes, Major. Deputy Chief of Staff for Personnel (DCSPER), Department of Army Statistics on the Personnel on the Medical Profile status for the Army, Received by the author on 16 December 1997, (703)697-2403.

² Ibid.

³ Ibid.

⁴ Ibid.

⁵ G.E. Willis, "Soldiers: Some troops cannot deploy. What does that do to the rest of the Army?," *Army Times*, 8 Jul 1996, 12.

⁶ Government Accounting Office, *Military Readiness: Current Indicators to Be Expanded for a More Comprehensive Assessment*. Statement of Neal P. Cutrin (Washington, DC: Government Printing Office, 1994), 1-2.

⁷ Grimes.

⁸ LTC Allen M.G. Gildersleeve, "Mountains or Molehills, Permanent Physical Profiles in the Army Reserve" (Medford, Mass: Fletcher School of Law and Diplomacy, 6 May 1997), 2-3.

⁹ LeRoy B. Outlaw, Edmund F. Muendel, and David A. Smith. *Policy for DoD Management of Permanent Medical Nondeployable Personnel* (McLean, VA: Logistics Management Institute, March 1997), v.

¹⁰ Ibid., 5-6.

¹¹ Outlaw, vi.

APPENDIX A

PROFILES--PERMANENT AND TEMPORARY

AR 40-501 defines a permanent profile as, “permanent unless a modifier of “T” (temporary) . . . A permanent profile may only be awarded or changed by the authority designated in paragraph 7-6 [AR 40-501]. Permanent profiles may be amended at any time if clinically indicated and will automatically be reviewed at the time of a soldier’s periodic examination. The soldier’s commander may also request a review of a permanent profile.”¹

AR 40-501 defines Temporary Profiles as, “Given if the condition is considered temporary, the correction or treatment of the condition is medically advisable, and correction usually will result in a higher physical capacity. Soldiers on active duty and reserve component soldiers not on active duty with a temporary profile will be medically evaluated at least once every 3 months at which time the profile may be extended by the profiling officer.”²

The Army’s physical profile serial system covers the function of the body as it relates to military duties. The profile system assigns profiles to soldiers based on the six factors of “P-U-L-H-E-S.” The system provides a numerical index to a soldier between one to four.³ AR 40-501 defines the numbers as follows:

- An individual having a numerical designation of “1” under all factors is considered to possess a high degree of medical fitness.
- A physical profile designator of “2” under any or all factors indicates that an individual possess some medical condition or physical defect which may require some activity limitations.

- A profile containing one or more numerical designators of “3” signifies that the individual has one or more medical conditions or physical defects which may require significant limitations. The individual should receive assignments commensurate with his or her physical capability for military duty.

A profile serial containing one or more numerical designators of “4” indicates that the individual has one or more medical conditions or physical defects of such severity that performance of military duty must be drastically limited. The numerical designator “4” does not necessarily mean that the soldier is unfit because of physical disability as defined in AR 635-40. When a numerical designator “4” is used, there are significant limitations which must be fully described if such an individual is returned to duty.⁴

AR 40-501 defines the definition of P-U-L-H-E-S as follows:

- P--Physical capacity or stamina. This factor, general physical capacity, normally includes conditions of the heart; respiratory system; gastrointestinal system; genitourinary system; nervous system; allergic, endocrine, metabolic and nutritional diseases; diseases of the blood and blood forming tissues; dental conditions; diseases of the breast, and other organic defects and diseases which do not fall under other specific factors of the system.
- U--Upper extremities. This factor concerns the hands, arms, shoulder girdle, and spine (cervical, thoracic, and upper lumbar) in regard to strength, range of motion, and general efficiency.
- L--Lower extremities. This factor concerns the feet, legs, pelvic girdle, lower back musculature and lower spine (lower lumbar and sacral) in regard to strength, range of motion, and general efficiency.
- H--Hearing and ears. This factor concerns auditory acuity and disease and defects of the ear.
- E--Eyes. This factor concerns visual acuity and diseases and defects of the eye.
- S--Psychiatric. This factor concerns personality, emotional stability, and psychiatric diseases.⁵

A “111111” rating means that a soldier can be assigned anywhere and is medically fit for any duty. A P-U-L-H-E-S rating with a “2” in it means that the soldier is combat ready, but he or she may have assignment limitations to prevent further damage

to the medical condition. A profile serial with a "3" or "4" means the soldier "possesses impairments which limit functions or assignments but within which the individual is capable of performing military duty."⁶ A soldier with HIV would receive a P4 rating. The Army documents this rating on soldiers' records such as the Officer Record Brief (ORB) to manage soldiers efficiently.

