Agency Report

DEPARTMENT OF THE ARMY
OFFICE OF THE ASSISTANT SECRETARY
MANPOWER AND RESERVE AFFAIRS
111 ARMY PENTAGON
WASHINGTON, DC 20310-0111

APR 03 2008

The Honorable Scott J. Bloch
The Special Counsel
U.S. Office of Special Counsel
1730 M Street, N.W., Suite 300
Washington, D.C. 20036-4505

RE: Whistleblower Investigation – Guthrie Clinic, Fort Drum, New York (OSC File Number DI-07-1676)

Dear Mr. Bloch:

In accordance with Title 5, United States Code (USC), Sections 1213(c) and (d), the enclosed report is submitted in response to your referral of information requesting an investigation of allegations and a report of findings in the above referenced case.

As the Agency head, the Secretary of the Army (SA) has delegated to me his authority to review, sign, and submit to you the report required by Title 5, USC, Sections 1213(b), (c) and (d) [redacted].

Note that this report and its exhibits contain the names and duty titles of employees of the Fort Drum Medical Department Activity (FD MEDDAC),[1] as well as other Department of the Army Soldiers and civilian employees. Subsequent release of this information may result in violations of the Privacy Act,[2] and breaches of personal privacy interests. Accordingly, those releases required by Title 5, USC, Section 1213(e) excepted, the Department of the Army requests the opportunity to coordinate in advance on any release of this report outside the Office of Special Counsel (OSC).

---

[1] The Fort Drum Medical Department Activity (FD MEDDAC) is located at Fort Drum, New York. Within the Army, a MEDDAC is "an organization encompassing a [United States Army Community Hospital (USACH)] or designated US Army Health Clinic and the associated activities which are responsible for providing health services to authorized persons within an assigned Health Service Area (HSA)." *See* Army Regulation (AR) 40-4, *Army Medical Department Facilities Activities*, paragraph 10 [redacted].

[2] The Privacy Act of 1974 is codified at Title 5, USC, Section 552a.

INFORMATION INITIATING THE INVESTIGATION

By letter dated May 17, 2007, the OSC referred to the SA its conclusion that there was a substantial likelihood that Mr. Richard C. Blunden, a pharmacist at the Guthrie Ambulatory Health Care Clinic, Fort Drum, New York,[3] violated a law, rule or regulation when he ordered laboratory tests of his own blood [redacted].

According to the OSC correspondence, an anonymous whistleblower provided information demonstrating the following:

(1) From approximately January 1997 until May 2006, Mr. Blunden used agency resources to have his blood drawn and improperly ordered approximately fifty laboratory tests of his own blood, despite both a lack of authorization and a lack of eligibility for these services.

(2) Mr. Blunden's blood tests either were processed in-house at the FD MEDDAC, or sent to an outside laboratory for analysis at additional agency expense.

(3) Mr. Blunden is employed by the Federal Government as a pharmacist in the grade of General Schedule 11 (GS-11); he is not a health care provider (HCP) or a clinical pharmacist within the meaning of Army Regulation (AR) 40-3, *Medical, Dental, and Veterinary Care.* As such, he was not authorized to order laboratory analysis of his or any other person's blood.

(4) Mr. Blunden used Army resources, both to obtain his blood samples for analysis and for the analyses themselves.

(5) Mr. Blunden was not eligible to avail himself of medical services or blood tests at the Guthrie Ambulatory Health Care Clinic because he was not an active duty serviceman and he was not enrolled in the Defense Enrollment Eligibility Reporting System (DEERS).

(6) Mr. Blunden has been unable to access the computer system at the Fort Drum Clinic, and thus has been unable to initiate orders for laboratory tests, since 2006 when the Army introduced a new healthcare tracking system called the Armed Forces Health Longitudinal Technology Application (AHLTA). However, the former, but still operational, healthcare computer system still contains relevant records of Mr. Blunden's laboratory results.

CONDUCT OF THE INVESTIGATION

By statute, an agency is afforded sixty days to complete the report required by Title 5, USC, Section 1213. On May 24, 2007, the Office of the Army General Counsel (OGC) forwarded the OSC request for investigation to the Office of the Staff Judge Advocate (OSJA), the United States Army Medical Command (MEDCOM) for action [redacted]. This referral was appropriate because The Surgeon General of the Army, who is dual-hatted as the Commanding

---

[3] The Guthrie Ambulatory Health Care Clinic is one of the three clinics that comprise the FD MEDDAC. *See* http://www.drum.amedd.army.mil/default.htm.

General, MEDCOM, has "overall responsibility for the development, policy direction, organization, and management of an Army-wide health services system."[4] MEDCOM, in turn, forwarded the allegations to the Commander of the FD MEDDAC to initiate an investigation.

On June 4, 2007, [redacted], who then was the Commander of the FD MEDDAC, appointed [redacted] as an Investigating Officer (IO) under the provisions of Army Regulation (AR) 15-6, *Procedures for Investigating Officers and Boards of Officers,* with a mandate to conduct an informal investigation into allegations of misconduct by Mr. Blunden.[5] More specifically, [redacted] appointed [redacted] to investigate allegations that Mr. Blunden improperly used Army resources to order approximately 50 laboratory tests on his own blood while he was working as a pharmacist at the Guthrie Ambulatory Health Care Clinic from on or about January 1997 to May 2006, and that Mr. Blunden's actions violated AR 40-3 because Mr. Blunden was not authorized or eligible to receive such services [Tab 8-3].

In the course of his investigation, [redacted] gathered documentary evidence, to include a list of the laboratory tests Mr. Blunden ordered on his own blood [redacted]; a list of the laboratory test results posted for Mr. Blunden in the Composite Health Care System (CHCS) [redacted];[6] a report showing the laboratory and medication orders Mr. Blunden entered into the CHCS I [redacted];[7] Mr. Blunden's medication profiles [redacted];[8] and a laboratory sign-in log for August 5, 2005, showing that Mr. Blunden signed in as a patient at the Guthrie Ambulatory Health Care Clinic that day [redacted].[9] In addition, [redacted] interviewed several key witnesses, to include: Mr. Blunden; the Chief of Laboratory Services for the Guthrie Ambulatory Health Care Clinic, [redacted]; and five laboratory technicians, [redacted] [Tabs 8-H to 8-L and 8-P to 8-Q].

---

[4] *See* AR 40-1, *Composition, Mission, And Functions of the Army Medical Department*, paragraph 1-6 [Tab 21].

[5] On June 25, 2007, the new Commander of the FD MEDDAC, [redacted], directed [redacted] to continue his investigation [Tab 8-6].

[6] The Composite Health Care System (CHCS) provides automated medical information support to Military Treatment Facilities (MTFs) worldwide. CHCS I was the original database, and ALTHA (or CHCS II) is the "next generation" system [Tab 51].

[7] [redacted] requested this report to look for laboratory and medication orders that Mr. Blunden entered into CHCS I.

[8] [redacted] requested two medication profiles for Mr. Blunden—a short medication profile that provided a brief overview of the medications that had been ordered for Mr. Blunden [redacted], and a long medication profile that provided additional details, to include the patient's name, the name of the medication, the name of the HCP who placed the order, the prescribed dosage, the date the medication order was filled, the expiration date of the prescription, and directions for dispensing the medication [redacted].

[9] [redacted] reviewed the laboratory sign-in rosters for the period January 1, 2005, to December 31, 2006, because the FD MEDDAC only maintains sign-in rosters for approximately two years. No other rosters relevant to the period under investigation were available for review.

On June 20, 2007, [redacted] completed his findings and recommendations, and submitted his draft Report of Investigation (ROI) to the Fort Drum OSJA for legal review in accordance with [redacted] instructions [Tab 8-4]. [redacted] found that: (1) Mr. Blunden violated AR 40-3 by ordering laboratory tests; (2) Mr. Blunden violated AR 40-3 by accessing laboratory services for the purpose of having laboratory tests drawn; (3) Mr. Blunden violated AR 40-3 by entering medication orders for himself in CHCS I; (4) Mr. Blunden violated AR 40-3 by filling prescriptions for his personal use; (5) two medication orders that were filled were cancelled in CHCS I; and (6) Mr. Blunden had five laboratory tests ordered through the Occupational Health Program. As a result, [redacted] recommended: (1) forwarding the case to Mr. Blunden's first-line supervisor for action; and (2) creating a laboratory Standard Operating Procedure (SOP) for identifying persons eligible for care "that goes beyond asking for the patient's identification card and checking for active orders in CHCS I."

On June 21, 2007, [redacted], who is an Attorney-Advisor in the OSJA at Fort Drum, completed a legal review of the draft ROI and determined that it was "legally sufficient" [redacted]. Subsequently, the report was forwarded to the OGC for review.

