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QUALITY ASSURANCE IN MILITARY HOSPITALS-

A PROPOSAL FOR REFORM

A Thesis

Presented to

The Judge Advocate General's School, United States Army

The opinions and conclusions expressed herein are those of the author and do not necessarily represent the views of either The Judge Advocate General's School, the United States Army, or any other governmental agency.

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United States Army

36th JUDGE ADVOCATE OFFICER GRADUATE COURSE

April 1988

QUALITY ASSURANCE IN MILITARY HOSPITALS-
A PROPOSAL FOR REFORM

by Captain David W. Engel

ABSTRACT: This thesis examines the statutory and regulatory structure of medical quality assurance in the Department of Defense. This structure raises fundamental questions about the effectiveness of current medical quality assurance efforts at both the Department of Army and Department of Defense levels. This thesis concludes that deficiencies in current quality assurance efforts may be remedied through promulgation of Department of Defense directives creating medical quality assurance and credentials review programs at the Department of Defense level.

**QUALITY ASSURANCE IN MILITARY HOSPITALS-
A PROPOSAL FOR REFORM**

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QUALITY ASSURANCE IN MILITARY HOSPITALS- A PROPOSAL FOR REFORM

I. INTRODUCTION

Debate about how to reduce medical malpractice and improve the quality of health care is an emotionally charged issue.¹ It strikes at the very heart of our values of equity and ethics and is not resolved merely by collecting data about the problem.²

The quality of health care is important for a number of reasons. First, all active duty Army lawyers and their dependents are potential beneficiaries of the military health care system.³ Thus, every military lawyer has a direct personal interest in seeing that military hospital health care is of the highest quality.

Second, medical quality assurance legal issues are not solely the esoteric concern of medical claims judge advocates, the U.S. Army Claims Service or Litigation Division, Office of The Judge Advocate General. Quality assurance and medical malpractice issues are items of command interest for staff judge advocates.⁴

Third, quality assurance issues are not concerned solely with medical malpractice claims and litigation. For example, utilization review, that aspect of quality assurance concerned with cost control, resource, personnel, and procurement management, is often of vital interest to contract law attorneys.⁵ Patient care assessment, that aspect of quality assurance concerned with measuring the quality of patient care results, is important to administrative law attorneys who may be forced to deal with issues of disclosure and privacy raised by the Freedom of Information Act (FOIA)⁶ or

Privacy Act,⁷ especially if the medical records used to assess care are disseminated outside the Department of Defense or are used to assist the Department of Justice in litigation involving the Army. Credentialing, the process a hospital uses to grant a health care provider the privilege of exercising his professional judgment in a health care setting, is important to labor counselors, administrative law attorneys, legal assistance officers,⁸ and even lawyers assigned to the Trial Defense Service. These lawyers may one day be called upon to advise either the commander or health care providers facing suspension or revocation of their privilege to practice medicine on administrative elimination or separation under applicable military⁹ or civilian personnel regulations.¹⁰

It is therefore critical that military lawyers be able to identify, address and resolve the many legal issues that exist in this multifaceted area. It is through the recognition and resolution of these legal issues that lawyers may better address the needs of the medical commands they are assigned to serve.

Not only must military lawyers be able to identify potential legal issues; they must also understand the operational and program structures in which those legal issues operate. To that end, I will provide an overview of the health care force structure, a framework analysis of quality assurance, and an explanation of how it works in military hospitals. I will then highlight the deficiencies in the existing system and present a proposal that the Department of Defense promulgate both a quality assurance and a health care provider credentials review program directive to cure these deficiencies.

II. OVERVIEW OF QUALITY ASSURANCE

A. GENERAL

The military medical operations budget for fiscal year 1986 was approximately \$9.6 billion, \$3.4 billion of which was earmarked for the Army.¹¹ The Department of Defense operates 561 clinics and 168 hospitals worldwide.¹² These facilities are staffed by over 170,000 health care providers including 13,000 physicians.¹³ On any given day, 23,500 beneficiaries of this system will be treated as inpatients¹⁴ in either a military facility or under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) system in a civilian hospital.¹⁵ During the course of the year, over ten million different people will receive medical care during some fifty-six million outpatient¹⁶ visits to military facilities.¹⁷

Because of its large size and high visibility, it is not surprising that the public debate on how to best regulate the provision of health care has focused on cost control¹⁸ and accountability.¹⁹ This focus, however, has overshadowed the more traditional concern of improving the quality of care.²⁰

It is the purpose of this thesis to discuss the efforts the Department of Defense has made in addressing those concerns for quality health care. Before doing so, some background into the historical basis of quality assurance would be helpful.

B. HISTORICAL BASIS OF QUALITY ASSURANCE

1. General

The civilian health care sector experienced a medical malpractice²¹ crisis beginning in the mid-1970s. This was a period in which the incidence of filed medical malpractice claims and money judgment and settlement awards increased dramatically.²² In fact, the U.S. Department of Justice estimates that the number of medical malpractice claims doubled between 1976 and 1981.²³

Since that time the problem has grown worse, not better.²⁴ There is no consensus on the solution to the problem, but all agree that malpractice should be reduced and the quality of care improved.²⁵

The exact number of malpractice claims filed across the nation is unknown because there is no central data yet available.²⁶ Some data, however, is available for comparison. Estimates indicate that 73,472 medical malpractice claims were closed in the civilian sector in 1984.²⁷ The armed forces, by comparison, closed an estimated 496 claims that same year.²⁸

More comprehensive data shows that 3,396 claims were filed against the Department of Defense in fiscal years 1982 through 1985.²⁹ The number of claims tapered off slightly in 1986 and 1987.³⁰ Despite the reduction in the number of filed malpractice claims, the total amount paid in court judgments and settlements has risen steadily from \$29 million in 1982 to \$67.6 million in 1987.³¹

This specter of medical malpractice first came to the forefront at the Department of Defense in 1982. In 1982, the CBS television program 60 Minutes aired a

documentary concerning medical malpractice by an Air Force surgeon.³² The adverse publicity generated by that telecast prompted a review of the quality of health care in military hospitals to determine the nature and the extent of the problem.³³

The problem areas discovered during this review centered on inadequate health care provider credentials review, inadequate supervision of nonphysician health care providers, and lack of standards to measure clinical outcomes.³⁴ Since 1982, the rising number of claims and the attention given to medical malpractice issues by Congress,³⁵ the medical profession,³⁶ and the popular press³⁷ has forced the Department of Defense to more closely examine the quality of care in hospitals under its control.

2. Department of Defense Quality Assurance Efforts

a. Organization and Staffing

Shortly after the reviews precipitated by the 60 Minutes telecast, the Assistant Secretary for Defense for Health Affairs created the Quality Assurance Office to make, implement, and enforce Department of Defense quality assurance policy.³⁸ The Quality Assurance Office, in turn, created a Tri-Service Committee on Quality Assurance to review, assess, and propose quality assurance policy.³⁹

This committee meets monthly.⁴⁰ Its purpose is to review, debate, and implement medical quality assurance policy at the Department of Defense level.⁴¹ It also serves to improve communications between the different military departments and the Department of Defense.⁴²

The committee's membership consists of the individuals listed below:

MEMBER	DUTY
Chief, Office of Professional Affairs and Quality Assurance Branch, Office of Ass't Sec'y of Defense (Health Affairs) or designee	Chairman
One senior policy analyst from each military department (Army, Navy, Air Force)	Member
One quality assurance director, from office of service surgeons general (Army, Navy, Air Force)*	Member
Coast Guard Representative	Member

*[Each military department's director of quality assurance has between two and four professional staff members led by a physician to focus on medical quality assurance issues].⁴³

b. Program Efforts

Since 1982, the Department of Defense efforts in quality assurance have developed into three major areas: 1) identifying substandard performers, 2) establishing professional norms, and 3) setting licensure requirements.⁴⁴

1. Identification of substandard performers

On July 29, 1982, then Deputy Assistant Secretary of Defense Frank Carlucci promulgated the first directive requiring collection of information on substandard physicians.⁴⁵ This directive imposed on each military service the responsibility for reviewing the credentials of any physician deemed for any reason to be "unfit for duty."⁴⁶ This was an initial effort designed solely for identifying substandard physicians; it did not address nonphysician health care providers. Its stated purpose was to identify substandard

physicians and not to establish a comprehensive quality assurance program: "This Directive establishes policy, provides guidance, and assigns responsibilities regarding dissemination of information concerning limitations imposed on DOD medical officers by official action."⁴⁷

A second directive was issued in 1984.⁴⁸ This second directive extended Department of Defense policy by spelling out in greater detail how the individual services were to develop mechanisms for identifying substandard health providers.⁴⁹ This directive expanded its scope to all health care providers, not just physicians. It also provided for the suspension of clinical privileges for acts of alleged improper, unethical, or unprofessional conduct.⁵⁰ Unfortunately, it did not define these specified acts of misconduct.

The most recent effort made to identify substandard performers is the National Data Bank. The National Data Bank is a national reporting system established by the Health Care Quality Improvement Act of 1986.⁵¹ The purpose of the act is to improve the quality of health care. It intends to do this by encouraging physicians to identify and discipline other physicians who are clinically incompetent or engage in unprofessional conduct.⁵²

The National Data Bank was created in response to what Congress saw as inadequate identification and discipline of substandard physicians by state licensing boards and professional societies.⁵³ Congress acted for two reasons. First, there was no central data bank to follow bad physicians from one jurisdiction to another. Second, organizations, especially hospitals, would often accept "voluntary" resignations of substandard physicians. In return, hospitals would maintain their silence as to the reasons for the "resig-

nation" to avoid lengthy and unpredictable litigation concerning the questioned physician's credentials and the adverse publicity that would come with it.

The statute creating the National Data Bank requires licensing boards and professional organizations that discipline doctors to report this type of adverse information to one central national authority for tracking purposes. This will eliminate the problem of substandard physicians escaping detection by simply moving their practice to another facility or state.⁵⁴

In particular, data concerning malpractice claims must be reported to the Secretary of the Department of Health and Human Services (DHHS).⁵⁵ State licensing boards must report to DHHS all cases of license revocations, suspensions, surrender, or other licensing actions taken because of incompetence or professional misconduct.⁵⁶ Health care entities that take actions affecting clinical privileges for thirty days or more, or that accept privileges during an investigation or to avoid one, or that take actions adversely affecting professional society membership, must report such to the appropriate state medical board.⁵⁷

Reports to the DHHS must be made at least monthly.⁵⁸ Hospitals must request information reported to the DHHS whenever a physician applies for privileges and they must update this information at least biennially thereafter.⁵⁹ This information may be reviewed by the physician concerned for accuracy and completeness.⁶⁰

The Department of Health and Human Services and the Department of Defense entered into a memorandum of understanding in 1987 to ensure participation in the program by the Department of Defense as mandated by statute.⁶¹ The memorandum of understanding merely establishes the willingness of the parties to partic-

ipate in the program. Specifics of the program will be spelled out in Department of Defense guidance expected to be promulgated soon, but it is clear from the statute that certain types of information must be collected.⁶²

The existing memorandum of understanding requires the Department of Defense to report all malpractice claims to the National Data Bank and to provide an assessment of the care rendered.⁶³ That assessment must include the name of the attending physician and an attribution of the cause of the events leading to the claim.⁶⁴ That attribution must be to either: 1) the facility or its equipment, or 2) a physicians or physicians , or 3) to a nonphysician or nonphysicians.⁶⁵ It also requires that care be graded as either: 1) meeting standards of care, or, 2) being a minor deviation from standards of care, or, 3) being a major deviation from standards of care.⁶⁶

This sounds like an excellent reporting mechanism to track substandard providers. The problem is that the program exists only on paper. Although Congress authorized creation of the program, it did not fund its implementation; thus the Department of Defense cannot comply with a nonexistent program.⁶⁷

Even assuming the program is eventually funded by Congress, it is apparent that critical guidance is missing from this memorandum of understanding. For example, the memorandum of understanding does not define the terms "minor deviations" or "major deviations" nor does it discuss how that information is to be provided, retained or analyzed.⁶⁸ It also fails to mention how this reporting mechanism works in conjunction with other quality assurance mechanisms such as credentialing. The memorandum of understanding requires reporting of only settled malpractice claims

and yet says nothing about how the information gathered will be used to improve the quality of care.

For example, data such as adverse drug reactions is excluded from the reporting requirements of the National Data Bank.⁶⁹ Although adverse drug reactions related to mislabeling by the manufacturer are specifically excluded from the reporting requirements, they may nevertheless be of significant legal interest and should not be ignored.⁷⁰

These initial efforts were definitely steps in the right direction to improve the quality of care through closer supervision of those providing that care. Their drawback, however, is that they focus attention on health care provider performance that may only be tangentially related to the provider's level of clinical competence.

For example, a military health care provider may engage in an adulterous affair with another health care provider with whom he has no professional relationship. This misconduct is potentially punishable under the Uniform Code of Military Justice,⁷¹ but does not reasonably reflect on the ability to practice medicine. Although this individual is clearly answerable to the entire law; we should focus our efforts in quality assurance on those areas related to the quality of health care and not personal conduct not related to health care.⁷²

The potential effect of the National Data Bank remains to be seen. Although measures are needed to regulate health care provider professional conduct, other more objective measures are needed to regulate the quality of health care provided and not just the conduct of health care providers. These deficiencies may be cured through Department of Defense instructional guidance currently under consideration by the

Department of Defense and is included in the proposed Department of Defense Directive as an appendix to this thesis.⁷³

2. Professional norms

The Assistant Secretary of Defense for Health Affairs recognized the shortfall of focusing solely on professional conduct and promulgated several directives designed to set standards for health care provider clinical performance. In 1983, the Department of Defense directed each military service to establish standards (or norms) for all health care providers, not just physicians.⁷⁴

Providers who fall below acceptable norms are monitored and these failings are noted in their permanent credentials file. The directive only requires that the provider's commander certify to the next higher commander that corrective action, if needed, was taken.⁷⁵ Annual summary reports to the surgeon general are required for substandard performers.⁷⁶ The drawback is that there is no requirement that the Department of Defense review the adequacy of the norms established by the military services and monitored at the installation level. This is so because no national norms yet exist which are suitable for use in all military hospitals.⁷⁷

A second directive was issued requiring an examination of all health care providers' credentials⁷⁸ according to standards set by each military department.⁷⁹ These credentials are maintained in local personnel files that must be updated at least once every six months except for interns,⁸⁰ residents,⁸¹ and fellows⁸² who are all considered to be physicians in training.⁸³

Norms are designed to measure the qualitative end product of patient outcomes while credentials focus on the qualifications of individuals performing health care functions. These efforts are designed to ensure an adequate record is maintained at the local level of provider's qualifications to practice. The most noticeable omissions from the list of required qualifications for military practitioners were the requirement for licensure and delineated supervisory responsibilities. The latter directive made no provision for professional licensure or supervision in its discussion of provider credentials.⁸⁴ These omissions did not go unrecognized.

3. Licensure and supervision of health care providers

The most recent line of Department of Defense initiatives focus on professional licensure and supervision. In the earliest of these directives,⁸⁵ the Department of Defense directed that all nonphysician health care providers⁸⁶ work under the supervision of a physician.⁸⁷ In particular, nonphysician providers must meet three requirements: 1) they must work under the supervision of a physician; 2) they must have a functional written listing of their responsibilities and limits on their authority and; 3) they must meet specific educational requirements as established by that person's military service.⁸⁸

The purpose of this directive is obvious: to ensure that nonphysicians are properly supervised by physicians presumed competent to carry out their supervisory tasks. It is this presumption that drew serious criticism from Congress and led to the most sweeping initiative: physician licensure.

Complaints concerning the lack of a physician licensing requirement within the Department of Defense surfaced during the Congressional hearings⁸⁹ on proposed legislative repeal of the Feres doctrine.⁹⁰ In particular, one Congressman noted during these 1985 hearings:

I was appalled to learn that there is currently no requirement, either by law or by military regulation, that military physicians be licensed.

While that issue was raised in the recent Department of Defense authorization bill during the past couple of weeks, as of the current time there is no such licensing requirement.

It is no wonder that some malpractice occurs in military hospitals....⁹¹

This assumes that a license to practice medicine granted by a state licensing authority is some guarantee of competence.⁹² Such is not the case. Although professional in nature, a medical license is roughly analogous to a business license in that it ensures that the health care provider seeking entry into the profession has met the minimum entry requirements for practice, not clinical competence after licensure.⁹³ Before proceeding further with this analysis, a brief description of health care provider licensure is in order.

With the exception of Puerto Rico, all U.S. jurisdictions use the Federal Licensing Examination (FLEX) as the official licensing examination.⁹⁴ The FLEX examination was first created in 1968 and was substantially modified in 1985.⁹⁵ The National Board of Medical Examiners (NBME), a nonprofit private organization, designed the 1985 test to assess the candidate's basic scientific and clinical knowledge as well as independent judgment ability in a clinical setting.⁹⁶

The FLEX is divided into two components. The first component consists of 500 multiple choice questions that test underlying scientific principles and clinical knowledge.⁹⁷ The second component is practice oriented and consists of fifteen patient management problems. The test is a three day examination with an overall national pass rate of 64%.⁹⁸

The process for foreign medical graduates is different. Their licensing procedure is made through the Educational Commission for Foreign Medical Graduates (ECFMG). The purpose of the ECFMG is to assess by certification the abilities of foreign medical graduates to enter medical practice or enroll in a residency or fellowship program in the United States.⁹⁹ "Foreign medical graduates" are defined as those who earned their degrees outside the United States or its territories, Puerto Rico, or Canada.¹⁰⁰

To be eligible for ECFMG certification, an individual must: (1) pass the medical science examination administered as the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS); (2) pass the ECFMG English language proficiency test; and (3) show documentary evidence that the individual has completed all educational requirements to practice medicine in the country where the medical education was obtained.¹⁰¹ A passing FMGEMS examination grade allows non-United States citizens to meet the medical science requirements to obtain a visa to enter the United States under the 1976 Amendments to the Immigration and Nationality Act.¹⁰²

The Department of Defense is required by statute to monitor the licenses of its health care providers to ensure they are maintained to the same extent as a private person in the independent practice of his profession.¹⁰³ This statute is implemented by a 1985

Department of Defense Directive,¹⁰⁴ and a 1987 Army regulation.¹⁰⁵ As a result, all Department of Defense health care providers are required to possess a valid state license no later than November 8, 1988 unless specifically exempted from this requirement by the service surgeon general or the Assistant Secretary of Defense for Health Affairs.¹⁰⁶ The Department of the Army has moved that date forward to July 18, 1988.¹⁰⁷

This discussion of how the Department of Defense came about licensing its health care professionals, however, still assumes that licensure, standing alone, is some indication of physician competence. This is not so. For example, recent Department of Defense statistics show that ninety percent of all adverse actions on clinical privileges¹⁰⁸ involved providers who already possessed licenses!¹⁰⁹

Licensing requirements are by their very nature minimum standards below which no practitioner may fall without being subject to sanctions such as revocation or other limitations on the privilege to practice his profession. It is designed to protect the public from substandard performers, but is in reality a mechanism geared towards minimal standards compliance through negative reinforcement.

Such a system contains no positive incentives or rewards for exceeding the minimum standards. Positive incentives to improve quality of health care beyond the minimum such as peer review, prestige, or economic incentives to improve one's practice, take place outside the arena of licensing.

4. Significant Omissions in the Department of Defense Quality Assurance Program

a. Lack of a defined quality assurance program

All Department of Defense quality assurance efforts are focused primarily on identification of substandard performers and the regulation and licensure of health care providers.¹¹⁰ The text of the promulgated directives and instructions do not indicate any attempt to define a comprehensive quality assurance program at the Department of Defense level.

An approach to quality assurance focused mainly on health care providers may at first appear reasonable because the Assistant Secretary of Defense for Health Affairs and his staff are primarily responsible for health care policy only.¹¹¹ Since quality assurance efforts at the service level predate those at the Department of Defense level,¹¹² it made little sense to create a program at the Department of Defense level if a lesser solution would solve the problems of improving the quality of care. A small correction would leave the implementation of health care quality assurance programs to the military departments who provide that care with the least disruption of existing programs.¹¹³

The thrust of this thesis is that such an approach, although perhaps initially responsive to the problem of identifying and regulating substandard providers, is inadequate today. It is inadequate because mechanisms for data collection and program evaluation are not currently in place to coordinate at the Department of Defense level the considerable

efforts made at the military service level¹¹⁴ to insure both standards of uniformity and quality within the Department of Defense. The current Department of Defense quality assurance directives and instructions are probably more notable for what they fail to contain than for what they actually address.

**b. Lack of patient care
assessment guidance**

For example, there is virtually no Department of Defense guidance on patient care assessment, that aspect of quality assurance focused on review of medical records and other sources to evaluate the quality of patient care.¹¹⁵ This does not mean that patient care assessment is not conducted in military hospitals. It simply means that no published Department of Defense directives or instructions have been promulgated on the subject.

**c. Lack of utilization
review guidance**

In addition, no Department of Defense directive or instruction currently discusses utilization review, that aspect of quality assurance concerned with cost control and resource management. The Department of Defense requires each military department to provide data on patient loads¹¹⁶ and even medical risk assessment,¹¹⁷ but the term utilization review is not mentioned in its directives nor are any standards established for the individual services to follow.

The Department of Defense has measured the workload in military hospitals since 1956 by the Composite Work Unit (CWU).¹¹⁸ The CWU is a weighted sum of bed-

days, inpatient admissions, live births, and outpatient visits.¹¹⁹

This method of measuring workload has two serious drawbacks. It makes no distinction between different types of inpatient care; a routine appendicitis case counts just as much as a complex neurosurgery case.¹²⁰ The weighted formula favors inpatient visits as one inpatient admission counts the same as ten outpatient visits. This means that a military hospital would have to handle approximately fifty outpatient visits to equal one average hospital stay.¹²¹

In an effort to correct this problem, the Department of Defense has begun using a new method of measuring workload, the Health Care Unit (HCU).¹²² The HCU is like the CWU but is a weighted average broken down by clinical categories. For example, surgical admissions which require more resources than non-surgical admissions are given greater weight.¹²³ While this is an improvement over the CWU system, it is still an inadequate resource management tool.

This does not mean that improvements in utilization review are not forthcoming. Quite the contrary. Congress has directed the Department of Defense to publish directives establishing Diagnosis Related Groups (DRGs) as the primary resource management tool for allocating resources among military medical facilities.¹²⁴

The Department of Defense must develop a DRG system similar to that used in the civilian health care sector.¹²⁵ It must publish directives concerning inpatient visits by October 1, 1988; and outpatient visits by October 1, 1989.¹²⁶ They must include provisions for: 1) classification of inpatient treatment within such groups, 2) methodology for classifying specific treatments within such groups and, 3) an

appropriate weighing factor for such DRGs which reflects the relative resources used by a facility with respect to treatments classified within other groups.¹²⁷

The DRG system is a highly sophisticated classification system that will more accurately determine workload and the resources needed to carry out that work, but full implementation is still years away.¹²⁸ It should prove an effective resource management tool once in place. This is especially true since Congress has authorized the Department of Defense to share medical resources with both the civilian sector¹²⁹ and the Veterans Administration in an effort to provide medical care to more eligible beneficiaries.¹³⁰

d. Lack of risk management guidance

No Department of Defense directive or instruction addresses the issue of risk management, that aspect of quality assurance concerned with accident and injury prevention and reducing financial losses after an incident has occurred. No published standards exist for the individual services to follow although a current directive requires that all malpractice claims be processed in accordance with individual service regulations.¹³¹ Quarterly summaries of malpractice data are also reported to the Assistant Secretary of Defense for Health Affairs but that data is not uniform among the three services.¹³²

e. Lack of accreditation guidance

It should be noted that the terms licensure and accreditation are not synonymous. They are terms of

art and should not be confused. Licensure is carried out as a government regulatory function with the full force of law to enforce standards set forth by that government body.¹³³ Accreditation is granted by organizations that do not have governmental authority to enforce compliance with standards. Accreditation, unlike licensure, is a review of procedures and resources to assess compliance with current standards of care, but is not required by law.¹³⁴

No department of Defense directive or instruction addresses the issue of hospital accreditation. Although no current directive or instruction mandates accreditation of military hospitals; it is common knowledge among military health care providers that Department of Defense hospitals are accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).¹³⁵ Each of the military services has addressed the issue of JCAHO accreditation.¹³⁶ The problem with their guidance, however, is that it does not make JCAHO accreditation mandatory.¹³⁷ This guidance is also incomplete, obsolete,¹³⁸ and inconsistently applied between the military departments.¹³⁹

The JCAHO is a private organization that wields considerable authority.¹⁴⁰ Its accreditation is required to conduct approved residency training programs.¹⁴¹ A discussion of the organization, purpose, and functions of the JCAHO is, therefore, in order.

The JCAHO is a private nonprofit corporation with headquarters located in Chicago, Illinois.¹⁴² It is governed by a board of twenty-two commissioners appointed by the member organizations of the JCAHO.¹⁴³ Of these twenty-two commissioners, three are representatives of the American College of Surgeons, three are representatives from the American College of

Physicians, one is a representative of the American Dental Association, seven are representatives of the American Medical Association, seven are representatives of the American Hospital Association, and one member is appointed as a public member.¹⁴⁴

Commissioners meet at least three times a year.¹⁴⁵ The JCAHO's stated purposes are to establish standards for the operation of hospitals and other health care related facilities; to conduct survey and accreditation programs that will encourage members of the health professions to voluntarily promote quality health care in their respective facilities; to recognize compliance with standards by issuance of certificates of accreditation; and, to conduct programs of education and research and publish the results thereof.¹⁴⁶

Accreditation standards are developed by members of the Commission's six Professional Technical Advisory Committees (PTACs) and ad hoc task forces drawn from the medical professions.¹⁴⁷ Their findings are then reported through the Standards and Surveys Procedures Committee of the Board of Commissioners to the full Board of Commissioners who then votes on approval of these standards.¹⁴⁸ Accreditation is voluntary and based on a standard of substantial compliance.¹⁴⁹ This means that the surveyed hospital must substantially comply with JCAHO standards as a whole and not every single JCAHO standard.¹⁵⁰

The JCAHO conducts on-site surveys in accrediting military hospitals. It does this through use of an Accreditation Manual for Hospitals (AMH) which is updated annually. The manual also serves as the basis for the survey report from which inspectors report on-site findings.¹⁵¹

The manual is in outline format.¹⁵² Each standard and characteristic is numbered for easy reference¹⁵³

and graded on a rating scale from 1 through 5 and "NA" ("not applicable").¹⁵⁴ That scale is as follows:

1. Substantial Compliance, indicating that the hospital consistently meets all major provisions of the standard or required characteristic.
2. Significant Compliance, indicating that the hospital meets most provisions of the standard or required characteristic.
3. Partial Compliance, indicating that the hospital meets some provisions of the standard or required characteristic.
4. Minimal Compliance, indicating that the hospital meets minimum provisions of the standard or required characteristic.
5. Noncompliance, indicating that the hospital fails to meet the provisions of the standard or required characteristic.
6. NA. Not Applicable, indicating that the standard or required characteristic does not apply to the hospital.¹⁵⁵

A hospital found in substantial compliance with JCAHO standards is awarded accreditation for three years.¹⁵⁶ The JCAHO will conduct a full survey more frequently than once every three years if specifically requested to do so.¹⁵⁷

Approximately eighteen months from the date of the next survey, the JCAHO sends the accredited facility a letter reminding it that recommended changes it received in the last survey must be completed to avoid possible accreditation problems in the upcoming survey.¹⁵⁸ The JCAHO may conduct an unannounced inspection at any time at its own cost and discretion.¹⁵⁹

All hospitals must undergo a full accreditation survey as results from the last survey are not automatically renewed.¹⁶⁰ A new application for survey is sent approximately seven months before the hospital's accreditation is due to expire and a new survey is conducted up to ninety days before accreditation is due to expire.¹⁶¹

All information obtained by the JCAHO is treated as confidential between the JCAHO and the accredited hospital.¹⁶² Survey results and recommendations are released only to the hospital surveyed.¹⁶³ The only information available to the general public upon request is:

- * Whether JCAHO has received an Application for Survey from a particular hospital;

- * A list of hospitals tentatively scheduled for survey, without indication of specific survey dates;

- * Upcoming survey dates for a particular hospital, after the hospital has been notified of the survey dates;

- * Whether or not a survey was conducted;

- * Whether a hospital is or is not accredited;

- * The accreditation history of a particular hospital.¹⁶⁴

Accreditation by the JCAHO is not a public regulatory program. The JCAHO's role is simply that of a consultant paid for and responsible to the health care industry.¹⁶⁵ Effective January 1, 1988, the JCAHO changed its method of pricing surveys from one based on a specific price per surveyor day system¹⁶⁶ to one based on program specific workloads at facilities seeking accreditation.¹⁶⁷ The increased emphasis on workloads in assessing accreditation fees will make the study and review of the utilization review process that much more important.

