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ABSTRACT

The Department of Defense's (DOD) efforts to assure that its physicians are qualified to perform their assigned duties are discussed. Five sections include: introduction; additional actions needed to help assure that military physicians have proper qualifications; hospital credentialing and privileging systems needed to comply with DOD requirements; improvements needed in reporting physicians' clinical privilege restrictions; and DOD physician dissatisfaction with physician utilization and medical resources. The results of a review of the individual credential files for 426 physicians, randomly selected from 1,070 files at 9 hospitals, showed that the files generally did not contain complete or adequate documentation to support the award of clinical privileges, and that privileges were awarded without documentation of required reviews. Some of the 18 appendices are: sampling methodology for physicians' questionnaires; methodology used for review of physicians' credentials files; methodology used for identification and analysis of decredentialed physicians; documentation of medical school evaluation in physicians' credential files; documentation of residency training; documentation of educational commission for foreign medical graduates certification in foreign trained physicians' files; status of cardiopulmonary resuscitation/advanced cardiac life support training documented in part-time emergency room physicians' credentials files; documentation of medical malpractice involvement; officially requested privileges documented; credentials committee review of privilege awards; status of most recent privileges at time of the credentials file review; and comments from DOD. The report contains 5 tables and 9 figures.(SM)

United States General Accounting Office

GAO

Report to Congressional Requesters

July 1988

DOD HEALTH CARE

Additional Efforts Needed to Verify Physicians' Qualifications

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-231236

July 18, 1988

The Honorable Beverly B. Byron
Chairman, Subcommittee on Military
Personnel and Compensation
Committee on Armed Services
House of Representatives

The Honorable Daniel K. Inouye
United States Senate

The Honorable Claiborne Pell
United States Senate

The Honorable Jim Sasser
United States Senate

This report discusses the Department of Defense's efforts to assure that its physicians are qualified to perform their assigned duties. Copies of this report are being sent to the Secretary of Defense, appropriate congressional committees, and to other interested parties.

Lawrence H. Thompson

Lawrence H. Thompson
Assistant Comptroller General

Executive Summary

Purpose

Highly publicized instances of problems in Department of Defense (DOD) medicine have resulted in much congressional concern and intense public scrutiny of DOD medical care. At the request of the Chairman, Subcommittee on Military Personnel and Compensation, House Committee on Armed Services, and Senators Daniel Inouye, Claiborne Pell, and Jim Sasser, GAO evaluated DOD systems used to determine the adequacy of physician qualifications.

Background

DOD requires that clinical privileges (the type of medical procedures to be performed) be individually awarded to all physicians given the authority and responsibility to initiate, alter, or terminate a regimen of care. Hospital credentials committees are responsible for reviewing physicians' credentials and recommending the award of clinical privileges, if appropriate, to the hospital commander who approves or disapproves the recommendation. The award of privileges, which presupposes a review of credentials, is intended to ensure that physicians possess the education, training, other qualifications, and demonstrated competence to deliver quality professional health care. Because DOD physicians change duty stations frequently throughout their careers and their qualifications and competence may be unknown at their new stations, adequate documentation and review of physician credentials is essential to the award of privileges at new stations.

Hospital commanders are also responsible for investigating and, when necessary, suspending or terminating clinical privileges of physicians whose conduct requires action to protect the health or safety of any patient, employee, or other person in the facility. When permanent limitations are placed on a physician's clinical privileges, such actions are required to be reported by the hospital through service-prescribed channels to the Surgeons' General, and to the Federation of State Medical Boards—a clearinghouse organization that maintains a national data bank on disciplined physicians.

The Assistant Secretary of Defense for Health Affairs is responsible for overall supervision of DOD health activities. The Surgeon General in each service is the key official responsible for overseeing hospital quality assurance programs, including the adequacy of oversight and maintenance of physician privileges. (See pp. 10-13.)