On July 16, 2007, the OGC requested the OSC to grant an extension to afford the OGC sufficient time to review MEDCOM's draft ROI and address several outstanding issues [Tab 3]. On July 18, 2007, the OSC granted the request for extension until September 17, 2007. On September 11, 2007, the OGC requested the OSC to grant a second extension to permit the MEDCOM sufficient time to investigate further the issues raised by the OSC, as well as collateral issues raised by the preliminary investigation and identified by the OGC during its review of the draft ROI [Tab 4]. On September 12, 2007, the OSC granted the request for extension until November 19, 2007.

After coordination between the MEDCOM OSJA and the OGC in August and September 2007, [redacted] was asked to answer additional questions and clarify certain portions of his initial investigation. As a result, [redacted] conducted additional interviews with [redacted]; [redacted], who had ordered several laboratory tests on Mr. Blunden in his capacity as a HCP at the Guthrie Ambulatory Health Care Clinic; and [redacted], who is the Chief of Pharmacy Services at the Guthrie Ambulatory Health Care Clinic and Mr. Blunden's immediate supervisor [Tabs 8-W to 8-Y].

Based on additional evidence gathered during these interviews, [redacted] revised his initial findings and recommendations in a memorandum dated September 28, 2007 [Tab 8-7]. Specifically, [redacted] found that: (1) Mr. Blunden violated AR 40-3 by ordering laboratory tests; (2) Mr. Blunden violated AR 40-3 and AR 40-400 by accessing laboratory services for the purpose of having laboratory tests performed that were not covered under the Occupational Health Program; (3) Mr. Blunden had five tests ordered through the Occupational Health Program; (4) Mr. Blunden had nine laboratory tests ordered by HCPs who are no longer FD MEDDAC employees;[10] (5) Mr. Blunden ordered twenty-five laboratory tests on his own blood;

[10] The individuals who are no longer MEDDAC employees are [redacted], [redacted], [redacted], and [redacted] [Tab 8-7, paragraph 5f].

(6) the FD MEDDAC is not contemplating any adverse privileging actions against Mr. Blunden;[11] and (7) Mr. Blunden did not order any medications for himself, and the FD MEDDAC pharmacy did not fill any prescriptions for Mr. Blunden.[12] Based on his revised findings, [redacted] added two new recommendations. [redacted] recommended that "Mr. Blunden reimburse the Federal Government for services he was not eligible to receive," and that "MEDCOM review the CHCS I and CHCS II Security Matrix to determine if staff pharmacists need to have laboratory ordering capability." The Commander of the FD MEDDAC approved [redacted] revised findings and recommendations in early November 2007 [redacted].[13]

On November 14, 2007, the OGC requested the OSC to grant a third extension to permit the OGC sufficient time to review MEDCOM's supplemental investigation, address any other outstanding issues, and prepare the final Army report [redacted]. On November 20, 2007, the OSC granted the request for extension until January 22, 2008. On January 18, 2008, the OGC requested the OSC to grant a fourth extension to permit the OGC sufficient time to reconcile apparent inconsistencies between the final MEDCOM ROI, the evidence generated during the investigation, and matters raised by Mr. Blunden in his response to the proposed removal action pending against him [redacted]. On January 22, 2008, in response to a request from the OSC, the OGC provided supplemental information to support its request for the fourth extension [redacted]. On January 24, 2008, the OSC granted the request for an extension until March 24, 2008. On March 21, 2008, the OGC requested the OSC to grant a fifth extension to permit the OGC to incorporate the final decision on the proposed removal action that had been pending against Mr. Blunden into the final report and finish staffing the report [redacted].

---

[11] Adverse action may be taken against a privileged provider (adverse privileging action) or a non-privileged health care professional (adverse practice action) "when there is reasonable cause to doubt an individual's competence to practice or for any other cause affecting the safety of patients or others." In this context, "reasonable cause" includes significant unprofessional, unethical, or criminal (serious misdemeanor or felony) conduct. The adverse action process in each case involves an investigation, a professional peer review, a hearing, and an appeal; may result in holding in abeyance, denying, suspending, restricting, reducing, or revoking the individual's clinical privileges or scope of practice; and may result in a report being filed with the National Practitioner Data Bank (NPDB) or the Health Integrity and Protection Data Bank (HIPDB), State licensing boards, and other regulatory agencies. *See* AR 40-68, *Quality Assurance Administration*, Chapter 10 and Appendix I [redacted]. An adverse privileging/practice action may result in the individual's removal from Federal service and, if reported to outside professional regulating authorities, may have an adverse impact on the individual's license and/or ability to practice elsewhere in the United States.

[12] Based on his additional investigation, [redacted] revised his conclusion that Mr. Blunden filled prescriptions for his personal use and deduced that the medication orders that had been entered into the CHCS I database showing Mr. Blunden as the patient were most likely entered as part of a training exercise [redacted].

[13] The exact date the Commander of the FD MEDDAC approved the revised ROI is unknown. [redacted], who is an Attorney-Advisor in the Fort Drum OSJA, indicated that the Commander of the FD MEDDAC approved the revised findings and recommendations shortly before he conducted his final legal review of the investigation, which is dated November 8, 2007 [redacted].

SUMMARY OF EVIDENCE OBTAINED FROM THE INVESTIGATION

The evidence regarding the allegations that Mr. Blunden misused Army resources over a period of nine years in violation of Army regulations is summarized below.

SECTION I.

OSC Allegation 1. From approximately January 1997 until May 2006, Mr. Blunden used agency resources to have his blood drawn and improperly ordered approximately fifty laboratory tests of his own blood, despite both a lack of authorization and a lack of eligibility for these services.

OSC Allegation 3. Mr. Blunden is employed by the Federal Government as a pharmacist in the grade of GS-11; he is not a health care provider (HCP) or a clinical pharmacist within the meaning of AR 40-3, *Medical, Dental, and Veterinary Care.* As such, he was not authorized to order laboratory analysis of his or any other person's blood.

OSC Allegation 4. Mr. Blunden used Army resources, both to obtain his blood samples for analysis and for the analyses themselves.

OSC Allegation 5. Mr. Blunden is not eligible to avail himself of medical services or blood tests at the Guthrie Ambulatory Health Care Clinic because he was not an active duty serviceman and not enrolled in the Defense Enrollment Eligibility Reporting System (DEERS).

1. Relevant Authorities:

a. Authorities Related to Mr. Blunden's Authority to Order Laboratory Tests:

(1) Army Regulation (AR) 40-3, *Medical, Dental, and Veterinary Care,* April 3, 2006,[14] at Tab 8-B, establishes policies, procedures and responsibilities pertaining to selected Army Medical Department (AMEDD) programs and initiatives, to include pharmacy and laboratory management. AR 40-3, Chapter 14, describes how the U.S. Army implements the Clinical Laboratory Improvement Program (CLIP) and contains the following relevant provisions:

(a) AR 40-3, paragraph 14-9a, specifies the categories of personnel who are authorized to order laboratory tests. In addition to uniformed and civilian physicians, dentists, veterinarians, optometrists, and podiatrists who are engaged in professional practice at uniformed services Medical Treatment Facilities (MTFs), other uniformed and civilian providers with privileges at the MTF are authorized to order laboratory tests, including, but not limited to

[14] AR 40-3 was promulgated on July 30, 1999 [Tab 22], and was revised on November 12, 2002 [Tab 23] and April 3, 2006 [Tab 8-B].

certified nurse midwives, nurse practitioners (NPs), physician assistants (PAs), chiropractors, dieticians, clinical pharmacists, and psychologists.[15]

(b) AR 40-3, paragraph 14-10b, states that "[o]nly qualified personnel will perform laboratory tests within the Medical Treatment Facility (MTF)," and the results of all laboratory tests performed in the MTF "will be entered into CHCS and in the appropriate patient record."

(2) AR 40-48, *Nonphysician Health Care Providers*, November 7, 2000, at Tab 28, established policies concerning privileges, duties, expanded roles, and supervision of nonphysician HCPs.[16] AR 40-48, Chapter 6, governed **clinical pharmacists**, who were required to be granted clinical privileges in a pharmaceutical care practice field (PCPF) by the MTF commander based upon the credentials committee's recommendation and a biennial review,[17] and contained the following relevant provisions:

(a) AR 40-48, paragraph 6-1c, stated that: "Each **clinical pharmacist** will develop a practice protocol consistent with his or her experience and the needs of the clinical area being supported. The protocol will be signed by the appropriate medical service or department chief and the chief of the pharmacy service, recommended by the credentials committee, and approved

---

[15] Both the 1999 and the 2002 versions of AR 40-3, which are included at Tabs 22 and 23, contained the following guidance:

> **14–9. Individuals authorized to order laboratory tests**
>
> * * * * *
>
> b. The following personnel are authorized to order medical laboratory tests only for selected procedures as established under the provisions of AR 40-48 and/or approved by the local commander:
>
> (1) Uniformed and civilian nurses, PAs, NPs, PTs, OTs, psychologists, and pharmacists engaged in professional practice at uniformed services MTFs and **privileged to order medical laboratory tests**.
>
> * * * * *
>
> (3) Other non-physician health care providers not listed above, but assigned to a uniformed service MTF **and granted limited medical laboratory test ordering privileges by the local commander**.