The Department of Defense's efforts to improve quality health care through mechanisms like accreditation are commendable, but inadequately focused. For reasons stated earlier, the quality assurance focus at the Department of Defense level is not nearly as well defined as the Army's Quality Assurance Program (QAP); which I will now discuss.

C. THE ARMY QUALITY ASSURANCE PROGRAM

1. General

The Army's Quality Assurance Program (QAP) is older than the Department of Defense's quality assurance efforts. It has nevertheless had a rapidly evolving history. The origins of the Army's quality assurance efforts may be traced back to 1974 with the development of uniform quality assurance guidelines based on JCAHO standards.¹⁶⁸ This program was called the Medical Care Evaluation Program and its intent was to conform to JCAHO standards as they existed at that time.¹⁶⁹

The Medical Care Evaluation Program conducted medical audits, which was the predecessor of patient care assessment.¹⁷⁰ Medical audits required a review of medical records for accuracy, timeliness, and completeness; review of all death cases, tissue reviews, blood utilization reviews, drug utilization reviews, reviews of adverse patient outcomes, use of consultations and consultants, and review of special care units.¹⁷¹

The program also established a utilization review function to review resource management practices and created the medical executive committee and medical care evaluation committee.¹⁷² These committees were the predecessor to the current utilization review, hospital executive committee¹⁷³ and quality assurance committees.¹⁷⁴

In November 1976, the credentials committee was added to the program to review credentials and privi-

leging actions.¹⁷⁵ A patient care outcome audit recommended by the JCAHO was also adopted.¹⁷⁶

In August 1979, categorical credentialing was initiated¹⁷⁷ and a requirement for delineation of individual clinical privileges according to national specialty board standards was established.¹⁷⁸ The practitioner's credentials file (PCF) was made a permanent record for the service career of the member.¹⁷⁹

In June 1980, the Medical Care Evaluation Program was renamed the Quality Assurance Program (QAP).¹⁸⁰ This change in name conformed to changes in JCAHO terminology and was incorporated into the new Army Regulation 40-66. The risk management program was also added at that time.¹⁸¹

In December 1982, the quality assurance program changed again. This time, a medical treatment facility (MTF) quality assurance committee was established; the risk management function expanded, and a credentials hearing and appeals process was established.¹⁸² The term "patient care auditing" was changed to "patient care assessment" to conform to changes in JCAHO terminology.¹⁸³

A separate quality assurance branch was established at the Army Surgeon General's office in 1983.¹⁸⁴ The purpose of that office is to supervise Army quality assurance efforts and to maintain current guidance for Army facilities.¹⁸⁵

Although numerous quality assurance initiatives were carried out prior to 1984,¹⁸⁶ their focus was unclear and application sporadic. This was especially true in the area of malpractice claims.¹⁸⁷

This scenario changed dramatically on June 25, 1984. On June 25, 1984, the Army Surgeon General and the Army Judge Advocate General entered into a Memorandum of Understanding.¹⁸⁸ This Memorandum of Under-

standing outlined in broad terms the duties and responsibilities of newly created risk management teams consisting of a risk manager, quality assurance coordinator (QAC), medical claims judge advocate (MCJA), and medical claims investigator (MCI) whose responsibilities will be discussed in detail later.

Styled the Medical Claims Judge Advocate Program by its creator,¹⁸⁹ this program was the first Army action to establish hospital risk management teams with full-time army lawyers. The program's stated objectives were focused on risk management with the intent of improving methods for identifying and investigating medical malpractice claims and adverse patient outcomes that had the potential to become possible malpractice claims. It was designed to enhance the Army's capability to settle meritorious claims at less cost to the Army and to more capably defend nonmeritorious claims through more thorough investigations and marshaling of evidence needed to successfully defend such cases.¹⁹⁰ It is for these reasons that the eight Army medical teaching centers¹⁹¹ were chosen as the sites for these newly created risk management teams. These medical centers were also chosen because of their large patient populations and teaching missions as the most likely to incur the greatest number of malpractice claims.

The Army's efforts would not remain focused solely on these risk management in Army medical centers for long. The Army published expanded quality assurance guidance on January 31, 1985¹⁹² followed by revised guidance on April 1, 1987.¹⁹³

Chapter 9 of AR 40-66 sets forth in detail the current requirements for implementation of the Army QAP. This guidance is specifically designed for implementation of the program at the hospital level.¹⁹⁴ It is a four point program consisting of: patient

care assessment, credentialing, utilization review, and risk management, which are carried out by the various types of Army medical treatment facilities (MTFs) described below.

2. Overview of the Army Medical Department (AMEDD) Force Structure

Military medical facilities operated by the Army provide direct comprehensive medical care to active duty service soldiers and their dependents, and retirees and their dependents.¹⁹⁵ They range in size from large medical centers with extensive capabilities and teaching programs to small clinics with limited capabilities.¹⁹⁶

The Department of the Army Medical Department (AMEDD) operates both fixed¹⁹⁷ and nonfixed¹⁹⁸ facilities. I will not discuss nonfixed facilities as they normally exist in the context of field exercises and combat operations under existing modified tables of organization and equipment (MTOEs).¹⁹⁹ Fixed facilities on the other hand, are placed into three classifications: medical centers, hospitals, and clinics.²⁰⁰

A medical center is defined as a large hospital appropriately equipped to provide a wide range of specialized and consultative support for all medical facilities within its geographic area of responsibility. A medical center also conducts graduate medical education and training in the health professions.²⁰¹

A hospital is defined as "a health treatment facility capable of providing definitive patient care. It is staffed and equipped to provide diagnostic and therapeutic services in the field of general medicine, surgery, and preventive medicine services."²⁰² The term "definitive care" refers to care that is rendered

at the hospital. This means that the patient is cared for at the facility and not merely held and stabilized until he can be evacuated to another facility as often occurs in nonfixed facilities in the field.²⁰³ The Army has two different types of hospitals. These are U.S. Army Community Hospitals (USACHs); or, if a hospital also covers a limited geographic area of responsibility, it is called a medical department activity (MEDDAC).²⁰⁴

A clinic is defined as a "health treatment facility appropriately staffed and equipped to provide emergency treatment and ambulatory services."²⁰⁵ It is capable of performing nontherapeutic services such as physical examinations, immunizations, medical administration, and preventive medicine services to support a given command or mission requirement.²⁰⁶

All Army facilities are acute care facilities. This means their function is to "treat and release" all patients coming under their care. They do not provide nursing home or domiciliary care.²⁰⁷

Each MTF, regardless of size, has a committee structure modified to its specific needs in implementing the Army quality assurance program. I will now discuss the purposes and functions of some of those committees.

3. Quality Assurance Program (QAP) Committees

a. Hospital Executive Committee

The hospital executive committee (HEC) is normally the ultimate decision making committee at the MTF and is normally chaired by the commander.²⁰⁸ The committee considers matters brought before it, but the commander is ultimately responsible for the quality

assurance program at the MTF. The HEC composition may vary with each facility but its membership must include: the commander or his representative, the deputy commander for clinical services (DCCS), the deputy commander for administration (DCA), the chief of the department of nursing, and a recorder.²⁰⁹

The executive committee also serves a second function. It acts as the liaison committee for unresolved problems at the hospital level that must be sent to the next higher command for resolution.²¹⁰ For example, if an injury in a hospital located in the continental United States (CONUS) is attributable to inadequate staffing; the executive committee through the commander, will submit a request to the U.S. Army Health Services Command who could authorize resources to overcome the deficiency.²¹¹

b. Quality assurance committee

1. General

The quality assurance committee is responsible for supervising the hospital quality assurance program. This includes all patient care assessment, utilization review, and risk management activities at the hospital.²¹² Credentialing matters are handled by the credentials committee²¹³ which reports its findings and conclusions differently than other activities of the quality assurance program.²¹⁴

2. Structure

The committee should consist of not less than three physicians, the chief of the department of nursing (or representative), the deputy commander for

administration (or representative), the chief, patient administration division (or representative) and the risk manager; whose specific responsibilities will be discussed later. A physician must act as chairperson of the committee.²¹⁵

Some local regulations further describe the composition of the committee which varies with each hospital. A typical medical center committee²¹⁶ might consist of the following individuals:

MEMBER	DUTY
Deputy Command for Clinical Services (DCCS)	Chairman
Commander, Dental Activity (DENTAC)	Member
Deputy Commander For Administration (DCA)	Member
Chiefs, Clinical Departments	Member
Chief, Department of Nursing	Member
Director, Patient Administration Division (medical records)	Member
Medical Claims Judge Advocate (MCJA) or Post Claims Judge Advocate (PCJA)	Member
Quality Assurance Coordinator	Recorder

3. Reporting

The quality assurance committee has authority to set problem solving priorities²¹⁷ and to take appropriate corrective action.²¹⁸ Hospital quality assurance committees must meet at least monthly.²¹⁹ The Army regulation does not specify the mechanism for reporting issues raised at the departmental level that need to be addressed by the hospital quality assurance committee.

This method varies with each hospital. Those hospitals offering a relatively narrow range of clinical services and that have a small patient population will

meet less frequently than a large teaching center, with a wide range of clinical services and large patient population. I have based my reporting model on a large medical center but this model may be scaled down to accommodate smaller hospitals or clinics.

The quality assurance committee reporting model is one of decentralized data collection and centralized reporting. Individual clinical departments review the utilization review, patient care assessment, and risk management data that pertain to that department and provide a summarized monthly report of trends and problems to the hospital level quality assurance committee.²²⁰

For example, the department of nursing might notice an increased incidence of medication errors. We may assume that all errors were caught in time without any injury to patients. A review of these cases might reveal these errors to be due to a combination of drug mislabeling by the manufacturer and improper packaging by the hospital pharmacy. This trend of increased incidents should be reported to the quality assurance committee to ensure that the different departments involved in this case coordinate their efforts and that the drug manufacturer is notified and the problem corrected before a patient injury occurs.

Only those problems that cannot be resolved at the department level should be forwarded to the hospital quality assurance committee. An example of such a problem is the nursing department example just given, budgeting requests, or any action involving two or more clinical departments.²²¹ Problems not resolved by the hospital quality assurance committee are reported to the hospital executive committee.²²²

4. Confidentiality

Quality assurance records are confidential and privileged and may not be disclosed except as authorized by statute.²²³ This includes all quality assurance records and not just quality assurance committee records. A "quality assurance record" is defined as any "proceedings, records, minutes, or reports that emanate from quality assurance program (QAP) activities."²²⁴ A "medical quality assurance program" is defined as "any activity carried out...to assess the quality of care."²²⁵

As a general rule, quality assurance records are not subject to pretrial discovery disclosure nor are they admissible in evidence in medical malpractice litigation except as authorized by statute.²²⁶ Judge advocates should be aware; however, that numerous other sources of medical information are merely medical records kept in the ordinary course of business. These records are subject to possible pretrial discovery and disclosure despite the fact that they may also be contained in a quality assurance committee record. Examples of such records include, but are not limited to, inpatient and outpatient medical records, fetal heart tapes, labor and delivery room logs, emergency room and ambulance logs, pharmacy logs, equipment and procurement maintenance documents, inspector general reports,²²⁷ hospital and departmental rules, guidelines, protocols, standard operating procedures (SOPs), and investigative reports conducted under the auspices of AR 15-6.²²⁸

Improper disclosure of such records may not only injure the government's claims negotiations or litigation posture in a particular case, but could seriously undermine efforts in gathering information by

those involved in the quality assurance program. Health care providers who will ordinarily provide information if it is kept confidential will not do so if it can be used against them in malpractice litigation.

The Army lawyer need not face this problem alone. Judge advocates in doubt about whether to release a document should consult with other hospital quality assurance committee members and the U.S. Army Claims Service or Litigation Division, Office of The Judge Advocate General to determine whether a document should be released.

c. Hospital credentials committee

1. General

As noted earlier, credentialing is the process an MTF uses to evaluate the professional qualifications of health care providers working within that facility. The hospital credentials committee's function is to evaluate the professional qualifications of health care providers seeking to practice in that facility and to make recommendations to the commander.²²⁹

It does this through evaluation of each provider's practitioner's credentials file (PCF). The PCF contains personal professional credentials information on each health care provider.²³⁰ This information includes copies of diplomas, certificates, licenses, continuing medical education certificates, a list of lectures given, papers published, clinical profile information, usually provided through the AQCESS system; which I will discuss later, as well as documents pertaining to both favorable and adverse personnel actions.²³¹ This file is updated periodically and is maintained throughout that provider's entire career.²³²

2. Structure

The Army's regulation does not dictate who will serve on the credentials committee but does recommend that committee members "be physicians."²³³ The committee's composition is frequently established by local regulation or policy. At a typical medical center, the committee might consist of the following individuals:

MEMBER	DUTY
Deputy Commander for Clinical Services (DCCS)	Chairperson
Chief, Department of Medicine	Member
Chief, Department of Surgery	Member
Chief, Department of Primary Care	Member
Commander, Dental Activity (DENTAC)**	Member
Chief, Department of Psychiatry**	Member
Chief, Department of Radiology**	Member
Chief, Department of Pathology	Member
Chief, Obstetrics and Gynecology**	Member
Chief, Department of Pediatrics**	Member
Chief, Orthopedic Service (if separate from Department of Surgery)**	Member
Chief, Clinical Support Division	Nonvoting Member
Secretary, Clinical Support Division	Recorder

(** Indicates those to be present only when a practitioner considered for practice in that specialty is being discussed).²³⁴

The credentials committee is an ad hoc organization, meeting as needed, but in no event less than once a year.²³⁵ Meetings are held on at least five days written advance notice to allow sufficient time to appraise the practitioner's credentials.²³⁶

A "yes" or "no" vote on credentials takes place by secret written ballot. Abstentions are not allowed.²³⁷ Once the vote is tabulated and the com-

mittee's recommendation for approval or disapproval is made; it is forwarded to the commander for his personal decision.²³⁸ Recommendations are not routed through the quality assurance committee.²³⁹

All minutes maintained by the credentials committee must be dated.²⁴⁰ The names and professional positions of those attending the committee meeting as well as those practitioner's whose files were voted on must be recorded.²⁴¹ The final committee action taken, whether to approve, disapprove, or limit credentials must also be recorded in the committee's meeting minutes.²⁴²

The chairperson, usually the DCCS, is required to keep and maintain control of the committee reports and Practitioner's Credentials Files (PCFs).²⁴³ These records are not kept in the personal possession of the committee chairperson, but are maintained by the Clinical Support Division (CSD), an administrative office answerable to the DCCS. That office is usually supervised by a Medical Service Corps officer (non-physician) and not a Medical Corps officer (physician); thus he has no vote on the committee.

The hospital conducts its QAP through its various committees, but what about the program itself? How does it work? To that end, I will now discuss the four elements of the Army QAP: patient care assessment, utilization review, risk management, and credentialing.

4. Patient Care Assessment

a. General

Patient care assessment is defined as "a review of medical records to evaluate the quality of patient care."²⁴⁴ In large hospitals, patient care assessment

may be conducted by individual departments while in smaller hospitals and clinics this function may be carried out on a facility wide basis.²⁴⁵ The department of nursing is considered a separate department, regardless of the clinical department served by the assigned nursing staff.²⁴⁶

Patient care assessment is a complex monitoring system consisting of eleven subelements.²⁴⁷ Those subelements are: assessment criteria, documentation review of medical records, entry deficiencies in medical records, missing category summary reports, review of deaths, treatment related review, which is implemented through use of the Automated Quality Care Evaluation Support System (AQCESS) system;²⁴⁸ anesthesia review, blood utilization review, drug use review, special reviews, and support services.²⁴⁹

A review of these eleven subelements reveals that some are closely related and may be combined for purposes of discussion. I will discuss; therefore, patient care assessment as it is practiced by means of peer review and medical records assessment.

b. Peer review

The term peer review is circular in its usage. That is, the term defines its function and vice-versa. Peer review is a critical self-evaluation process whereby health care providers evaluate one another's care, either individually or collectively with the goal of improving the quality of health care.

Peer review is conducted by means of criteria. Criteria are a means of setting standards and are divided into two major divisions. Explicit criteria are written standards of care. Health care functions under review are checked against this list to evaluate

the quality of care.²⁵⁰ Implicit criteria evaluate the quality of care based solely on the credentials or reputations of the evaluating health care providers with nothing written down. These evaluators are usually the in-house medical staff with occasional assistance from outside civilian and military consultants. The assumption is made that since good health care providers are assessing the quality of care, they will be able to make valid and reliable assessments by review of their peers.²⁵¹

How does peer review work? Peer review may be conducted by the medical staff as a group or by senior members reviewing the work of junior members and outside consultants reviewing the work of senior members. For example, a clinical department will establish written standards that define acceptable health care. If the care rendered matches those written criteria and the patient has a good outcome, we know that the patient received good care. If the outcome was still good but the criteria were not met, the case will be reviewed more closely by the medical staff as a group to see if the care was adequate, and if not, then appropriate action may be taken. This process is roughly comparable to the supervisory control section chiefs in the staff judge advocate office exercise over attorneys within their branches with the occasional visit by The Judge Advocate General²⁵² acting as the evaluative oversight of the staff judge advocate and office in general.

This places the burden of peer review on MTFs and their accrediting institutions.²⁵³ Hospital Peer review requirements are set forth by the JCAHO,²⁵⁴ the accrediting body that accredits military MTFs discussed earlier. They are published in the Accreditation Manual for Hospitals (AMH) published by the JCAHO.²⁵⁵

Standard VI of the AMH (1988) states: "The medical staff [shall] provide mechanisms to monitor and evaluate the quality and appropriateness of patient care and clinical performance of all individuals with delineated clinical privileges,...[so that] important problems in patient care are identified and resolved, and opportunities to improve care are addressed."²⁵⁶

The overall responsibility for the quality of hospital medical care rests with the assigned medical staff.²⁵⁷ The medical staff must establish and perform specific functions for monitoring and improving its medical practice in order to fulfill that responsibility. These functions include, but are not limited to: surgical assessment,²⁵⁸ review of pharmacy and therapeutic activities,²⁵⁹ nursing care assessment,²⁶⁰ blood utilization reviews,²⁶¹ morbidity and mortality reviews; which is normally informal peer review at the hospital departmental level, and other patient related professional activities.

Military MTF peer review does not differ substantially from that outlined by the JCAHO. Peer review committees²⁶² in military hospitals are established by Army,²⁶³ or local regulation,²⁶⁴ that sets forth the responsibilities of that committee, as well as its reporting and quality control requirements. These peer review bodies are individually structured at each medical treatment facility, usually along departmental lines or along a narrow interdisciplinary focus.²⁶⁵

The purpose of these committees is simple. They ensure that health care providers responsible for the provision of care critically review that care. For example, the tissue committee may review all appendicitis cases. Each case in which both an inflamed or normal appendix was removed is reviewed. The surgeons and supporting staff then review the indications for

surgery in each case and explain or justify all major discrepancies between preoperative and postoperative diagnoses, especially when a normal appendix is removed at the time of surgery.

This type of review ensures that acceptable standards of medical care are met. This assumes that medical records on which a great deal of peer review assessment is based, are accurate and complete.

c. Medical records review

Medical records review takes place in one of three ways: external review, review by the hospital patient administration division (PAD), and the Automated Quality Care Evaluation Support System (AQCESS). I will briefly discuss each of these reviews.

1. External review

In 1985, the Assistant Secretary of Defense for Health Affairs entered into personal service contracts with private health care providers. The contract is currently held by the Forensic Medical Advisory Service of Bethesda, Maryland.²⁶⁶ This group currently reviews approximately ten percent of all medical records, randomly selected, for completeness, accuracy of diagnosis coding data, and appropriateness of treatment. Summarized monthly reports broken down by both facility and geographic region are sent to the Department of Defense every month.²⁶⁷ This is a Department of Defense-wide program that costs approximately \$7 million per year to administer.²⁶⁸

This external peer review program is conducted much the same way as internal peer review. If care matches criteria and the patient had a good outcome, we

know that the patient received good care. If either the criteria are not met or the patient had a bad outcome, those cases will be reviewed more carefully by the civilian peer review group to determine whether in fact the care was adequate.²⁶⁹

The only drawback to the system is the delay between the time the care is rendered and the time cases are reviewed and reported to the Department of Defense. Case reviews take place 3-4 months after the care is rendered and 7-8 months before substandard cases are fully reviewed and reported to the Department of Defense.²⁷⁰

2. Patient administration division

The patient administration division (PAD) provides support services to the hospital.²⁷¹ These services include: patient admissions and discharges, CHAMPUS program administration, hospital treasury functions, and most importantly for purposes of this discussion, inpatient and outpatient medical records administration.²⁷²

The PAD's hospital records responsibility is vital to the overall quality assurance program. The PAD must notify the hospital risk manager or assigned Army lawyer of medical record entry deficiencies suggesting potential legal liability.²⁷³ It must also make summarized quarterly reports to the quality assurance committee of the number of inpatient records that are incomplete because of missing history and physical examinations, operative reports, and narrative summaries.²⁷⁴ Some local regulations impose on the PAD the additional duty of advising the hospital staff on administrative matters pertaining to JCAHO accreditation.²⁷⁵ They may also require full participation in

the quality assurance program, especially the risk management and utilization review aspects discussed more fully below.²⁷⁶

The importance of good medical records cannot be overstated. Accurate, timely, and complete records not only contribute to quality health care through better documentation of diagnosis and therapy; they provide the only documentation readily available to defend against a claim for alleged medical malpractice.

3. Automated Quality Care Evaluation Support System (AQCESS)

The term AQCESS is an acronym that stands for the Automated Quality Care Evaluation Support System.²⁷⁷ It is a complex computer software program developed by the Quality Assurance Automation Working Group, a tri-service committee that meets weekly to develop and improve automation related to quality assurance.²⁷⁸ The Deputy Assistant Secretary of Defense (Health Affairs) for Professional Affairs and Quality Assurance is responsible for oversight of the program.²⁷⁹ It is a relatively new program. It began operation in November 1985 but was not fully operational until April, 1986.²⁸⁰

The AQCESS is a clinical data base.²⁸¹ It contains both a profile function, which contains data on personnel²⁸² and provider credentials,²⁸³ and a monitoring and evaluation function.²⁸⁴ It is this monitoring and evaluation function that permits the collection of clinical data to monitor acceptable aspects of care and trending of care to identify improvable patterns of care.²⁸⁵ The evaluation aspect of this function permits attribution of health care outcomes to individual providers, departments, administrative sec-

tions, or even the institution as the circumstances require.²⁸⁶

For example, the computer could be easily programmed to alert the medical staff of abnormal outcomes. In the appendicitis example used earlier, the computer could be programmed to alert the medical staff of all surgeries where a normal appendix was removed at the time of surgery.

In another example, the computer could be programmed to identify all APGAR scores²⁸⁷ of six or less for infants weighing less than 2,000 grams (four pounds) at birth. In such cases, this could alert a commander of trends in high risk pregnancies that should be monitored closely and sent to a medical center which is more likely to have the necessary neonatal intensive care required to medically manage such cases.²⁸⁸

This trends data is coded by a computerized generic screening process which encodes every patient outcome entered into the computer, especially adverse patient outcomes. Judge advocates need not concern themselves with the specific aspects of the computer software automation involved as this is mainly the concern of computer specialists and health care providers.

What is important for judge advocates to understand is that trends data can be established at the hospital level to include provider specific information. Identified adverse trends data may then be brought to the attention of the quality assurance committee and commander for resolution at which time the assigned judge advocate may be called upon for legal advice, particularly in the area of medical malpractice claims. The major drawbacks to this system are that it does not report its data to the Department

of Defense Health Affairs Office, nor does it extend to outpatient visits, which constitute the bulk of hospital visits.²⁸⁹

5. Utilization Review

a. Purpose

Utilization review is defined as the "ongoing evaluation of health resources management."²⁹⁰ Its purpose is to improve quality of care through proper allocation and management of resources within the hospital. Better management allows more and better health care with existing resources. Resource deficiencies hindering improved patient care can also be identified and addressed.

b. Concept

The utilization review program at most hospitals has centralized reporting and decentralized implementation.²⁹¹ Utilization review activities conducted at the clinical department level include evaluation of patient admission and discharges, patient scheduling, and review of patient lengths of stay,²⁹² especially long-term patients managed under the long-term patient roster²⁹³.

This long-term roster is reviewed every month²⁹⁴ to determine whether each patient considered should be retained in that facility. Since military hospitals are acute care facilities only; it is critical that domiciliary care patients be referred to appropriate facilities.²⁹⁵

There are two reasons for this. First, domiciliary care requires a different type of expertise

than acute care treatment and transfer to such a facility is often beneficial to the patient. Second, resource constraints do not allow military hospital providers to provide such care, especially when it would deprive other eligible recipients of health care.

c. Responsibilities

Specific responsibilities are often established by local regulation.²⁹⁶ These regulations frequently place a particularly heavy burden on clinical department chiefs to develop a utilization review program and incorporate it into their overall departmental quality assurance plan. This includes the development of peer review mechanisms to ensure timely review of patient admissions, discharges, and lengths of stay.²⁹⁷

Most utilization review issues are dealt with at the department level. Those issues determined to be of hospital wide application or which affect more than one department such as a centralized appointment system or shared administrative support between departments might be sent to the hospital quality assurance committee pursuant to local regulation.²⁹⁸ Since the DCCS is often the chairman of the hospital quality assurance committee,²⁹⁹ that person is the hospital wide utilization review coordinator.³⁰⁰

Large hospitals or medical centers might wish to have a separate standing utilization review committee. Smaller hospitals or clinics may wish to combine utilization review as a function of its patient care assessment committee. If a facility wishes to establish a separate utilization review committee, it must ensure that the following individuals are included in membership on that committee: the deputy commander for clinical services, the deputy commander for admin-

istration, the chief of the department of nursing, and the chief of the patient administration division.³⁰¹

6. Risk Management

a. General

The risk management program is a hospital wide program concerned with accident and injury prevention and reduction of potential financial losses after an injury has occurred.³⁰² The risk management program forms the critical link between the health care providers' concerns for quality health care and the legal implications and costs of medical malpractice and is of the greatest interest for Army lawyers.³⁰³

The heart of the risk management program is timely and thorough investigation of potentially compensable incidents (PCIs)³⁰⁴ and filed malpractice claims. All serious incidents must be investigated, whether they are compensable or not.³⁰⁵ This means that even those cases involving active duty soldiers whose claims are barred by the Feres doctrine³⁰⁶ must be investigated.

In addition to its role in reducing accidents and minimizing legal liability, the risk management program serves one additional function. It serves as an additional mechanism along with patient care assessment to identify substandard providers so that they may be reported to the credentials committee or quality assurance committee for further action.