¹ Department of Army, AR 40-501 *Standards of Medical Fitness* (Washington DC: Government Printing Office, 30 Aug 1995), 45.

² Ibid.

³ AR 40-501, 45.

⁴ Ibid.

⁵ Ibid.

⁶ Ibid., 49.

APPENDIX B

PHYSICAL PROFILE GUIDE

Table 13. Physical Profile Functional Capacity Guide

Profile Serial	P Physical Capacity	U Upper Extremities	L Lower Extremities	H Hearing - Ears	E Vision- Eyes	S Psychiatric
1	Good muscular development with ability to perform maximum effort for indefinite periods.	No loss or digits or limitation of motion; no demonstrable abnormality; able to do hand to hand fighting.	No loss of digits or limitation of motion; no demonstrable abnormality; able to perform long marches, stand over long periods.	Audiometer average level for each ear not more than 25dB at 500, 1000, 2000, Hz with no individual level greater than 30 dB. Not over 45 dB at 4000Hz.	Uncorrected visual acuity 20/200 correctable to 20/20, in each eye.	No psychiatric pathology. May have history of a transient personality disorder.
2	Able to perform maximum effort over long periods.	Slightly limited mobility of joints, muscular weakness, or other musculoskeletal defects which to not prevent hand to hand fighting and do not disqualify for prolonged effort.	Slightly limited mobility of joints, muscular weakness, or other musculoskeletal defects which to not prevent moderate marching climbing, running, digging, or prolonged effort	Audiometer average level for each ear at 500,1000,2000Hz, or not more than 30 dB, with no individual level greater than 35 dB at these frequencies, and level not more than 55 dB at 4000 Hz; or audiometer level 30 dB at 500 Hz, 25 dB at 1000 and 2000 Hz, and 35 dB at 4000 Hz in better ear. (Poorer ear may be deaf.)	Distant visual acuity correctable to 20/40-20/70, 20/30-20/00, 20/20-20/400.	May have history of recovery from an acute psychotic reaction due to external or toxic causes unrelated to alcohol or drug addition. Individuals who have been evaluated by a physician (psychiatrist) and found to have a character and behavior disorder will be processed throughout appropriate administrative channels.
3	Unable to perform full effort except for brief or moderate periods.	Defects of impairments which interfere with full function requiring significant restriction of use.	Defects or impairments which interfere with full function requiring significant restriction of use.	Speech reception threshold in best ear not greater than 30 dB HL measured with or without hearing aid or, acute or chronic ear disease not falling below retention standard. Aided speech reception threshold measured at "comfort level"; i.e., volume control of hearing aid adjusted to 50 dB HL speech noise.	Uncorrected distant visual acuity of any degree which is correctable not less than 20.30 in the better eye or an acute chronic eye disease not falling below retention standards.	Satisfactory remission from an acute psychotic or neurotic episode which permits utilization under specific conditions (assignment when outpatient psychiatric treatment is available or certain duties can be avoided.)

Table 13 Continued

Profile Serial	P Physical Capacity	U Upper Extremities	L Lower Extremities	H Hearing - Ears	E Vision- Eyes	S Psychiatric
4	Functional level Below P 3. Organic defects, strength, stamina, agility, energy, muscular coordination, function, and similar factors	Functional level Below U3 Strength, range of motion, and general efficiency of upper arm, shoulder girdle and back, including cervical, thoracic, and lumbar vertebrae.	Functional level Below L3 Strength, range of movement, and efficiency of feet, legs, pelvic girdle, and lower back..	Hearing level below H3 Auditory sensitivity and organic disease of the ears.	Visual acuity below E3 Visual acuity, and organic disease of the eyes and lids.	Does not meet S3 above. Type severity and duration of the psychiatric symptoms or disorder existing at the time the profile is determined. Amount of external precipitating stress. Predisposition as determined by the basic personality makeup intelligence performance and history of past psychiatric disorder impairment of functional capacity.