In accordance with this provision, **clinical pharmacists** could order medical laboratory tests; however, **staff pharmacists** could only order medical laboratory tests if they were granted authority to do so by the local MTF commander. Mr. Blunden has not alleged—and there is no evidence to support the conclusion—that the Commander of the FD MEDDAC ever gave him the authority to order laboratory tests for himself or any other individual.

[16] AR 40-68 superseded AR 40-48 on February 26, 2004 Tab 35. An earlier version of the AR 40-48, dated August 1, 1995 Tab 27, contained provisions that were the same or similar to those discussed in paragraphs 1a(2), above.

[17] Pharmacists who wished to be privileged in a pharmaceutical care practice field (PCPF) were required to complete one of the two educational and experiential combinations described in AR 40-48, paragraph 6-1a Tab 28.

by the MTF commander. Individual clinical privileges will be consistent with the general scope for that PCPF."

(b) AR 40-48, paragraph 6-2, indicated that pharmacists granted clinical privileges could be used only in those recognized PCPFs for which they had been educationally and experientially prepared; were required to participate in peer review and patient care audits established by the specialty care service or the department they supported; and were required to be monitored by the pharmacy service's own locally developed quality improvement review mechanisms.

(c) AR 40-48, paragraph 6-2g, indicated that **clinical pharmacist**s were allowed to order tests and laboratory studies appropriate for the medications they had been approved to initiate, adjust, or renew. In addition, **clinical pharmacist**s who were recognized by the local credentials committee as providers of a pharmacokinetic consultation service could be privileged to initiate orders for sample collection according to a drug kinetic study. These same individuals could write consultation notes on recommended dosage adjustment following receipt of laboratory values.

(3) AR 40-68, *Clinical Quality Management*, February 26, 2004, at [redacted], establishes policies, procedures, and responsibilities for the administration of the AMEDD Clinical Quality Management Program (CQMP).[18] AR 40-68, paragraph 7-8, provides general information and specific professional requirements related to **clinical pharmacists**, and contains the following relevant provisions:

(a) AR 40-68, paragraph 7-8a, describes **clinical pharmacists** as "licensed pharmacists with complex clinical skills and capabilities acquired through advanced education and practical experience . . . [who] practice collaboratively in the area of pharmacoeconomics and with patients requiring therapy (for example, anticoagulant, asthma, hypertension, diabetes, hyperlipidemia, immunization, and oncology nuclear) . . . [and] function[] under clinical treatment protocols or [clinical practice guidelines (CPGs)] developed in coordination with the medical staff, recommended by the [pharmacy and therapeutics (P&T)] committee, and approved by the [executive committee of the medial staff (ECMS)], or DOD/USAMEDCOM-developed and approved CPGs."

(b) AR 40-68, paragraph 7-8c, states that **clinical pharmacists** "may be granted clinical privileges to provide clinical treatment protocol/CPG-based direct patient care." These privileges may include ordering and assessing laboratory tests necessary to evaluate drug therapy

---

[18] AR 40-68 was promulgated on December 20, 1989 [redacted], and was revised on February 26, 2004 [redacted]. The 1989 version of the regulation did not specifically address clinical pharmacists, but it did note that clinical pharmacists could be given individual clinical privileges. In addition, paragraphs 4-1c, f and h of the 1989 version of the regulation specifically stated that "[o]ther HCPs who function under a standard job description protocol, or policies and procedures will not be privileged;" "[i]n no instance may a person be assigned or privileged to perform professional duties unless qualified by education, training, and experience to perform them;" and "[c]linical privileges may be ignored only in the case of an emergency" [redacted]. The 2004 version of the regulation superseded AR 40-48 [redacted].

effects and therapeutic outcomes, as well as conducting and coordinating clinical investigations and research approved by a local or regional investigational review board and participating in outcome studies generated by the department of pharmacy and approved by the P&T committee.

b. Authorities Related to the Department of Defense (DoD) Occupational Health Program:

(1) Department of Defense (DoD) Manual 6055.5-M, *Occupational Medical Surveillance Manual*, May 4, 1998,[19] at Tab 20, contained the following relevant provisions:

(a) DoD 6055.5-M, paragraph C1.4.2., indicated that occupational medical examinations are conducted to determine whether an individual is capable of performing a specific job from a medical standpoint; whether performing the job will place an individual at risk of significant health harm; or whether allowing an individual to perform the job will place someone else at risk or pose an unacceptable risk to public health.

(b) DoD 6055.5-M, paragraph C3.2.3.2.1, indicated that healthcare workers (HCWs) may be exposed to a number of occupational hazards, to include hazardous drugs, chemical hazards, and blood-borne pathogens [redacted].

(c) DoD 6055.5-M, paragraph C3.2.3.2.6.8.5, indicated that a complete blood count with differential white blood cell count, liver function tests, blood urea nitrogen, creatinine, and urinalysis is recommended for HCWs with potential exposure to hazardous drugs.

(2) AR 40-5, *Preventive Medicine*, October 15, 1990,[20] at Tab 25, explained the Army Preventive Medicine Program and identified Army occupational safety and health standards applicable over the period from 1990 until 2005. AR 40-5, Chapter 5, prescribed the Occupational Health Program and services for military and civilian personnel.

(a) AR 40-5, paragraph 5-2, stated that the objectives of the Occupational Health Program were to: "[a]ssure that all eligible personnel (military and civilian) are physically, mentally, and psychologically suited to their work at the time of their assignment, and that physical and mental health are monitored to detect early deviations from the optimum;" "[p]rotect employees against adverse effects of health and safety hazards in the work environment;" "[a]ssure proper medical care and rehabilitation of the occupationally ill and injured;" "[r]educe economic loss caused by physical deficiency, sickness, and injury of civilian

---

[19] DoD 6055.5-M was revised on May 2, 2007, and is now designated as DoD 6055.05-M, *Occupational Medical Examinations and Surveillance Manual* Tab 8-11.

[20] AR 40-5 was revised on July 22, 2005 Tab 26. The 2005 version of the regulation does not include a chapter that specifically addresses the Occupational Health Program. Instead, the regulation merely states that: "The Army Occupational Health Program's medical components will be developed and provided consistent with the Defense Safety and Occupational Health Program and implemented according to the detailed instructions and guidance published in DA Pam 40–11, chapter 5."

employees;" and "[p]revent decreased combat readiness caused by occupational illness and injury of military personnel."[21]

(b) AR 40-5, paragraph 5-3a, stated that the Occupational Health Program "encompasses special preventive measures for both military and civilian personnel who are exposed or potentially exposed to toxic materials, infectious agents, or other hazardous influences of the work environment."

(c) AR 40-5, paragraph 5-3e, stated that the Occupational Health Program included the following minimum elements: (i) an inventory of chemical, biological, and physical hazards in the work environment of all installation activities; (ii) job-related medical surveillance; (iii) administrative medical examinations; (iv) employee education about job-related health hazards; (v) treatment of occupational illness and injury and emergency treatment of non-occupational illness and injury; (vi) hearing conservation; (vii) occupational vision; (viii) pregnancy surveillance; (ix) job-related immunizations; (x) illness absence monitoring; (xi) **chronic disease surveillance**; (xii) epidemiologic investigation of occupational illness and injury; (xiii) maintenance of occupational health (OH) medical and administrative records and reports; and (xiv) industrial hygiene surveys and safety and health inspections.

(d) AR 40-5, paragraph 5-3f, indicated that additional services could be provided when adequate resources were available, including, but not limited to, group counseling on specific problems or habits affecting health; **disease screening**; and voluntary periodic health examinations on an age-related basis.[22]

(e) AR 40-5, Chapter 5, Section III, identified "the clinical and preventive medicine services authorized for military personnel and civilian employees within the Occupational Health Program."

(i) AR 40-5, paragraph 5-9a, stated that "[p]replacement, job transfer, periodic, and termination examinations will be provided to all...civilian employees potentially exposed to health hazards in the work environment."

(ii) AR 40-5, paragraph 5-9e, stated that **health maintenance examinations were encouraged**, although not required, for civilian employees "subject to availability of health resources." These examinations could include **single or multiple disease screening** or more detailed medical evaluations, and could be offered on an age-related basis or to specific target groups.[23]

---

[21] A similar provision now appears in Department of the Army Pamphlet (DA Pam) 40-11, *Preventive Medicine*, July 22, 2005, paragraph 5-1d [redacted].

[22] DA Pam 40-11, paragraph 5-23f, now specifically states that: "At the discretion of the MTF commander, a variety of occupational health-related, clinical and nonclinical health promotion and wellness services may be provided to civilian employees at Government cost. These services may include **cholesterol testing**; hypertension screening; and tobacco use cessation services such as clinical visits, group counseling, information, and medications" [redacted].