The risk management team is alerted to potential risks that require investigation through a number of sources. Those sources include data collected by health care providers as part of the patient care assessment program such as departmental committee findings, medical records reviews, and departmental

morbidity and mortality conference conclusions.³⁰⁷ Other sources of information may include departmental utilization review assessment studies, reports of complaints to the local Inspector General (IG), inspection results from JCAHO and Army IG surveys, patient or staff survey results, and the most frequently filed report, the unusual occurrence report which I will discuss in more detail later.³⁰⁸

b. Concept

The risk management function is carried out by a four person team consisting of: a risk manager, a quality assurance coordinator, a medical claims judge advocate (MCJA), if the facility is a medical center; otherwise, the post claims judge advocate (PCJA); and a medical claims investigator (MCI), if the facility is a medical center; otherwise, the post claims judge advocate's legal clerk or investigator.³⁰⁹

The risk management committee is the focal point of the risk management program at the hospital. The risk management team investigates PCIs and filed malpractice claims³¹⁰ and then determines which cases are sent to the risk management committee for further review. The procedure for doing this is often determined by local regulation or policy because there is, strangely enough, no Army requirement that every hospital have a risk management committee although most facilities do.³¹¹

Although there is no prescribed risk management committee structure, one suggested organization is based on physician majority representation.³¹² This formula is adjustable according to the size of facility and the frequency with which meetings are held.

For example, a typical medical center committee might consist of the following individuals:

MEMBER	DUTY
Deputy Commander for Clinical Services	Chairman
Deputy Commander for Administration (or representative)	Member
Chief, Department of Nursing	Member
Risk Manager (if someone other than the DCCS)	Member
Senior Physician Assistant	Member
MCJA or PCJA	Member
Chief, Clinical Departments*	Member
Chief, Clinical Support Division	Member
Quality Assurance Coordinator	Recorder

* Only if needed to discuss the clinical aspects of the case.³¹³

One method of determining which cases to forward to the committee is to require committee review of all filed malpractice claims, regardless of substantive merit or Feres bar.³¹⁴ Potentially compensable incidents (PCIs) should be evaluated and sent forward to the committee on a case-by-case basis if the facts so warrant. Local regulation might suggest that committee recommendations be forwarded to the U.S. Army Claims Service³¹⁵ on a case-by-case basis. The better practice might be to forward those recommendations in all filed claims cases.

c. Responsibilities

1. Risk manager

As noted earlier, the risk management team is headed by the risk manager. The risk manager is an AMEDD officer or civilian equivalent of the rank of major or higher. This individual has a number of re-

sponsibilities to include serving as the chairman of the risk management committee.³¹⁶

In addition to his duties as committee chairman, the risk manager must also direct the risk management program, screen incidents to determine whether they require further physician analysis or risk management intervention, and systematically analyze internal hospital data sources described earlier to identify PCIs and other potential problem areas.³¹⁷ He must also incorporate quality control procedures for medical materiel into the overall quality assurance program and coordinate with the chief of the hospital logistics division on problems that may potentially impact on government liability.³¹⁸

The risk manager's most important responsibilities center on his relationship to his assigned Army lawyer. The risk manager must notify the MCJA or the PCJA within 24 hours of identifying a potentially compensable incident, and coordinate followup action.³¹⁹ He must also seek the MCJA's or PCJA's guidance concerning the conduct of any potential post-incident discussions between the medical staff and patient or his family.³²⁰ Finally, he serves as the point of contact should any problems arise concerning the conduct or scheduling of investigative interviews with the MCJA, PCJA, or representatives of the U.S. Army Claims Service.³²¹

The DCCS is frequently the risk manager.³²² He is often unable to devote his efforts full-time to the risk management program because of his many other duties. The Army recognized this problem and requires that a designated senior physician in each facility provide medical consultation on investigations to both the risk manager and MCJA or PCJA as needed.³²³ This assistance includes helping the risk manager screen PCIs, providing assistance in obtaining military and

civilian specialist reviews, and providing general consultative advice to MCJAs and PCJAs in conducting investigations.³²⁴

2. **Medical Claims Judge Advocate (MCJA) or Post Claims Judge Advocate (PCJA)**

The MCJA or PCJA is the legal advisor to the risk management team.³²⁵ He attends all hospital risk management and quality assurance committee meetings and serves as the primary point of contact with the U.S. Army Claims Service on all filed claims cases.³²⁶

An effective MCJA or PCJA does not serve on these committees as a mere spectator. He must take an active role and review all case files before they are reviewed by the committee. He must pose such questions and discuss such points as necessary to make an initial determination of the legal significance of a case. Once this is done, only then may he advise the committee about what steps should be taken to resolve those issues addressed. This is more difficult in practice than it might appear because such questioning and discussion not only requires a great deal of preparation, but a good understanding of tort negligence law, a basic understanding of the medical issues and terminology used, and a solid understanding of the command and personnel being advised.

The MCJA or PCJA is personally responsible for the investigation of filed claims at the hospital.³²⁷ As a result, he must coordinate closely with the risk manager to ensure that he receives pertinent patient care assessment, utilization review, credentials and medical materiel data that have a bearing on risk management. He must further ensure that he is on the routing list to receive reports of filed patient com-

plaints, JCAHO survey results, and that he is notified of IG complaints that relate to risk management.

The Army regulation imposes on individual health care providers the duty to report all incidents of unintended or unexpected results arising from human error or mechanical failure during patient care.³²⁸ This report of unusual occurrence,³²⁹ DA Form 4106 (Report of Unusual Occurrence), must be must be forwarded to the clinical department chief within 24 hours of the incident and to the risk manager within 48 hours.³³⁰

The MCJA or PCJA must ensure that he is on the routing system to receive all DA Form 4106s (Reports of Unusual Occurrence). Although the regulation implies that all DA Form 4106s need not go to the MCJA or PCJA,³³¹ it is critical that they do so.

The risk manager is an AMEDD officer who is not trained in the law. Even cases with good defensible health care sometimes carry the potential for legal liability and only the MCJA or PCJA is best able to make that determination. A medical officer is simply not competent to make a determination about the legal implications of an incident regardless of his qualifications to evaluate the quality of medical care given. To avoid this potential problem, the MCJA or PCJA should request that he be formally placed on the routing list for review of the DA Form 4106.³³²

In addition to his investigative duties, the MCJA has a special reporting requirement. In the area of potential claims, a claims review must be sent to the U.S. Army Claims Service in PCI cases involving: emergency service incidents; operating room, surgical or anesthesia incidents; adverse drug reactions, injuries caused by medical devices, adverse patient outcomes due to improper treatment, and adverse out-

comes due to improper diagnosis.³³³ Although this requirement is not specifically imposed on PCJAs, as they are not normally full time hospital attorneys; this type of information should nevertheless be forwarded in serious cases on a case-by-case analysis.

Both MCJAs and PCJAs must report immediately all malpractice claims in excess of \$15,000 to the Commander, U.S. Army Claims Service.³³⁴ They must also forward an accurate and complete copy of the medical records³³⁵ to both the U.S. Army Claims Service³³⁶ and to the Department of Legal Medicine at the Armed Forces Institute of Pathology (AFIP) in Washington, D.C. for a medical legal assessment.³³⁷

The Department of Legal Medicine at the AFIP is staffed by team of doctor/lawyers who specialize in medical malpractice case reviews. One of their missions is the resolution of medical malpractice claims and the analysis of malpractice data to identify patterns of substandard care to report back to hospitals.³³⁸ The staff at the AFIP is an extremely valuable source of help for Army lawyers and must not be overlooked in conducting a thorough investigation of malpractice claims.

Special attention must be given to malpractice claims that proceed from the administrative claims procedure³³⁹ to litigation. For example, the MCJA or PCJA may likely be tasked with preparing an investigative report.³⁴⁰ This is true because he conducted the investigation while the claim was still being processed by the U.S. Army Claims Service. As such, he is the best able to relate the facts to the litigator. Likewise, all Army lawyers, not just MCJAs or PCJAs, should be aware that only the Litigation Division, Office of The Judge Advocate General; and not

the hospital, can authenticate medical records for litigation.³⁴¹

Finally, the MCJA or PCJA must closely coordinate his efforts with the next higher headquarters. This is a basic principle that is frequently violated in practice.

For example, military lawyers frequently attempt to discuss cases in litigation with the U.S. Army Claims Service and administrative claims files with Litigation Division, Office of The Judge Advocate General. This a common mistake and is easily avoided. Medical malpractice actions filed under the Federal Tort Claims Act (FTCA)³⁴² are the dual responsibility of the U.S. Army Claims Service and Litigation Division, Office of The Judge Advocate General.³⁴³ It is imperative that the Army lawyer understand that the U.S. Army Claims Service is exclusively responsible for a malpractice claim from initial filing until suit is instituted at which time the Litigation Division assumes exclusive responsibility for the case.³⁴⁴ This matter is one of command interest³⁴⁵ and outlines the importance of keeping abreast of the status of claims investigations.

3. Quality Assurance Coordinator (QAC)

The position of quality assurance coordinator (QAC) was originally created in 1984 as a liaison officer between the risk management team and other quality assurance efforts.³⁴⁶ Since that time, that role has expanded greatly.

The scope of the QAC's responsibilities are probably defined by local regulation as the Army regulation does not address this issue.³⁴⁷ These responsibilities often include the monitoring and investi-

gation of all departmental quality assurance related committee activities through review of departmental or committee meeting minutes and problem solving logs, service as the representative of the DCCS in consulting with clinical department chiefs, maintenance of a central file on all quality assurance related committees, and service as the liaison to external agencies such as the JCAHO or American Hospital Association (AHA).³⁴⁸

Because of these multiple liaison and investigative roles, the QAC is a valuable source of information concerning problems and trends in the hospital and should be consulted regularly by the MCJA or PCJA. Although not mentioned in the Army quality assurance regulation, it is important for Army lawyers to know that such an individual exists as either a full-time employee at large medical centers or hospitals or as a part-time employee at smaller hospitals or clinics. This individual is an important asset in carrying out the risk management program and should not be overlooked in conducting thorough investigations.

4. Medical Claims Investigator (MCI) or Post Claims Investigator

The Medical Claims Investigator (MCI) is a position unique to medical centers. As the fourth member of the risk management team, this person is responsible for full-time investigations of PCIs and malpractice claims. This person is usually a senior legal clerk E-7 or higher in rank.³⁴⁹

Hospitals and clinics do not have an assigned MCI. In those situations, the post staff judge advocate may simply detail a full or part-time legal clerk from the claims section to investigate cases depending on office workload. Since PCIs and medical claims investigations

require immediate investigation,³⁵⁰ this individual should be designated in advance and should be familiar with the investigative requirements contained in Chapter 2, AR 27-20, and Chapter 9, AR 40-66.

7. Credentialing

a. General

Credentialing is the process a hospital uses to grant a health care provider the privilege of exercising his independent professional judgment in a health care setting. This process may be done on an individual basis for those providers responsible for making independent judgments to start, stop, or alter a course of treatment;³⁵¹ or categorically for other health care providers who function in a support role.³⁵² Examples of those required to be individually credentialed include physicians, dentists, podiatrists, nurse anesthetists, nurse practitioners, nurse midwives, physician assistants, optometrists, and clinical psychiatrists.³⁵³

Categorical credentialing involves granting of privileges to personnel according to their professional category rather than as individuals.³⁵⁴ Professional qualifications for each category such as education, training, and experience must be written and clearly stated.³⁵⁵ These qualification standards are then submitted to the credentials committee to be voted on as a professional category.³⁵⁶ Examples of such professional categories include physical therapists, social workers, clinical dietitians, and speech pathologists.³⁵⁷

b. Standards

Each clinical department will establish standards for granting privileges to practice in that department.³⁵⁸ Individual and categorical credentials are then reviewed by the department and forwarded to the credentials committee for decision.³⁵⁹ A written copy of departmental credentialing standards must be maintained with the credentials committee's records, usually at the clinical support division (CSD).³⁶⁰

c. Explanation of privileges

1. General

The credentials committee may, after review, approve an application for privileges. If it does so, it may grant one of several types of privileges. They are courtesy, consulting, temporary (provisional), conditional, and full privileges.

2. Courtesy privileges

Courtesy privileges are given to providers assigned to the hospital for short periods of time. An example of this would be a provider on temporary duty (TDY) for 180 days or less.³⁶¹ Courtesy privileges may be granted either in writing or telephonically.³⁶² Better practice would require those privileges to be in writing to create an audit trail should a problem develop.

3. Consulting privileges

Consulting privileges is as the term suggests. It is given to military or civilian providers designated as consultants,³⁶³ usually from outside the hospital while serving in a consulting role.³⁶⁴

4. Temporary privileges

Temporary privileges are given to military providers arriving at a new duty station without a Practitioner's Credentials File (PCF).³⁶⁵ The military provider who arrives on permanent change of station orders without his PCF preceding him and requests in writing to be granted privileges may be granted temporary privileges. The commander may grant these privileges on the recommendation of the appropriate clinical department chief or the DCCS.³⁶⁶

These temporary privileges may not exceed thirty days.³⁶⁷ If the PCF has not arrived at the end of thirty days, that provider is restricted from all medical practice until the file has been located, reviewed by the credentials committee and acted upon by the commander.³⁶⁸

5. Conditional privileges

Conditional (provisional) privileges are given to military providers entering on active duty or civilians beginning employment with the AMEDD.³⁶⁹ This type of privilege is extended to providers on permanent change of station orders who arrive with a PCF, or who graduate from a continuing medical education (CME) program in a different specialty, or are undergoing a period of remedial training, or are returning to clinical medi-

cine after serving in a nonclinical capacity for more than one year.³⁷⁰

The period for which conditional privileges extends varies with the type of provider involved.³⁷¹ A military provider may be separated from service for failure to attain clinical proficiency in performing the full range of normal duties within the applicable conditional privilege period.³⁷² For a civilian provider, that period begins on the date of appointment.³⁷³ Failure to attain proficiency levels may result in adverse personnel action under the Federal Personnel Manual.³⁷⁴

6. Full privileges

Full privileges are also known as appointment status.³⁷⁵ These are privileges given the provider after completion of the conditional period allowing that individual to perform the full range of normal duties in the specialty assigned.³⁷⁶

d. Procedures

1. Application and renewal

The Army has developed an elaborate scheme concerning the initial application³⁷⁷ and renewal of privileges.³⁷⁸ Most of these procedures deal with technical forms reporting requirements and are not of interest to Army lawyers. What is significant for Army lawyers to know is that clinical privileges must be renewed at least once every two years.³⁷⁹

2. Delineation of privileges

The Army requires delineation of privileges based on education, training, and experience.³⁸⁰ This delineation simply spells out what a provider is and is not allowed to do in his clinical practice. Army lawyers must be aware that these provisions may be supplemented by local regulations.³⁸¹

The significance of this elaborate procedure does not surface for Army lawyers until a problem develops. That problem usually involves the withdrawal, suspension, or revocation of provider privileges.

3. Withdrawal, suspension, or revocation of privileges

a. General

The loss of clinical privileges may serve as the basis for administrative separation of a health care provider, military or civilian.³⁸² As such, it is the subject of a detailed procedure laid out in AR 40-66.³⁸³

b. Actions taken to limit, suspend, or revoke privileges

Information concerning provider misconduct or substandard medical practice must be forwarded to the clinical department chief or credentials committee for action.³⁸⁴ There are two kinds of action, each with its own procedures: summary actions, and routine actions.³⁸⁵

1. Summary actions

The summary procedure is used when a provider's performance requires immediate action to protect the health and safety of patients, employees, or others at the facility.³⁸⁶ If the provider's performance constitutes an immediate threat, the chairman of the credentials committee; usually the DCCS, may immediately limit or suspend that provider's privileges pending final hearing.³⁸⁷ It is important to note that the regulation does not limit conduct to instances of clinical incompetence. The regulation is broadly worded so that it can easily encompass instances of misconduct presenting an immediate harm such as sexual misconduct with a patient or drug abuse.³⁸⁸

The provider is given written notice that his conduct will be reviewed by the credentials committee. This notice includes the nature of the conduct complained of, the limitations placed on his privileges, and the notice of the right to a hearing if a written demand is made within ten days from the date of notice of suspension.³⁸⁹

If the provider fails to request a hearing or fails to appear, he waives his right of written appeal to the MACOM medical command.³⁹⁰ If a hearing is not held, the credentials committee's recommendations will be based on the evidence brought before it, without a hearing, and will be forwarded to the commander for review and final decision, and becomes a permanent part of that provider's PCF.³⁹¹

2. Routine actions

The routine procedure is used when there are indications of provider misconduct or substandard care

and the summary action procedure is not warranted by the facts.³⁹² As in the case of summary actions, the matter must be submitted to the credentials committee for review.³⁹³

The chairman of the credentials committee may order an investigation if more information is needed.³⁹⁴ If he does this, he must notify the next higher headquarters within two days that an investigation has begun.³⁹⁵ This is followed by weekly status reports until the investigation is concluded.³⁹⁶ The findings and conclusions stated in the investigative report, if any, are not binding on either the credentials committee or the commander.³⁹⁷

After review, the credentials committee may recommend to the commander that no action be taken or that a hearing be held. If no action is taken and the allegation deemed unsupported, the commander must send a report through the next higher headquarters to the Army Surgeon General within seven days, providing a summary of the information giving rise to the investigation, the rationale for the commander's decision, and a notation signifying confidence in the provider's conduct or performance.³⁹⁸ If a hearing is deemed appropriate, procedures similar to that taken in the summary action procedure are used with one notable exception.³⁹⁹

The regulation specifically states that the routine action hearing is administrative in nature and that formal rules of evidence as applied in trials by courts-martial do not apply.⁴⁰⁰ The provider has the right to consult with legal counsel but no right to representation at the hearing itself.⁴⁰¹ Military counsel will not be made available to represent a provider at such a hearing.⁴⁰² Civilian counsel, if retained at the provider's own expense, may act as his

advisor during the hearing but cannot question witnesses or present oral argument.⁴⁰³

Once the committee reaches a recommendation (e.g., suspension, reinstatement, revocation), those findings are submitted to a judge advocate officer for legal review.⁴⁰⁴ This review must take place before the commander takes action on the record.⁴⁰⁵

Judge advocates need to know that the government may be held liable for negligent failure to adequately investigate credentials. Since liability for negligent acts under the Federal Tort Claims Act⁴⁰⁶ is governed by state substantive tort law,⁴⁰⁷ judge advocates need to understand and properly advise hospital commanders of potential liability for negligent privileging of health care providers under a theory of corporate liability. This type of respondeat superior vicarious liability may be imposed not only for the negligent granting of privileges⁴⁰⁸ but also under a theory of apparent agency⁴⁰⁹ that may be sufficiently broad to impose tort liability on the United States.

Although FTCA case precedent holds that the government is not liable for acts of independent contractors,⁴¹⁰ judge advocates should not rely too heavily on these decisions. This is so because recent guidance from the Assistant Secretary of Defense promulgated after these cases were decided states that the government will grant privileges and exercise control over contract physicians to the same extent as government employees; in essence making them employees of the United States for FTCA purposes.⁴¹¹

III. DEFICIENCIES IN CURRENT QUALITY ASSURANCE EFFORTS

A. GENERAL

On review of the quality assurance efforts outlined thus far, the judge advocate soon to be assigned as an advisor on quality assurance matters might ask; "How can anything so meticulously detailed be defective?" The short answer is that there is relatively little fault at the Army and installation level. Fundamental problems do exist, however, at the Department of Defense planning level.

The heart of the problem centers on the fact that the Department of Defense does not have a clearly defined quality assurance program such as exists at the Army level. Health care in the Department of Defense is provided through three highly autonomous systems, headed by the surgeons general of each of the military services.⁴¹² Each service manages its hospitals and clinics in its own way without any central administrative authority.⁴¹³

There is currently no mechanism for reporting or analyzing trends from the voluminous quality assurance data generated at the Army and installation level. This in turn prevents policy planners from better coordinating the separate but related quality assurance functions of utilization review, patient care assessment, risk management, and credentialing.

This discussion centers on deficiencies found at both the Army and Department of Defense levels. I will begin with the deficiencies in the Army quality assurance program (QAP). With the exception of accreditation and QAC duties guidance, these criticisms do not fault the concept, only the ministerial implementation of the Army QAP. I will then proceed to discuss

the deficiencies in the Department of Defense's quality assurance efforts which are more fundamental in nature.

B. DEFICIENCIES IN THE ARMY QUALITY ASSURANCE PROGRAM (QAP)

1. General

The Army's quality assurance program (QAP) is conceptually logical, coherent, and has a central focus of purpose: improved quality health care. Its implementation, however, is deficient in several areas.

In conducting this analysis, I have assumed little or no knowledge of the reader in the area of quality assurance except that gleaned from the discussion thus far. For judge advocates experienced in the field, the deficiencies noted do not present any substantial barrier to understanding the program. To the new or inexperienced lawyer, however, these deficiencies may at first appear an insurmountable barrier to understanding and often result in considerable wasted time and effort, especially in the area of legal research.

2. Dispersed regulatory guidance

First, the Army's QAP addresses the core issues of patient care assessment, utilization review, risk management, and credentialing in one central regulation, namely AR 40-66. The problem is that other issues closely related to quality assurance do not appear in that regulation, but elsewhere.

For example, nursing quality assurance,⁴¹⁴ non-physician health care provider credentialing,⁴¹⁵ medical materiel quality assurance,⁴¹⁶ AFIP medical-legal assessments of medical malpractice claims,⁴¹⁷ and

hospital accreditation⁴¹⁸ are all set out in different regulations and are poorly cross-referenced.

What aggravates this situation further is that quality assurance related issues are governed by widely dispersed guidelines spelled out in statutes, Army regulations, command messages, policy letters, and memoranda of understanding, some of which are unpublished or otherwise unavailable to the military lawyer who needs these materials as research tools.⁴¹⁹

Since the inception of Army quality assurance efforts in 1974, the Army has undergone six versions of that program and is soon ready to promulgate its seventh edition.⁴²⁰ Since 1982, the Department of Defense has promulgated more than a dozen directives and instructions relating in whole or in part to quality assurance and is considering several others.

Furthermore, there is no body of case law available to interpret this rapidly developing area such as exists in criminal law, contracts, or FTCA litigation.⁴²¹ This does not mean the research materials are unavailable, only that staff judge advocates and claims attorneys must be more creative in their approach to legal research on quality assurance issues.⁴²²

This is not a conceptual problem with the quality assurance program, but a critique advocating ministerial simplicity. These aspects of quality assurance should be combined with the existing quality assurance regulation or at least more adequately cross-referenced to simplify understanding for both military lawyers and health care providers alike.

It is axiomatic that soldiers cannot follow orders they have neither been given nor have knowledge. If regulatory guidance is relatively simple and easy to understand, it is more likely to be followed.

For example, reporting requirements to the National Data Bank⁴²³ or to the surgeon general's office⁴²⁴ will be followed once they are generally known. The problem with these two requirements is that neither the Department of Defense/Health and Human Services Memorandum of Understanding nor the Army Surgeon General's message setting forth these requirements are available in widely published materials or regulations for judge advocates to research and follow. Once these provisions and others like it are generally understood; patient care assessment, utilization review, risk management, and credentialing functions may be conducted more efficiently to improve the quality of patient care.

3. Deficient hospital accreditation guidance

Hospital accreditation standards guidance is conceptually deficient. This guidance is contained in Chapter 5, AR 40-2. It is grossly inadequate, consisting of a single page. These standards on their face are not only old but inaccurate. This guidance refers to 1976 JCAHO accreditation standards⁴²⁵ in CONUS Army hospitals.⁴²⁶ This not only fails to recognize the fact that standards change annually⁴²⁷ but that JCAHO accredits Army hospitals worldwide; a practice that has existed for years.⁴²⁸ The only logical conclusion a reader can draw from a facial analysis of the Army's regulation is that either the Army is using 1976 accreditation standards or that only hospitals in CONUS are subject to JCAHO accreditation surveys, neither of which is true!⁴²⁹

This situation may be easily remedied. Current guidance need simply be incorporated into the existing Army regulation. Current guidance on accreditation

standards and requirements can only enhance the quality of care by keeping military hospitals up to date on acceptable standards of care.

4. Deficient QAC guidance

The same analysis may be used in assessing the guidance concerning the QAC's quality assurance responsibilities. If the QAC's duties are important enough to warrant discussion in a joint Surgeon General-TJAG memorandum of understanding, and to serve such a vital role in the overall quality assurance process;⁴³⁰ that individual's duties should be clearly stated in the Army's regulation. It is much easier to carry out duties effectively if the person responsible for those duties knows what they are.

5. Inadequate committee coordination

I will next consider adverse credentials reports that may affect risk management. As described earlier, the risk management committee may refer matters to the quality assurance or credentials committee as appropriate. Although utilization review and patient care assessment are normally handled at the clinical department level,⁴³¹ unresolved and multidepartment problems are brought to the attention of the hospital quality assurance committee. Since the MCJA or PCJA is normally a member of that committee, he is able to learn of issues with potential risk management implications.

This is not necessarily true of credentialing matters for two reasons. First, as noted earlier, the credentials committee's findings and recommendations go directly to the commander and are not sent through the

quality assurance committee.⁴³² Since the MCJA or PCJA is normally not a member of the credentials committee, he must rely solely on updates from the QAC to keep him informed of what is going on.

This is inadequate. In the case of an MCJA who is a full-time hospital attorney, this does not present an insurmountable obstacle. For a PCJA at a USACH or MEDDAC who may be in the hospital on a part-time or sporadic basis, the breakdown in communications could potentially be disastrous.

The differences between what the QAC and Army lawyer thinks is legally significant may differ greatly. The MCJA or PCJA should not have to rely on the QAC's legal analysis of a case any more than the clinician should rely on the lawyer to assess a patient's clinical outcome.

Second, the Army lawyer advising the commander on credentials matters is normally not the same lawyer who advises the command on the other aspects of quality assurance, especially risk management. An MCJA or PCJA is a defense oriented lawyer, especially in the areas of risk management and medical malpractice claims. Giving advice to the command on credentialing matters, particularly adverse personnel actions, may subject the MCJA or PCJA to conflict of interest problems, and cause an instant loss of credibility with the medical staff the MCJA or PCJA may be called upon to defend against allegations of malpractice.

This problem is easily resolved. The credentials committee should simply be required to report all adverse credentials actions as well as any other cases it deems appropriate to the risk management committee, MCJA, or PCJA. This allows the assigned lawyer to sit down with the medical staff to work through any legal

problems that may surface as a result of adverse credentialing actions.

6. Voluntariness of risk management committee

Finally, the Army program is deficient for not making the establishment of a hospital risk management committee mandatory. Paragraph 9-9a, AR 40-66 states that, "If possible, an RM committee will be set up." If the risk management program is critical enough to require the Army Surgeon General and The Judge Advocate General to enter into a memorandum of understanding,⁴³³ and is an integral part of the Army's regulatory quality assurance program;⁴³⁴ it warrants a mandatory committee structure to serve as the focal point of that program.

It should be noted; however, that although the regulatory language is precatory, most hospitals have a risk management committee, even if it is only an ad hoc committee meeting as needed.⁴³⁵ The advantage of the committee is that it allows a full discussion to take place at the hospital level with a documented audit trail of recommendations made and action taken. These recommendations and actions can then, in the case of filed claims cases, be shared with the U.S. Army Claims Service and the Department of Legal Medicine, AFIP, thus improving PCI and claims assessments as the program was designed to do.

7. Pending Revisions to Army Quality Assurance Program

Many of these noted deficiencies have not gone unnoticed by the Army Surgeon General. In fact, the proposals to integrate nursing quality assurance issues

into the general quality assurance regulation AR 40-66, to discuss the role of the QAC, and to create a mandatory risk management committee are currently under consideration⁴³⁶ and contained in a proposed revision of AR 40-66 pending publication.⁴³⁷

C. DEFICIENCIES IN THE DOD'S QUALITY ASSURANCE EFFORTS

1. General

One may conclude from the discussion thus far that a great deal has been accomplished in quality assurance by the Department of Defense, especially in the area of credentialing. The problem does not center on the effort expended, but its focus. At the Army and installation levels, these identified deficiencies center on ministerial aspects of program administration rather than concepts or doctrine.