GAO examined the systems used within DOD to determine the qualifications of physicians at the time of entry into service; to validate the education, training, and licensure status of on-board physicians; and to

report the restriction of physicians' clinical privileges to the Federation. Detailed work was performed at nine military hospitals where GAO evaluated the adequacy of physician credentials files, which DOD requires to contain essential information on physician qualifications and performance for use in awarding clinical privileges. (See pp. 13-16.)

Results in Brief

DOD and the military services have taken substantial action in recent years toward assuring the medical qualifications of their physicians. Directives and regulations have been issued and systems have been set up that should result in only qualified physicians practicing medicine. However, emphasis needs to be placed on implementing the requirements, especially at the hospital level.

GAO's review of the individual credentials files for 426 physicians, randomly selected from 1,070 files at nine hospitals, showed that the files generally did not contain complete or adequate documentation required by DOD and the services' regulations to support the award of clinical privileges. For example, about 53 percent of the files did not contain authenticated medical diplomas. Neither the files nor credentials committee minutes showed what was considered, discussed, and reviewed in the evaluation and award of clinical privileges.

Privileges were awarded without documentation of required reviews. In addition to the potential consequences to beneficiaries of allowing physicians whose performance has not been documented to practice medicine, there could be potential problems in defending the government against malpractice claims involving such physicians. Poor medical care does not necessarily result from incomplete documentation of physicians' qualifications and performance or from the untimely award of clinical privileges. On the other hand, complete implementation of the system required by DOD offers much more assurance that only qualified physicians are practicing medicine in properly approved specialties. (See 30-42.)

Principal Findings

Validations of Physician Qualifications Should Be Completed

Validating the qualifications of DOD physicians is an important step to ensure that only qualified physicians practice medicine in the military. DOD has made substantial progress in this area. Since 1984, preemployment screening of new physicians has been tightened substantially. Validations of the qualifications of on-board physicians have also been made but the approaches taken by the Navy and Air Force need to be more thorough and the Army needs to resolve the remaining discrepancies found during its validation efforts. (See pp. 17-22.)

Many Physicians Unlicensed as Deadline Approaches

In July 1985, DOD required its physicians to have a valid and current state medical license by July 18, 1988. A medical license is required for the private practice of medicine in each state. Questionnaires returned to GAO by a random sample of DOD physicians in late 1986 showed that nearly 1,800 physicians did not have a current state license, including about 1,200 that had never been licensed. DOD told us in May 1988 that there are still many unlicensed physicians and expressed concern about the possible effects on access to health care if a large number of physicians were not allowed to practice medicine independently because they did not have a license. (See pp. 22-24.)

DOD Waives Licensure for Some Foreign National Physicians

Under Public Law 99-145 and the applicable DOD Directive, DOD is permitted to waive licensure requirements under unusual circumstances. Of 246 foreign national physicians practicing medicine in DOD overseas facilities, 134 had not passed the examination administered by the Educational Commission for Foreign Medical Graduates. DOD has decided to grant waivers to some of these physicians because, according to DOD officials, there are many excellent physicians in this group.

As DOD proceeds with its process of making case-by-case determinations on whether to grant waivers to its foreign national physicians, GAO believes DOD should reassess the educational background of these physicians. GAO believes this is important because of problems previously identified in the educational and training programs of several foreign medical schools.[1] (See pp. 24-27.)

[1]See Policies on U.S. Citizens Studying Medicine Aboard Need Review and Reappraisal (HRD-81-32, Sept. 21, 1980) and Federal, State, and Private Activities Pertaining to U.S. Graduates of Foreign Medical Schools (GAO/HRD-85-112, Sept. 27, 1985).

Need for Central Credentials Data System

To improve the efficiency of the credentialing system, the Army is establishing a central data base on individual physicians, including authenticated information on education, training, experience, certification, licensure, and the status of actions against privileges. GAO believes central data systems would be appropriate for all services because the systems would eliminate duplicate verifications of physician qualifications and permit improved management oversight of the credentialing process. Such systems should also be (1) used to support the requirements of the Health Care Quality Improvement Act of 1986 on the reporting of certain adverse actions taken against physicians and (2) interfaced with the centralized DOD malpractice information system GAO recommended in its June 1987 report.[2] This latter system will also contain information on physician performance. (See pp. 43-46.)