[23] This provision now appears in DA Pam 40-11, paragraph 5-2c(9) [redacted].

(iii) AR 40-5, paragraph 5-10a(1), stated that: "Diagnosis and treatment of injury or illness sustained in performance of official duties is authorized by AR 40-3 and under the Office of Workers' Compensation Program (FPM chap 810). Employees who request examination and treatment will be provided it at no cost at any Army MTF, other Federal MTF, or by a physician or hospital of his or her choice. If an Army dispensary, clinic, hospital, emergency room, or local facility under contract with the Army is available at the activity, locally prescribed procedures will require that the injured employee be initially referred to that MTF."[24]

(iv) AR 40-5, paragraph 5-10a(2), stated that "[d]efinitive diagnosis and treatment of non-occupational illness and injury cases are not responsibilities of the Occupational Health Program;" however, first aid or palliative treatment could be given "if the condition was one for which the employee would not reasonably be expected to seek attention from a personal physician, or to reduce absenteeism by enabling the employee to complete the current work shift before consulting a personal physician." In addition, **minor treatments or services**, such as administering allergy treatments, monitoring blood pressure and providing physiotherapy, could be furnished "at the discretion of the responsible physician if resources are available . . . [and a request is] submitted in writing by the employee's personal physician."[25]

(3) AR 40-400, *Patient Administration*, October 13, 2006,[26] at Tab 8-R, provides guidance on patient administration in Army MTFs, and contains the following relevant provisions:

(a) AR 40-400, paragraph 2-2a, states that: "All persons . . . must show satisfactory evidence of their beneficiary status."

(b) AR 40-400, paragraph 2-2c, states that: "MTF personnel will not provide routine care to patients with questionable eligibility."

(c) AR 40-400, Chapter 3, specifies the categories of persons who are eligible for care in Army MTFs, to include members of the uniformed services on active duty, retired members of the uniformed services, and family members of the uniformed services.

(i) AR 40-400, Chapter 3, Section V, describes the types of medical care for which Federal civilian employees are eligible.

---

[24] Mr. Blunden has not alleged that he contracted [redacted] as a result of his employment at the FD MEDDAC. If he did, however, he clearly would have been entitled to treatment for the disease at the FD MEDDAC at no cost to him.

[25] Similar provisions now appear in DA Pam 40-11, paragraphs 5-23 and 5-27 Tab 38.

[26] AR 40-400 was revised on October 1, 1983 Tab 36, March 12, 2001 Tab 37, and October 13, 2006 Tab 8-R. The 1983 version of the regulation did not address patient eligibility; however, the 2001 version of regulation contained provisions that were the same or similar to those discussed in paragraph 1b(3), above.

(ii) In accordance with paragraphs 3-14 and 3-15, Federal civilian employees are eligible for emergency medical care for on-the-job injuries or illnesses; limited disability physicals; **occupational health services authorized by AR 40-5**; and treatment for alcoholism.

(4) FD MEDDAC Regulation 40-1, *Reporting of Communicable Diseases*, January 30, 2006,[27] at [redacted], prescribes "the mechanism for reporting communicable diseases and other conditions of public health and command significance," [redacted].

(a) Paragraph 5b indicates that patients with reportable conditions are identified so that: (1) epidemiological information...may be obtained and exchanged with federal and state public health authorities;" and (2) "epidemiological investigations are conducted in order to identify and follow-up with contacts to ensure community and intra-family spread of certain communicable diseases is curtailed through the use of treatment, immunization and health education . . .."

(b) Paragraph 6d requires all HCPs who are responsible for diagnosing and treating patients to report "required reportable conditions" and "assist in the identification and prophylaxis/treatment of disease contacts . . .."

(c) Appendix B indicates that [redacted] is reportable to the FD MEDDAC Community Health Nursing Service, which is responsible for reporting the disease to the New York State Department of Health and the US Army Center for Health Promotion and Preventive Medicine.

(5) FD MEDDAC Regulation 40-4, *MEDDAC and DENTAC Employee Health Program*, February 28, 2006,[28] at [redacted], establishes "procedures and responsibilities for the timely and prompt management of an employee health program for health care personnel at Fort Drum, New York," and contains the following relevant provisions:

(a) Paragraph 5 states that: "The goal of the MEDDAC/DENTAC Employee Health Program is to foster the health, safety, productivity and wellness of MEDDAC/DENTAC workers, their families and the community, and protection of the environment" through "[i]dentification, evaluation, prevention, and management of occupational, environmental, and personal health risks;" "[p]romotion of the maximum recovery and reintegration of the individual into a fully productive life by the prompt management and treatment of illness and injury;" [a]ssurance of quality care, conservation of resource and reduction of unnecessary costs by efficient management of health care;" "[c]reation of healthy work cultures and promotion of health lifestyles;" "[e]xpansion and application of the knowledge of toxicology, communicable

---

[27] FD MEDDAC Regulation 40-1 was revised on March 29, 1988 [redacted], November 28, 2000 [redacted], February 5, 2004 [redacted], and January 30, 2006 [redacted]. The 1988, 2000 and 2004 versions of the regulation contain the same provisions discussed in paragraphs 1b(4), above.

[28] FD MEDDAC Regulation 40-4 was revised on May 20, 1999 [redacted], April 7, 2000 [redacted], March 1, 2004 [redacted], and February 28, 2006 [redacted]. The relevant provisions of the 1999, 2000 and 2004 versions of the regulation are the same, except as noted below.

diseases, epidemiology, ergonomics, biostatistics, and related disciplines of occupational and environmental medicine;" "[p]romotion of continuous quality improvement by use of outcome assessments, practice guidelines, integrated health data systems, and other methods; "[p]rovision of expert counsel to employees, families, labor organizations and the community;" and "[d]evelopment and implementation of a pattern of environmental responsibility."

(b) Paragraph 6c requires the Chief, Occupational Health (OH), to perform several tasks, to include "[coordinating] with . . . [various] personnel when a health evaluation indicates that an employee does not meet the medical fitness requirements or that an employee's continued performance in a specific job will be hazardous to his/her health or the health of others;" "[evaluating and monitoring] the health of employees returning to work following an injury or illness;" "[providing] medical evaluation of military and civilian personnel who have a possible infectious disease or infectious disease exposure;" "[providing] follow-up and continuation of treatment or prophylaxis for military and civilian personnel who are injured or become ill on the job;"[29] "[determining] final work restrictions for the injury, illness, or exposure;" "[evaluating] military and civilian personnel working in patient care areas to determine suitability to return to duty after an illness;" "[investigating] cases of work-related communicable disease exposure in coordination with the Infection Control (IC) Officer and [ensuring] prophylaxis or treatment as appropriate to employees and other contacts;" and "[providing] reports of infectious disease occurrence and investigations to the Facility Epidemiologist and the Infection Control Committee."[30]

(d) Paragraph 6i requires the Chief, Urgent Care Clinic (UCC), to "[p]rovide initial medical evaluation of military and civilian personnel who have a possible infectious disease or infectious disease exposure" and "[p]rovide initial treatment or prophylaxis as appropriate."[31]

(e) Paragraph 6k requires the Infection Control Officer to "[m]onitor infectious disease occurrences among patients and personnel and perform epidemiological investigations of infectious disease outbreaks in coordination with the Preventive Medicine Service."

(f) Appendix C, paragraph 2c, requires supervisors to refer all personnel with possible exposure to a communicable disease to the UCC for initial diagnostic evaluation and treatment. The UCC then refers these personnel to the Occupational Health Clinic for follow-up and a final determination regarding work restrictions, if any.

---

[29] Civilians who are not authorized military medical care are referred to civilian health care resources if the necessary treatment requires more than the initial plus one follow-up visit.

[30] The 2004 version of the regulation also required the Chief, OH, to develop and oversee a tobacco cessation program [Tab 45].

[31] The 1999 and 2000 versions of the regulation also required the Chief, UCC, to perform certain tasks in the absence of an available OH medical officer, to include determining initial work restrictions for infectious disease exposure and determining an employee's suitability to return to work after an illness [Tabs 43 and 44].

(g) Appendix D provides guidance on the FD MEDDAC's infection control program, some of the objectives of which are "[m]onitoring and investigating infectious diseases, potentially harmful infectious exposures, and outbreaks of infection among personnel;" "[p]roviding care to personnel for work-related illnesses or exposures;" and "[i]dentifying infection risks related to employment and instituting appropriate preventive measures."