Source: Department of the Army, AR 40-501 *Standards of Medical Fitness* (Washington DC: Government Printing Office, 30 Aug 1995), 48-49.

APPENDIX C

MEDICAL EVALUATION BOARD REQUIREMENTS BY SERVICE

Table 14. MEB Referral Requirements for Permanent PMND

PMND Condition	DoDD 1332.18 (Encl. 4)	Army (AR 40-501)	Air Force (AFI 48-123)	Navy and Marine Corps (SECNAVINST 1850.4C)
Asthma	Associated with more than mild irreversible reduction in pulmonary function (ventilator tests) and symptoms of such severity as to interfere with the satisfactory performance of duty [Para. L.2.b.]	Soldiers diagnosed for asthma may be placed on a temporary profile with a T3 under the P factor of the physical profile, for up to 12 months trial of duty, when medically advisable. [Para. 3-27.a.(4)]	Unless due to well-defined, avoidable precipitant cause. [Requires MEB referral], [Para.A2.6.]	Associated with more than mild irreversible reduction in pulmonary function (ventilatory tests) and symptoms of such severity as to interfere with the satisfactory performance of duty. [Para.L.2.b.]
Cardiac Conditions	Numerous reasons and conditions may be causes for referral. [Para. K.1-3]	Various cardiac conditions are afforded trials of duty between 90 to 180 days by a MEB prior to referral to an MEB is required. [Para. 3-21 and 3-24]	MEB within 90 days of myocardial infarct. Final evaluation for continued active duty is conducted not more than 1-year post-infarct. [Para. A.2.7.] Hypertensive cardiovascular disease and hypertensive vascular disease require MEB processing with 90 calendar days of surgery, regardless of results. [Para. A.2.7.1.]	Numerous reasons and conditions may be causes for referral. (Para. K.1-3.)
Cancer	Of such a nature as to preclude satisfactory performance of duty. [Para. S.1]	Malignant neoplasms that are unresponsive to therapy, or when the residuals of treatment are in themselves unfitting under other provisions of Chapter 3. [Para. 3-42.a.]	All neoplasms must meet with a MEB within 90 calendar days of initial diagnosis or as soon as the medical condition stabilized. [Para. A.2.18.]	Of such a nature as to preclude satisfactory performance of duty. [Para.S.1.]
Diabetes Mellitus	When proven to require insulin. [Para.F.5]	When proven to require hypoglycemic drugs in addition to restrictive diet of control. [Para. 3-11.d.]	When proven to require insulin or oral hypoglycemic drugs; MEB processing is done within 90 calendar days. [Para.A.216.]	When proven to require insulin. [Para. F.5.]
Inflammatory bowel disease	Ulcerative colitis. No amplifying guidance. [Para. B.A.A]	Except when responding well to treatment. [para.3.5m.]	Ulcerative Colitis. No amplifying guidance. [Para A.2.9.11]	Ulcerative Colitis. No amplifying guidance. {Para.B1.1]

Table 14 Continued

PMND Condition	DoDD 1332.18 (Encl. 4)	Army (AR 40-501)	Air Force (AFI 48-123)	Navy and Marine Corps (SECNAVINST 1850.4C)
Seizures	[Refer general neurological disorders] when, after . . . treatment, residual symptoms . . . interfere with the performance of duty. [Para. N.15] [No specific mention is made of seizures or the epilepsies.]	Seizures by themselves are not disqualifying unless they are manifestations of epilepsy. Upon recommendation of a neurologist, a soldier is given a T3 profile and placed on a trial of duty for 1 year. If incident free, profile and placed on a trial of duty P2 with assignment restricted to an area where medical treatment is available. Recurrence beyond 6 months of initial treatment requires PEB referral. [Para. 3-30.i.]	For active duty, MEB processing must be done within 90 days of the first episode. [Para. A2.11.]	[Refer general neurological disorders] when, after . . . treatment, residual symptoms . . . interfere with the performance of duty. [Para. N/15/], [No specific mention is made of seizure or the epilepsies.]