Recommendations

GAO recommends that the Secretary of Defense (1) focus on completing validations of the qualifications of all DOD physicians, (2) reemphasize the importance of fully implementing the physician credentialing system at all military hospitals, (3) and establish a central data base to support the credentialing system. (See pp. 28, 46, and 54.)

Agency Comments

DOD generally agreed with GAO's findings and recommendations. DOD believes that it has already taken the necessary actions to resolve the problems identified during GAO's review. Regarding the recommendation on the establishment of central data bases to support the credentialing system, DOD wants to make sure that the Army's system is effective and efficient before requiring the Navy and Air Force to establish similar systems. (See pp. 89-94.)

GAO agrees that improvements have been made. However, action is still needed to establish a central data base on individual physicians as soon as possible and to ensure that all hospitals are implementing the required physician credentialing system. (See pp. 28, 29, 47, 48, and 54.)

[2]DOD Health Care: Better Use of Malpractice Data Could Help Improve Quality of Care (GAO/HRD-87-30 June 1987).

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Abbreviations

DOD	Department of Defense
GAO	General Accounting Office

Introduction

Highly publicized instances of medical malpractice with Department of Defense (DOD) hospitals have resulted in intense public scrutiny of military health care. Findings by the DOD Inspector General and military service internal auditors during reviews made from May 1983 through July 1984 identified, among other things, credentials files of military physicians containing insufficient evidence of physician qualifications and current competence. These findings also heightened concerns over the quality of DOD health care.

As a result of these concerns, the Chairman, Subcommittee on Military Personnel and Compensation, House Committee on Armed Services, and Senators Daniel K. Inouye, Claiborne Pell, and Jim Sasser asked us to review several areas pertaining to the quality of care provided in military health care facilities.

Our first report in response to these requests assessed the adequacy of DOD and service systems to identify and analyze medical malpractice information.[1] We concluded that improvements are needed in the identification, investigation, and analyses of medical malpractice information, and recommended, among other things, that a DOD-wide system be developed to collect, analyze, and use medical information from malpractice investigations.

This report deals with our assessment of the systems DOD uses to assure that physicians are qualified to perform their assigned duties.

Organization, Size, and Mission of DOD Medical Care System

The military health care system operates over 500 treatment facilities, including 168 hospitals, in the United States and at U.S. military installations throughout the world. These facilities are staffed by a health professional force of over 43,000 active duty personnel, including approximately 13,000 physicians. The system is responsible for the treatment of a beneficiary population of approximately 9 million, including active duty personnel and their dependents, retirees, and dependents of retired and deceased personnel. The total budget for the DOD health care system was about $11.2 billion for fiscal year 1987,

[1] DOD Health Care: Better Use of Malpractice Data Could Help Improve Quality of Care (GAO/HRD-87-30 June 1987).

including $8.8 billion for the Army, Navy, and Air Force direct care systems, and $1.7 billion for the Civilian Health and Medical Program of the Uniformed Services.[2]

At the DOD level, the Assistant Secretary of Defense for Health Affairs is the principal advisor to the Secretary on health policies, programs, and activities. He is responsible for overall supervision of DOD health activities, including medical quality assurance, which is the responsibility of the Office of the Deputy Assistant Secretary for Professional Affairs and Quality Assurance. That office is responsible for monitoring and evaluating the quality of care provided in military medical treatment facilities and for developing policies and programs to maintain and improve the quality of care. In the services, the offices of the surgeons general, and also of the commander of the Naval Medical Command, are responsible for overseeing operation of the hospitals' quality assurance programs. Hospital commanders are responsible for the approval of medical procedures that individual physicians are permitted to perform at the hospital level.

Service Procedures and Practices for Assuring Physician Quality

The quality of DOD professional health care services depends on a number of factors: (1) the quality of physicians recruited and retained; (2) the extent of physician professional development through assignments and continuing education and training designed to enhance medical knowledge, skills, and abilities; and (3) the adequacy of health care facility oversight and monitoring of physician credentials as a part of facility quality assurance programs.