At the Department of Defense level, however, they are more fundamental in nature. This criticism of quality assurance efforts centers on inadequate data collection and analysis and lack of standards at the Department of Defense planning level. First, let us begin with an analysis of quality assurance data collection and assessment.

2. Insufficient planning data

a. Patient care assessment

As noted earlier, several aspects of the Department of Defense quality assurance program exist on paper only. One such example is the National Data Bank.⁴³⁸

The Department of Defense never issued its supplemental guidance to put that program into action; however, because that program remains unfunded by Congress. The Department of Defense plan currently sits on the shelf as a proposed modification to the existing memorandum of understanding.⁴³⁹ This is certainly a major flaw, but the Department of Defense Health Affairs should not be taken to task for failure to carry out what Congress has chosen not to fund.⁴⁴⁰ It nevertheless creates a gap in potential combined patient care assessment/risk management data not likely to be filled through other sources. To aggravate this problem, patient care assessment data gathered by the AQCESS system is not forwarded to the DOD Health Affairs Office.⁴⁴¹ Not only is patient care assessment trends data not available through AQCESS, it is not available through other sources.⁴⁴²

This is inadequate. This means that patient care assessment trends data does not reach Department of Defense policy planners,⁴⁴³ thus undermining the substantial efforts made by the Department of Defense in the area of credentialing. It makes little sense to monitor providers' licensing and credentials if we do not simultaneously review the quality of their work product as measured by patient care assessment.

b. Risk management

Even assuming the National Data Bank's existence; which I do not, a focus on actual filed claims alone is not enough. As noted earlier, the time between an incident occurrence and the filing of a claim may vary from months to years.⁴⁴⁴ Information on filed claims is useful, but information on PCIs can provide information on systemic problems or patterns of substandard

care on a more current basis.⁴⁴⁵ The advantages of current information over data that may be months or years out of date is obvious.

Investigative data is usually more complete if conducted shortly after the incident is identified when witnesses and evidence are still available and recollections are fresh rather than months or years later when the claim is filed.⁴⁴⁶ This data serves two functions. It alerts policy planners at the Department of Defense level of serious potential problems more quickly than a scheme reporting only filed claims.⁴⁴⁷ It also improves the hospital's ability at the local level to ensure that the data it reports are based on timely, accurate and complete records. This is very easy to do shortly after an incident occurs and frequently impossible after the passage of months or years.

Centralized potential claims and claims data could also serve other purposes. For example, information concerning defective medical equipment or adverse drug reactions discovered by one military service may be shared with the other services so that the problem is addressed once, rather than multiple times, resulting in needless patient injury.⁴⁴⁸ This type of reasoning is the whole purpose behind the joint use of facilities and exchange of information between services. The same analysis can be used concerning providers who change employment from one military service to another.

c. Utilization review

The Department of Defense has imposed upon itself⁴⁴⁹ and has had imposed on it from without⁴⁵⁰ criteria for measuring resource allocation. Although data is collected concerning hospital patient loads,⁴⁵¹

and soon will be collected on DRGs,⁴⁵² it has created no mechanism to coordinate that data with the patient care assessment and risk management data to determine whether it is using its vast resources⁴⁵³ in the most effective way to increase the maximum quality of health care to the maximum number of people.

The current system allocates funds through analysis of CWU workload data.⁴⁵⁴ The military hospital that generates the greater number of patient visits may appear more productive on paper although this says nothing about the quality of care in those facilities.⁴⁵⁵

This may be remedied through utilization review data that not only looks at patient workload but cross references this information with patient outcomes to improve the quality of care for the greatest number of people. For example, a 1988 Congressional Budget Office report noted:

If the services were to close some of their smallest and oldest hospitals, or convert them to outpatient facilities, they would be able to reassign active-duty medical staff to catchment⁴⁵⁶ areas where the demands for care are heaviest. Large military hospitals would be able to operate more beds, and therefore reduce their reliance on CHAMPUS.

Several current initiatives show the possibility of realigning medical assets. At Fort Drum, New York, for instance, the Army avoided having to build a small hospital to support an expanded installation by working out agreements with local civilian hospitals and physicians to provide care under CHAMPUS. Sharing resources with the Veterans Administration is another option. The Air Force was able to convert the small and aging hospital at Kirtland Air Force Base, New Mexico, into an outpatient center because it worked out an agreement to staff 40 beds in a nearby V.A. medical center.⁴⁵⁷

This data also serves one other function that is often overlooked. The primary mission of the AMEDD and other military health professionals is to sustain the fighting forces in the field in time of war.⁴⁵⁸ The same type of data that are used to determine the amount

and type of care we can provide with existing resources and their allocation can be used to formulate medical resource planning in time of war, not a small area of concern to Congress and the health professions.⁴⁵⁹

For example, Congressional investigators found that despite the widespread use of CHAMPUS, only 60% of available bed space was operational in 1985.⁴⁶⁰ Although excess hospital capacity is desirable for wartime readiness contingency reasons, better analysis could explain why Army and Air Force hospitals operate their hospitals at two thirds capacity whereas the Navy operates at less than half the rate of the other services.⁴⁶¹

Medical wartime planning in Europe suffers from the same lack of coordinated planning. In fact, one United States Senator recently noted:

In another example, we learned that the Air Force was planning to evacuate a particular hospital in Europe in the event of war because it believed the hospital would be destroyed almost immediately. At the same time, the Army was planning to move in and use the same hospital after the Air Force left. Now, Mr. President, who is in charge over there anyway? There is no excuse for this type of situation.⁴⁶²

Other wartime problems are likely to center on staffing and personnel, especially nurses.⁴⁶³ For example, only one out of 18 physicians practicing in military hospitals is a civilian.⁴⁶⁴ For nurses, that figure is one out of five.⁴⁶⁵ In the Navy, that figure is one out three.⁴⁶⁶

The impact on wartime readiness and deployability will be great if we rely too heavily on civilians to provide care in military hospitals. Such problems can be addressed only at the Department of Defense level, especially in the planning of joint operations.

d. Credentialing

The credentialing aspect of quality assurance has been well addressed by the Department of Defense Health Affairs staff.⁴⁶⁷ The problem is not with the guidance issued as much as the fact that credentials data such as PCFs are maintained locally⁴⁶⁸ with no central reporting system. A central credentials data reporting system could be used to identify substandard performers, especially if it is coordinated effectively with centralized risk management and claims reporting.⁴⁶⁹

For example, DOD policy planners may want to know: What types of practitioners do we want to recruit to work in our hospitals? Do we want to increase or decrease the number of foreign medical graduates? Do we want to emphasize academic credentials or clinical experience in our accession selection criteria? As noted earlier, statistics collected thus far indicate that foreign medical graduates make up 9% of the total medical care provider force yet constitute 33% of all sanctions cases, mostly for incompetence. The Assistant Secretary of Defense (Health Affairs) might, therefore, decide to curtail the recruitment of foreign medical graduates, thus reducing a large source of PCIs, improving the quality of health care.⁴⁷⁰

This centralized credentials reporting could also serve two other purposes. Although there is no evidence of widespread falsification of professional credentials, spot checking has often resulted in the discovery of false⁴⁷¹ or incomplete⁴⁷² credentials data which needs to be eliminated if the system is to work effectively.

Centralized credentials data will assist military lawyers engaged in identifying and interviewing physi-

cians in litigation involving more than one military service. For example, the highly mobile nature of military patients and the joint nature of military operations presents obstacles for army lawyers defending malpractice suits. They should not have to seek background information about each provider from each separate facility where that provider practices. In complex cases where care is rendered over the course of several years in many different facilities by two or more military services, the litigation burden in answering interrogatories and other pretrial discovery⁴⁷³ can be intolerably difficult. This needlessly wastes legal assets which might be better spent interviewing witnesses than in trying to locate them and their credentials files.⁴⁷⁴

In the case of physicians, this should not be difficult to obtain.⁴⁷⁵ Failure to centralize this data could very well lead to another case similar to that of Dr. Stanford which was the impetus for the Department of Defense quality assurance effort in the first place.

e. Accreditation

One major flaw in accreditation guidance is that it is not recognized for the vital aspect of quality assurance that it is. This problem can easily be remedied by its inclusion in a centralized Department of Defense quality assurance program.

The second major flaw centers on the voluntariness of the accreditation function.⁴⁷⁶ If the accreditation process is important enough to be mentioned in service regulations⁴⁷⁷ and is a prerequisite for residency training programs in our teaching hospitals;⁴⁷⁸ it should be mandatory, not voluntary.

A voluntary system can circumvent the purposes of the accreditation process if it allows substandard hospital facilities to avoid detection by simple refusal to have those hospitals surveyed. This is precisely what occurred in Wurzburg and Bad Canstadt, West Germany in 1987 when JCAHO surveyors were not invited to survey those hospitals. These facilities were known to be substandard in the area of physical facilities although there were no suspected deficiencies in the clinical competence of those manning the facilities.⁴⁷⁹ The same situation exists at the 121st General Hospital in Seoul, Korea.⁴⁸⁰

The Assistant Secretary of Defense (Health Affairs) has recognized this problem. Physical facilities are also one aspect of military construction and have not escaped the notice of Congress.⁴⁸¹ Mandatory JCAHO surveys would force disclosure of substandard facilities and would place the onus on Congress to fund new construction for those facilities if it is sincere about improving the quality of care for soldiers and dependents overseas.⁴⁸² This is precisely the approach taken in the Department of Defense's proposed quality assurance directive.⁴⁸³

3. Standards for uniformity

a. General

This discussion thus far has focused on insufficient data input at the Department of Defense level. The standards promulgated by the Department of Defense to the military services are also deficient. There are two types of standards: standards for uniformity and standards for quality. I will deal with each in turn.

b. Planning uniformity

As evident from the discussion thus far, the Department of Defense does not define its quality assurance efforts in the same way the Army does. The Department of Defense's efforts to date do not even address the issues of utilization review⁴⁸⁴ or risk management⁴⁸⁵ much less provide any guidance for monitoring service level programs.

Quality assurance supervision efforts at the Department of Defense level can only be less effective when their focus of program interest is based on a different program (or no defined program at all) from the service being supervised. An effective program can exist only if it is defined in the same way at all levels of the organization.

This point becomes more evident when the other services, who I have not generally addressed in this discussion, are factored into the equation. For example, the General Accounting Office (GAO) recently reviewed summary malpractice claims data reports filed by the three services with the Department of Defense Health Affairs office.⁴⁸⁶ The Health Affairs Office could not use the data for trending purposes because they were inconsistent.⁴⁸⁷ The GAO specifically noted:

The Navy reported the number of medical incidents resulting in claims, while the Army and Air Force reported the total number of claims. Because one incident may generate multiple claims, the reported information was not comparable. Further, at the time of our review, officials were not sure whether the data included claims filed by active duty service members, settled through the U.S. Attorney's offices, filed overseas,⁴⁸⁸ or settled by local military legal offices.

The Assistant Secretary of Defense for Health Affairs has even told the GAO, the investigative arm

of Congress, that a central quality assurance reporting system has merit.⁴⁸⁹ He noted, however, that the prerogatives of the three services would have to be considered before data could be maintained centrally but did not state a reason for this decision or state what these prerogatives might be.⁴⁹⁰ Congress responded to this argument by directing the Assistant Secretary of Defense (Health Affairs) to submit a report to the various congressional appropriations committees by June 1, 1988, telling them of steps taken to implement the plan for creating a uniform system of collecting and analyzing quality assurance data.⁴⁹¹

If trends analysis is not possible when information such as malpractice claims data is reported, it is equally impossible when data is not available at all such as patient care assessment data created by the AQCESS system. If data is not comparable or is unavailable for analysis, planning for improved patient care and supervision of resource allocation suffers. A uniform reporting system could avoid these deficiencies.

c. Joint use uniformity

Uniformity is important for one other reason. Current operational planning at the Department of Defense is focused on joint operations. Medical services are treated no differently. In fact, the Department of Defense must plan for and practice the joint use of medical facilities.⁴⁹² This requirement is not only a cost saving measure to reduce, consolidate, or eliminate facilities, but a method for exchanging medical education and training between the various services.⁴⁹³

This is not merely an area of academic interest. The need for a commonly defined program has surfaced, for example, in the recently formed San Antonio Joint Military Medical Command (JMMC) where Brooke Army Medical Center and assigned Army medical personnel in the San Antonio area are placed under the supervision of the Air Force.⁴⁹⁴ A uniform Department of Defense quality assurance program can only facilitate these efforts and future efforts like it.⁴⁹⁵

3. Standards for quality

At the Army and installation level, patient care assessment data can be compared against provider credentials data. This information can in turn be analyzed in the light of risk management malpractice data, utilization review patient workload data, and JCAHO accreditation survey findings. This type of data, when properly analyzed by the quality assurance committee and its functional subcommittees can answer many of the difficult questions arising in quality assurance such as: Are adverse patient results due to substandard provider care or some other cause? What effect does an increased (decreased) patient workload have on the quality of care?⁴⁹⁶ Are there identifiable trends in filed malpractice claims that signify problems that should be addressed in order to improve the quality of care? Will the purchase or use of new or different technology improve the quality of care or will it result in unnecessary clinical and legal risks?

This type of analysis need not be limited to purely medical malpractice concerns. For example, the Department could examine all death cases to determine the cause of death, not only for clinical reasons, but for reasons such as safety accidents, child abuse and

the like. Raw data on deaths in hospitals is not meaningful to policy planners, but trends data that translates this loss in human life to force equivalents may be useful and measurable. For example, the significance of fifty active duty deaths due to health related and safety incidents over the last several years may not impress a policy planner. If that same figure, however, is presented as the equivalent of an infantry platoon lost due to substandard care or inadequate safety programs, he is more likely to take action as appropriate.

The bigger question in this analysis is, if such a mechanism exists at the installation level, why not at the Department of Defense planning level? The types of questions suggested are multidisciplinary in nature and require a comprehensive quality assurance program to answer them. Planners need to be able to identify potential problems before they can address solutions. Treating the symptoms of malpractice claims rather than the real problem of improving the quality of health care may only make matters worse in the long run. This analysis has worked well at the Army level and there is no evidence to suggest that it cannot also work at the Department of Defense level.

Congress recognizes that additional resources will be needed to carry out a centralized data analysis system.⁴⁹⁷ This impact can be minimized, however, if the work is allocated among the different organizations already performing quality assurance functions. For example, the Armed Forces Institute of Pathology⁴⁹⁸ could abstract data, develop statistical summaries and prepare case studies.⁴⁹⁹ The military department Judge Advocates General could abstract claims and litigation data, develop statistical summaries, and prepare case studies on risk management issues. The Department of

Defense Health Services Advisory Board could abstract patient load data, develop statistical summaries, and prepare studies on utilization review, resource sharing for peacetime and wartime operations. The Department of Defense Health Affairs staff could then analyze the data and advise the services who in turn could focus their attention on the most significant problems.⁵⁰⁰ The fact that some additional resources might be needed should not stifle quality assurance initiatives.

In light of the continued concern about Army and Department of Defense health care and the continual pressure from Congress⁵⁰¹ and the popular press⁵⁰² for greater accountability and additional action, it is apparent that more needs to be done if we are to achieve the goal of rendering the best possible care for our soldiers and their dependents. To that end, I propose the promulgation of two Department of Defense directives creating a quality assurance and health care provider credentials program.

IV. PROPOSED DOD QUALITY ASSURANCE AND CREDENTIALS REVIEW DIRECTIVE

Enclosed as appendices to this article are two proposed Department of Defense directives creating quality assurance and credentials reporting data programs at the Department of Defense (DOD) level. Although these directives are relatively short and self-explanatory, I will nevertheless discuss the highlights of their provisions. These proposed directives closely mirror proposed quality assurance directives currently under consideration at the DOD Health Affairs Office.⁵⁰³

The proposed DOD quality assurance program consist of five components: patient care assessment,

utilization review, risk management, credentialing, and accreditation. Patient care assessment, utilization review, and risk management are added to provide the required uniformity discussed earlier if the DOD quality assurance program is to work effectively. The element of accreditation was added in recognition of the significant role it plays in assessing the quality of care and is specifically included in the proposed DOD quality assurance directive under consideration by the DOD Health Affairs Office.

The proposed DOD credentials review directive simply updates requirements concerning health care provider performance and conduct. It provides specific guidance concerning what is to be reported, when, and to whom, with specific requirements for the reporting and use of such data.

The approach taken is simple. These directives simply require data of trends in each of the respective areas of quality assurance to be reported through the chain of command where it will eventually reach the DOD Quality Assurance Committee. The focus is on trends data; raw data runs the risk of becoming unmanageable and may result in needless and counterproductive micromanagement by DOD policy planners.

I have inserted provisions that as appropriate, will require the military services and their representatives to coordinate with the already existent Quality Assurance Automation Working Group and DOD Health Services Advisory Board in working out the specific details as to what level and types of data reporting is both useful and manageable.

This will avoid the inaction likely to result if automation specialists or health care providers operate separately in devising a system. Neither has the expertise to operate in the other's area of practice.

The frustrations of operating in a multidisciplinary area without the proper tools may force most quality assurance personnel to simply place the project in the "too hard to handle" category and simply do nothing.

The directive will use data that already exists in most cases at the installation level where it is created, with several notable exceptions. The risk management and credentials reporting provisions are new and fairly specific for two reasons.⁵⁰⁴ First, the type of information sought will be more easily reported and compared to information contained in the National Data Bank once it is made operational. Second, credentials data and malpractice claims are perhaps the most closely scrutinized aspects of quality assurance. This data will help provide the information and accountability that is demanded of the DOD health care system, especially by congressional reviewers.⁵⁰⁵

These directives require no substantial force structure changes, especially for the individual services and the Army in particular. It simply proposes initiatives already contemplated by the DOD Health Affairs Office. They provide a focus for the considerable efforts already being made at that level. These directives are designed to take effect six months from the date promulgated to allow the services adequate time for coordination and planning in accordance with the directives.

V. CONCLUSION

In this article, I have attempted to lay out four major points. First, that the DOD and the Department of the Army have a need for quality assurance programs in their hospitals and that such programs exist in one form or another. Second, although considerable efforts

have already been made; deficiencies exist both as to the quality assurance program structure and reporting mechanisms. Third, many problems in the existing system have not gone unrecognized but the initiatives taken to date are inadequate if we are to reach our goal of providing the optimum level of care for our soldiers and dependents. Fourth, these outlined deficiencies may be corrected through promulgation of two DOD quality assurance directives that will focus the considerable but disjointed efforts of the DOD Health Affairs Office to improve the quality of health care.

The need for reform is obvious. Realistically, there are only two alternatives; continue with the present system or enact reforms of the nature described in this thesis.

The first alternative is not realistic. Quality assurance is not a static program but a dynamic process that needs to change with the changing demands of health care. Continuation under the present system will mean that DOD planners at all levels will no longer be in control of events, but will eventually be overcome by them, most likely in the form of additional congressional oversight. Although the DOD Health Affairs Office must be responsive to the will of Congress; its efforts might be better spent in carrying out its programs than in testimony before oversight committees explaining deficiencies in the current system.

The second alternative, that proposed by this thesis, and similar initiatives currently being contemplated in whole or in part by the DOD Health Affairs Office, is a reasonable solution to a complex problem. The need for uniformity and improved quality reporting mechanisms and management supervision makes this proposal the only reasonable reform available absent a

major restructuring of the DOD quality assurance system, which is neither necessary nor contemplated at this stage.

FOOTNOTES

1. United States General Accounting Office, Report No. GAO/HRD-87-73, Medical Malpractice: A Framework for Action 9, May 20, 1987 [hereinafter GAO: Medical Malpractice Action Report].

2. Id.

3. Dep't of Army, Reg. No. 40-3, Medical Services-Medical, Dental, and Veterinary Care, paras. 4-1, 4-12 (15 Feb. 1985) [hereinafter AR 40-3]. See generally Dep't of Defense Directive No. 1341.1, Defense Enrollment Eligibility Reporting System (DEERS) (Oct. 14, 1981); Dep't of Defense Instruction No. 1341.2, Defense Enrollment Eligibility Reporting System Procedures (Mar. 2, 1982).

4. See Policy Letter 82-3, Office of The Judge Advocate General, U.S. Army, subject: Medical Malpractice Claims (16 Apr. 1982), reprinted in The Army Lawyer, May 1982, at 2 (making the installation medical malpractice claims program an item of interest during inspections by The Judge Advocate General conducted pursuant to Uniform Code of Military Justice art. 6, 10 U.S.C. § 806 (1982)) [hereinafter UCMJ].

5. See, e.g., Dep't of Defense Instruction No. 6025.5, Personal Services Contracting Authority for Direct Health Care Providers (Feb. 27, 1985); Dep't of Army, Reg. No. 40-60, Medical Services-Policies and Procedures for the Acquisition of Medical Materiel (15 Mar. 1983); Dep't of Army, Reg. No. 40-61, Medical Services-Medical Logistics Policies and Procedures (30 Apr. 1986) [hereinafter AR 40-61]; Dep't of Army, Reg. No. 40-65, Medical Services-Review Procedures for High Cost Medical Equipment (1 Nov. 1986). See also infra notes 290-301 and accompanying text for a fuller dis-

cussion of utilization review and its functions.

6. 5 U.S.C. § 552 (1982); Dep't of Army, Reg. No. 340-17, Office Management-Release of Information and Records from Army Files, ch. 5 (1 Oct. 1982).

7. 5 U.S.C. § 552a (1986); Dep't of Army, Reg. No. 340-21, Office Management-Release of Information and Records from Army Files (1 Oct. 1982); Dep't of Army, Reg. No. 340-21-1, Office Management-The Army Policy Program-Systems Notice and Exemption Rules, ch. 10 (16 Dec. 1985).

8. Few lawyers will agree to represent a client on matters relating to professional credentials. This area of the law, like medical malpractice litigation, is highly specialized. It is essential that the legal assistance officer learn enough about the Army's regulatory procedure outlined in Dep't of Army, Reg. No. 40-66, Medical Services-Medical Record and Quality Assurance Administration, ch. 9 (1 Apr. 1987) [hereinafter AR 40-66], to properly refer these clients to civilian lawyers competent to handle these matters. This is especially true since military attorneys will not be made available at either summary or routine credentials hearings discussed later in this paper. AR 40-66, para. 9-17; See infra notes 386-411 and accompanying text for a discussion of adverse credentials actions,

9. E.g., Dep't of Army, Reg. No. 635-100, Personnel Separations-Officer Personnel, para. 3-58a (105, 1 Oct. 1985) [hereinafter AR 635-100].

10. Federal Personnel Manual, Chapter 752; AR 40-66, para. 9-11e(1). See also AR 40-66, para. 9-17 (requiring legal review on any adverse credentialing matter before the commander takes action on that file).

11. Military Medical Care System: Hearings Before the Subcomm. on Manpower and Personnel of the Senate Comm. on Armed Services, 99th Cong., 1st Sess. 13 (1985) (statement of William Mayer, M.D., Ass't Sec'y of Defense for Health Affairs) [hereinafter Senate Military Health Care System Hearings]. Medical expenditures rose to \$11.1 billion in 1987. See generally United States Congressional Budget Office, Reforming the Military Health Care System 1, Jan., 1988 [hereinafter CBO: Health Care System Report].

12. United States General Accounting Office, Report No. GAO/HRD-87-30, DOD Health Care: Better Use of Malpractice Data Could Help Improve Quality of Care, June 4, 1987 [hereinafter GAO: DOD Health Care].

13. Senate Military Medical Care System Hearings, supra note 11, at 99.

14. Dep't of Defense Instruction No. 6015.1, Classification, Nomenclature, and Definitions Pertaining to Fixed Medical Treatment Facilities (Sept. 22, 1977) [hereinafter DOD Inst. 6015.1] states:

An inpatient is an individual other than a transient patient who is admitted (placed under treatment or observation) to a bed in a medical treatment facility which has authorized or designated beds for inpatient medical or dental care.

A transient patient is a patient en route from one medical treatment facility to another medical treatment facility.

15. The origins of the CHAMPUS program go back more than 30 years. Military health care beneficiaries could not get direct health care on their own before 1956. In 1956, Congress created a Military Medicare plan that provided for limited hospitalization, surgery, and maternity care in civilian hospitals at government expense. This program was greatly expanded in 1966 by the Military Medical Benefits Amendments, 1966, Pub. L. 89-614, 10 U.S.C. §§ 1071-1088 (1982). This 1966 statute greatly expanded the old Military Medicare plan coverage to include outpatient care, psychiatric care, prescription drugs, and general comprehensive care. The Military Medicare program was renamed CHAMPUS in 1968. For an excellent discussion of the CHAMPUS program and its history, see CBO: Health Care System Report, supra note 11, at 35-77.

See also Dep't of Defense Instruction No. 6010.8, Administration of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) (Oct. 24, 1984). Regulations promulgated under this program authorize care for civilian dependents and retirees under the age of 62 in civilian health care institutions at government expense. The National Defense Authorization Act of 1987, Pub. L. 99-661, § 701, 100 Stat. 3894-3899 (1986), established the Military Health Care Account and directed the CHAMPUS program be paid from that account. Congress appropriated \$2.26 billion for this program in 1988, \$733 million of which was earmarked for the Army. See H.R. No. 58, 100th Cong., 1st Sess., at 169, reprinted in 1988 U.S. Code & Admin. News 1175.

16. "An outpatient is an individual receiving health services for an actual or potential disease or injury that does not require admission to a medical treatment facility for inpatient care." DOD Inst. 6105.1 at 3.

17. Senate Military Medical Care System Hearings, supra note 11, at 14.

18. See GAO: Medical Malpractice Action Report, supra note 11 and accompanying text; CBO: Health Care System Report, supra note 11, at 1-6. Jost, The Joint Commission on the Accreditation of Hospitals: Private Regulation of Health Care and the Public Interest, 24 B.C.L. Rev. 835, 837 (1983) [hereinafter Jost].

19. E.g., The Feres Doctrine and Military Medical Malpractice: Hearing on S. 489 and H.R. 3174, Before the Subcomm. on Admin. Practice and Procedure of the Senate Comm. on the Judiciary, 99th Cong., 2d Sess. 11 (1986) (statement of Sen. Edward M. Kennedy); Military Medical Malpractice Liability for Injuries Resulting From the Atomic Weapons Testing Program: Hearing on H.R. 1054 and H.R. 1341 Before the Subcomm. on Admin. Law and Governmental Relations of the House Comm. on the Judiciary, 100th Cong., 1st Sess. 120 (1987) (summary of statement by Robert W. Guimond, Ph.D., J.D., Professor of Medical Physiology, Univ. of Mass. at Boston, in support of H.R. 1054).

20. See Jost, supra note 18, at 837; Military Medical Malpractice: Hearings on H.R. 1161 Before the Subcomm. on Admin. Law and Governmental Relations of the House Comm. on the Judiciary, 99th Cong., 1st Sess. 255 (1985) (statement of Richard K. Willard, Acting Ass't Att'y Gen., Civil Div., U.S. Dep't of Justice) [hereinafter House Hearings on H.R. 1161].

21. Medical malpractice is defined as follows:

Medical malpractice. In medical malpractice litigation, negligence is the predominant

theory of liability. In order to recover for negligent malpractice, the plaintiff must establish the following elements: (1) the existence of the physician's duty to the plaintiff, usually based upon the existence of the physician-patient relationship; (2) the applicable standard of care and its violation; (3) a compensable injury; and (4) a causal connection between the violation of the standard of care and the harm complained of.