(h) Table 2 provides guidelines for work restrictions due to infectious disease. [redacted][32]

(6) FD MEDDAC Circular 40-1, *Plan for the Provision of Patient Care Services*, May 15, 2006,[33] at [redacted], provides an overview of the FD MEDDAC's "policies and procedures concerning the provision of health care services to its patient population" and contains the following relevant provisions:

(a) Appendices R and S describe, respectively, the scope of services and scope of practice of the Fort Drum Occupational Health Clinic. Appendix R states that the Fort Drum Occupational Health Clinic provides direct and indirect programs that benefit Fort Drum's employees and are directed toward "prevention of occupation illness and/or injury, health maintenance and prevention/monitoring of occupation hazards." The programs provided include medical examinations, reproductive hazard surveillance, hearing and vision conservation, ergonomics, medical work-site visits, illness/absence monitoring, respiratory protection, employee modified duty, patient education, immunizations, and employee in/out processing. Appendix S indicates that Physicians and Physician Assistants may perform physical examinations, to include periodic health or medical surveillance and fitness for duty investigations.

(b) Appendices T and U describe, respectively, the scope of services and scope of practice of the Department of Pathology Laboratory.[34] Appendix T indicates that the Guthrie Ambulatory Health Care Clinic performs testing "on blood and body fluids for the purpose of aiding healthcare providers in the diagnosis, treatment, assessment or prevention of disease and impairments" for "[a]ctive duty military, retired military and dependent family members of both." Appendix T also indicates that the Guthrie Ambulatory Health Care Clinic utilizes Quest Diagnostics, which is a DoD-contracted laboratory, to perform tests it cannot do itself. Appendix U provides the list of lab tests authorized for in-house testing.

---

[32] The 2000 version of the regulation does not contain this table [Tab 40].

[33] FD MEDDAC Circular 40-1 was revised on March 23, 2001 [Tab 46], February 14, 2004 [Tab 47], and May 15, 2006 [Tab 48]. The relevant provisions of the 2001 and 2004 versions of the regulation are the same, except as noted below.

[34] The 2001 version of the regulation did not have appendices for the scope of services and scope of practice of the Department of Pathology Laboratory [Tab 46].

2. Discussion:

a. AR 40-3, paragraph 14-9a, specifies the categories of personnel who are authorized to order laboratory tests in Army MTFs [redacted]. Mr. Blunden is a **staff pharmacist** [redacted]. He is not a clinical pharmacist. Therefore, he is not authorized to order laboratory tests for himself or any other patient.[35]

b. AR 40-400, Chapter 3, specifies the categories of the persons who are eligible for care in Army MTFs [redacted]. As a civilian employee, Mr. Blunden was eligible only for emergency medical care for on-the-job injuries or illnesses and occupational health services authorized by DoD 6055.5-M, and AR 40-5.[36]

c. On June 4, 2007, in the context of his investigation of the OSC-referred allegations, [redacted] queried the CHCS I database and requested two reports covering the period January 1, 1997, to June 4, 2007. The first report shows that Mr. Blunden ordered twenty-five laboratory tests on his own blood between April 7, 1997, and February 24, 2003[37] [redacted]; however, the second report shows that one of the tests was cancelled because it was a duplicate test [redacted].[38] The second report also shows that thirty-seven[39] separate laboratory **test results** for 50 individual **tests** were posted for Mr. Blunden between January 8, 1997, and September 22, 2004, not including the test that was cancelled [redacted]. Some of these

---

[35] In accordance with both the 1999 and the 2002 versions of AR 40-3, **clinical pharmacists** could order medical laboratory tests; however, **staff pharmacists** could order medical laboratory tests only if they were granted authority to do so by the local MTF commander. Mr. Blunden has not alleged—and there is no evidence to support the conclusion—that the Commander of the FD MEDDAC ever gave him the authority to order laboratory tests for himself or any other individual. *See* FN 15, above.

[36] Mr. Blunden admitted in his statement that he was not an active member of Army Reserves or the Army National Guard; he was not a retired member of uniformed services; and he was not a dependent spouse of an active or retired member of the uniformed services [redacted].

[37] Mr. Blunden ordered the following tests on his own blood: [redacted]

[38] The [redacted] test Mr. Blunden ordered on [redacted], was cancelled because it was a duplicative test [redacted]

[39] [redacted] indicated in his report that there were thirty-eight separate laboratory test results; however, a review of the document at [redacted] indicates that there were only thirty-seven.

results were the outcome of laboratory tests Mr. Blunden ordered on his own blood.[40] The remaining results were the outcome of laboratory tests that other HCPs had ordered for Mr. Blunden.[41]

d. Other evidence that supports the conclusion that Mr. Blunden ordered laboratory tests without authority and accessed laboratory services to which he was not entitled include:

(1) The CHCS I report that [redacted] requested, which confirms that Mr. Blunden ordered twenty-five laboratory tests on his own blood [redacted].

(2) Mr. Blunden's statement, in which he admitted having laboratory tests performed in addition to those he allegedly ordered to test the protocols he had developed for the Lipid Clinic and the test [redacted] ordered as part of the Occupational Health Program to determine whether he had [redacted] [Tab 8-Q].

(3) Mr. Blunden's September 20, 2007, response to the original removal action,[42] in which he admitted that he "did in fact enter orders for laboratory tests into CHCS where [he] was both the patient and the ordering provider," and that "a total of 9 of the lab tests [that he ordered for himself] . . . were in violation of AR 40-400" [Tab 10].

(4) Mr. Blunden's verbal admission during his September 27, 2007, meeting with the Deputy Chief of Clinical Services (DCCS) for the FD MEDDAC that he did not have the authority to order laboratory tests on his own blood, and that he had no explanation for nine of the laboratory tests he had ordered on his own blood [Tab 11].

---

[40] The number of laboratory results differs from the number of individual tests because several tests are often combined into a single report. For example, the laboratory report for [redacted], shows the results of two separate tests—[redacted]—in a single report [redacted]

[41] In addition to the results of the twenty-five laboratory tests that Mr. Blunden ordered on his own blood, the laboratory results reflect the following twenty-five laboratory tests: [redacted]

[42] Mr. Blunden's removal was proposed initially on August 31, 2007, and amended on November 30, 2007 [Tabs 9and 12]. Within this report, the August 31, 2007, proposed removal will be referred to as the "original removal action," and the November 30, 2007, proposed removal will be referred to as the "amended removal action."

(5) Mr. Blunden's December 24, 2007, response to the amended removal action, in which he admitted that he "made a mistake when [he] continued to have 9 lab tests done beyond the [Lipid Clinic] startup at a MTF in which [he] was not authorized to receive care," and that his actions were a violation of AR 40-400 [Tab 13].

(6) Mr. Blunden's verbal admission during his December 27, 2007, meeting with the Commander of the FD MEDDAC that some of the laboratory tests he ordered on his own blood were not associated with the Lipid Clinic [Tab 14].

e. Mr. Blunden has produced no evidence to show that he was authorized to order laboratory tests on his own blood.

(1) Mr. Blunden asserted in his September 20, 2007, response to the original removal action that he was authorized to enter laboratory orders for himself based on the protocols being developed for a Lipid Clinic.[43] More specifically, Mr. Blunden asserted that he "had the authority to enter labs based on the protocol we were developing for the Lipid Clinic;" that the lab manager, [redacted],[44] "suggested that [he] should have the test done and the results would post back to [him] as they would for the provider;" and that [redacted] told him "don't worry about it, the tests only cost about a dollar" when he "voiced a concern about the cost of the test and [the fact] that [he] was not an eligible beneficiary" [Tab 10].

(2) Mr. Blunden submitted several documents to support his assertions.[45] However, these documents support only the conclusion that he was a member of a Process Action Team

---

[43] Of the twenty-five laboratory tests Mr. Blunden ordered on his own blood, seven included the notation [redacted]" two included the notation [redacted]" and five were [redacted] Of the remaining ten tests that were actually performed, [redacted]

[44] [redacted] is no longer employed at the FD MEDDAC [Tab 8-7, paragraph 5f]. Therefore, [redacted] could not interview her as part of his investigation.

[45] Mr. Blunden submitted: (1) his DA Form 7222-1, Senior System Civilian Evaluation Report Support Form, for the period November 1, 1996, to October 31, 1997, in which he stated that he served on the Lipid Process Action Team (PAT) and that he drew up the original protocol for the Lipid Clinic [Tab 10, Attachment 9]; (2) his DA Form 7222, Senior System Civilian Evaluation Report, for the period November 1, 1997, to October 31, 1998, in which his rater stated that he "[c]ontinued to sit on Carepath Teams for Lipids and Diabetes" [Tab 10, Attachment 10]; (3) a DD Form 1556, Request, Authorization, Agreement, Certificate of Training and Reimbursement, which indicated that he took a 2-day course, entitled "The Management of Lipid Disorders for Teams," at the Northeast Regional Lipid Training Center in Rochester, New York, in November 1997 for the purpose of "reviewing [the] scientific basis for Lipid management and treatment strategies;" "receiv[ing] materials and protocols to establish [a] Lipid Clinic;" "observ[ing] a Lipid Clinic in operation;" and "discuss[ing] issues in implementing a Lipid Clinic" [Tab 10, Attachment 11]; (4) a DD Form 1556, Request, Authorization, Agreement, Certificate of Training and Reimbursement, which indicated that he took a 3-day course, entitled "Lipid Clinic Preceptorship," at the Veterans Administration Medical Center in Buffalo, New York, in December 1997 for the purpose of "develop[ing]... protocols at [Fort] Drum on Lipid management" and "establish[ing] . . . [a] Lipid Clinic" [Tab 10, Attachment 12]; and (5) an individual development plan that he and his supervisor signed on April 6, 2001, which listed "Get Lipid Clinic Underway" as a short range performance and career goal and "Study of disease states and lab monitoring" as a needed self-development action [Tab 10, Attachment 13].