Physician Recruitment, Selection, and Assignment

Each military service recruits its own active duty physicians from three primary sources: the Health Professions Scholarship Program, the Uniformed Services University of Health Sciences,[3] and civilian physician volunteers. For active duty physicians, service recruiters obtain applications from possible candidates for direct commission as active duty

[2]The Civilian Health and Medical Program of the Uniformed Services provides medical care to dependents of active duty members and retirees and their dependents. This medical care is obtained from civilian providers.

[3]The scholarship and university programs were authorized by the Uniformed Services Health Professions Revitalization Act of 1972 (Public Law 92-426). The scholarship program provides scholarships to medical and other health profession students in return for specified periods of active duty service. The Uniformed Services University is a degree-granting Federal institution located at the Naval Hospital, Bethesda, Maryland, established to educate physicians and other health professionals, also in return for specified periods of active duty service.

officers. Recruitment personnel are required to verify each applicant's background, training, and qualifications and forward such information to the Surgeons' General where qualifications are evaluated and selections are made by physician selection boards.

In contrast, civilian physician recruitment is performed by local personnel offices who are responsible for recruitment. For the Army and Navy, this process includes local verification of applicant/selectees background, training, and qualifications. The Air Force's Military Personnel Center verifies all applications for Air Force civilian physicians.

Fully qualified physicians—those who have completed all required training—must have a state license at the time of employment or entry into the service. However, physicians who enter the service before all required post-graduate training has been completed were not, until July 1985, required to obtain a state license upon completion of their training. In July 1985, DOD changed its licensure regulation to require physicians who enter the service in a post-graduate training position to obtain a license within 1 year of completing their graduate medical education. Also, this regulation required all on-board physicians to have a current state license by July 18, 1988.[4]

Foreign national[5] physicians employed at U.S. overseas installations will also be required, as of July 18, 1988, to have a license from their country of residence and a certificate from the Educational Commission for Foreign Medical Graduates. The Commission is responsible, through verification of education, training, and testing for assessing the readiness of graduates of foreign medical schools to enter residency or fellowship programs in the United States. Certification is a prerequisite for licensure to engage in the private practice of medicine in virtually every state.

Following recruitment and selection of direct commission physicians for active duty, service personnel officials make initial duty station assignments and reassign physicians on a periodic rotational basis. The services' needs, such as numbers of physician vacancies, are considered in making initial assignments and reassignments. The length of a duty tour varies, but generally does not exceed 4 years at any one location.

[4]A DOD Health Affairs official told us in April 1988 that DOD was planning to extend this date to November 8, 1988, to make the requirement consistent with the deadline in Public Law 99-145.

[5]Foreign nationals are non-U.S. citizens working at overseas military facilities.

Award, Renewal, and Withdrawal of Medical Privileges

The award of medical privileges, or the medical procedures that a physician is approved to perform, occurs at individual medical facilities. At individual treatment facilities, hospital commanders award medical privileges to physicians based on the physicians' education, training, experience, demonstrated competence, and certifying examinations. Following award of privileges, practitioner performance is monitored through committees on quality assurance/risk management and through periodic performance evaluations. These review and monitoring activities are intended to assure that high standards of medical practice are maintained and that medical practice privileges continue to be justified. Privilege renewals, as required both by Joint Commission on Accreditation of Healthcare Organizations[6] standards and service regulations, must occur at least every 2 years and must be based on reappraisals of the individuals at the time of renewal.

Hospital commanders are also responsible for investigating and, when necessary, suspending or terminating clinical privileges of physicians whose conduct requires action to protect the health or safety of any patient, employee, or other person in the facility. When permanent limitations are placed on a physician's clinical privileges, such actions are required to be reported by the hospital through service-prescribed channels to the Surgeons' General, and to the Federation of State Medical Boards. The Federation is a clearinghouse organization that maintains a national physician disciplinary data bank.