Black's Law Dictionary 864 (5th ed. 1979).

22. United States Department of Justice, Report of the Tort Policy Working Group on the Causes, Extent, and Policy Implications of the Current Crisis in Insurance Availability and Affordability 47 (1986) cited in Priest, The Current Insurance Crisis and Modern Tort Law, 96 Yale L. J. 1521, 1522 (1987).

23. Id.

24. See Federal Incentives for State Health Care Professional Liability Reform Act of 1985: Hearings on S. 1804 Before the Senate Comm. on Labor and Human Resources, 99th Cong., 2d Sess. 1-3 (1986) (statement of Comm. Chairman Sen. Orrin G. Hatch).

25. See generally United States General Accounting Office, Report No. GAO/HRD-86-50, Medical Malpractice: No Agreement on the Problems or Solutions, Feb. 24, 1986.

26. But see The Health Care Quality Improvement Act of 1986, §§ 421-427, 42 U.S.C. §§ 11131-11137 (1986) (creating the National Data Bank to collect precisely this type of information). Statistics to be compiled by that system are not yet available.

27. United States General Accounting Office, Report No. GAO/HRD-87-55, Medical Malpractice: Characteristics of Claims Closed in 1984, Apr. 22, 1987 [hereinafter GAO: 1984 Medical Malpractice Claims Report].

28. GAO: DOD Health Care, supra note 12, at 11.

29. Data shows that 689 claims were filed against the Department of Defense in 1982, 833 in 1983, 854 in 1984, and 930 in 1985. Noted in Dep't of Defense, Information Paper-Management of Malpractice in the Department of Defense (1988) (unpublished monograph) [hereinafter DOD Information Paper]; See also GAO: DOD Health Care, supra note 12, at 10. The significance of data concerning closed claims should be reviewed cautiously. The fact that a claim is closed in any given year is no assurance that the malpractice complained of occurred in that year. Of those claims closed in 1984, about 73% concerned incidents that occurred between 1979-1982, with the remaining 27% involving incidents as far back as 1953 or as late as 1984. It should be further noted that the average time from the time a claim is filed until it is finally resolved through settlement or litigation in the civilian sector is 25 months. (emphasis added) cited in GAO: Medical Malpractice Action Report, supra note 1, at 20.

30. DOD Information Paper, supra note 29. The number of claims declined from 930 in 1985 to 895 in 1986, to 876 in 1987.

31. Id.

32. Oversight on Issues Relating to the VA's Department of Medicine and Surgery: Hearing Before the Senate Comm. on Veterans' Affairs, 98th Cong., 2d Sess. 98

(1984) (statement of J. Jarrett Clinton, M.D., Acting Ass't Dep. Sec'y of Defense for Professional Affairs and Quality Assurance) [hereinafter Senate Oversight Hearings].

The 60 Minutes telecast focused on the case of Dr. William Stanford, the Chief of Cardiothoracic Surgery at Wilford Hall Air Force Medical Center in San Antonio, Texas. The facts of the Stanford case are set forth in Green v. United States, 530 F. Supp. 633, 636-639 (E.D. Wis. 1982), aff'd, 709 F.2d 1158 (7th Cir. 1983). Those facts are summarized below.

Dr. Stanford was an Air Force surgeon stationed at Wilford Hall Air Force Medical Center in San Antonio, Texas (Wilford Hall). He received his medical degree from the University of Iowa in 1956, was board certified in general surgery in 1965, and in thoracic surgery in 1966. He served as the chief of cardiothoracic surgery at Wilford Hall from 1969-1980, and as chief of the department of surgery from July 1975 to September 1977.

Suspensions concerning his clinical competence arose in 1976. Clinical statistics showed that Dr. Stanford's death rate was almost four times higher than those of other doctors performing the same type of surgery. These findings were presented to the hospital commander who took no action on this initial report.

The issue was again reported to the commander when anesthesiologists and other assistants refused to perform surgery when Dr. Stanford was assigned cases as the primary surgeon. This time the commander reported his findings to the Air Force's national civilian consultant on cardiothoracic surgery.

Dr. Stanford's performance was found deficient and he was given the option of attending a one year fellowship program. He was subsequently assigned to work

with civilian health care practitioners in Wisconsin to bring his surgical skills up to an acceptable level. No warning of his deficiencies was given to either his patients or fellowship instructors. In fact, his instructors did not question his qualifications simply because he was the chief of surgery at a large military teaching hospital!

During his fellowship year, Dr. Stanford performed coronary artery bypass surgery on Takuye Green at Milwaukee Lutheran Hospital. During the connection of the heart-lung machine, the lines to and from the machine were reversed. As a result, oxygen depleted blood was sent to her brain and she suffered irreversible brain damage.

Dr. Stanford returned from his fellowship year and was given the title of chief of cardiothoracic surgery at Wilford Hall, but was not allowed to perform surgery except under the supervision of another surgeon. No other action was taken to correct Dr. Stanford's clinical deficiencies which were not corrected during his fellowship year. It was this inaction in dealing with Dr. Stanford; as brought out in the Green malpractice suit, that caught the attention of the media in general and 60 Minutes in particular.

33. Senate Oversight Hearings, supra note 32, at 98.

34. Id. at 99, 100.

35. House Hearings on H.R. 1161, supra note 20, and accompanying text; GAO: DOD Health Care, supra note 12, and accompanying text.

36. See, e.g., Fiscina, Malpractice Claims in the Military Health Care System: Survey of Contributing Factors, With Recommendations, 150 Mil. Med. 511 (1985); Vira, Perspectives on Malpractice in the

Military Health Care System, 150 Mil. Med. 524 (1985); Burkhalter, The Credentialing Process, 152 Mil. Med. 509 (1987); Moore, The Twofold Challenge to the 18th Medical Command: Peacetime Quality of Care and Military Preparedness in the Republic of Korea, 152 Mil. Med. 494 (1987).

37. Act to Avoid Malpractice Suits, DOD Advised, Army Times, Oct. 28, 1985, at 41, col. 1; Army Times, Mar. 28, 1983, at 4, col. 1.

38. Senate Oversight Hearings, supra note 32, at 99.

39. Id. at 100.

40. Letter from William Mayer, M.D., Ass't Sec'y of Defense for Health Affairs, to Frank C. Conahan, Ass't Comp. Gen., Nat'l Security and Int'l Affairs Div., United States General Accounting Office (Mar. 20, 1987) (discussing the Dep't of Defense response to the General Accounting Office draft report: DOD Health Care: Better Use of Malpractice Data Could Help Improve Quality of Care, reprinted in GAO: DOD Health Care, supra note 12, at 93-95.

41. Interview with Colonel Edward Haines, United States Army Medical Corps, Senior Policy Analyst for Quality Assurance, Professional Affairs and Quality Assurance Branch, Office of the Ass't Sec'y of Defense (Health Affairs), at the Pentagon (Mar. 11, 1988) [hereinafter Interview with Colonel Haines].

42. Id.

43. Id. Colonel Haines is a voting member of the Tri-Service Quality Assurance Committee.

44. Senate Oversight Hearings, supra note 32, at 99, 100.

45. Dep't of Defense Directive No. 6000.7, Dissemination of Information on Medical Officers (July 29, 1982) [hereinafter DOD Dir. 6000.7].

46. Id.

47. Id. (setting forth the Directive's statement of purpose).

48. Dep't of Defense Directive No. 6025.3, DOD Health Care Provider Conduct (Aug. 24, 1984) [hereinafter DOD Dir. 6025.3].

49. Id.

50. Id.

51. 42 U.S.C. §§ 11101-11152 (1986).

52. H.R. 99-903, 99th Cong., 2d Sess. 2, reprinted in 1986 U.S. Code Cong. & Admin. News 6384-6386.

53. Id.

54. Id.; But compare Statement of President Ronald Reagan upon signing S. 1744, 22 Weekly Comp. Pres. Doc. 1565 (Nov. 17, 1986) (expressing concerns about the antitrust aspects of this legislation and the potential danger that the anticompetitive nature of the statute might in fact reduce rather than improve the quality of health care). See generally J. Del Real, The Reagan Administration's Health Care Approach, 4 Pub. L. Forum 8 (1984); Exec. Order 12,607, 52 Fed. Reg. 34,190 (1987) (proposing industry reform based on private standards for government regulation).

55. 42 U.S.C. § 11131 (1986).

56. Id. § 11132.

57. Id. § 11133.

58. Id. § 11134.

59. Id. § 11135.

60. Id. § 11136.

61. Id. § 11131.; Memorandum of Understanding Between The Department of Health and Human Services and The Department of Defense (Sept. 20, 1987) [hereinafter Nat'l Data Bank Memorandum].

The language of this memorandum does not yet appear in any Department of Defense directive or instruction or any Army regulation. It does, however, appear in a proposed Department of Defense directive. Because of the sweeping nature of this reporting requirement and the fact that it is not yet reprinted in easily locatable legal resources, it is reproduced below:

MEMORANDUM OF UNDERSTANDING
BETWEEN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND THE DEPARTMENT OF DEFENSE

AUTHORITY: This MOU between the Health and Human Resources Administration (HRSA), Department of Health and Human Services (DHHS), and the Department of Defense (DOD) ensures the participation of the DOD in the national reporting system established under Part B of the Health Care Quality Improvement Act of 1986 (the Act), Pub. L. 99-660, in accordance with the intent of Congress as set forth in Section 432 of the Act.

GENERAL DESCRIPTION OF ACTIVITIES:

(a) **Malpractice Reports**

1. A report shall be filed with the National Data Bank, as established by regulations at 45 C.F.R., Part 60, on any payment for a malpractice claim against the DOD, an agency of the DOD, or a health care practitioner working for the DOD. In accordance with the DOD policy, all malpractice claims will be analyzed by peer

review, assigned a category of responsibility, and reported as follows:

Standard Medical Care. Payments made for claims in which the patient was found to have received appropriate care shall be reported under the name of the primary physician.

Minor Deviation From Standards of Care. When payments are made for claims in which the patient was found to have received care that was substandard in minor respects, a separate report shall be submitted for each practitioner found to have provided substandard care.

Major Deviations From Standards of Care. When payments are made for claims in which the patient was found to have received care that was substandard in major respects, a separate report shall be submitted for each practitioner found to have provided substandard care.

2. Payments made for claims where there is deviation from standards of care but outside the control of health care practitioners (e.g., power failure, accidents unrelated to patient care, and drugs mislabeled by the supplier) shall not be reported to the data bank.

3. The report shall include the following:

- * The diagnosis for which the patient received care and the nature of the alleged negligence leading to the malpractice claim and settlement.

- * The name and other identifying data of the practitioner responsible for care.

- * Identification of the health care facility.

- * Amount of the payment and means of settlement (i.e., administrative settlement, litigation settlement, or judicial judgment).

(b) Professional Sanction Reports. The DOD

shall report all instances in which a DOD health care practitioner's clinical privileges are denied, limited (restricted), revoked by an agency of the DOD for reasons of incompetence or negligent performance.

(c) Practitioner Misconduct Reports. The DOD shall report all instances in which a DOD health care provider is found guilty (after appellate review), pleads guilty, or is discharged in lieu of court-martial for unprofessional conduct as defined in DOD directives.

(d) Practitioner Data Inquiries. Inquiries for data on practitioners will be made to the data bank in accordance with Section 425 of the Act and its implementing regulations, as follows:

1) By the appropriate recruiting agency at the time of application for employment by an agency of the DOD.

2) By the health treatment entity at the time a practitioner applies for clinical privileges.

3) By the health treatment entity every 24 months or whenever the practitioner reapplies for clinical privileges.

4) By the health care entity at the beginning of any investigation of a practitioner for substandard clinical performance for unprofessional conduct

(e) All reports from the data bank are considered confidential as required by the Act and its implementing regulations.

Period of agreement. This agreement is indefinite; it is subject to termination by either party with 60 days notice.

Implementation date. Under Section 424(a) of the Act, information must begin to be reported to the National Data Bank by November 14, 1987.

Periodic consultation. The signatories (or their designees) will consult at least annually on the implementation of this Memorandum of Understanding.

Report to Congress. Section 432 of the Act requires the Secretary, DHHS to submit a report on this MOU and on the cooperation among officials in regards to establishing it. DHHS will submit this report to DOD for comment.

62. Interview with Colonel Edward Haines, supra note 41. See also infra Appendix A, para. F.5 (reprinting the text of most of the proposed Dep't of Defense memorandum supplemental guidance currently under consideration by the Dep't of Defense Health Affairs Office).

63. Nat'l Data Bank Memorandum, supra note 61 and accompanying text.

64. Id.

65. Id.

66. Id.

67. Telephone interview with Colonel Edward Haines, Senior Policy Analyst, Professional Affairs and Quality Assurance Branch, Ass't Sec'y of Defense (Health Affairs) (Feb. 25, 1988).

68. See supra note 61 and accompanying text.

69. Id.

70. See, e.g., AR 40-66, para. 9-9i; Dep't of Army, Reg. No. 27-20, Legal Services-Claims, para. 2-8z (10 July 1987) [hereinafter AR 27-20].

71. UCMJ art. 134.

72. See generally Dep't of Army, Military Rules of Professional Conduct Rule 8.4 (Commentary 1987) (using this analysis in discussing misconduct on the part of Army lawyers).

73. See infra notes 503-505 and accompanying text. See also infra Appendix A, para. F.5.

74. Dep't of Defense Directive No. 6025.1, Standards for DOD Health Care Provider Performance (Apr. 19, 1983) [hereinafter DOD Dir. 6025.1].

75. Id.

76. Id.

77. Interview with Colonel Edward Haines, supra note 41.

78. Credentials are the professional qualifications needed to practice in a chosen profession.

79. Dep't of Defense Directive No. 6025.4, Credentialing of Health Care Providers (Feb. 11, 1985) [hereinafter DOD Dir. 6025.4].

80. An intern is an individual in his first year of postgraduate accredited training. This training includes work in laboratory skills, diagnosis, radiologic interpretation, physical medicine, and pathology. An intern is usually referred to in medical circles as a "PGY-1" (post graduate year one) noted in Dep't of Army, Reg. No. 351-3, Schools-Professional Education and Training Programs of the Army Medical Department, para. 6-2a (8 Feb. 1988) [hereinafter cited as AR 351-3].

81. A resident is defined as an individual in his second or subsequent postgraduate year of accredited training leading to eligibility for certification by an

American specialty board. A resident is usually referred to in medical circles as a "PGY-2" (or higher) noted in AR 351-3, para. 6-2**b**.

A chief resident is an individual assigned to his last year of clinical training. AR 351-3, para. 6-2**c**.

82. A fellow is an individual undergoing formal graduate medical education other than an intern or a resident. noted in AR 351-2**f**.

83. DOD Dir. 6025.4.

84. Id.

85. Dep't of Defense Directive No. 6025.2, DOD Non-physician Health Care Providers (Nov. 17, 1983) [hereinafter DOD Dir. 6025.2].

86. The directive defines nonphysician health care providers as: nurse practitioners, nurse midwives, nurse anesthetists, physician assistants, clinical assistants, independent duty technicians, and any other individuals responsible for starting, ceasing, or altering a regimen of care. For a full description of their responsibilities, see Dep't of Army, Reg. No. 40-48, Medical Services-Nonphysician Health Care Providers (16 Aug. 1985) [hereinafter AR 40-48].

87. DOD Dir. 6025.2.

88. Id.

89. House Hearings on H.R. 1161, supra note 20, at 2.

90. The Feres doctrine derives its name from the case of Feres v. United States, 340 U.S. 135 (1950). In Feres, the Court held that a member of the uniformed services could not sue the government in tort for injuries received in the course of activity incident to military service.

91. Hearings on H.R. 1161, supra note 20, at 2.
92. For an excellent discussion of the continuing debate between quality of health care, competition in the health care industry, and the role that licensure plays in that process, see Christoffel, Hiring on the Cheap: Health Care Costs, the Eclipse of Physicians and Change in Licensing Laws, 4 Pub. L. Forum 57 (1984).
93. See generally J. Pena, P. Haffner, P. Rosen, and D. Light, Hospital Quality Assurance: Risk Management and Program Evaluation 138-140 (1986) [hereinafter Pena].
94. American Medical Association, 1985 Annual Report 41, U.S. National Licensure Statistics 1984 and License Requirements 1985 (1986) [hereinafter AMA Statistics]. See also The Federation of State Medical Boards of the United States, The Exchange (1987). The Exchange is a three volume document which contains information on licensing requirements, examinations, and specialty board certification. It is divided as follows: Section 1: FLEX and M.D. Licensing Requirements, Section 2: FLEX and D.O. Licensing Requirements, and Section 3: Physician Licensing Boards and Physician Discipline.
95. AMA Statistics, supra note 94, at 1.
96. Id.
97. Id.
98. Id.
99. Id. at 41.
100. Id.
101. Id. at 42.

102. Health Professions Educational Assistance Act of 1976, § 3, 8 U.S.C. § 1182(a)(32) (1982). Admission into the United States under this Act does not grant the foreign medical graduate a license to practice medicine in the United States. It merely permits that person to enter an internship or residency program. Foreign medical graduates must take the FLEX examination just as a United States medical graduate must if they wish to obtain a license.

103. 10 U.S.C. § 1094 (1986). The Department of Defense Authorization Act of 1986, Pub. L. 99-145, § 653(b), 99 Stat. 658 (1986) provides: "Section 1094 of Title 10, United States Code, as added by subsection (a), does not apply during the three-year period beginning on the date of enactment of this Act with respect to the provision of health care by a person who on the date of the enactment of this Act is a member of the Armed Forces."

104. Dep't of Defense Directive No. 6025.6, Licensure of DOD Health Care Providers (July 18, 1985) [hereinafter DOD Dir. 6025.6].

105. AR 40-66, para. 9-25.

106. DOD Dir. 6025.6.

107. AR 40-66, para. 9-25.

108. See infra text accompanying notes 351-411 for a discussion of privileges.

109. Interview with Colonel Edward Haines, supra note 41. Colonel Haines noted further that foreign medical graduates, who make up only 9% of the total medical provider force, were responsible for 32% of sanction actions. Foreign medical graduates tended to be

sanctioned for incompetence while United States medical graduates tended to be sanctioned for misconduct.

110. See supra notes 45-73 and 85-109 and accompanying text.

111. Dep't of Defense Directive No. 5136.1, Assistant Secretary of Defense (Health Affairs) (Oct. 5, 1984) [hereinafter DOD Dir. 5136.1]; Senate Oversight Hearings, supra note 32, at 99.

112. E.g., Dep't of Army, Reg. No. 40-400, Medical Services-Patient Administration (31 Oct. 1974) (superseded by Dep't of Army. Reg. No. 40-66, Medical Services-Medical Records and Quality Assurance Administration (15 June 1980) (superseded by Dep't of Army, Reg. No. 40-66, Medical Services-Medical Record and Quality Assurance Administration (31 Jan. 1985)).

113. DOD Dir. 5136.1; See also Senate Oversight Hearings, supra note 32, at 101.

114. See, e.g., AR 40-66, ch. 9; Dep't of Navy, Naval Medical Command Instruction No. 6320.7, Guide for Quality Assurance Program (6 Sept. 1984); Dep't of Air Force, Reg. No. 168-13, Medical Administration-Quality Assurance, The Air Force Medical Service (31 May 1984) [hereinafter AF Reg. 168-13].

115. DOD Dir. 6025.1 and DOD Dir. 6025.2, mentioned previously, briefly discuss norms for patient care but do not establish clear guidelines for the individual services to follow nor do they describe how data is to be evaluated once obtained.

116. Dep't of Defense Instruction No. 6015.14, Report on Selected Data Concerning Medical Care Provided at Fixed Military Medical Care Facilities (Nov. 14, 1977)

[hereinafter DOD Instr. 6015.14]. This directive was promulgated by the Comptroller, Department of Defense, and makes no provision for cross-referencing this information to assist quality assurance efforts.

117. Dep't of Defense Directive No. 6000.9, The Department of Defense Health Services Systems Information Resource Management Program (Oct. 3, 1986) [hereinafter DOD Dir. 6000.9]. This directive establishes the Defense Health Services Advisory Board whose function it is to oversee medical logistics, wartime readiness, mobilization planning, and medical risk assessment although this latter term is never defined.

118. CBO: Health Care System Report, supra note 11, at 21.

119. Id. at 22. This formula is computed as follows:

CWU= No. of occupied bed-days + 10 X (No. of admissions) + 10 X (No. of live births) + (No. of out-patient clinic visits).

120. CBO: Health Care System Report, supra note 11, at 22.

121. Id. at 22, note 13.

122. Id. at 22.

123. Id.

124. National Defense Authorization Act of 1987, § 701, 10 U.S.C. § 1101(a) (1986).

The Health Care Finance Administration (HCFA), the federal agency that administers Medicare, has established a prospective payment system (PPS) in place of the previous Medicare cost based reimbursement sys-

tem. 42 U.S.C. § 1395ww (1986); See generally R. Kasten, The Physician's DRG Handbook 1 (1986) [hereinafter Kasten] (providing a simple explanation of the purpose and function of DRGs). This effort began as part of an effort by Congress to reduce deficit spending through budget cuts. See Consolidated Omnibus Budget Reconciliation Act of 1985, §§ 9101, 9102, Pub. L. 99-272 (1986) (amending 42 U.S.C. § 1395ww (1982) by changing the Medicare system from one of cost reimbursement to one of prospective payments). The objective of the PPS is cost control through incentives for the hospital to reduce patient stay lengths to control the consumption of health care resources.

To carry out this program, the HCFA created a preset price for 467 different Diagnosis Related Groups (DRGs). Id. This amount is paid at the time of the patient's discharge. Kasten at 1, 2. If the hospital can deliver the required care for less than the reimbursement, it may keep the profit. Id. If it exceeds the reimbursement allowance, it will either assess its resource usage or face the economic consequences. Id.

125. 10 U.S.C. § 1101(c) (1986). The civilian health care sector is governed by the Social Security Act, 42 U.S.C. § 1395ww (d)(4) (1986).

126. See National Defense Authorization Act for Fiscal Years 1988 and 1989, Pub. L. 100-180, § 724, 101 Stat. 1116 (1987) (amending 10 U.S.C. § 1101(c) (1986) by postponing the effective date of the statute for one year).

127. 10 U.S.C. § 1101(c) (1986).

128. CBO: Health Care System Report, supra note 11, at 22.

129. See 10 U.S.C. § 1096(a) (1986) (creating the Military-Civilian Health Services Partnership Program). See also Dep't of Defense Instruction No. 6010.12, Military-Civilian Health Services Partnership Program (Sept. 4, 1987). This directive allows the Secretary of Defense to enter into sharing agreements with civilian health care providers to improve economies of scale and wider access of health care services to health care beneficiaries.

130. The Veterans Administration-Department of Defense Resources Sharing Act, § 3, 38 U.S.C. § 5011 (1982); See also CBO: Health Care System Report, supra note 11, at xix.

131. Dep't of Defense Directive No. 6000.6, Medical Malpractice Claims Against Military and Civilian Personnel of the Armed Forces (Aug. 24, 1977) [hereinafter DOD Dir. 6000.6].

132. GAO: DOD Health Care, supra note 12, at 31.

133. See R. Miller, Problems in Hospital Law 41 (1986).

134. Id.

135. The organization's name was changed from the Joint Commission on the Accreditation of Hospitals (JCAH) to the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) by the organization's Board of Commissioners in August 1987, noted in Letter from Laura K. Botwinick, Dir. of Board and Comm. Activities, Joint Commission on the Accreditation of Healthcare Organizations to Captain David W. Engel (Dec. 3, 1987) (discussing the JCAHO's bylaws and name change). See also Senate Oversight Hearings, supra

note 32, at 118 (statement of Alvin Tucker, Dep. Ass't Inspector Gen. for Auditing, Office of The Inspector Gen., Dep't of Defense).

136. See, e.g., AR 40-2, ch. 5; NAVCOMEDINST 6000.2C; AF Reg. 168-13, para. 1-2.

137. Id.

138. See, e.g., infra notes 426-429 and accompanying text.

139. Published Army guidance seeks to have all CONUS hospitals in compliance with JCAHO standards. AR 40-2, ch. 5. Navy regulations call for a two-year accreditation period instead of the three-year JCAHO accreditation period. NAVCOMEDINST 6000.2C. Air Force regulations simply require that the quality assurance program "be consistent with" JCAHO standards. AF Reg. 168-13, para. 1-2.

140. At present, 36 states have incorporated JCAHO standards into their accreditation decisions. Nursing Home Survey and Certification, Assuring Quality Care: Hearings Before the Senate Special Comm.on Aging, 99th Cong., 2d Sess. 74 (1982) (testimony of John E. Affeldt, M.D., former Pres. of the JCAHO). Some go so far as to say that licensing renewal standards have been met by virtue of JCAHO accreditation standing alone.

E.g., Ala. Code § 22-21-24 (1979); Alaska Stat. § 18.20.080(a) (1986); Ariz. Rev. Stat. Ann. §§ 36-401, 424 (1984); Ga. Code Ann. § 31-7-3(b) (1983); Mass. Regs. Code tit. 130, § 020(A) (1986); Minn. Stat. Ann. § 144.55 (West 1986); Mont Code Ann. § 50-5-103(4) (1979); N.M. Stat. Ann. § 24-1-5 (1978); Or. Rev. Stat. § 441.055(2) (1977); 35 Pa. Cons. Stat. Ann. § 448.810(a) (Purdon 1980); Tenn. Code Ann. § 68-11-210(b)(5) (1987); Tex. Rev. Civ. Stat. Ann. art. 4437h

(Vernon 1982).

For a more detailed history of the JCAHO, see L. Davis, Fellowship of Surgeons: A History of the American College of Surgeons (1960).

141. American Medical Association, 1987-1988 Directory of Graduate Medical Education Programs 12 (1987); AR 351-3, para. 6-6c.

142. Jost, supra note 18, at 840.

143. Joint Commission on the Accreditation of Healthcare Organizations, Bylaws of the Joint Commission on the Accreditation of Healthcare Organizations, ART. VI, Board of Commissioners, Sec. 1 (rev. ed. 1984) [hereinafter Bylaws of the JCAHO].

144. Id.

145. Bylaws of the JCAHO, supra note 143, ART. VI., Board of Commissioners, Sec. 7.

146. Bylaws of the JCAHO, supra note 143, ART. I, Purpose. This thesis will not address issues concerning the accreditation of child, adolescent, and adult psychiatric facilities. See Joint Commission on the Accreditation of Healthcare Organizations, Consolidated Standards Manual for Child, Adolescent, and Adult Psychiatric, Alcoholism, and Drug Abuse Facilities (1981).

Nor will this thesis discuss accreditation as it pertains to community health services or long-term health care facilities. See Joint Commission on the Accreditation of Healthcare Organizations, Accreditation Manual for Long-Term Facilities (1986); See also Nursing Home Survey and Certification: Assuring Quality Care: Hearings Before the Senate Special Comm. on Aging, 97th Cong., 2d Sess. 103-105 (1982)

(statement of John Affeldt, M.D., former Pres. of the JCAHO).

147. Telephone interview with Harold J. Bressler, General Counsel, Joint Commission on the Accreditation of Healthcare Organizations (Feb. 22, 1988).

148. Id.

149. Jost, supra note 18, at 841.

150. Id. at 842, n. 51.

151. Joint Commission on the Accreditation of Healthcare Organizations, Accreditation Manual for Hospitals ix (1988) [hereinafter AMH].

152. Id.

153. Id.

154. Id.

155. Id.

156. Id. at xxi; But Cf. Dep't of Navy, Naval Medical Command Instruction No. 6000.2C, Policy and Procedures Regarding Accreditation of Regional Medical Centers and Naval Hospitals (30 June 1980) [hereinafter NAVCOMEDINST 6000.2C] (discussing the different accreditation periods recognized by the Navy).