(PAT) that was exploring the possibility of establishing a Lipid Clinic at the FD MEDDAC, and that he may have drafted the original protocols for such a clinic.[46] These documents do not support the conclusion that Mr. Blunden actually had the authority to order laboratory tests on his own blood.[47]

(a) Ms. Marek had no authority to authorize Mr. Blunden to order laboratory tests on his own blood.[48]

(b) Mr. Blunden has produced no evidence that the Commander of the FD MEDDAC authorized him to order laboratory tests in accordance with AR 40-3, paragraph 14-9b(3),[49] for himself or anyone else.

(c) Mr. Blunden admitted in his September 27, 2007, meeting with the DCCS for the FD MEDDAC that he did not have the authority to order laboratory tests on his own blood [Tab 11].

f. Similarly, Mr. Blunden has produced no evidence to show that he was authorized to access laboratory services other than those for which he qualified under the Occupational Health Program.

---

[46] [redacted] did not have the evidence Mr. Blunden submitted with his September 20, 2007, response to the original removal action when he submitted his revised findings and recommendations, and he was not able to confirm that a Lipid Clinic had ever been established at the FD MEDDAC [Tab 8-7, paragraph 5f]. After reviewing the evidence that Mr. Blunden submitted, however, it is clear that the FD MEDDAC was exploring the possibility of establishing a Lipid Clinic [Tab 10, Attachments 9-13].

[47] Mr. Blunden failed to produce the protocols that he allegedly drafted for the Lipid Clinic; he failed to produce any evidence that he was granted clinical privileges as a member of the PAT that would have allowed him to order laboratory tests for himself or anyone else; and he failed to produce any evidence that [redacted] actually authorized him to order laboratory tests on his own blood (or that [redacted] had the authority to do so). In addition, Mr. Blunden failed to produce any evidence that the Commander of the FD MEDDAC gave him limited laboratory test ordering privileges in accordance with the version of AR 40-3 that was in effect during the relevant periods of time. *See* FN 15, above.

[48] [redacted] is no longer employed at the FD MEDDAC [Tab 8-7, paragraph 5f], and is not available to corroborate or refute Mr. Blunden's assertions. However, according to Mr. Blunden, [redacted] was a laboratory manager [Tab 20], and the security matrix for the CHCS II does not give laboratory personnel the authority to order laboratory tests [Tab 8-BB]. Accordingly, it is logical to conclude that [redacted] had no authority to authorize Mr. Blunden to order laboratory tests on his own blood.

[49] *See* FN 15, above.

(1) Of the twenty-five tests Mr. Blunden ordered on his own blood, some may have fallen within the broad parameters of the Occupational Health Program had they been ordered by a HCP with the authority to do so.[50] However, Mr. Blunden has not asserted that any of these tests were actually part of the Occupational Health Program.[51] Instead, Mr. Blunden has stated—without producing any definitive proof—that the tests he ordered on his own blood were either authorized as part of a planned Lipid Clinic, or were an "unwritten 'employee benefit'" [Tab 10, paragraphs 2c and 3b].

(2) Of the twenty-five laboratory tests that other HCPs had ordered for Mr. Blunden, four were clearly part of the Occupational Health Program;[52] one clearly fell within the parameters of the program;[53] and one was labeled as "Occupational Health."[54] Unfortunately, the purpose of and authority for the remaining tests is not entirely clear. Most, however, appear to have fallen within the broad parameters of the Occupational Health Program.[55] Therefore, we have no reason to believe that any of these tests were unauthorized.[56]

---

[50] To the extent that Mr. Blunden may have been [redacted], the following tests may have fallen within the broad parameters of the Occupational Health Program if they had been ordered by HCPs to monitor the disease and assess any risk Mr. Blunden posed to public health: [redacted]

[51] Mr. Blunden has not alleged that he contracted [redacted] as a result of his employment at the FD MEDDAC; however, [redacted] is a contagious disease and Mr. Blunden routinely had contact with patients [redacted] Therefore, it may have been appropriate to monitor the disease as part of the Occupational Health Program.

[52] The following tests were clearly part of the Occupational Health Program: [redacted]

[53] The [redacted] test [redacted] ordered on [redacted], clearly fell within the parameters of the Occupational Health Program [redacted]

[54] The [redacted] ordered on [redacted], was ordered for the Occupational Health Clinic [redacted] incorrectly labeled this test a "[redacted]" in his findings of fact [Tab 8-7, paragraph 5e].

[55] Again, to the extent that Mr. Blunden may have been exposed to or infected by [redacted], many of the tests that HCPs ordered for him may have fallen within the broad parameters of the Occupational Health Program. Moreover, the Army regulations that have governed the Occupational Health Program since 1990 clearly give the MTF Commander broad authority to provide civilian employees "a variety of occupational health-related, clinical and nonclinical health promotion and wellness services," to include cholesterol and other disease screening. *See* paragraphs 1b(2)(d) and 1b(2)(e)(ii) and FN 22, above.

[56] This conclusion is contrary to the conclusion [redacted] reached; however, there is nothing in [redacted] report to indicate that he reviewed AR 40-5 or DA Pam 40-11 as part of his investigation. As a result, it appears that he erroneously concluded that only five of the laboratory tests that HCPs ordered for Mr. Blunden were authorized under the Occupational Health Program [Tab 8-7, paragraph 5e].

(a) The Chief of Laboratory Services at the FD MEDDAC, [redacted], indicated in her statement that either the Preventive Medicine Clinic or the Occupational Health Clinic had conducted cholesterol screenings "10 plus years ago,"[57] and that employees were sometimes asked to provide blood donations when the laboratory had to perform correlation studies, establish normal reference ranges, or participate in other quality control or quality assurance exercises [redacted].

(b) [redacted] who ordered thirteen laboratory tests for Mr. Blunden, indicated in his statement that he had only seen Mr. Blunden as a patient through the Occupational Health Program; that he sometimes ordered laboratory tests for the Occupational Health Program when he was working in the Family Practice Clinic because the Occupational Health Program did not always have an assigned provider; and that he believed he had "wide latitude to 'care' for [employees]" under the Occupational Health Program[58] [redacted].

3. Conclusions:

a. The allegation that Mr. Blunden used agency resources to have his blood drawn and improperly ordered approximately fifty laboratory tests of his own blood is substantiated in part. From April 8, 1997, to February 23, 2003, Mr. Blunden ordered twenty-five laboratory tests on his own blood, despite a lack of authorization and a lack of eligibility for the laboratory services he accessed. However, most of the remaining twenty-five tests ordered for Mr. Blunden by other HCPs appear to have fallen within the broad parameters of the Occupational Health Program and were, therefore, legitimate tests.

b. The allegation that Mr. Blunden is not authorized to order laboratory analysis of his or any other individual's blood is substantiated. Mr. Blunden is a staff pharmacist. He is not a health care provider or a clinical pharmacist within the meaning of Army Regulation 40-3, *Medical, Dental, and Veterinary Care*, and he was never authorized to order laboratory tests. Therefore, Mr. Blunden is not authorized to order laboratory tests for himself or any other patient.

c. The allegation that Mr. Blunden used Army resources, both to obtain his blood samples for analysis and for the analyses themselves, is substantiated. Mr. Blunden had a total of fifty individual laboratory tests performed. Army resources were used to obtain and analyze Mr. Blunden's blood for each test.

d. The allegation that Mr. Blunden is not eligible to avail himself of medical services or blood tests at the Guthrie Ambulatory Health Care Clinic is substantiated in part. Mr. Blunden is not an active duty service member; he is not an active member of the Army Reserves or the Army National Guard; he is not a retired member of uniformed services; and he is not a dependent

---

[57] The [redacted] that various HCPs ordered for Mr. Blunden would have qualified as [redacted]

[58] The version of AR 40-5 that was in effect when [redacted] ordered most of the laboratory tests on Mr. Blunden supports [redacted] assertion that he had "wide latitude" to care for Mr. Blunden since the regulation provided for disease screening and health maintenance examinations for civilian employees, subject to the availability of resources. *See* paragraphs 1b(2)(d) and 1b(2)(e)(ii) and FN22, above.

spouse of an active or retired member of the uniformed services. Mr. Blunden is, however, a Federal civilian employee. Therefore, Mr. Blunden is eligible for occupational health services authorized by DoD 6055.5-M, AR 40-5 and DA Pam 40-11.[59]

4. Corrective Actions:

a. Action was initiated to remove Mr. Blunden from his position as a Pharmacist at the FD MEDDAC and from Federal Service for violating an administrative regulation and making a false statement during an official investigation [Tabs 9 and 12].[60] However, the Commander of the FD MEDDAC only found Mr. Blunden guilty of violating an administrative regulation. Therefore, the Commander of the FD MEDDAC chose not to remove Mr. Blunden.[61] Instead, the Commander of the FD MEDDAC chose to suspend Mr. Blunden from duty without pay for twenty-eight days, effective March 24, 2008 [Tab 15].[62]

b. The DCCS for the FD MEDDAC is addressing the patient identification issue in the laboratory to ensure that only authorized persons receive laboratory services in the future.