Objectives, Scope, and Methodology

The objectives of our review were to (1) evaluate the adequacy of DOD's and the services' procedures and processes used to assure that physicians are properly qualified to perform their assigned duties based on their education, training, experience, and past performance and (2) determine what impact the new DOD and service physician licensure requirements will have on DOD unlicensed physicians and the military health care system.

We performed our review at the Office of the Assistant Secretary of Defense-Health Affairs; the Army, Navy, and Air Force Offices of the Surgeons General; the Army, Navy, and Air Force medical commands, recruiting services, and personnel centers; selected military hospitals; the American Medical Association; the Federation of State Medical Boards; the Joint Commission on Accreditation of Healthcare Organizations; and the Educational Commission for Foreign Medical Graduates.

[6]Formerly the Joint Commission on Accreditation of Hospitals.

At the Office of the Assistant Secretary of Defense-Health Affairs, the Surgeons General, and the service major medical commands we analyzed policies and procedures pertaining to the recruitment and selection, assignment, and rotation of physicians; reviewed the services' procedures and processes for verifying physician education, training, and licensure status; examined the procedures for identifying, handling, and reporting poor performers or decredentialed providers (those physicians who have had their medical privileges limited, suspended, or revoked) to appropriate licensure authorities; and discussed the potential impact of the new DOD and service licensure requirements on unlicensed physicians and on the DOD health care systems.

To determine whether physician qualifications are validated at the time of entry into service, we reviewed service regulations and procedures that the military medical recruitment services follow in verifying education, training, and experience. We also performed a limited test of active duty Army, Navy, and Air Force recruiting files to determine whether the applicants' education, training, and past performance were verified as part of the preemployment screening process, as required. Our limited test included the files of 24 of the physicians hired by the Army recruitment service and 7 of the physicians hired by the Air Force recruitment service during fiscal year 1987. In October 1987, we examined the only three recruitment files that were available for the Navy.

To assess the adequacy of the services' actions to validate the education, training, and licensure status of on-board physicians, we reviewed the procedures they used to validate the qualifications of their physicians. We also assessed the actions taken by the services against physicians identified with past histories of licensure problems or with education that the services were unable to validate. As a part of this analysis we also visited the American Medical Association, Federation of State Medical Boards, and Educational Commission for Foreign Medical Graduates. These civilian organizations maintain physician data bases against which service validations were performed. At these organizations we discussed the sources of their data bases and the adequacy of the services' approaches to validating military physician education and licensure data.

To determine (1) the percentage of physicians who are unlicensed (these data are not maintained in DOD data bases) and (2) whether the physicians believe they are qualified to perform their assigned duties, we

developed and mailed questionnaires to a random sample of 1,350 physicians—worldwide. For those who were unlicensed we determined (1) their background characteristics (i.e., age, board certifications, specialties, etc.), (2) why they are unlicensed, (3) what they plan to do in response to the new DOD and service licensure requirements, and (4) if they plan to obtain a license, and what difficulties they anticipate in attempting to obtain one. Details of our physician questionnaire sampling, which was designed for a 95-percent confidence level, and our analyses methodologies are discussed in appendix I.

We also obtained from the Surgeons General the number of foreign national physicians employed at U.S. installations overseas and their status as it relates to service licensure requirements. For foreign national physicians who do not meet service licensure requirements, we discussed, with the Deputy to the Assistant Secretary of Defense-Health Affairs, representatives of the Surgeon Generals, and the Assistant Chief of Staff for Professional Services of the Army 7th Medical Command Europe, the services' plans for assuring that foreign national physicians are qualified to perform their assigned duties.

To determine whether physician credentials files were complete and provide an adequate basis for hospital credentials committees to assure that physicians are properly qualified to perform their assigned duties, we reviewed 426 credentials files from a sample of 1,070 physicians at nine military hospitals. The hospitals were selected to include small, medium, and large size hospitals, three from each service, with a worldwide geographical dispersion.