157. AMH, supra note 126, at xxi (1988).

158. Id.

159. Id.

160. Id.

161. Id.

162. Joint Commission on the Accreditation of Healthcare Organizations, General Administrative Policy and Procedures, reprinted in AMH at xxiii (1988).

163. Id.

164. Id.

165. Jost, supra note 18, at 842.

166. Under the old system, costs ran \$1,000 per day per surveyor. Four surveyors normally served on each survey team. With the base \$250 application fee included, the consulting cost for a one day survey for small hospitals and clinics was \$4,250 with, of course, larger fees for large hospitals and medical centers whose surveys may take several days. See generally Affeldt, The Three Year Cycle: What Effect Will It Have on Fees?, 55 Hospitals 69 (1981).

167. Letter from Donald W. Avant, Vice-Pres. for Accreditation Surveys, Joint Commission on Accreditation of Healthcare Organizations to Erna Jantzen, Quality Assurance Analyst, Quality Assurance Div., Office of the Surgeon General, Dep't of the Army (Jan. 11, 1988). This new system will raise the survey cost for a small hospital or clinic from \$4,250 to approximately \$15,000 with even larger fees for large hospitals and medical centers.

168. Dep't of Army, Reg. No. 40-400, Medical Services-Patient Administration (31 Oct. 1974) (superseded by Dep't of Army, Reg. No. 40-66, Medical Services-Medical Record and Quality Assurance Administration (15 June 1980) [hereinafter AR 40-400].

169. Id.

170. Id.; See infra notes 244-289 and accompanying text.

171. AR 40-400, ch. 10 (superseded by Dep't of Army, Reg. No. 40-66, Medical Services-Medical Record and Quality Assurance Administration (15 June 1980)).

172. Id.

173. See infra notes 208-211 and accompanying text.

174. AR 40-400, ch. 10; See also infra notes 212-228 and accompanying text.

175. AR 40-400 (C1, 1 Nov. 1976) (superseded by Dep't of Army, Reg. No. 40-66, Medical Services-Medical Record and Quality Assurance Administration (15 June 1980)).

176. Id.

177. AR 40-400, ch. 10 (C2, 15 Aug. 1979) (superseded by Dep't of Army, Reg. No. 40-66, Medical Services-Medical Record and Quality Assurance Administration (15 June 1980)); See infra notes 354-357 and accompanying text.

178. AR 40-400, ch. 10 (C2, 15 Aug. 1979) (superseded by Dep't of Army, Reg. No. 40-66, Medical Services-Medical Record and Quality Assurance Administration (15 June 1980)).

179. Id.

180. Dep't of Army, Reg. No. 40-66, Medical Services-Medical Record and Quality Assurance Administration, ch. 9 (15 June 1980) (superseded by Dep't of Army, Reg. No. 40-66, Medical Services-Medical Record and Quality Assurance Administration (31 Jan. 1985)).

181. Id.

182. Dep't of Army, Reg. No. 40-66, Medical Services-Medical Record and Quality Assurance Administration, ch. 9 (C2, 1 Nov. 1982) (superseded by Dep't of Army, Reg. No. 40-66, Medical Services- Medical Record and Quality Assurance Administration (31 Jan. 1985)).

183. Id.

184. Interview with Erna Jantzen, Quality Assurance Analyst, Quality Assurance Div., Office of the Surgeon General, Dep't of the Army, at Bailey's Crossroads, Virginia (Mar. 14, 1988).

185. Id.

186. E.g., DOD Dir. 6000.7; See supra notes 168-185 and accompanying text.

187. See supra note 4 and accompanying text; See generally Wagner, Quality Assurance in the Military Hospital: The Revised Risk Management Program, The Army Lawyer, May 1983, at 18. This lack of focus was probably due to the newness of the quality assurance office which had just been created in 1983.

188. Memorandum of Understanding Between The Surgeon General, and The Judge Advocate General, Relating to Legal Support for Risk Management Programs at Army Medical Centers, 25 June 1984 [hereinafter Surgeon General-TJAG Memorandum].

189. Telephone interview with Mr. Joseph H. Rouse, Chief, Gen. Claims Div., U.S. Army Claims Service, Fort Meade, Maryland (Mar. 16, 1988) (creator of the Medical Claims Judge Advocate Program).

190. Surgeon General-TJAG Memorandum, supra note 188.

191.

- 1) Dwight David Eisenhower Army Medical Center, Fort Gordon, Georgia.
- 2) Walter Reed Army Medical Center, Washington, D.C.
- 3) Fitzsimons Army Medical Center, Aurora, Colorado.
- 4) Brooke Army Medical Center, San Antonio, Texas.
- 5) William Beaumont Army Medical Center, El Paso, Texas.
- 6) Letterman Army Medical Center, San Francisco, California.
- 7) Madigan Army Medical Center, Tacoma, Washington.
- 8) Tripler Army Medical Center, Honolulu, Hawaii.

192. Dep't of Army, Reg. No. 40-66, Medical Services-Medical Record and Quality Assurance Administration, ch. 9 (31 Jan. 1985) (superseded by Dep't of Army, Reg. No. 40-66, Medical Services-Medical Record and Quality Assurance Administration, ch. 9 (1 Apr. 1987)).

193. AR 40-66, ch. 9. This regulation is currently under revision.

194. Id. para. 9-1.

195. AR 40-3, ch. 4.

196. Dep't of Army, Reg. No. 40-4, Medical Services-Army Medical Department Facilities/Activities (1 Jan. 1980) [hereinafter AR 40-4].

197. DOD Inst. 6015.1; AR 40-4, paras. 7 to 15.

198. DOD Inst. 6015.1; AR 40-4, paras. 7 to 15. It is interesting to note that nowhere in either DOD Inst. 6015.1 or AR 40-4 are the terms "fixed" or "nonfixed" defined.

199. AR 40-4, para. 16.
200. AR 40-4, paras. 7 to 15.
201. DOD Inst. 6015.1; AR 40-4, paras. 7 to 15.
202. DOD Inst. 6015.1; AR 40-4, paras. 7 to 15.
203. Dep't of Army, Field Manual No. 63-3J, Combat Service Support Operations-Corps, ch. 10 (12 Aug. 1985).
204. AR 40-4, para. 10.
205. DOD Inst. 6015.1; AR 40-4, para. 14.
206. DOD Inst. 6015.1; AR 40-4, para. 4.
207. See 10 U.S.C. § 1077(b) (1982) which states:
The following types of health care may not be
provided under Section 1076 of this title:
[dependent health care under the CHAMPUS program]
(1) Domiciliary or custodial care.

The Army has implemented this statute through regulation AR 40-3, paras. 2-4a, 2-4b. The Navy has published regulations in the Federal Register pertaining to eligibility for care in its facilities. 32 C.F.R., Parts 728, 732 (1987).

208. See, e.g., Wm. Beaumont Army Med. Center, Reg. No. 40-66-1, Medical Services-Quality Assurance Program (25 June 1985) [hereinafter WBAMC Reg. 40-66-1].
209. AR 40-66, para. 9-2a(2).
210. In CONUS (including Alaska and Hawaii), that next higher command is the U.S. Army Health Services Command. Dep't of Army, Reg. No. 10-43, Organization and Functions-United States Army Health Services

Command, para. 3a(1) (15 Jan. 1980). In Europe, that command is the 7th Medical Command and in Korea that command is the 18th Medical Command.

211. Id.; Letter from Colonel Joseph A. Dudzik, Jr., Staff Judge Advocate, U.S. Army Health Services Command to Captain David W. Engel, Medical Claims Judge Advocate, Wm. Beaumont Army Med. Center, El Paso, Texas (Oct. 19, 1984) (discussing the purpose of hospital committee meeting minute disclosures to higher headquarters).

212. AR 40-66, para. 9-2b.

213. Id. para. 9-2c.

214. Id. para. 9-2b(4) (requiring hospital credentials committee reports be sent directly to the hospital commander for action without first going through the quality assurance committee).

215. Id. para. 9-2b(2).

216. E.g., WBAMC Reg. 40-66-1, para. 1.7.a.

217. AR 40-66, para. 9-2b(1)(b).

218. Id. para. 9-2b(1)(c).

219. Id. para. 9-3.

220. E.g., WBAMC Reg. 40-66-1, para. 1.5.

221. AR 40-66, para. 9-2b(1)(f).

222. Id. para. 9-2b(1)(d).

223. 10 U.S.C. § 1102 (1986).

224. Id. § 1102(j)(2).

225. Id. § 1102(j)(1). For an excellent discussion of this topic, see Woodruff, The Confidentiality of Medical Quality Assurance Records, The Army Lawyer, May 1987 at 5 [hereinafter Woodruff].

226. 10 U.S.C. § 1102(b)(1) (1986).

227. Dep't of Army, Reg. No. 20-1, Assistance, Inspections, Investigations, and Followup-Inspector General Activities and Procedures, para. 1-29 (16 Sep. 1986) [hereinafter cited as AR 20-1]. These materials, although designated as confidential, are not protected by the quality assurance record confidentiality statute. An Army regulation may not be sufficient, standing alone, to support a claim of privilege for factual materials contained in an inspector general (IG) report. See, e.g., Adams v. United States, 673 F.Supp. 1249, 1258, 1259 (S.D.N.Y. 1987). Army lawyers should also be aware that the appropriate release authority for Inspector General reports is The Inspector General (TIG). AR 20-1, para. 1-30a. Army lawyers should always coordinate with that office as well as the Office of the Judge Advocate General, Litigation Div., before attempting to release any such information.

228. Dep't of Army, Reg. No. 15-6, Boards, Commissions, and Committees-Procedures for Investigating Officers and Boards of Officers (24 Aug. 1977)(C1, 15 June 1981); Woodruff, supra note 225, at 11.

229. AR 40-66, para. 9-2c.

230. Id. para. 9-20.

231. Id.

232. Id. para. 9-20d.

233. Id.
234. E.g., WBAMC Reg. 40-66-1, para. 5.11.
235. AR 40-66, para. 9-2c(4).
236. Id.
237. Id. para. 9-2c(5).
238. Id. para. 9-2b(4).
239. Id.
240. Id.
241. Id.
242. Id. para. 9-2c.
243. Id.
244. Id. para. 9-7.
245. Id.
246. See generally Dep't of Defense Directive No. 1125.1, Utilization of Nursing Personnel (Sept. 16, 1967); Dep't of Army, Reg. No. 40-407, Medical Services-Nursing Records and Reports, ch. 6 (1 Dec. 1979) [hereinafter AR 40-407] (requiring the chief of nursing and assigned nursing staff to develop criteria for monitoring problems. This must be done to comply with JCAHO nursing care assessment requirements).
247. AR 40-66, para. 9-7.
248. See text accompanying notes 277-289 for a discussion of the AQCESS system.
249. AR 40-66, para. 9-7.
250. Pena, supra note 93, at 9.

251. Id.

252. UCMJ art. 6.

253. Pena, supra note 93, at 20; Jost, supra note 18, at 858, 859.

254. Peer review in the private sector is not governed solely by JCAHO standards. Peer review in the private sector was formerly governed by Peer Standards Review Organizations (PSROs). Statutory provisions concerning PSROs were repealed by the Peer Review Improvement Act of 1982, §§ 141-150, 42 U.S.C. §§ 1305, 1320c, 1320c-1 to 1320c-12, 1395b-1, 1395g, 1395k, 1395L, 1395x, 1395y, 1395cc, 1396pp, 1396a, 1396b (1982). The new law provides that the Secretary of Health and Human Services will provide peer review of Medicare and Medicaid claims by contracting for such reviews with organizations composed largely of practicing physicians. These organizations are known as Provider Reimbursement Review Boards. These peer review organizations are exempt from Freedom of Information Act (FOIA) requests and have limited accountability to the general public.

255. AMH, supra note 151, at 235-240 (1988).

256. Id. at 125.

257. Id. at 125-129.

258. AR 40-66, para. 9-7g.

259. Id. para. 9-7i. See also Dep't of Army, Reg. No. 40-2, Medical Services- Army Medical Treatment Facilities General Administration, paras. 7-5d(9) (3 Mar. 1978) [hereinafter AR 40-2] (outlining the specific reporting requirements for all adverse drug reactions).

260. See Dep't of Army, Reg. No. 40-6, Medical Services-Army Nurse Corps, para. 2-21 (30 Oct. 1987) [hereinafter AR 40-6] (discussing the functions of the quality assurance nurse).

261. AR 40-66, para. 9-7h.

262. E.g., Quality assurance committee, risk management committee, tissue committee, tumor board, transfusion committee, departmental morbidity and mortality committee meetings, and credentials committee to name but a few.

263. AR 40-66, ch. 9.

264. E.g., WBAMC Reg. 40-66-1.

265. E.g., U.S. Army Health Services Command, Reg. No. 40-1, Medical Services-Cancer Program (Tumor Registry) (25 Mar. 1983). This regulation establishes at the medical center level a peer review committee with a narrow interdisciplinary focus known as the Tumor Board. The Tumor Board is a multidisciplinary body consisting of clinicians ranging from oncologists (cancer specialists), and other internal medicine specialists, to surgeons and nursing staff, yet whose sole function is gauging statistics and treatment care trends for patients who have been diagnosed as having suffered from tumors.

266. Interview with Colonel Edward Haines, supra note 41.

267. Id.

268. Interview with Colonel Edward Haines, Senior Policy Analyst for Quality Assurance, Professional Affairs and Quality Assurance Branch, Office of the Ass't Sec'y of Defense (Health Affairs), at the

Pentagon (Feb. 8, 1988).

269. Id.

270. Id.

271. Dep't of Army, Reg. No. 40-400, Medical Services-Patient Administration (1 Nov. 1983).

272. Id.; AR 40-66, chs. 2-8.

273. AR 40-66, para. 9-7c.

274. Id. para. 9-7d.

275. E.g., Wm. Beaumont Army Med. Center, Reg. No. 10-1, Organization and Functions, ch. 3, Sec. 18 (1 Mar. 1985) [hereinafter WBAMC Reg. 10-1]; See infra notes 290-315 and accompanying text.

276. See infra notes 290-315 and accompanying text.

277. AR 40-66, para. 9-7f.

278. Office of the Ass't Sec'y of Defense (Health Affairs), AQCESS Quality Assurance: The Next Generation, TAB A (1987) (unpublished monograph) [hereinafter AQCESS Monograph].

279. Id.

280. Interview with Colonel Edward Haines, supra note 41.

281. AQCESS Monograph, TAB A.

282. Id., TAB D.

283. Id.

284. Id.

285. Id.

286. Id.

287. The APGAR is used to draw attention to clinically depressed infants and provides a standard for comparing infants at birth. At one and five minutes after birth, five objective signs are evaluated and each is given a score of 0, 1, or 2. The sum of the five scores is the APGAR score. K. Niswander, Manual of Obstetrics: Diagnosis and Therapy 396-397 (1980).

A score of 7-10 is an excellent score. A score of 3-6 indicates a moderately depressed infant. A score of 0-2 indicates a severely depressed infant. The APGAR score at one minute correlates with survival and the five minute score is a better indicator of possible neurologic damage at one year of age. Id.

The APGAR scoring chart is as follows:

SIGN	0	1	2
Heart rate	Absent	<100 bpm	>100 bpm
Respirations	Absent	Slow, irreg.	Good
Muscle tone	Flaccid	Some flexion of extrem.	Active Motion
Reflex irri- tability	No response	Grimace	Good Cry
Color	Blue; pale	Body pink; extrem. blue	All Pink

288. Interview with Colonel Edward Haines, supra note 41.

289. AQCESS Monograph, TAB H; CBO: Health Care System Report, supra note 11, at 7, 8.

290. AR 40-66, para. 9-8a.
291. E.g., WBAMC Reg. 40-66-1, para. 4.4.
292. AR 40-66, para. 9-8a.
293. Id. ch. 6.
294. Id. para. 9-8a(4).
295. See supra note 207 and accompanying text.
296. E.g., WBAMC Reg. 40-66-1, para. 4.4.
297. Id.
298. Id.
299. See, e.g., WBAMC Reg. 40-66-1, para. 4.4.
300. AR 40-66, para. 9-8b.
301. Id. para. 9-8b(4).
302. Id. para. 9-9a.
303. GAO: DOD Health Care, supra note 12, at 11.
304. A potentially compensable incident (PCI) is one where a breach of the standard of care has resulted in injury. AR 40-66, para. 9-9b(4). Practitioners in the field may also refer to PCIs as simply "adverse patient outcomes." The reason for this latter term is the confusion that sometimes results when the term PCI is used to describe the investigation of a case barred by the Feres doctrine from presenting a compensable claim. The terms PCI and adverse patient outcome may be used interchangeably in the risk management context.
305. Id. para. 9-9a.
306. See supra note 90 and accompanying text.
307. See, e.g., WBAMC Reg. 40-66-1, para. 4.5.

308. AR 40-66, para. 9-9c.

309. See Surgeon General-TJAG Memorandum, supra note 188, and accompanying text.

310. AR 40-66, para. 9-9a.

311. Id. In fact, AR 40-66, para. 9-9a states: "If possible, an RM Committee will be set up." This suggests that a hospital need not even establish a risk management committee although most do have such a committee.

The mere fact that the Army has had a risk management function in its quality assurance program since 1980 is commendable since only six states require risk management programs as part of their overall hospital quality assurance programs. Alaska Stat. § 18.020.075 (1976); Fla. Stat. Ann. § 395.041 (West 1986); Kan. Stat. Ann. § 40-3403(c) (1987); Mass. Gen. Laws Ann. ch. 111, § 203(d) (West 1986); N.Y. Pub. Health Law §§ 2805j(d)-(g) (McKinney 1986); Wash. Rev. Code Ann. § 70.41.200 (1986) noted in GAO: Medical Malpractice Action Report at 17.

312. Proposed regulation, Dep't of Army, Reg. No. 40-66, Quality Assurance, para. 3-5a (20 Nov. 1987) (final draft).

313. E.g., WBAMC 40-66-1, para. 3.2.

314. But see AR 27-20, paras. 2-3a(8), 3-4j, 4-7r which exempt Feres doctrine cases from the requirement for immediate investigation. For an excellent discussion of the Feres doctrine and issues of equity in health care, see Bernott, Fairness and Feres: A Critique of the Presumption of Injustice, 44 Wash. & Lee L. Rev. (1987).

315. WBAMC Reg. 40-66-1, para. 3.2.

- 316. AR 40-66, para. 9-9b.
- 317. Id.
- 318. Id. para. 9-9i.
- 319. Id.
- 320. Id.
- 321. Id.
- 322. E.g., WBAMC Reg. 40-66-1, para. 4.4.
- 323. AR 40-66, para. 9-9c.
- 324. Id.
- 325. Id. para. 9-9b(5).
- 326. AR 27-20, para. 2-3a(8).
- 327. Id. para. 2-4c(2).
- 328. AR 40-66, para. 9-9d.
- 329. Dep't of Army, Form No. 4106, Report of Unusual Occurrence (June 1973) [hereinafter DA Form 4106].
- 330. AR 40-66, para. 9-9d.
- 331. Id.
- 332. E.g., WBAMC Reg. 40-66-1, para. 3.4.
- 333. AR 40-66, para. 9-9e.
- 334. AR 27-20, para. 2-11b(2).
- 335. AR 40-66, para. 9-9g.
- 336. AR 27-20, para. 2-7.
- 337. Dep't of Army, Reg. No. 40-31, Medical Services-Armed Forces Institute of Pathology and Armed Forces Histopathology Centers, ch. 5 (15 Dec. 1980) [here-

inafter AR 40-31].

338. GAO: DOD Health Care, supra note 12, at 35.

339. AR 27-20, chs. 2, 4.

340. Dep't of Army, Reg. No. 27-40, Legal Services-Litigation, para. 2-4 (4 Dec. 1985) [hereinafter AR 27-40].

341. Id. para. 7-4**b**.

342. 28 U.S.C. §§ 1346(b), 2671-2680 (1982).

343. Letter, DAJA-LTT, Office of the Judge Advocate General, U.S. Army, to Staff and Command Judge Advocates, subject: Federal Tort Claims Act (15 Mar. 1987), reprinted in The Army Lawyer, May 1987 at 4.

344. Id.

345. Id.

346. Surgeon General-TJAG Memorandum, supra note 188, and accompanying text.

347. E.g., WBAMC Reg. 40-66-1, para. 1.6.

348. Id.

349. Surgeon General-TJAG Memorandum, supra note 188, and accompanying text.

350. AR 27-20, para. 2-3**a**(8).

351. AR 40-66, para. 9-10**a**.

352. Id.

353. Id.

354. Id. para. 9-12**b**.

355. Id.

356. Id.
357. Id.
358. Id. para. 9-10b.
359. Id.
360. Id.
361. Id. para. 9-11b.
362. Id.
363. Id. para. 9-11c.
364. AR 40-2, para. 1-18 (CI01, 15 May 1987).
365. AR 40-66, para. 9-11d. The Practitioner's Credentials File (PCF) and its contents are discussed in AR 40-66, para. 9-20.
366. Id.
367. Id.
368. Id.
369. Id. para. 9-11e.
370. Id.
371. Practitioners initially coming on active duty are granted privileges for up to one year. AR 40-66, para. 9-11e(1). That period is shortened to not less than 90 days, but not greater than six months for providers who complete a graduate education in a different specialty, Id. para. 9-11e(2); up to six months for those providers undergoing remedial training, Id. para. 9-11e(3); not more than six months for providers working in a nonclinical area for more than one year, Id. para. 9-11e(4); and up to 90 days for providers on permanent change of station orders

with a PCF file. Id. para. 9-11e(5).

372. Id. para. 9-11e(1).

373. Id.

374. Id.

375. Id. para. 9-11f.

376. Id. paras. 4-11e(1), 4-11f.

377. Id. para. 9-13.

378. Id. para. 9-15.

379. Id.

380. Id. para. 9-12.

381. E.g., WBAMC Reg. 40-66-1, para. 5.12.

382. E.g., AR 635-100, para. 3-58a; AR 40-66, para. 9-17.

383. AR 40-66, paras. 9-17, 9-18.

384. Id. para. 9-17.

385. Id.

386. Id. para. 9-17a.

387. Id.

388. For the procedure for dealing with providers impaired because of drug abuse, see Dep't of Defense Directive No. 1010.14, Prevention, Early Identification, and Treatment of Alcohol and Other Drug Impairment in DOD Health Care Providers' (Sept. 10. 1986); AR 40-66, ch. 10.

389. AR 40-66, para. 9-17a.

390. Id. paras. 9-17a, 9-18.
391. Id. para. 9-17a.
392. Id. para. 9-17b.
393. Id.
394. Id.
395. Id.
396. Id.
397. Id.
398. Id. para. 9-17b(2).
399. Id.
400. Id. para. 9-17d.
401. Id.
402. Id.
403. Id. para. 9-17d(3).
404. Id. para. 9-17e(3).
405. Id.
406. 28 U.S.C. §§ 1346(b), 2671-2680 (1982).
407. Id. § 2672 states inter alia:

The head of each Federal Agency or his designee in accordance with regulations prescribed by the Attorney General, may consider, ascertain, adjust, determine, compromise, and settle any claim for money damages against the United States for injury or loss of property or personal injury or death

caused by the negligent or wrongful act or omission of any employee of the agency while acting within the scope of his office or employment, under circumstances where the United States, if a private person, would be liable to the claimant in accordance with the law of the place where the act or omission occurred (emphasis added).

408. See, e.g., Storrs v. Lutheran Hosp. & Homes Soc'y of America, 661 P.2d 632, 634 (Alaska 1983); Tucson Medical Center, Inc. v. Misevch, 113 Ariz. 34, 545 P.2d 958, 960 (Ariz. 1976); Purcell v. Zimbelman, 18 Ariz. App. 75, 500 P.2d 335, 341, 342 (1972); Buckley v. Lovallo, 2 Conn. App. 579, 381 A.2d 1286, 1289 (Conn. App. 1984); Mitchell County Hosp. Auth. v. Joiner, 229 Ga. 140, 189 S.E.2d 412, 414 (Ga. 1972); Darling v. Charleston Community Memorial Hosp., 33 Ill.2d 326, 211 N.E.2d 253 (1965), cert. denied, 383 U.S. 946 (1966); Ferguson v. Gonyaw, 64 Mich. App. 685, 236 N.W.2d 543 550 (1975).

409. E.g., Walker v. Winchester Memorial Hosp., 585 F. Supp. 1328, 1331 (W.D. Va. 1984); Stewart v. Midani, 525 F. Supp. 843, 850-853 (N.D. Ga. 1981); Elam v. College Park Hosp., 132 Cal. App. 3d 335, 183 Cal. Rptr. 156, 165 (1982); Schagrin v. Wilmington Medical Center, Inc., 304 A.2d 61, 64 (Del. Super. Ct. 1973); Mehlman v. Powell, 281 Md. 269, 272-275, 378 A.2d 1121, 1123, 1124 (Md. App. 1977). Contra Reynolds v. Swigert, 102 N.M. 504, 697 P.2d 504, 508 (N.M. Ct. App. 1984).

410. See, e.g., Lurch v. United States, 719 F.2d 333, 336-337 (10th Cir. 1983); Walker v. United States, 549 F. Supp. 973, 975-976 (W.D. Okla. 1982). But see Ayers

v. United States, 750 F.2d 449 (5th Cir. 1985) (holding the United States jointly liable for malpractice of contract physician based on theory of negligent supervision).

411. Dep't of Defense Instruction No. 6025.5, Personal Services Contracting Authority for Direct Health Care Providers (Feb. 27, 1985). This directive states inter alia:

The appearance of an employer-employee relationship created by the DOD supervision of a personal services contractor will normally support a limited recognition of the contractor as equal in status to a DOD employee in disposing of personal injury claims arising out of the contractor's performance. Personal injury claims alleging negligence by the contractor within the scope of his or her contract performance, therefore, will be processed as claims alleging negligence by DOD military or civil service personnel.

412. CBO: Health Care System Report, supra note 11, at 6.

413. Id.

414. AR 40-6, para. 2-2; AR 40-407, ch. 6.

415. AR 40-48, paras. 2-1, 3-1, 4-1, 5-1, 6-1, 8-2, 9-1.

416. AR 40-61, paras. 2-13 to 2-20.

417. AR 40-31, ch. 5.

418. AR 40-2, ch. 5.

419. See supra notes 61-62, 188 and 277-289 and accompanying text.

420. See supra notes 168-193 and accompanying text.
421. L. Jayson, Handling Federal Tort Claims (1985).
422. Materials that do not directly address quality assurance may nevertheless prove invaluable in identifying and resolving issues related to quality assurance. See, e.g., Warren, Research Note: Current Resources for Health Law Research, 11 J. of Health Politics, Policy, and Law 137 (1986); Deardorff, Informed Consent, Termination of Medical Treatment and the Federal Tort Claims Act-A New Proposal for the Military Health Care System, 115 Mil. L. Rev. 1 (1987).
423. See supra notes 51 to 70 and accompanying text.
424. See infra note 490 and accompanying text.
425. See AR 40-2, para. 5-4, which states: "The basic criteria for accreditation are contained in the Joint Commission's Accreditation Manual for Hospitals, 1976." (emphasis added).
426. Id. para. 5-3 states inter alia:
It is an objective of the Department of the Army that-
- a. All eligible U.S. Army hospitals located within the 50 United States be accredited by the Joint Commission on Accreditation of Hospitals, and
 - b. All AMEDD hospitals comply with the Joint Commission on Accreditation Standards on medical care evaluation.
427. See supra note 151 and accompanying text.
428. See supra note 147.
429. See, e.g., Wagner, Quality Assurance in the Military Hospital: The Revised Risk Management Program, The Army Lawyer, May 1983, at 18, 19, n. 8.