Source: LeRoy B. Outlaw, Edmund F. Muendel, and David A. Smith. *Policy for DoD Management of Permanent Medical nondeployable Personnel* (McLean, VA: Logistics management Institute, March 1997), H-3 to H-4.

APPENDIX D

PERMANENT PROFILE NONDEPLOYABLE STATISTICS

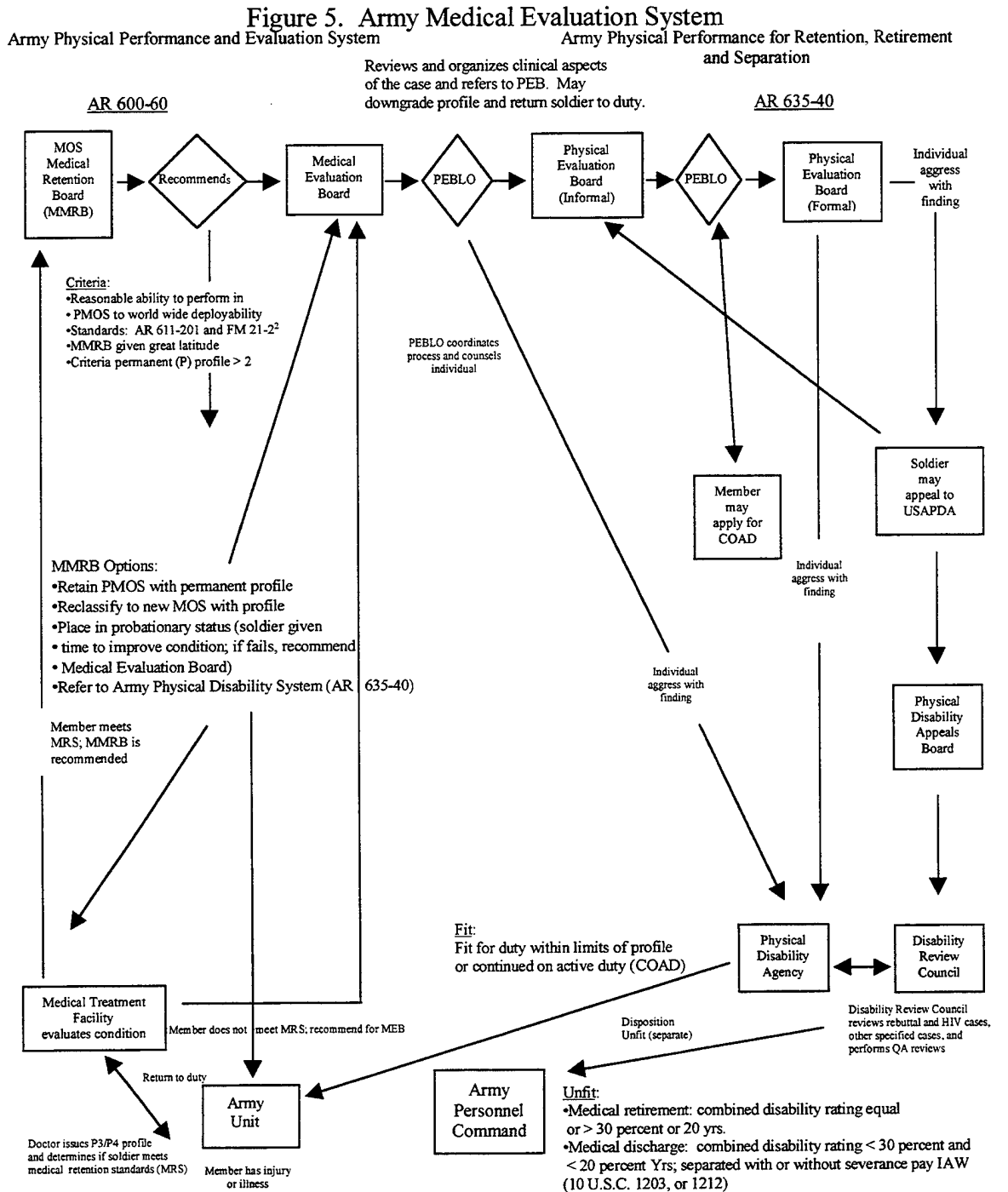
Table 15. Army Permanent Nondeployables for September 1996 and 1997