To perform our evaluation at the hospitals, we designed structured data collection instruments (one for each of the services) for our use in reviewing physician files to ascertain, among other things, evidence of education, licensure, certification, performance appraisals, formal review and approvals of requested privileges, and documentation of malpractice incidents. The hospitals included in our review, the physician universes at each hospital at the time of our review, the sample size of credentials files reviewed, and details on our sampling and analyses methodologies are presented in appendix II. As a part of this effort, we also visited the Joint Commission on Accreditation of Healthcare Organizations and identified and discussed the standards they use to evaluate the adequacy of hospital-based physician credentialing systems.

To determine (1) the characteristics of individuals who have had their medical privileges limited, suspended, or revoked (decredentialed physicians) during the period October 1, 1984 through June 2, 1986, and (2) whether decredentialed physicians were being reported to the Federation of State Medical Boards as required by DOD and service regulations, we obtained the names of all 288 physicians decredentialed by the services during that time. For these physicians we developed a standardized data collection instrument that was completed for us by the services, one for each decredentialed physician. We did not validate the information provided to us. We used the instrument to collect information on, among other things, (1) physician background characteristics (i.e., licensure status, and medical school from which they were graduated), (2) the principal reasons for the decredentialing actions, and (3) evidence of prior performance problems. Details of our identification and analyses methodologies are discussed in appendix III. For physicians who had their medical privileges limited, suspended, or revoked during the period of our review, we ascertained (1) whether reporting to the Federation had occurred, as appropriate, and (2) the timeliness of such reporting.

Our review, conducted between December 1985 and July 1987, was made in accordance with generally accepted government auditing standards. DOD provided comments on a draft of this report on May 16, 1988. These comments are included as appendix XVIII. Our evaluation of the comments is at the end of chapters 2, 3, and 4.

Additional Actions Needed to Help Assure Military Physicians Have Proper Qualifications

DOD and the military services have taken several actions in recent years to strengthen their procedures for validating the medical qualifications of their physicians. In 1985 the military recruitment services began verifying physicians' education and past performance to help ensure that only qualified physicians are brought into the military. Validation of the qualifications of on-board physicians recruited before 1986 has also received much attention from the services but more remains to be done. Validation approaches need to be more thorough in the Navy and Air Force, and the Army needs to resolve discrepancies found during its validation efforts.

The importance of validating physicians' qualifications, as well as implementing fully the DOD-required system for awarding clinical privileges to physicians at the hospital level (discussed in ch. 3), is shown by the following example. To qualify as an active duty physician, a person presented the Army with a certified copy of a medical school transcript, a certificate from the Education Commission for Foreign Medical Graduates, and a valid and current state license when entering the service in July 1981. The Army verified the state medical license and accepted the other credentials at face value. After the person had treated patients for several years as an active duty physician, the Army discovered that he had a fraudulent medical diploma from a foreign medical school.

DOD directed its physicians in July 1985 to have a valid and current state medical license by July 18, 1988.[1] Information we collected in late 1986 from a random sample of 10,371 physicians (see app. I) showed that nearly 1,800 physicians did not have a current state license and that about 1,200 of these had never been licensed. A medical license is required for the private practice of medicine in each of the states. All three military services are confident that most of their physicians will be able to fulfill the licensure requirement.

DOD also requires foreign nationals to possess, by July 1988, a license from their country of residence and a certificate from the Educational Commission for Foreign Medical Graduates. One of the requirements to obtain a certificate is to pass a written medical examination. According to DOD, 134 of the 246 foreign national physicians (as of August 1987) have not passed the examination administered by the Commission. DOD and the services believe some of these physicians will not be able to

[1]The term "state medical license," as used in this report, includes the individual states and the District of Columbia, the Commonwealth of Puerto Rico, Guam, and the U.S. Virgin Islands.

meet this licensure requirement. Information obtained from the Education Commission for Foreign Medical Graduates shows that between 16 and 39 percent of those who took the Commission's written examination passed the test during 1986.

Both DOD Directive 6025.6, dated July 18, 1985, and Public Law 99-145, enacted on November 8, 1985, permit DOD to waive licensure requirements under unusual circumstances. DOD has decided to grant waivers to foreign national physicians when the physician's competency can be verified after a case-by-case review.