The facial analysis of the Army quality assurance regulation made in The Army Lawyer article is correct but nevertheless factually unsupported. The Army has periodically conducted accreditation surveys overseas for over twenty years. Telephone interview with Harold J. Bressler, General Counsel, Joint Commission on Accreditation of Healthcare Organizations (Mar. 15, 1988). The Army has accredited its hospitals overseas continually since 1980 but did not update its regulation, thus leading to the erroneous conclusion in The Army Lawyer in 1983 that only hospitals in the United States are accredited. Interview With Erna Jantzen, Quality Assurance Analyst, Quality Assurance Div., Office of the Surgeon General, Dep't of the Army, at Bailey's Crossroads, Virginia (Mar. 14, 1988).

430. See supra notes 188 and 346-348 and accompanying text.

431. See supra notes 244-301 and accompanying text.

432. AR 40-66, para. 9-2**b**(4).

433. Surgeon General-TJAG Memorandum, supra note 188, and accompanying text.

434. AR 40-66, para. 9-9.

435. E.g., WBAMC 40-66-1, para. 3.2.

436. Proposed regulation, Dep't of Army, Reg. No. 40-66, Quality Assurance, paras. 2-1**c**, 2-1**d**, Appendix E (20 Nov. 1987) (final draft).

437. Id.

438. See supra notes 51-70 and accompanying text.

439. See Proposed Department of Defense Memorandum of Understanding, Implementation of the Memorandum of Understanding Between the Department of Health and Human Services and the Department of Defense Relating to Requirements of Public Law 99-160, "The Health Care Quality Improvement Act of 1986." Infra Appendix A, para. 5.
440. See supra note 67 and accompanying text.
441. See supra note 277-289 and accompanying text.
442. See supra notes 110-114 and accompanying text.
443. See supra notes 277-289 and accompanying text.
444. See supra note 29 and accompanying text.
445. GAO: DOD Health Care, supra note 12, at 37.
446. AR 27-20, para. 2-1a(1).
447. GAO: DOD Health Care, supra note 12, at 37.
448. Id. at 38.
449. See DOD Inst. 6015.14.
450. See supra notes 124-130 and accompanying text.
451. See DOD Inst. 6015.14.
452. See supra notes 124-130 and accompanying text.
453. See supra notes 11-17 and accompanying text.
454. CBO: Health Care System Report, supra note 11, at 20.
455. Id.
456. Id. at 13.
457. Id. at xix.

458. Senate Military Medical Care System Hearings, supra note 11, at 2.

459. See, e.g., Senate Military Medical Care System Hearings, supra note 11, at 205-210; Mayer, Wartime Medical Readiness, 43 Med. Bull. 338 (1986); Johnson, Wartime Medical Support in the United States, 33 Med. Serv. Dig. 229 (1982).

460. CBO: Health Care System Report, supra note 11, at 23.

461. Id.

462. 131 Cong. Rec. S12,536 (daily ed. Oct. 3, 1985) (statement of Sen. Nunn).

463. See, e.g., Money, Nurse Shortages Deal Hospitals a One-Two Punch, Army Times, Mar. 28, 1988, at 1, col. 2.

464. CBO: Health Care System Report, supra note 11, at 26.

465. Id.

466. Id. at 27.

467. See supra notes 44-73 and 85-109 and accompanying text.

468. AR 40-66, para. 9-20.

469. GAO: DOD Health Care, supra note 12, at 39; See also Senate Military Medical Care System Hearings, supra note 11, at 2 (making reference to the highly publicized adverse credentials action cases of Dr. Watson at Fort Dix, New Jersey and Dr. Billig, Bethesda Naval Medical Center, Maryland).

470. Interview with Colonel Edward Haines, supra note 41.

471. See Schaffer, Falsification of Clinical Credentials by Physicians Applying for Ambulatory Staff Privileges, 318 New Engl. J. Med. 356 (1988).

472. See generally Burkhalter, The Credentialing Process, 152 Mil. Med. 509 (1987).

473. See generally Fed. R. Civ. P. 26-37.

474. E.g., Raskin v. United States, 84-8507-CIV-HASTINGS (S.D. Fla., filed Oct. 12, 1984) (joint Army, Air Force case); Larson v. United States, EP-85-CA-304 (W.D. Tex, filed Sept. 4, 1985) (joint Army, Air Force case); Craig v. United States, Civ. No. 83-0-754, D. Neb., dismissed by settlement July 3, 1985) (joint Army, Air Force case) (in all of these cases, a greater amount of legal resources was devoted to locating witnesses as opposed to interviewing them).

475. In addition to information already available at the installation level, the American Medical Association has pledged its full support in making available information from its Masterfile, the only source of basic credentialing data on every physician practicing in the United States. See American Medical Association, Report QQ: AMA Initiative on Quality Medical Care and Professional Self-Regulation (1986) reprinted in 256 J. Am. Med. Assoc. 1036 (1986).

476. See supra notes 136-167 and accompanying text.

477. AR 40-4; NAVCOMEDINST 6000.2C; AF Reg. 168-13.

478. See supra note 141 and accompanying text.

479. Interview with Colonel Edward Haines, Senior Policy Analyst, Professional Affairs and Quality Assurance Branch, Ass't Sec'y of Defense (Health Affairs), at the Pentagon (Dec. 3, 1987).

480. Interview with Erna Jantzen, Quality Assurance Analyst, Quality Assurance Div., Office of the Surgeon General, Dep't of the Army, at Bailey's Crossroads, Virginia (Mar. 14, 1988). But compare Moore, The Twofold Challenge to the 18th Medical Command: Peacetime Quality of Care and Military Preparedness in the Republic of Korea, 152 Mil. Med. 494 (1987).

481. See, e.g., Military Health Care System Hearings, supra note 11, and accompanying text.

482. See Proposed Dep't of Defense Directive, DOD Medical Quality Assurance, which does precisely that (preliminary draft). Since the next three year accreditation cycle is not scheduled to begin until 1990, the DOD quality assurance regulation proposed by this thesis mandates survey for all hospitals greater than 25 beds not later than 1990. Why 25 beds? Only these hospitals are large enough to provide definitive patient care that meets the minimum requirements for facilities eligible for accreditation surveys as outlined in the AMH (1988).

483. Proposed Dep't of Defense Directive, DOD Medical Quality Assurance Directive (preliminary draft).

484. See supra notes 116-117 and accompanying text.

485. See supra note 131-132 and accompanying text.

486. GAO: DOD Health Care, supra note 12, at 31.

487. Id.

488. Id.

489. Id. at 40.

490. GAO: DOD Health Care, supra note 12, at 4. What is most unusual about this policy stance is that Army policy mandates an investigation "[W]henver there is substantial question that death or bodily injury may have resulted from substandard care or negligence." Dep't of Army Message 161200Z, Oct 85, subject: Command and Management and Reporting Requirements of Service Incidents Resulting From Potentially Substandard Care, reprinted in Dep't of Army Message 091715Z, June 86, subject: Command Management and Reporting Requirements of Service Incidents Resulting From Potentially Substandard Care cited in Woodruff, supra note 206, at 11.

491. DOD Information Paper, supra note 29, and accompanying text.

492. Dep't of Defense Directive No. 6015.5, Joint Use of Military Health and Medical Facilities and Services (Feb. 5, 1985).

493. Id.

494. Dep't of Defense Instruction No. 6015.21, San Antonio Joint Medical Military Command (JMMC) (Sept. 18, 1987).

495. Interview with Colonel Edward Haines, supra note 41. A second Army-Navy JMMC is planned for the Philadelphia, Pennsylvania/ Fort Dix, New Jersey region.

496. See, e.g., Dep't of Defense Instruction No. 6015.20, Changes in Services Provided at Military Medical Treatment Facilities (MTFs) (June 23, 1987).

497. GAO: DOD Health Care, supra note 12, at 46.
498. See supra notes 337-338 and accompanying text.
499. GAO: DOD Health Care, supra note 12, at 46; DOD Information Paper, supra note 29, and accompanying text.
500. Id.
501. See supra note 19 and accompanying text.
502. E.g., Washington Post, Feb 18, 1988, at A3, col. 5; Kimble, Dependents, Retirees Criticize Health Care, Army Times, July 20, 1987, at 3, col. 1.
503. Proposed Dep't of Defense Directive, DOD Medical Quality Assurance Program (preliminary draft); Proposed Dep't of Defense Directive, DOD Health Care Provider Credentials Review and Clinical Privileging (preliminary draft).
504. For example, the proposed risk management report form calls for various patient and clinical data. For purposes of statistical abstracts, however, a more scientific approach for classifying diseases and patient outcomes is needed. Such a system already exists. See generally Dep't of Defense Instruction No. 6040.33, Medical Diagnoses and Surgical Operations and Procedures Nomenclature and Statistical Classification (May 12, 1986).

On the form [attached as an Addendum to the Appendix], there is a notation that reads "ICD.9CM." This data is to be collected on inpatient records only. The term "ICD.9CM" stands for a 3 volume set entitled, The International Classification of Diseases, 9th Rev., Clinical Modification. Its legal citation is Department of Health and Human Services, International Classification of Diseases, Clinical Modification, DHHS Pub. No. (PHS) 80-1260 (9th Rev. 1980).

Although this three volume set contains literally thousands of coding entries, this does not present any substantial barrier to the lawyer reporting the data. The reason for this is simple. If the inpatient records are complete and accurate, the needed code numbers will appear on the face of the inpatient record cover sheet and need only be copied over to the reporting form. If the numbers are missing or otherwise unavailable, it is a clear signal that the record is incomplete and needs to be reviewed by medical records specialists at the patient administration division.

505. See, e.g., GAO: DOD Health Care, supra note 12, and accompanying text.

APPENDIX A

Proposed Department of Defense Directive

SUBJECT: DOD Medical Quality Assurance Program

References:

(a) Dep't of Defense Directive No. 5136.1, Assistant Secretary of Defense (Health Affairs) (Oct. 5, 1984).

(b) Dep't of Defense Directive No. 6000.7, Dissemination of Information on Medical Officers (July 29, 1982).

(c) Dep't of Defense Instruction No. 6000.9, The Department of Defense Health Services Systems Information Resource Management Program (Oct. 3, 1986).

(d) Dep't of Defense Instruction No. 6015.1, Classification, Nomenclature, and Definitions Pertaining to Fixed Medical Treatment Facilities (Sept. 22, 1977).

(e) Dep't Defense Instruction No. 6015.14, Report on Selected Data Concerning Medical Care at Fixed Military Medical Facilities (Nov. 14, 1971).

(f) Dep't of Defense Directive No. 6025.1, Standards for Health Care Provider Performance (Apr. 13, 1983).

(g) Dep't of Defense Directive No. 6025.2, DOD Nonphysician Health Care Providers (Feb. 11, 1985).

(h) Dep't of Defense Directive No. 6025.3, DOD Health Care Provider Conduct (Aug. 24, 1984).

(i) Dep't of Defense Directive No. 6025.4, Credentialing of Health Care Providers (Feb. 11, 1985).

(j) Dep't of Defense Directive No. 6025.6, Licensure of DOD Health Care Providers (July 18, 1985).

(k) 10 U.S.C. § 1102 (1986).

(l) Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101-11152 (1986).

A. PURPOSE

This directive establishes the DOD Quality Assurance Program (QAP) to direct quality assurance programs in military medical departments and facilities. The Assistant Secretary of Defense for Health Affairs (ASD (HA)) is authorized to set policy pursuant to Reference (a).

B. APPLICABILITY AND SCOPE

This directive:

1. Applies to the Office of the Secretary of Defense (OSD) and all military departments including their Reserve and National Guard components.

2. Describes the elements of the quality assurance program (QAP) required of all DOD medical treatment facilities.

C. DEFINITIONS

1. Quality assurance. The formal and systematic exercise of monitoring and reviewing medical care delivery and outcome; designing activities to improve health care and overcome identified deficiencies in providers, facilities, or support systems; and carrying out followup steps or procedures to ensure that actions have been effective and that no new problems have been introduced.

2. Patient care assessment. The review of medical records and other appropriate sources to evaluate the quality of patient care.

3. Utilization review. The ongoing evaluation of health resources management.

4. Risk management. The ongoing program of evaluation and preventive measures taken to reduce the number of accidents or injuries and the lowering of financial losses after an incident has occurred.

5. Credentialing. The process used by a medical treatment facility to grant a health care provider the privilege of exercising his independent professional judgment in a health care setting.

6. Accreditation. A review of medical facilities resources by a private body, not having the force of law, to assess whether that facility meets recognized accepted standards of care.

7. Potentially Compensable Incident (PCI). An event or outcome during medical care treatment in which the patient suffers a lack of improvement, injury, or illness of severity greater than ordinarily experienced by patients with similar procedures or illnesses. Injury of disability shall be classified as follows:

a. None or minor. Examples include fainting without sequelae, appendectomy surgery for perforated appendix but with no delay in recovery, missed diagnosis of fracture recognized at a later date and healing with no residual deformity, or delayed recovery from anesthesia not impeding overall recovery.

b. Temporary. Examples include falls with lacerations or fractures, appendectomies with a single incident of post-operative episode of infection, delayed union of a fracture, incisional hernia, and fracture of a tooth during anesthesia.

c. Long-term or permanent. Examples include falls with neurological injury, a healed forearm fracture with loss of motion in wrist or elbow, post-operative inadvertent retention of a foreign body,

loss of a thumb or finger, anesthetic related cardiac or respiratory arrest, and loss of life other than in terminal illness.

D. POLICY

It is DOD policy that:

1. Each military medical department shall have a quality assurance program (QAP) that shall organize efforts toward achieving and documenting optimal health care of eligible beneficiaries. Each QAP shall include the following elements:

- a. Patient care assessment
- b. Utilization review.
- c. Risk management.
- d. Credentials review and clinical privileging.
- e. Accreditation.

2. All quality assurance data and documents shall be treated as confidential as provided under 10 U.S.C. § 1102 (1986), reference (k).

E. RESPONSIBILITIES

1. Assistant Secretary of Defense for Health Affairs (ASD(HA)) shall monitor the implementation of this directive.

2. Quality Assurance Automation Working Group shall assist the ASD (HA) and monitor the automation aspects of data collection required by this Directive.

3. DOD Health Service Advisory Board shall assist the ASD (HA) on the utilization review aspects of data collection required by this Directive.

4. Service Secretaries shall ensure implementation and compliance with this Directive.

5. Service Surgeons General shall monitor data collection efforts for treatment facilities under their control, and assist in the collection of such other information deemed necessary by the ASD (HA) to formulate and implement policy.

6. Service Judge Advocates General shall monitor data collection and analysis efforts on medical malpractice claims and litigation cases, and assist in the collection of such other risk management information deemed necessary by the ASD (HA) to formulate and implement policy.

F. PROCEDURES

1. The ASD (HA) shall establish a Joint-Service Quality Assurance Committee. The responsibilities of the Committee shall be as follows:

a. Advise the ASD (HA) on quality assurance policy formulation and implementation of existing policy.

b. Advise the service surgeon generals of quality assurance policies and proposed changes.

c. Assist in planning the implementation of quality assurance policies to include analysis of trends data collected pursuant to this directive.

2. Patient care assessment.

a. All medical treatment facilities shall have programs to monitor health care. These programs shall include occurrence screens, outcome indicators, morbidity and mortality assessments, and other programs that may be developed by the respective medical professions.

b. The DOD and the military departments shall review patient care assessment data reported centrally to the DOD Quality Assurance Committee to identify trends in care and patient outcomes. The services shall abstract summarized data from reports prepared by the services through the use of the AQCESS system for this reporting requirement. The services, in coordination with the Quality Assurance Automation Working Group, shall reach a single determination of trends data to be reported, but must include:

1. Occurrence screening monitors (AQCESS). Practice specific monitors shall be developed through tri-service consultation with health care providers in that specialty.

2. Trends analysis data cross-referenced to risk management, utilization review and accreditation functions.

3. Other clinical monitors as developed by professional peer groups or headquarters organizations approved by ASD (HA).

3. Utilization review.

a. All medical treatment facilities shall have utilization review programs to ensure effective resource management.

b. As a minimum, all utilization review programs will include the following areas:

1. Planned review of care received by hospitalized patients with excessive lengths of stay for diagnosis, diagnosis related groups (DRGs), or procedures as specified by MTF or higher headquarters.

2. Review and assessment of resource utilization statistics on accessibility of care, personnel and staffing, and volume of care actually delivered to patients.

3. Mechanisms to evaluate equipment and procurement policies.

4. Policies on discharge planning.

c. The DOD and the military departments shall review utilization review data centrally to identify trends in resource and patient management. The services shall abstract summarized data concerning admissions, discharges, and patient loads in accordance with DOD Inst. 6015.14, reference (e). The services in coordination with the Quality Assurance Automation Working Group and the DOD Health Services

Advisory Board, established by DOD Inst. 6000.9, reference (c), shall reach a single determination of trends data to be reported pertaining to materiel resource management.

4. Risk Management

a. All medical treatment facilities shall have risk management programs and an established risk management function. The risk management committee shall meet on a regularly scheduled basis, shall be multidisciplinary, and shall review cases and events representing liability or injury risk to patients and staff and shall recommend methods of decreasing liability risk.

b. As a minimum, all risk management programs will have procedures providing for review of the following subjects:

1. All filed malpractice claims,
2. All potentially compensable incidents (PCIs),
3. Patient complaints or requests through Inspector General (IG), congressional, and patient assistance offices,
4. Accidents and injuries to patients, staff, or visitors,
5. Results of patient satisfaction surveys,
6. Results of occurrence screening or other appropriate clinical monitoring trends data as well as trends data received from utilization review, credentialing, or accreditation sources.

c. To simplify coding and trends assessment, all PCIs reviewed shall be graded as to the permanency

of injury as (1) none or minor, (2) temporary, or (3) long-term or permanent as defined for PCIs generally. The military departments shall implement policies to ensure adequate investigation of cases, with moderate or severe injuries. Such investigation shall include, but not be limited to the following:

1. Abstraction of data for inclusion in the risk management trends data (See Enclosure 1 [Addendum to this appendix].
2. Medical-legal investigation by the Department of Legal Medicine, Armed Forces Institute of Pathology, the case of all filed claims, or in the case of PCIs, those cases involving significant risk of liability or medical disability board proceedings.

d. The DOD and the military departments shall review risk management centrally to identify trends in care and areas of increased risk. Enclosure 1, [Addendum to this Appendix], sets forth the installation risk management reporting requirements to be forwarded through the service surgeons general to the DOD quality assurance committee. The services shall abstract data of risk management cases reported through the MTF risk management committee. The DOD and the military departments shall define together uniform guidelines governing which risk management cases require formal investigations to be sent to the MTF risk management committees.

e. Risk management data reported centrally shall use codes for facilities (Defense Medical Information System-DMIS), providers (AQCESS access code), and patient identification. All such data is

deemed to be quality assurance material and exempt from disclosure except as expressly authorized by statute, 10 U.S.C. § 1102 (1986), reference (k).

5. National Data Bank

The following guidance applies to data collected for the National Data Bank created by the Health Care Quality Care Improvement Act of 1986, 42 U.S.C. §§ 11131-11137 (1986), reference (l).

a. When a malpractice claim is filed against a health care practitioner, a health care entity, or the United States government, the agency processing the claim shall report the claim to the Office of the Surgeon General (OTSG) of the military department concerned. The health care entity shall review the health care provided to the patient and shall provide an assessment of the health care to the OTSG. The assessment shall include the following:

1. The name of the attending physician or dentist.

2. Attribution of the cause of the events leading to the claim. This attribution shall include one or more of the following:

- a. The facility or its equipment.
- b. A physician or nonphysicians.
- c. A nonphysician or nonphysicians.

3. Results of the performance review of providers to whom the care was attributed shall be graded in one of the following categories:

- a. Met standards of care.
- b. Minor deviation(s) from standards of care.
- c. Major deviation(s) from standards of care.

4. The OTSG shall maintain a file in all such cases.

5. Any claim settlement shall be reported to the OTSG or designated authority of the involved military departments. This shall include cases settled administratively by the military department Judge Advocate General's Corps as well as litigation settled in or out of court by the Department of Justice. Military departments shall implement procedures for sending applicable reports to the National Data Bank within 40 days of settlement.

6. The OTSG shall be responsible for submitting reports to the National Data Bank within three weeks of being notified of any settlement in which a claim was attributed to a health care practitioner(s). A separate report shall be submitted to the National Data Bank for each licensed practitioner identified as responsible for the claim.

a. When case review demonstrates that all licensed health care practitioners provided expected standards of care and that the cause of the patient injury or death was not attributable to negligence, a report to the National Data Bank shall be made only in the name of the attending physician or dentist.

b. When case review demonstrates that one or more licenses practitioners failed to practice within expected standards of care, a separate report shall be submitted for each provider found to have performed at less than expected standards.

c. When case review demonstrates that all licensed health care practitioners provided expected standards death was negligence not under the control of the licensed practitioners, no report shall be submitted to the National Data Bank. Examples of this include power failures, accidents to patients, or

visitors caused by factors unrelated to patient care, and drugs mislabeled by the manufacturer.

b. At the completion of appellate review, a report shall be sent to the National Data Bank on any licensed practitioner when the practitioner's clinical privileges are limited or restricted for reason of illness, incompetence, or negligence.

c. A report shall be sent to the National Data Bank on any licensed health care practitioner, who is convicted, pleads guilty, pleads nolo contendere, receives a discharge in lieu of court-martial, receives a discharge instead of criminal investigation, or receives a less than honorable discharge for any of the misconduct actions listed in Addendum 4 of the Proposed DOD Health Care Provider Credentials Review and Clinical Privileges Directive [Appendix A to this thesis].

6. Credentialing

a. All medical treatment facilities shall review credentials and assign clinical privileges of health care providers with clinical privileges in accordance with the provisions of DOD Dir. 6000.7, DOD Dir. 6025.1, DOD Dir. 6025.2, DOD Dir. 6025.3, DOD Dir. 6025.4, DOD Dir. 6025.6, references (b), (f), (g), (h), (i), and (j).

b. All individually credentialed health care providers shall be appointed as members of the medical staff. The medical staff shall recommend uniform standards of care and criteria for use in assessing quality of care, and shall perform peer review and patient care assessment.

c. All medical treatment facilities shall document the training, experience, and current competence of all categorically credentialed providers.

d. Required qualifying degrees shall be verified for authenticity prior to allowing the provider to work other than under direct supervision. Evidence of verification by a previous medical treatment facility or the recruiting agency shall constitute adequate proof of authenticity.

e. Copies of qualifying degrees, licenses, and certificates required for assigned duties shall be provided to the first medical treatment facility to which the provider is assigned. They shall be filed with the appropriate officer as designated by service regulation and provided to the receiving medical treatment facility on transfer of the provider.

f. Medical treatment facilities shall establish means to monitor and evaluate performance of assigned personnel. Providers found to perform below standards shall be retrained, or restricted to those procedures which they are able to perform up to acceptable standards, or terminated..

g. The service surgeon general or designated authority shall be notified when licensed health care providers are reported to the National Data Bank.

h. The DOD and military services shall review credentials data centrally to identify trends involving potentially substandard providers. This central reporting requirement is established by Dep't of Defense Directive, DOD Health Care Provider Credentials Review and Clinical Privileging [Appendix B to this thesis].

i. The military services shall be responsible for notifying the ASD(HA) and the Federation of State Medical Boards when providers required to possess a license by DOD Dir. 6025.6, reference (j), have had that license revoked,

suspended, or otherwise limited by that issuing authority.

5. Accreditation

The military services shall be responsible for instituting a system of medical treatment facility periodic inspection and survey to ensure that facilities have programs required by this and other DOD directives concerned with quality of health care.

Survey by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) is considered an effective means of achieving this purpose and shall be considered mandatory for all hospitals of more than 25-bed capacity not later than 1990. Survey through use of the JCAHO Multihospital Survey Program is encouraged. The DOD and military services shall review JCAHO accreditation survey data centrally to identify trends in care and status of MTF physical plant and facilities in an effort to improve care.

G. **REPORTING REQUIREMENTS**

1. The case abstract for malpractice and risk management reports is attached as Enclosure 1 [Addendum to this appendix].

2. Each military service shall submit an overall quality assurance summary report to the DOD Quality Assurance Committee with a brief review of major milestones, goals, impact on care, and any other specific subjects as directed by ASD(HA). These reports shall be provided to the ASD(HA) no later than 60 days after the end of each calendar year.

H. **EFFECTIVE DATE**

This directive is effective within 180 days of signature.

ADDENDUM

Case Abstract for Malpractice and
Risk Management Reports

1. Name of Facility _____ DMIS Code: _____
2. Provider Information:

Social Security Number	Profession	Specialty
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
3. Malpractice Claims Management Data:
 - a. PCI () Date of event _____
 - b. Malpractice claim () Date Filed _____
Was this malpractice claim previously
identified as a PCI by the facility?
() Yes () No
 - c. Closure of claim () Date closed _____
 1. Denied payment ()
Reason for denial: _____

 2. Administrative settlement ()
Amount _____
 3. Litigation settlement:
 - a. Out of court () Amount _____
 - b. Judgment () Amount _____
6. Diagnosis _____ ICD9-CM Code _____
(Inpatient records only)
7. Procedures _____ ICD9-CM Code _____
(Inpatient records only)
8. Nature of alleged negligent act or acts: _____

9. Peer review assessment: Standards of care met ()
Standards not met ()
Not provider related ()

10. Patient Data:

- a. Sex: Male () Female ()
b. Age: _____
c. Sponsor's social security number: _____
d. Patient status:
1. Active duty ()
2. Dependent of active duty ()
3. Retired member ()
4. Civilian emergency ()
[individual entitled to care on emergency
basis only].
5. Other (specify) _____

INSTRUCTION SHEET
CASE ABSTRACT FOR MALPRACTICE CLAIMS

This is the instruction sheet for filling out the Case Abstract for Malpractice Claims form. This form is to be used for reporting to the Assistant Secretary of Defense (Health Affairs) data abstracted from all malpractice claims at the time the claims are closed. Claims are to be abstracted and reported whether closed favorably for the plaintiff or the United States. Forms sent to update or correct previously reported information should identify the report as an update or correction.

Item 1. Name of Facility. Enter either the name of the health care facility or the Defense Medical Information System (DMIS) code for the facility.

Item 2. Provider Information. Enter the social security number, profession, and (if applicable) specialty of each health care professional either named in the claim or found by professional review to be responsible for the outcome of the case. When professional review results indicate that all care was within usual standards, the data provided should be for the primary physician responsible for care at the time of the event.

Item 3. Malpractice Claims Dates:

- A. Provide the dates requested.
- B. Indicate how the claim was closed and other information requested.

Items 4 and 5. Diagnoses and Procedures. For inpatients, list the diagnoses, procedures, and ICD9-CM codes shown on the front sheet of the medical record. If the case involves ambulatory or dental care, enter the diagnoses and procedures that best reflect the circumstances leading to the claim.

Item 6. Injury Classification. Check the box that best describes the duration of any anticipated disability resulting from the events leading to the claim.

Item 7. Patient Allegation(s) of Negligent Care. Provide either the plaintiff's allegation(s) of negligent act and/or omissions or provide the applicable classification code from the taxonomy found in Enclosure 1 to this instruction sheet.

Item 8. Professional Review Assessment. Check the box best reflecting the findings of professional review of the care provided to the patient.

Item 9. Patient Demographics. Provide the information requested. The social security number requested in that used for the patient's medical or dental records.