CATEGORY	SEPT 96	HIV POS	HIV POS	PROFILES PERM	PROFILES PERM	PROFILES TEMP	PROFILES TEMP	SEPT 1997	HIV POS	HIV POS	PROFILES PERM	PROFILES PERM	PROFILES TEMP	PROFILES TEMP
		Male	Female	Male	Female	Male	Female		Male	Female	Male	Female	Male	Female
D-10		0	0	0	0	0	0		0	0	0	0	0	0
D-9		0	0	0	0	0	0		0	0	1	0	0	0
D-8		0	0	0	0	0	0		0	0	1	0	0	0
D-7		0	0	2	0	2	0		0	0	0	0	0	0
D-6		0	0	43	10	23	4		0	0	29	11	21	13
D-5		4	0	72	18	34	13		3	0	40	26	38	33
D-4		11	1	55	17	42	22		8	1	40	19	30	34
D-3		8	0	42	24	49	28		5	0	23	21	44	57
D-2		0	0	10	6	17	13		0	0	10	3	15	16
D-1		0	0	5	2	7	3		0	0	8	1	11	20
Total		23	1	229	77	174	83		16	1	152	81	159	173
CW5		0	0	4	0	4	0		0	0	8	0	2	0
CW4		0	0	22	2	7	0		1	0	19	3	3	0
CW3		0	0	22	4	8	1		1	0	19	2	13	3
CW2		2	0	12	2	11	0		1	0	13	6	16	1
CW1		0	0	1	0	5	2		1	0	0	0	2	0
Total		2	0	61	8	35	3		4	0	59	11	36	4
E-9		3	0	39	2	14	0		3	0	38	3	15	2
E-8		7	1	145	20	81	21		7	1	81	18	42	13
E-7		40	4	414	78	200	72		35	5	317	57	167	44
E-6		61	3	469	114	297	81		61	3	434	68	208	94
E-5		83	8	562	115	338	122		68	6	503	134	262	118
E-4		51	8	637	195	515	241		36	8	718	218	398	209
E-3		7	0	192	58	206	86		6	1	164	62	142	82
E-2		0	1	52	17	72	29		0	0	73	27	69	42
E-1		1	0	20	4	34	13		0	0	31	3	48	11
S-total		25	25	2530	603	1757	665		216	24	2359	590	1351	615
Total		27	26	2820	688	1966	751		236	25	2570	682	1546	792
All		304	3508	2717		261	3252	2338						

Source: Major Steven Grimes, Sent to Major Harold W. Reeves, Jr., Department of Army Statistics on the Personnel on the Medical Profile status for the Army, Deputy Chief of Staff for Personnel (DCSPER), (703)697-2403, Received on 16 December 1997.

APPENDIX E

ARMY MEDICAL EVALUATION SYSTEM DIAGRAM



Source: Major Steven Grimes, Sent to Major Harold W. Reeves, Jr., Department of Army Statistics on Personnel on the Medical Profile status for the Army, Deputy Chief of Staff for Personnel (DCSPER), (703)697-2403, Received on 16 December 1997.

BIBLIOGRAPHY

Books

- Allen, George R. *The Graduate Students' Guide to Theses and Dissertations—A Practical Manual for Writing and Research*. Washington: Jossey-Pass Publishers, 1974.
- Davis, Lois M., Susan D. Hosek, Michael G. Tate, Mark Perry, Gerard Hepler, and Paul S. Steinberg. *Army Medical Support for Peace Operations and Humanitarian Assistance*. Santa Monica, CA: Rand, 1996.
- Rosenberg, Morris. *The Logic Of Survey Analysis*. New York: Basic Books, Inc., Publishers, 1968.
- Rowntree, Derek. *Statistics Without Tears: A Primer for Non-Mathematicians*. New York: Charles Scribner's Sons, 1981.
- Stanley, Jay and John D. Blair. *Challenges in Military Health Care: Perspectives on Health Status and the Provision of Care*. New Brunswick, NJ: Transaction Publishers, 1993.
- Turabian, Kate L. *A Manual for Writers of Term Papers, Theses, and Dissertations*. Chicago: The University of Chicago Press, 1996.