Validation of Physician Qualifications Now Required at Time of Entry Into Service

DOD Directive 6025.4, Credentialing of Health Care Providers, dated February 11, 1985, requires validation of health care providers desiring entry for active duty, civilian, or contractual employment. Before 1985, the services did not have specific procedures for verifying physicians' qualifications. Implementation of the DOD directive by the military services should increase assurances that new physicians have the appropriate credentials to practice medicine.

Past failure to validate precredentialing information permitted physicians with questionable qualifications to enter the service. DOD and service regulations now require that precredentialing documentation be completed and verified before applicants are considered for employment. Also, the military services are required to determine if applicants have any disciplinary actions stemming from civilian medical practice.

We examined 34 recruiting files that showed the services verified the applicants' education and training as part of the precredentialing process. These files showed that the services made an extensive review of the applicants' background, training, experience, and qualifications before they were selected. In general, recruiting personnel at the local level verified each applicant's qualifications and forwarded the results to the services' recruitment commands for further review. When the command levels were satisfied that information was complete, the applicants' files were given to the selection boards for consideration.

Validation of Qualifications of On-Board Physicians Still Needs Attention

Validating the qualifications of on-board physicians is important to ensure that only qualified physicians practice medicine in the military. There are data bases that can be used to verify physicians' qualifications and past performance. The American Medical Association maintains a data base on physicians who are both U.S. and foreign medical graduates. This data base includes such information as physicians' medical school and post-graduate training, certifications, and licensure. The Federation of State Medical Boards maintains a national data bank on disciplinary action taken against physicians. The Educational Commission for Foreign Medical Graduates maintains a data base on the education, training, and testing of foreign medical graduates. In our opinion, a review of all three sources, when appropriate, offers the best assurance that a physician's qualifications have been validated.

However, in our opinion, the best source to use in validation is to go directly to the original source whenever possible. For example, validating that a physician graduated from a certain medical school could be done by corresponding directly with the school involved. Also, new standards adopted by the Joint Commission on Accreditation of Healthcare Organizations will require that hospitals verify physicians' credentials with primary sources before granting staff privileges whenever possible. These standards took effect on January 1, 1988.

Recognizing weaknesses in past verification processes, each service initiated efforts in late 1984 to validate the qualifications of physicians. The services compared the credentials and licensure status of their on-board physicians to one or more of the data bases maintained by the American Medical Association, the Educational Commission for Foreign Medical Graduates, and the Federation of State Medical Boards. The services also validated the qualifications of reserve and national guard physicians during 1986. In total, the qualifications of over 21,000 physicians were examined. The Army verified physicians' education, training, and certifications to the original sources, and the Navy initiated a similar effort in late 1986. However, completeness of the validation efforts varied by service.

Army Validations Use All Sources of Information

The Army compared the qualifications of its physicians to data obtained from the American Medical Association, the Federation of State Medical Boards, and the Educational Commission of Foreign Medical Graduates. In addition, several task forces were appointed to perform original source validation of the education, training, and certification of all Army physicians. The task forces also examined all active duty, civilian,

and Army Reserve and National Guard physician personnel files to identify, among other things, physicians with poor performance evaluations.

As a result of its validation efforts, the Army identified 18 active duty, 8 reserve, and 14 national guard physicians who have had disciplinary action taken against them. The physicians' problems included narcotics violations, improper medical treatment, or improper conduct. After these physicians were identified, the task forces forwarded cases to the appropriate agencies for further review and resolution. In some cases, the Army found that physicians' state licenses had been fully restored or that the reasons for the suspended licenses were such that no further action was needed. In the other cases, the Army took action to discharge physicians from the services.