ENCLOSURE 1 TO INSTRUCTION SHEET

TAXONOMY OF ALLEGATIONS OF NEGLIGENCE

1. Diagnosis
 - 1.1 Delayed diagnosis.
 - 1.2 Missed diagnosis (original diagnosis wrong)
 - 1.3 Failure to diagnose (no diagnosis made)
2. Anesthesia
 - 2.1 Inadequate equipment preparation, testing, and monitoring
 - 2.2 Improper positioning
 - 2.3 Intubation related
 - 2.4 Failure to monitor
 - 2.5 Improper agent, route, or dosage
 - 2.6 Extubation and recovery related
3. Invasive Procedures
 - 3.1 Endoscopy
 - 3.2 Invasive radiology (includes cardiac catheterization)
 - 3.2.1. Diagnostic
 - 3.2.2. Therapeutic
 - 3.3 Surgery
 - 3.3.1. Improper performance
 - 3.3.2. Unnecessary surgery
 - 3.3.3. Wrong side or body part
 - 3.3.4. Retained foreign body
4. Pharmacy and Therapeutics
 - 4.1. Wrong medication, dosage, or route ordered
 - 4.2. Wrong medication, dosage, or route administered
 - 4.3 Drug reaction
 - 4.4. Intravenous infusion injury

- 5. Obstetrics
 - 5.1. Improper prenatal care
 - 5.1.1. Inappropriate medication during pregnancy
 - 5.2. Failure to monitor during labor
 - 5.3. Failure or delay in performing Caesarian section
 - 5.4. Unnecessary Caesarian section
 - 5.5. Failure to adequately treat fetal distress
 - 5.6. Injury of fetus
- 6. Mental Health
 - 6.1. Wrongful death (suicide)
 - 6.2. False imprisonment (admitted against patient's will)
 - 6.3. Drug and alcohol rehabilitation treatment related
- 7. Blood Products
 - 7.1. Unnecessary use of blood products
 - 7.2. Wrong type of blood product administered
 - 7.3. Contaminated blood product
 - 7.3.1. Human immunodeficiency virus (AIDS)
 - 7.3.2. Hepatitis
 - 7.3.3. Other
- 8. Administrative Procedures
 - 8.1. Failure to obtain informed consent
 - 8.2. Failure to follow MTF, service, or DOD policies
 - 8.3. Abandonment
 - 8.4. Failure to provide care availability
 - 8.5. Failure to obtain consultation
 - 8.6. Breach of confidentiality
- 9. Accidental Trauma
 - 9.1. Slip and falls
 - 9.2. Burns
 - 9.3. Needle pricks or cuts
 - 9.4. Other

APPENDIX B

Proposed Department of Defense Directive

**SUBJECT: DOD Health Care Provider Credentials Review
and Clinical Privileging**

References:

(a) Dep't of Defense Directive No. 6000.7, Dissemination of Information on Medical Officers (July 29, 1982) (hereby canceled).

(b) Dep't of Defense Directive No. 6025.1, Standards for DOD Health Care Providers Performance (Apr. 19, 1983).

(c) Dep't of Defense Directive No. 6025.3, DOD Health Care Provider Conduct (Aug. 24, 1984) (hereby canceled).

(d) Dep't of Defense Directive No. 6025.6, Licensure of DOD Health Care Providers (July 18, 1985).

(e) Dep't of Defense Directive No. 6025.4, Credentialing of Health Care Providers (Feb. 11, 1985).

(f) Privacy Act, 5 U.S.C. § 552a (1986).

(g) Uniform Code of Military Justice arts. 1-140, 10 U.S.C. §§ 801-940 (1982).

(h) 10 U.S.C. § 1094 (1986).

(i) 10 U.S.C. § 1102 (1986).

(j) Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101-11152 (1986).

(k) Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. §§ 801-967 (1982).

A. PURPOSE

This directive:

1. Reissues references (a), (c), and (e) and updates policies for developing and maintaining practitioners credentials files (PCFs) and practitioners activity file (PAF) according to policies in references (b), (f), (h), (i), and (j).

2. Implements reporting requirements of references (b), and (c).

B. APPLICABILITY AND SCOPE

1. This directive applies to the Office of the Secretary of Defense (OSD) and the military departments (including their National Guard and Reserve components).

2. The directive applies to all health care providers with individual clinical privileges and to all fixed DOD medical and dental treatment facilities (MTF/DTF).

3. Sections of this directive on reporting of substandard performance and misconduct apply also to other licenses health care facilities.

C. DEFINITIONS

1. Credentials. The documents that constitute evidence of training, licensure, experience, and expertise of a provider.

2. Credentials, Verified. Documents for which confirmation of authenticity has been obtained from the primary source by the MTF/DTF, a previous MTF/DTF, or a representative of the military department.

3. Formal Charges. A criminal indictment or information filed by civil authorities, or charges referred to a court-martial for trial by a proper court-martial convening authority, pursuant to reference (g) above.

4. Health Care Provider. Military (active or Reserve component) and civilian personnel (Civil Service and providers working under contractual arrangement) granted privileges to diagnose, initiate, alter, or terminate health care treatment regimens. This category includes physicians, dentists, nurse practitioners, nurse anesthetists, nurse midwives, podiatrists, optometrists, clinical social workers, clinical psychologists, and physician assistants. Physical therapists, occupational therapists, audi-

ologists, clinical dietitians, clinical pharmacists, and speech pathologists shall be included when granted clinical privileges.

5. License (Certificate), Verified. A license (or certificate that is current (active) and that allows the provider to engage in practice within the jurisdiction of the issuing authority.

6. Peer. A health care professional of the same or equivalent training.

7. Peer Review. Assessment of professional performance by professionally equivalent military or civilian providers.

8. Clinical Privileges. Permission to provide medical and other patient care services in the granting institution, within defined limits, based on the individual's education, professional license and experience, competence, ability, and judgment.

a. Temporary Privileges. Privileges granted to active duty military providers who have arrived at a permanent change of station assignment without the PCF.

b. Provisional Privileges. Initial privileges granted a provider at an MTF/DTF are given for a set length of time during which the clinical performance shall be assessed by peers and supervisors. The length of time shall be consistent for all providers in a health care facility.

c. Staff Privileges. Privileges granted to providers for a period of time not to exceed 24 months. Performance assessment shall be documented before each renewal of privileges. A provider's privileges are based on review of both credentials and performance. Depending on the provider's relationship with the MTF/DTF staff, staff privileges may be temporary, defined, consulting, or courtesy. Military

department regulations shall define these categories for each military department.

1. Consultant Privileges. Privileges granted to a civilian or military provider designated as a consultant. Civil service regulations refer to this category as "expert."

2. Courtesy privileges. Privileges awarded to providers assigned to the MTF/DTF for short periods of time (i.e., temporary duty (TDY)) for 180 days or less. They may apply to providers located in geographic proximity to a MTF/DTF during military training exercises but not assigned to the facility. MTFs/DTFs may grant courtesy privileges to a provider who is assigned temporarily or permanently to an area in proximity to the MTF/DTF.

3. Defined Privileges. Privileges extended to members of the facility staff who have completed a provisional period and who care for patients independently or under supervision of other providers.

9. Privilege Actions. The various actions available to the commander following documented performance. The following types of actions are included:

a. Augmentation. Addition of clinical privileges previously not held. Augmentation shall be based on additional training, sustained superior performance, correction of previously demonstrated deficiencies, or other objective evidence of increased expertise.

b. Abeyance. The temporary removal of a provider from clinical duties while an internal or external peer review is conducted. Such privilege abeyances shall not exceed 14 days that the commander may grant a single extension of 14 days. Abeyances are not to be considered adverse actions.

c. Suspension. The temporary partial or complete removal of privileges from a provider based on peer assessment or command decision that this action is needed to protect patients or the integrity of the command during the process of extensive peer review, credentials committee review, hearing(s), and command action on cases involving incompetence, negligence, or misconduct.

d. Restriction (Limitation). Permanent removal of a portion of a provider's clinical privileges. Restriction of clinical privileges may be based on substandard performance, misconduct, physical impairment, or other factors limiting a provider's capability.

e. Revocation. Permanent removal of all clinical privileges of a health care provider. In most cases, such action should be followed by action to terminate the provider's affiliation with the DOD.

10. Provider Activity File (PAF). A quality assurance file containing provider specific performance and productivity data. The contents of the PAF are active quality assurance documents and are protected from disclosure by 10 U.S.C. § 1102 (1986), reference (i). The PAF shall contain the following information:

a. The provider activity profile summary report from the data base in AQCESS or other data base. A provider profile summary report shall be placed in the PAF at least every six months.

b. Copies of any pertinent committee minutes, patient records, patient statements, other provider statements, and counseling statements that concern the provider.

11. Practitioners Credentials File (PCF). The file containing the documents concerning the training,

education, experience, and current competence of the provider. The PCF is protected from disclosure to the general public by 10 U.S.C. § 1102 (1986), reference (i).

12. Supervision. The process of reviewing, observing, and accepting responsibility for assigned personnel. The following levels of supervision are pertinent to privileges.

a. Indirect. The supervisor performs retrospective record review of selected records. Criteria used for review relate to quality of care, quality of documentation, and the provider not exceeding the granted privileges.

b. Direct. The supervisor is involved in the decision making process. This may be further subdivided as follows:

1. Verbal. The supervisor is contacted by telephone or informal consultation before implementing or changing a regimen of care.

2. Physically Present. The supervisor is present physically through all or a portion of care.

D. **POLICY**

It is DOD policy that:

1. All health care providers must be prepared by training, education, and experience for the scope of practice for which they are granted privileges. Current expertise, performance, and health status shall be assessed and documented at regular intervals. Substandard performance and reportable misconduct shall be evaluated, prompt corrective action taken, and timely reports filed with applicable Federal, state, and national organizations.

2. All reasonable efforts shall be made to protect the identity of a person who alleges misconduct or substandard performance on the part of DOD health

care provider. Release of the identity of persons making such allegations shall be only to parties authorized such information on a need-to-know basis.

3. Investigations of DOD health care providers resulting in adverse sanctions shall be subject to the due process appeals procedures defined in 42 U.S.C. §§ 11101-11152 (1986), reference (j), and applicable military department regulations.

E. RESPONSIBILITIES

1. The Assistant Secretary of Defense (Health Affairs)-ASD(HA), shall monitor implementation of this directive.

2. The Secretaries of the Military Departments, or Designees, shall ensure compliance with this directive, and recommend changes in the program to the Secretary of Defense through the ASD(HA).

F. PROCEDURES

1. Credentials Review and Clinical Privileging. These processes are composed of the following five stages:

a. Accession Credentials Review. A provider's credentials shall be reviewed before the provider enters DOD service, employment, or works under a contractual arrangement. All providers shall have a PCF established by the recruitment agency to which they apply. On request, PCFs or other available information on nonselected providers shall be made available to recruiting agencies of other DOD military departments. Either the PCF or authenticated, true copies of all documents shall be sent to the first MTF/DTF to which the provider is assigned and shall serve as the basis of the PCF throughout that provider's federal service. The minimum contents of the initial PCF are listed as Addendum 1 to this directive.

b. Delineation of Clinical Privileges.

Each military department shall be responsible for developing standardized privilege lists by profession and specialty. MTFs/DTFs using these lists shall be responsible for modifying them to meet any facility specific characteristics. For privileged providers requiring supervision, the credentials committee shall recommend the level of supervision and frequency of reports from the appointed supervisor. Examples of providers who may require supervision are given in Addendum 2 to this directive.

c. Review and Assessment Prior to Granting Staff Privileges. This review shall be carried out by the commander and designated officers at the facility or unit to which a health care provider is assigned. The steps in this review are as follows:

1. The health care provider updates the curriculum vitae and any other applicable data in the PCF and submits an application for privileges.

2. The facility requests information available from any central clearing house or data bank that each military department shall designate in implementing instructions. The services may obtain such information on all applicable health care providers by prior arrangement and shall then notify MTFs/DTFs of previously unreported information on applicable providers.

3. The commander's authorized designee for credentials review and the MTF/DTF department and/or service chiefs review the PCF contents and privilege application and recommend appropriate provisional privileges.

4. The commander or authorized designee grants defined provisional privileges.

5. Provisional clinical privilege appointments shall be for a specified time not to exceed 12 months and shall be of uniform duration for all individually privileged practitioners at an MTF/DTF.

6. Before the end of the provisional period of privileges, the credentials committee shall review the PCF together with performance assessment(s) from peer(s) and/ or MTF/DTF department service chiefs and recommend defined clinical privileges. For non-physician providers, peer recommendations should be obtained, when possible, in addition to MTF/DTF department chief appraisal, if the department chief is a physician.

7. Defined clinical privilege appointments shall be for a specified period of time not to exceed 24 months and shall be of uniform duration for all practitioners at an MTF/DTF.

8. Reserve components shall provide the PCF or a PCF summary for practitioners assigned to attached to DOD MTFs/DTFs. Provisional or courtesy privileges shall be approved by the commander or authorized designee after review of the PCF and any other pertinent information available. If Reserve component providers are on extended duty, the MTF/DTF may choose to appoint full privileges after the provisional period. In some cases, the PCF of a Reserve component provider may be maintained at a DOD MTF/DTF.

d. Ongoing Assessment of Performance. Commanders shall have ongoing programs to monitor and assess performance of all health care providers. Included in monitoring and assessment programs shall be policies for patient medical or dental record review, and clinical monitoring review. Clinical monitors shall include both generic (i.e., hospital-wide) and

department specific events. Clinical monitors may be developed by the facility and higher headquarters. When peer review indicates that health care providers fail to meet standards of care, the case shall be referred to the credentials committee for review. If the credentials committee substantiates substandard care, the case shall be documented and appropriate action(s) recommended. In all cases, the providers shall be notified of the action(s) recommended and other their right to due process appeal or review as specified in 42 U.S.C. §§ 11101-11152 (1986), reference (j) and Dep't of Defense Directive, DOD Medical Quality Assurance Program, Para. F.5. No actions shall be considered final until all applicable due process procedures are completed.

1. A PAF shall be maintained for each provider with clinical privileges. The PAF shall be kept separate from the PCF. Material in the PAF shall include data reflecting workload (productivity), peer review, outcome indicators, and performance assessment. Examples of the PAF's contents are listed in Addendum 3 to this directive. Military department implementing documents shall list basic PAF content requirements. Providers shall be allowed to review the contents of their PAF. The MTF/DTF department chairman or the supervisor of the provider shall use the PAF when preparing clinical performance assessments, letters of recommendation, and counseling statements. The data in the performance assessment and PAF shall be reviewed by the credentials committee before renewal of clinical privileges, reassignment, retirement, or separation of a provider. The PAF data may be removed and destroyed only after the credentials committee judges that the data are reflected accurately and completely in the most current performance assessment and privileges.

After approval, the performance assessment document shall be made a permanent part of the PCF. The performance assessment document shall contain both quantitative and supervisory assessment of provider performance.

2. Data documenting superior or substandard performance of Reserve component providers shall be sent to the provider's Reserve component commander for inclusion in the provider's PCF. Due process appeals shall be carried out as specified in 42 U.S.C. §§ 11101-11152 (1986), reference (j), and applicable military department regulations.

3. PCFs shall be kept and transmitted securely. Health care providers shall be allowed to review the contents of their PCFs for accuracy and completeness.

e. Reporting of Assessment. Performance assessment shall be documented in the PCFs of all providers. Additionally, certain types of performance shall be reported to higher headquarters and specified civilian agencies.

1. In cases of superior care, the PCF shall contain documentation of these facts in the performance assessment as described in subparagraph F.1.d.1. above. This shall constitute adequate reporting of such care.

2. In cases of documented substandard performance, the PCF shall contain sufficient documentation to justify any action(s) taken. When actions have included periods of supervision or restriction, steps shall be taken to obtain periodic reassessment of performance until the credentials committee believes that improved performance is documented adequately. These reassessments shall be

kept in the PAF and a summary placed in the PCF at the end of the period of supervision.

3. Any adverse clinical privilege action shall be reported through the next higher headquarters to the Surgeon General of the military department within 3 duty days. The commander shall rescind permission for off-duty employment until review and applicable due process appeal procedures are completed.

4. The commander shall notify the Surgeon General of the applicable military department through the next higher headquarters at the completion of any adverse clinical privilege action. Military departments shall be responsible for reporting any permanent privilege restriction or revocation action to the state(s) of known licensure, the Federation of State Medical Boards (FSMB), or other applicable professional disciplinary data bank, and the ASD (HA). When actions are appealed by the provider, notification of civilian agencies shall be carried out following completion of due process appeals to the Surgeon General or designated authority of that military department unless earlier notice by the military department is deemed necessary in the interest of the public's health and welfare.

5. Substandard performance allegations received up to 1 year following discharge or separation from DOD service shall be investigated and reported.

2. Misconduct of Health Care Providers. Commanders shall evaluate allegations of misconduct of health care providers including, but not limited to, those acts listed in Addendum 4, paragraphs A and B. Where there is substantial evidence that the provider may have committed act(s) to compromise patient safety, the commander shall suspend all or part of the

provider's clinical privileges pending further information. When applicable, command investigations shall be coordinated with criminal investigators.

a. When a health care provider is alleged to have committed any of the acts in Addendum 4, the commander shall notify within 3 duty days the Office of the Surgeon General or a designated authority through the next higher headquarters of the allegations and of the commander's action on the provider's clinical privileges. The commander shall rescind permission for the provider to engage in off-duty employment until investigations are completed.

b. The military departments shall be responsible for the following reports:

1. Acts listed in paragraph A of Addendum 4 shall be reported to state(s) of known licensure, the FSMB, other applicable clearing houses for professional information, and ASD (HA) within 7 days following completion of due process appeal procedures.

2. Acts listed in paragraph B of Addendum 4 shall be reported to state(s) of known licensure and ASD(HA) at the time of referral for trial by a general court-martial convening authority or indictment by a civilian court. Reports to states of indictment and referral for trial shall state that a final report will be sent following jury verdict, adjudication, or administrative disposition.

3. The military department shall notify the state(s) of licensure and ASD(HA) of final disposition of providers referred for trial by court-martial or by civilian authorities. When disposition is by guilty verdict, guilty plea, nolo contendere, discharge in lieu of court-martial, or discharge instead of investigation, the FSMB or other applicable

professional disciplinary data bank shall be notified of the misconduct charges and means of disposition.

4. Reserve component commanders learning of providers being charged with misconduct acts listed in Addendum 4, paragraphs A or B, shall review the charges and facts available and decide what effect, if any, the charges shall have on military status. Providers indicted for acts listed in Addendum 4, paragraph B shall be separated from direct patient care until results of resolution of the charges are received. Commanders of Reserve component providers shall report such cases to the Surgeon General of the military department. The military departments need not report to the FSMB or other civilian agencies cases of providers indicted by civilian courts for acts of misconduct separate from military status.

5. Written requests from state licensure boards for copies of indictments, referral for court-martial, hearings, and information of privilege determination shall be honored by the Office of the Surgeon General for providers licensed by the state or applying for licensure by the state. Any such request received by an MTF/DTF shall be forwarded to the Office of the Surgeon General or designated authority for action. Care shall be taken to protect the confidentiality of other providers and patients names as required by 5 U.S.C. § 552a (1986), reference (f).

6. Charges of misconduct acts filed up to 12 months following separation from DOD service shall be investigated and reported as described in subparagraphs F.2.b.1. through F.2.b.5., above. Providers shall be notified of the charges and of their rights to due process procedures.

3. Files of Providers in Graduate Professional Education (GPE) Programs. Training credential files shall be developed on all providers during GPE training. These files shall become the PCFs of such practitioners on graduation from the GPE program.

a. MTF/DTF with GPE programs shall start a training credentials file and a PAF for each provider during the first year of training. The training credentials file shall contain verified copies of diplomas, licenses, clearing house reports, training certificates, and practice experience documents (curriculum vitae). The files shall be maintained by an officer or committee designated by the commander.

b. The PAF for providers in training shall include academic performance assessments every 6 months and specific recommendation from the teaching chief for or against promotion to the next year's training level.

c. Where a provider is held back or removed from a program for lack of competency or disciplinary reasons, the facts shall be reported to the Surgeon General as described in subsections F.1. and F.2., above. The military departments shall report cases of misconduct to civilian agencies as described in subsection F.2. above.

d. Before completing training, each provider's performance shall be evaluated. A performance assessment document shall be prepared by the responsible instructors and shall reflect material in the PAF. This assessment shall be reviewed and approved or disapproved by the education committee. The education committee and the supervising instructor shall decide which, if any, of the materials in the PAF shall be made a part of the PCF of these providers on graduation from training. The PCF shall be forwarded to the provider's first duty station.

4. Credentials Files of Providers Who Have Separated From DOD Service.

a. Copies of the PCF of providers who have separated in good standing with no reprimand or restriction of privileges and no charges of misconduct shall be maintained in the MTF/DTF credentials files where the providers were last assigned for at least one year. Authorized requests for information shall be honored using information from or copies of these files.

b. Copies of PCF and PAF of providers with any professional or misconduct sanctions or investigations involving reportable events as defined in Section F.1 through F.3 shall be sent to the Office of the Surgeon General at the time of separation. They shall be retained by the military departments. Requests for information from state licensing boards or civilian MTFs/DTFs shall be honored in accordance with federal confidentiality statutes. In all cases, final privilege actions are considered public knowledge for release to MTFs/DTFs and state licensing agencies where the provider has applied for or received privileges or licensure.

G. **EFFECTIVE DATE AND IMPLEMENTATION**

This directive is effective within 180 days of signature. Military departments will forward one copy of implementing documents to the Assistant Secretary of Defense (Health Affairs) within 180 days.

ADDENDUM 1

Provider Credentials File Contents

1. Copies of qualifying educational degree(s) needed for the performance of clinical privileges (i.e. M.D., D.O., D.D.S., Ph.D.) and verification of the authenticity of these documents.
2. Copies of required post graduate training certificates (i.e., internship, residency, fellowship, or nurse anesthesia school) for requested clinical privileges, and verification of the authenticity of these documents.
3. Copies of current state licenses and current renewal certificates shall be in the file. A list of all health care licenses ever held shall be provided and an explanation of any licenses that are not current or that have ever been subjected to disciplinary action shall be attached. The recruiting agency shall verify the authenticity of at least the most current of the documents.
4. A current report from the American Medical Association Masterfile or other professional clearing house, as applicable, shall be obtained for all providers.
5. Copies of specialty board certificates and fellowship certificates.
6. Practice experience to account for all periods of time following graduation (curriculum vitae).
7. Proof of current professional competence (letters of reference and a recent description of clinical privileges as concurred with by the directors of the facility in which the provider is currently practicing).
8. Documentation of any medical malpractice claims, settlements, or judicial or administrative

adjudications with a brief description of the facts of each case listed.

9. Any history of disciplinary action by a hospital, state licensure board, or other civilian governmental agency. This shall include any resolved or open charges of misconduct, unethical practice, or substandard care.

10. Statement of physical and mental health to include any history of drug or alcohol abuse.

11. Interview summary by at least one military medical department officer of the same or a similar professional training.

ADDENDUM 2

Examples of Providers Who May Require Supervision

1. General practice physicians or dentists in "on-the-job training" specialty positions.**
2. Physicians or dentists in GPE programs.**
3. Providers with restricted privileges.
4. Physician assistants (PAs).**
5. Nurse practitioners, nurse anesthetists, and nurse midwives.
6. Physical therapists when diagnosing and instituting treatment for musculoskeletal disorders.
7. Clinical dietitians when diagnosing and instituting nutrition therapies or prescribing nutritional supplements.
8. Providers during provisional privilege periods.
9. Any other provider who is either exceeding the usual scope of practice for his or her training or, for whatever reason, is temporarily under restriction or supervision.
10. Providers not yet qualified for a license (after dates specified in Dep't of Defense Directive No. 6025.6, reference (d)).**

[** Identifies those provider categories where a supervising physician must be assigned].

ADDENDUM 3
Provider Activity File

The PAF may contain some invalidated information. It is a quality assurance document and is confidential pursuant to 10 U.S.C. § 1102 (1986), reference (i). It shall be kept separate from the PCF. Much of the PAF material may be obtained from the periodic summary report of the provider activity profile in AQCESS or an equivalent automated quality assurance computer system. PAF contents will include the following:

A. Quantitative Data.

1. For All Providers. Identification number and specialty code, number of continuing health education (CHE) hours credited, number of CHE lectures given, attendance at required staff meetings, attendance rate at required meetings of the health staff peer group to which provider is assigned, and approximate number of days absent for illness.

2. For Primary Care Providers Without Admission Privileges. Number of times assigned emergency services call, average daily patient load, percentage of time in deployed status, and name of supervising physician (as applicable).

3. For Providers With Admission Privileges. Number of admissions, number of discharges, number of procedures (by category), number of obstetrical deliveries, number of special care unit admissions, and number of inpatient mortalities.

4. For Supervised Providers. Periodic performance assessments as required by DOD directive, regulation, or the credentials committee.

B. Outcome Data.

1. Mortality, Morbidity, and Clinical Monitoring. Copies of minutes, counseling, and

sanctioning documents, and appellate documents of any case leading to investigation, sanction, or privilege action of the provider. The PAF shall keep copies of any material on the evaluation of a provider, whether the results were favorable or unfavorable to that provider. The PAF shall contain applicable copies of all of the material on any investigation, sanction, or commendation of a provider. These are the materials that may lead to a final performance assessment document that shall be kept in the provider's PCF.

2. Patient Generated. Copies of patient compliments or complaints together with documentation of validity and any applicable peer review material in the PAF.

3. Risk Management. Material on potentially compensable incidents (PCIs), and threatened, filed, or settled malpractice claims shall be kept together with any applicable peer review material in the PAF.

C. Other Data.

1. Copies of periodic physical examinations, Medical Evaluation Boards, and other health documents may be inserted in the PAF.

2. Copies (or title list) of scientific presentation and papers.

3. Administrative data reflecting the rate of chart delinquencies; health care record deficiencies (found in health record review of patient records); expiration data of basic cardiac life support (BCLS), advanced cardiac life support (ACLS), and advance trauma life support (ATLS) training certificates; quality assurance training; expiration date of state license; and, participation in activities of benefit to military medicine (for example, community health education, school health programs, and community BCLS training) may be kept in the PAF.

ADDENDUM 4

Reportable Actions of Misconduct

A. Misconduct Actions That Are to Be Reported Only After the Due Process Appeal Procedures Specified in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101-11152 (1986), reference (j).

1. Fraud or misrepresentation involving application for enlistment or commission into DOD service that results in discharge from the service.

2. Fraud or misrepresentation involving renewal of contracts for professional employment, renewal of clinical privileges, or extension of service obligation.

3. Proof of cheating on a professional qualifying examination.

4. Abrogation of professional responsibility through any of the following actions:

a. Deliberately making false or misleading statements to patients as regards clinical skills and/or clinical privileges.

b. Wilfully or negligently violating the confidentiality between provider and patient except as required by civilian or military law.

c. Being found impaired by reasons of drug abuse, alcohol abuse, or alcoholism.

d. Intentionally aiding or abetting the practice of medicine or dentistry by obviously incompetent or impaired persons.

5. Prescribing, selling, administering, or providing Schedule II substances as defined in The Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. §§ 801-967 (1982), reference (k), for the use of the provider or a family member of provider without prior waiver of policy.

6. Failure to report to the privileging authority any disciplinary action taken by professional or governmental organizations reportable under this directive.

7. Failure to report to the privileging authority malpractice awards, judgments, or settlements occurring outside of DOD facilities.

8. Failure to report to the privileging authority any professional sanction taken by a civilian licensing agency of health care facility.

9. Commission of a misdemeanor that is punishable by actual fine of over \$1000.00 or confinement for over 30 days.

B. Misconduct Actions That Are Reportable At the Time of Referral for Trial by Court-Martial or Filing of Indictment in a Civilian Court.

1. Commission of a felony, whether under civilian or military jurisdiction.

2. Entry of guilty, nolo contendere plea, or request for discharge in lieu of court-martial while charged with a felony.

3. Commission of an act or acts of sexual abuse or exploitation related to the practice of medicine or dentistry.

4. Receiving compensation for treatment of patients eligible for care in DOD hospitals.

5. Prescribing, selling, administering, giving, possessing, or using any drug legally classified as a controlled substance for other than medically acceptable therapeutic purposes.