Periodicals and Articles

- "A hollow military? Readiness suffers from cuts, mismanagement." *San Diego Union-Tribune*, 9 September 1997, B6.
- Adde, Nick. "Challenging a separation: Easier said than done." *Army Times*, 15 July 1996, 18.
- Brennan, Terrance, P. "Putting Politics Before Military Readiness." *Marine Corps Gazette* 78, no. 12 (December 1994): 52-53.
- Burrelli, David F. "HIV-1/AIDS and US Military Manpower Policy." *Armed Forces & Society* 18, no. 4 (Summer 1992): 452-475.
- Compart, Andrew. "Restrictions other than HIV may be ignored." *Air Force Times*, 28 March 1994, 10.
- "Defense Chief Affirms two-war Strategy." *The Kansas City Star*, 16 December 1992, A20.

- Evans, David. "Truth and Consequences on Gays." *Chicago Tribune*, 11 December 1992, 21.
- Graham, Bradley. "US Military Feels Strain Of Buildup: Gaps Are Showing In Other Theaters." *The Washington Post*, 5 February 1998, A6-A9.
- "High OPTEMPO has Corrosive effect." *Army Times*, 17 November 1997, 35.
- Hillen, John. "Unarmed Forces: In the Tank." *National Review*, 9 February 1998, 36-40.
- Hudson, Neff. "Deployments bring dilemma--What about those who can't go?" *Air Force Times*, 11 December 1995, 20.
- Komarow, Steven. "For Military, Bosnia has Become a Blessing: Mission comes with perks and a purpose," *USA Today*, 22 December 1997. Excerpt reprinted in *The Early Bird*. 22 December 1997, 3.
- Maze, Rick. "Another Large Drawdown Inevitable, Says Expert." *Army Times*, 24 November 1997, 10.
- Maze, Rick. "Divisions are showing – Some Republicans oppose proposed separation policy for HIV-positive in military." *Air Force Times*, 8 January 1996, 8.
- Maze, Rick. "If you can't deploy . . . Discharge is not mandatory, House says." *Air Force Times*, 27 June 1994, 10.
- Mackenzie, Ross. "On Recent Developments Affecting Warrior Community." *Richmond Times Dispatch*, 24 August 1997, FF.
- Naylor, Sean D. "NTC Training Called into question: Officials Deny E-mail Charges of Lowered Standards, Lying to Units." *Army Times*, 2 February 1998, 10.
- Nelson, Soraya S. "AIDS likely to cost military \$3 billion." *Air Force Times*, 19 March 1990, 10.
- Newman, Richard J. "Can Peacekeepers Make War: America's Warriors Have Many Jobs Today—Raising Fears That They are Less Prepared for Real Combat." *US News & World Report*, 19 January 1998, 38-44.
- Scarborough, Rowan. "Peacekeeping Puts Drag on Army's Mission." *Washington Times*, 23 December 1997. Excerpt reprinted in *The Early Bird*, 23 December 1997, 2-3.
- Schoby, Terri, E. "When the Bough Breaks: Pregnancy and the Marine Corps." *Marine Corps Gazette* 78, no. 12 (December, 1994): 53-54.

- Tice, Jim. "Apache Pilots Leaving in Drove: Reservists Sought to Reduce Number of Overseas Deployments." *Army Times*, 2 February 1998, 3-4.
- Weible, Jack. "Readiness Cracks Reflect Several Shortages." *Army Times*, 8 September 1998, 6.
- Weible, Jack. "Pentagon to Measure Deployment Tempo: Defense Officials Say it's Long Overdue for the Army and Air Force." *Army Times*, 19 January 1998, 4.
- Willis, G. E. "From the Top: The Army Hopes New Policies Will Help Ease the Strain of Deployment." *Army Times*, 15 July 1996, 12.
- Willis, G. E. "Nondeployables a workable issue for aviation regiment." *Army Times*, 8 July 1996, 1-4.
- Willis, G. E. "Profiles: Who gets them, what they mean." *Army Times*, 8 July 1996, 14.
- Willis, G. E. "Soldiers: Some troops cannot deploy. What does that do to the rest of the Army?" *Army Times*, 8 July 1996, 12-14.
- Willis, Grant. "Women less deployable than men during gulf war." *Air Force Times*, 10 Aug. 1992, 7.
- Wilson, George C. "Back-to-back deployments wrong." *Army Times*, 10 November 1997, 54.
- Wilson, George C. "Directives for 'Month at Home' set for January." *Army Times*, 22 December 1997. Excerpt reprinted in *The Early Bird*, 22 December 1997, 24.
- Wilson, George C. "Reimer: Guarantee Deployed Soldiers Time at Home Base." *Army Times*, 17 November 1997, 16.