5. Collateral Issues Related to Allegation 1:

a. When [redacted] queried the CHCS I database for the period January 1, 1997 to June 4, 2007, the report appeared to show that Mr. Blunden ordered two prescriptions for himself [redacted].[63] In addition, Mr. Blunden's medication profiles appeared to show that Mr. Blunden ordered and/or received four prescriptions for himself [redacted].[64] However,

---

[59] As noted above, the majority of the laboratory tests that other HCPs ordered for Mr. Blunden appear to have been a valid part of the Occupational Health Program.

[60] Mr. Blunden's removal was first proposed on August 31, 2007 [Tab 9]. Based on information Mr. Blunden provided as part of his reply to this proposed action, the original proposed removal action was amended on November 30, 2007 [Tab 12].

[61] The proposed removal action was predicated primarily upon the assertion that Mr. Blunden made a false statement to [redacted] during the course of his investigation. Therefore, when the Commander of the FD MEDDAC found Mr. Blunden not guilty of that charge, he concluded that removal was too severe a penalty to impose for the remaining offense of violating an administrative regulation [Tab 15].

[62] The Commander of the FD MEDDAC chose to exceed the 1-day suspension that the applicable Army regulation indicated was appropriate for violating an administrative regulation because he found that Mr. Blunden's conduct was more egregious in that he had violated Army regulations "repeatedly and intentionally over a long period of time and [he occupied] a position of great trust responsibility and trust" [Tab 15].

[63] The report appeared to show that Mr. Blunden ordered [redacted] however, both orders were listed as "cancelled" [redacted].

[64] The reports appeared to show that a "Military, Dr." placed two orders for [redacted] for Mr. Blunden [redacted]; that Mr. Blunden placed one order for [redacted] himself [redacted]; and that a "Military, Dr." placed one order for [redacted] for Mr. Blunden [redacted]

further investigation revealed that the medication orders were most likely entered into the CHCS I database as part of a training exercise [Tabs 8-Y and [redacted]].[65] Therefore, the evidence does not support the conclusion that Mr. Blunden ordered any prescriptions for himself.[66]

b. [redacted] indicated in her initial interview with [redacted] that "she had mentioned to the lab leadership that other MEDDAC employees who were not beneficiaries were having lab work performed in the MEDDAC lab," and that she was labeled as a "trouble maker" when she spoke up [Tab 8-I]. In a subsequent interview, [redacted] clarified that the Chief of Laboratory Services had simply advised her that non-beneficiaries should not be accessing laboratory services unless the tests were ordered under the Occupational Health Program. In addition, [redacted] clarified that non-beneficiaries, other than Mr. Blunden, had not been accessing laboratory services to which they were not entitled since 2005 [Tab 8-W]. Therefore, we have no reason to believe that non-beneficiaries are routinely accessing laboratory services to which they are not entitled at the FD MEDDAC. Further, no evidence was provided by anyone, to include [redacted], to show that she was reprised against, or that anyone specifically considered or referred to her as a "troublemaker." This was merely a label that she perceived without a factual basis.

c. Laboratory personnel assume that patients who have an identification card and a written or electronic laboratory order are eligible for laboratory services [Tabs 8-H to 8-L and 8-P]. They have no means of verifying eligibility, nor do they have any means of verifying the name of the HCP who ordered the test until the sample is analyzed and the results are ready to post.[67] As a

---

[65] [redacted] entered both of the orders on [redacted], as well as the order on [redacted]. The two orders entered on [redacted], were listed as "discontinued," and the order entered on [redacted], was listed as "expired." [redacted] entered the order on [redacted], and it was also listed as "discontinued" [Tabs 8-Y and [redacted]]. Both [redacted] and [redacted] are Pharmacy Technicians at the Guthrie Ambulatory Health Care Clinic.

[66] The Chief of Pharmacy Services, [redacted], indicated that the test orders should have been entered into the computer system using a test patient. However, the failure to do so on the three occasions involving Mr. Blunden does not appear to be a systemic problem that requires corrective action.

[67] [redacted] made the following findings of fact in his report:

> Currently lab personnel check the patient's identification card as a form of accurately identify [sic] the patient, if the patient is registered in CHCS I and CHCS II and there are lab orders in the computer, that is indicative that the person is eligible for our services as the patient has been screened earlier by clerks at the providers office. When lab orders are checked by lab personnel prior to drawing blood, the providers name is not visible. Lab personnel are able to see the clinic which submitted the order, but lab personnel are not able to see which provider ordered the lab work until the blood work is actually analyzed. After the blood is analyzed, the provider's name is available as the provider's name has to be entered with the lab results. The provider's name is entered into the CHCS so that the provider is aware of the lab results for his or her patient. Lab personnel could have potentially overlooked Mr. Blunden not be authorized [sic] for specific lab work as active orders existed in CHCS. Lab orders entered by Mr. Blunden would appear as any other orders entered by an authorized provider. Therefore, while Mr. Blunden may not have been authorized to have blood drawn for certain lab test; active orders existed in the computer system for lab personnel to execute. All lab personnel are aware that MEDDAC employees, who are not otherwise beneficiaries, are eligible to have lab tests performed through the Employee Occupational Health Program. As U. S. Army MEDDAC Fort Drum is a very busy outpatient

result, the laboratory personnel had no way of knowing that Mr. Blunden had ordered for himself laboratory tests for which he was not eligible. To remedy this problem, [redacted] has recommended that "the Laboratory Standard Operating Procedure for identifying persons eligible for care . . . include a verification process that goes beyond asking for the patient's identification care and checking for active orders in CHCS I and CHCS II" [Tab 8-7], and the Commander of the FD MEDDAC concurred [Tab 15].

SECTION II.

OSC Allegation 2. Mr. Blunden's blood tests were either processed in-house at the FD MEDDAC, or sent to an outside laboratory for analysis at additional Army expense.

1. Relevant Authorities: Appendix T of FD MEDDAC Circular 40-1 indicates that the Guthrie Ambulatory Health Care Clinic utilizes Quest Diagnostics to perform tests it cannot perform itself [Tab 48].

2. Discussion:

a. Of the twenty-four laboratory tests that Mr. Blunden ordered on his own blood and that were processed, twenty-one were processed at the FD MEDDAC; two were processed at Quest Diagnostics; and one was processed at Smith Kline [redacted]. The total cost of tests processed at the FD MEDDAC was $47.79, and the total cost of tests processed at outside laboratories was $23.13. Therefore, the total cost of the unauthorized laboratory tests was $70.92 [redacted].[68]

a. Of the twenty-five laboratory tests other HCPs ordered for Mr. Blunden, twenty-two were processed at the FD MEDDAC; two were processed at Walter Reed Army Medical Center (WRAMC); and one was processed at Quest Diagnostics [redacted]. The total cost of tests processed at the FD MEDDAC or the WRAMC was $36.53, and the total cost of tests processed at outside laboratories was $9.53. Therefore, the total cost of the legitimate laboratory tests was $46.06 [redacted].

---

clinic where 1,270 prescriptions, 170 X-rays, 610 lab specimens 970 clinic visit occur each day it would be extremely hard for the lab to verify the eligibility of every individual who presents to the lab. In addition it would be hard to track abuse within the current system as there are no rapid or uncomplicated auditing tools available on the present computer system. The lab does not have the capability to register patients in CHCS I and CHCS II or to verify eligibility. If patients present to the lab without an identification card, the patient is sent to the Patient Administration Division for a statement of eligibility.

[Tab 8-7, paragraph 5e].

[68] [redacted] is inconsistent with [redacted], and has been determined to be incorrect. The exhibit at [redacted] contains the correct cost data.

3. Conclusion: The allegation is substantiated. Most of Mr. Blunden's blood tests were processed using Army resources at the FD MEDDAC or WRAMC; however, three of Mr. Blunden's blood tests were processed at Quest Diagnostics and one was processed at Smith Kline. The total cost of the unauthorized laboratory tests was $70.92.