Government Documents

- Defense Department. "Lieutenant General George Fischer, Major General Max Baratz, Major General William Navas, Brigadier General Greg Gile, and Kenneth Bacon--Army Mobilization in Bosnia (Transcript)." Special Briefing. Washington, DC: Federal Information Systems Corporation, 18 December 1995.
- "Getting To The Desert: Deployment and Selective Callup Lessons, Desert Shield," *Newsletter*. No. 90-11. Ft. Leavenworth, KS: Center for Army Lessons Learned, 1990, 3.
- Government Accounting Office, *DOD Reserve Components: Issues Pertaining to Readiness*. Washington, DC: Government Printing Office, 21 March 1996.

Government Accounting Office. *Military Readiness: A Clear Policy Is Needed to Guide Management of Frequently Deployed Units*. Washington, DC: Government Printing Office, April 1996.

_____. *Military Readiness: Current Indicators to Be Expanded for a More Comprehensive Assessment*. Statement of Neal P. Cutrin. Washington, DC: Government Printing Office, 1994

_____. *Military Readiness: Data and Trends for January 1990 to March 1995*. Washington, DC: Government Printing Office, March 1996.

_____. *Military Readiness: DOD Needs to Develop a More Comprehensive Measurement System*. Washington, DC: Government Printing Office, October 1994.

_____. *OPERATION DESERT STORM: Race and Gender Comparison of Deployed Forces with All Active Duty Forces*. Washington, DC: Government Printing Office, June 1992.

_____. *OPERATION DESERT STORM: War Highlights Need to Address Problem of Nondeployable Personnel*. Washington, DC: Government Printing Office, August 1992.

_____. *Peace Operations: Heavy Use of Key Capabilities may Affect Response to Regional Conflicts*. Washington, DC: Government Printing Office, March 1995.

_____. *Reserve Forces: DOD Policies Do Not Ensure That Personnel Meet Medical and Physical Fitness Standards*. Washington, DC: Government Printing Office, March 1994.

Resource Planning and Force Management. Fort Leavenworth, KS: US Army Command and General Staff College, January 1998.

U.S. Congress. House. Committee on Government Reform and Oversight Subcommittee on Human Resource and Intergovernmental Relations. *Prepared Testimony of Dr. Garth L. Nicholson and Dr. Nancy L. Nicholson*. Washington, DC: Federal Information Systems Corporation, 26 June 1997.

_____. *Military Personnel Subcommittee Hearing. General Wallace Arnold – Prepared Remarks (Transcript)*. Washington, DC: Federal Information Systems Corporation, DC, 4 April 1995.

_____. Military Personnel Subcommittee Hearing. *Vice Admiral Frank Bowman – Prepared Remarks (Transcript)*. Washington, DC: Federal Information Systems Corporation, 14 March 1995.

U.S. Congress. Senate. Armed Services. Personnel Subcommittee Hearing. *Lieutenant General Billy Boles, Deputy Chief of Staff, USAF–Prepared Remarks (Transcript)*. Washington, DC: Federal Information Systems Corporation, 16 March 1995.

_____. Armed Services. Readiness Subcommittee Hearing. *Q&A: General Thomas Braaten, Admiral James Amernault, and General Roger Thompson – 98 Budget (Transcript)*. Washington, DC: Federal Information Systems Corporation, 19 March 1997.

_____. Armed Services Committee Hearing. *Q&A: William Cohen, Secretary of Defense and John Shalikashvili--Quadrennial Defense Review (Transcript)*. Washington, DC: Federal Information Systems Corporation, 20 May 1997.

Department of Army. AR 40-501, *Standards of Medical Fitness*. Washington, DC.: Department of the Army, 1995.

_____. AR 600-60, *Physical Performance Evaluation System*. Washington, DC: Department of the Army. 1985.

_____. AR 601-100, *Personnel Procurement, Appointment of Commissioned and Warrant Officers in the Regular Army*. Washington, DC: Department of the Army. 15 August 1981.

_____. AR 601-210, *Regular Army and Army Reserve Enlistment Program*. Washington, DC: Department of the Army. 28 February 1995.

_____. AR 635-40, *Physical Evaluation for Retention, Retirement, or Separation*. Washington, DC: Department of the Army, 1990.

_____. FM 63-3, *Corps Support Command*, Washington DC: Department of the Army, 30 September 1993, 2-24

Department of Defense. DoDD 1332.18, *Separation or Retirement for Physical Disability*. Washington, DC: Department of Defense, 4 November 1996, ASD(FMP).

_____. DoDD 6485.1, *Human Immunodeficiency Virus-1 (HIV-1)*. Washington, DC: Department of Defense, 19 March 1991, ASD(HA).

Unpublished Materials

Grimes, Steve Major. Deputy Chief of Staff for Personnel (DCSPER), Department of Army Statistics on the Personnel on the Medical Profile status for the Army, Received by the author on 16 December 1997 and 3 March 1998, (703)697-2403.

Knotts, Lester W. "Infantrypersons." SAMS Monograph. Command and General Staff College, Ft. Leavenworth, KS, 1996.

Martin, Bryan L. "Preinduction Standards for Soldiers with a History of Asthma." MMAS Thesis. Command and General Staff College, Ft. Leavenworth, KS, 1994.

Meigs, Montgomery. Lieutenant General. "Command and General Staff College (CGSC) Briefing." Presented by to the CGSC Students on 17 December 1997.

Miller, Kurt F. "Deny Flight and Deliberate Force: An Effective Use of Airpower?" MMAS Thesis. Command and General Staff College, Ft. Leavenworth, KS, 1997.

Portman Terrance, Lieutenant Colonel. "Congressional Staffer Report on Army CTCs," Reprinted from email 4 February 1998.

Received information from the Army Physical Disability Agency on 3 March 1998, 8120 Woodmont Ave., Bethesda, MD 20814-2743, COMM (301)295-1042/1038.

Reports, Proceedings, Studies, and Surveys

Flatter, John R. "First-Term Attrition Due to Pregnancy in the Marine Corps—Issues, Trends, and Options." Monterey, CA: Naval Postgraduate School, March 1996.

Gildersleeve, Allen M., Lieutenant Colonel. "Mountains or Molehills--Permanent Physical Profiles in the Army Reserve." Medford, MA: Fletcher School of Law and Diplomacy, 6 May 1997.

Greenburg, I. "Programming and Accounting for Nondeployable Selected Reserve Personnel." Bethesda, MD: Logistics Management Institute, March 1994.

Manning, Michelle. "Operational Readiness is the Issue: Unnecessary Friction the Detractor." Newport: RI Naval War College, May 1991.

Newman, G. E. "AIDS-Its Impact on the Armed Forces." Washington, DC: Industrial College of the Armed Forces, April 1989.

- Outlaw, LeRoy B., Edmund F. Muendel, and David A. Smith. "Policy for DoD Management of Permanent Medical Nondeployable Personnel." Logistics Management Institute. McLean, VA, March 1997.
- "Report of the Defense Science Board Task Force on Quality of Life." Office of the Under Secretary of Defense for Acquisition and Technology, Washington, DC, October 1995.
- Schmitt, H.H., Dr. Mary Clutter, Dr. Christopher C. Greer, LTG (USA Ret.) Marion C. Ross, Dr. Judith P. Swazey, Dr. Stanley C. White. "Ad Hoc Subgroup on Threat of AIDS on Operational Deployment of Army Forces to a Theater." Army Science Board, Washington, DC, August 1990.
- "Women in Combat Task Force Study Report—Coordinating Draft Report." Combined Arms Combat Development Activity, Ft. Leavenworth, KS, June 1986.

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