4. Corrective Action: [redacted] recommended that Mr. Blunden reimburse the Federal Government for the services he was not eligible to receive [Tab 8-7].[69]

SECTION III.

OSC Allegation 6: Mr. Blunden has been unable to access the computer system and thus cannot initiate orders for laboratory tests due to the introduction of the Army's new healthcare tracking system called the Armed Forces Health Longitudinal Technology Application (AHLTA) in 2006. However, the former, but still operational, computer healthcare system (CHCS) still contains relevant records of Mr. Blunden's laboratory results.

1. Relevant Authorities:

a. AR 40-66, *Medical Record Administration and Health Care Documentation*, June 21, 2006,[70] at [Tab 33], establishes policies and procedures "for the preparation, disposition, and use of Army electronic and paper medical records and other health care documentation . . .." AR 40-66, paragraph 1-1c, requires outpatient occupational health care provided to civilian employees be recorded in a civilian employee medical record (CEMR), and AR 40-66, Chapter 7, details the initiation, maintenance, and disposition of CEMRs.

b. Paragraph 1.2 of the Draft AHLTA 3.3 User's Manual, July 2007, states that: "An integral part of AHLTA security is the assignment of roles. Each user is assigned an AHLTA role. This role is determined by the user's job skill set. These roles are cumulative, allowing greater access to patient information as roles are added. Similar in concept to the Composite Heath Care System (CHCS) user level, an individual's role determines what information can be accessed or changed"[71] [Tab 50].

---

[69] No action has been taken to collect the $70.92 Mr. Blunden owes the Federal Government for the laboratory tests he ordered on his own blood because MEDCOM has not yet identified an effective way to compel Mr. Blunden to reimburse the Federal Government for the costs of the services he received [redacted]. However, MEDCOM intends to recommend to Mr. Blunden that he voluntarily write a personal check to the Miscellaneous Receipts Account of U.S. Treasury and submit that payment in satisfaction of this reimbursement concern.

[70] AR 40-66 was revised on May 3, 1999 [Tab 29], March 10, 2003 [Tab 30], July 20, 2004 [Tab 31], May 22, 2006 [Tab 32], and June 21, 2006 [Tab 33].

[71] The previous manual, dated July 27, 2005, was entitled "CHCS II Block 1 User's Manual Build 838" and contained the following similar provision: "An integral part of CHCS II security is the assignment of roles. Each user is assigned a CHCS II role. This role is determined by the user's job skill set. These roles are cumulative, allowing greater access to patient information as roles are added. Similar in concept to the CHCS user level, an individual's role determines what information can be accessed or changed" [Tab 49].

2. Discussion: [redacted] indicated in his report that Mr. Blunden was able to place laboratory orders, even though he was not authorized to do so, because the current CHCS I and CHCS II Security Matrices categorize pharmacists as providers[72] [Tab 8-7]. The individual who creates and assigns profiles in CHCS for the FD MEDDAC, [redacted], confirmed this fact, stating that: "CHCS does not delineate[] between a clinical pharmacist and [a] staff [p]harmacist. In CHCS[,] all pharmacist[s] have the provider class of pharmacist with a signature class of HCP. Also[,] all the pharmacist[s] have a secondary menu of order entry, which will allow[] them to submit any order type in[to] CHCS" [Tab 19]. The DCCS at the FD MEDDAC added that both "[c]linical and staff pharmacists have access to lab, x-ray and consult capability in CHCS as it currently exists. They are not credentialed to use this capability but can physically accomplish the task."

3. Conclusion: The assertion that the AHLTA system prevents Mr. Blunden from ordering laboratory tests on his own blood is not true. Mr. Blunden still has access to the electronic medical record and ordering system. However, there is no evidence to show that Mr. Blunden has ordered any laboratory tests on his own blood since February 24, 2003.

4. Corrective Action: [redacted] recommended that MEDCOM review the CHCS I and CHCS II Security Matrices to determine if staff pharmacists need to have laboratory ordering capability [Tab 8-7]. The recommended review is ongoing at this time.

CONCLUSION

Of the five allegations that Mr. Blunden misused Army resources, three are substantiated and two are substantiated in part.[73] As a staff pharmacist, Mr. Blunden is not authorized to order laboratory tests on his own blood. In addition, Mr. Blunden is not eligible for laboratory services outside the Occupational Health Program. Nevertheless, the evidence shows that Mr. Blunden ordered approximately twenty-five laboratory tests on his own blood between April 8, 1997, and February 24, 2003. In so doing, Mr. Blunden violated AR 40-3 because he was not authorized to order laboratory tests, and he violated AR 40-400 because he was not an eligible beneficiary for purposes of the tests he ordered on his own blood. However, most of the remaining twenty-five tests ordered for Mr. Blunden by other HCPs appear to have fallen within the broad parameters of the Occupational Health Program and were, therefore, legitimate tests. Since Mr. Blunden is a Federal civilian employee, Mr. Blunden is eligible for occupational health services authorized by

---

[72] [redacted] made the following findings of fact in his report: "Mr. Blunden was able to place orders even though he was not authorized to do so, as the current CHCS I and CHCS II Security Matrix for access to the electronic medical record and ordering system, allows the pharmacist to do so as pharmacist falls under the category of provider. As a provider, the pharmacist has the same access as a physician, physician assistant, or nurse practitioner. With access to all levels of the electronic record, to include laboratory and medication ordering function, a pharmacist has the capability to enter laboratory orders even when not authorized" [Tab 8-7, paragraph 5b].

[73] The remaining assertion dealt with Mr. Blunden's present ability to order laboratory tests on his own blood, and was shown to be untrue. Mr. Blunden still has the ability to order laboratory tests on is own blood; however, he has not done so since 2003.

DoD 6055.5-M, AR 40-5 and DA Pam 40-11. The cost of the unauthorized laboratory tests to the Federal Government was $70.92.

CORRECTIVE ACTION UNDERTAKEN

Mr. Blunden has been suspended from duty without pay for a period of twenty-eight days for violating AR 40-3 and 40-400. In addition, the DCCS at the FD MEDDAC is addressing [redacted] recommendation that "the Laboratory Standard Operating Procedure for identifying persons eligible for care . . . include a verification process that goes beyond asking for the patient's identification care and checking for active orders in CHCS I and CHCS II," and MEDCOM is reviewing the CHCS I and CHCS II Security Matrices to determine whether any changes are required to prevent abuse in the future. Finally, MEDCOM is continuing to explore ways to compel Mr. Blunden to reimburse the Federal Government for the cost of the tests he improperly ordered on his own blood if he fails to do so voluntarily.

CLOSING COMMENTS

Army Medical personnel must conduct themselves in a professional manner, with the highest degree of integrity in the performance of their duties, and refrain from using Army resources for their own benefit, unless authorized by law.

The Army takes its responsibility to address concerns brought to its attention by the OSC very seriously. The Army has addressed the issues raised by the instant allegations in a thorough and deliberate fashion. The allegations that Mr. Blunden improperly ordered laboratory tests on his own blood and improperly used Army resources to have his blood drawn and analyzed were substantiated. The substantiated allegations violated Army regulations and constituted an improper use of Army resources. Accordingly, Mr. Blunden was suspended from duty without pay for a period of twenty-eight days, effective March 24, 2008.

The investigation also revealed a need to reassess and revise the patient identification system being used at the FD MEDDAC to prevent personnel who are not authorized to access laboratory services from receiving such services, as well as a need to reassess the CHCS I and CHCS II Security Matrices to ensure that only individuals who are authorized to order laboratory tests are able to do so. These reassessments and appropriate policy revisions are ongoing. As the Assistant Secretary of the Army for Manpower and Reserve Affairs, I oversee health affairs policy for the Army and will ensure that the FD MEDDAC and MEDCOM follow through with all necessary corrective actions.

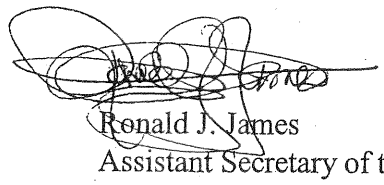
The investigation did not reveal a criminal violation.[74] Therefore, referral to the Attorney General pursuant to Title 5, USC, Sections 1213(c) and (d), is not being contemplated.[75]

---

[74] While an argument could be made that Mr. Blunden stole Government services, it is unclear that he did so knowingly. Mr. Blunden has presented evidence to show that he believed he was authorized to order most of the laboratory tests he ordered on his own blood as part of his work with the PAT for the Lipid Clinic, leaving only a small number of tests for which he has no legitimate explanation.

This letter, with enclosures, is submitted in satisfaction of my responsibilities under Title 5, USC, Sections 1213(c) and (d).

Sincerely,



Ronald J. James
Assistant Secretary of the Army
(Manpower & Reserve Affairs)

[75] Even if a case could be made that Mr. Blunden stole Government services, the value of the services he received is so low that it is extremely unlikely the Attorney General would pursue criminal charges against him.