The Army also was unable to verify the authenticity of diplomas for 353 active duty, 590 reserves, and 36 national guard physicians and 22 physicians who were classified as civilians. All of these physicians were foreign medical graduates. Starting in 1985, the Army wrote foreign medical schools requesting evidence that the unverified diplomas were valid. Although some schools provided the proper evidence, others did not respond to the Army's request. Army Quality Assurance officials said that the lack of response was probably due to various reasons, such as schools being out of business or in Eastern bloc countries. In 1987, the Army wrote the physicians involved requesting assistance in authenticating their diplomas. As of January 1988, the Army had not verified the diplomas of 8 active duty, 320 reserves, and 8 national guard physicians. An Army Quality Assurance official said that the Army plans to convene a review board to examine the personnel files of all physicians whose diplomas are unverified.

Navy Did Not Validate Qualifications of All Physicians

Navy validation efforts initially compared Navy physician education and licensure status to similar information in the physician data base of the American Medical Association. The Navy found two physicians with questionable qualifications. One was graduated from an unaccredited program and the other did not have a certificate from the Educational Commission for Foreign Medical Graduates. The physician from the unaccredited program was not allowed to practice medicine in the Navy and the other physician obtained a certificate.

Because of discrepancies in the Association data on individual physicians, such as incorrect data on residency training and on individual specialties, the Navy decided that additional validation should be done and,

in June 1986, tasked medical treatment facilities to validate their physicians' education, training, and licensure status to original sources. The Navy effort did not include physicians at Marine Corps installations or those stationed on-board ships.

The head of Navy Quality Assurance and Standards Branch told us that the qualifications of physicians at Marine Corps installations and those stationed on-board ships will be verified when they are reassigned to Navy medical treatment facilities. He said that the reason for delaying the validation of these physicians' qualifications is because treatment facilities have the personnel to perform original source verification. He said that reassignments for these physicians occurred about every 18 months. He also estimated that as of January 1988, about 90 percent of the Navy physicians have had their qualifications verified. In our opinion, the Navy should take the additional action to verify all physicians' qualifications rather than wait for their reassignment to medical treatment facilities.

An official of the Navy Quality Assurance office said that personnel at the medical treatment facilities who performed original source verification of assigned physicians' qualifications did not identify any physician with questionable qualifications.

Air Force Did Not Verify Its Data Against All Available Sources

The Air Force validation consisted of comparing its physician data base to that of the American Medical Association. The Air Force did not verify its data base against data bases maintained by the Federation of State medical Boards or, for foreign medical graduates, the Education Commission for Foreign Medical Graduates. The Air Force also did not perform original source validation of education, training, or certifications for its on-board physicians except when a difference was found between its data and the American Medical Association's data. A Surgeon General official told us that the Air Force relied on the American Medical Association data base as being the most reliable information.

The Air Force identified physicians with questionable qualifications from the American Medical Association data. There were five active duty, two civilians, four national guard, and two physicians assigned to the reserves identified as having had adverse licensure action against them. Some of these physicians were found to have had their licenses fully restored but at least three physicians were separated from the Air Force because of their previous licensure problems.

In addition, the Air Force could not verify the diplomas of 25 foreign medical graduates by use of the American Medical Association data. After further investigation, the Air Force found these diplomas to be valid.

Regarding how physicians with questionable qualifications were able to enter the services, a DOD Health Affairs Senior Analyst said that between 1968 and 1983, the military services were concerned about maintaining the privacy of physician applicants and did not carefully verify the physicians' academic and employment histories. The current recruitment procedures have corrected this situation.

Many DOD Physicians Unlicensed as Deadline Approaches

DOD Directive 6025.6, Licensure of Health Care Providers, dated July 18, 1985, requires physicians to possess a valid, current license by July 18, 1988. Foreign medical graduates who provide patient care in U.S. military facilities overseas are also required to have a license from their country of residence and a certificate from the Educational Commission for Foreign Medical Graduates by that time. A significant number of DOD physicians had not met the licensure requirements when they responded to our questionnaire in late 1986.

The requirements in the directive may be waived by the Assistant Secretary-Health Affairs on a case-by-case basis in unusual circumstances. If physicians fail to meet the requirements and no waivers are granted, the directive requires that such physicians may (1) provide patient care only under direct supervision of an appropriate licensed physician of the same discipline, (2) be subjected to adverse personnel actions, or (3) be separated. Public Law 99-145 contained licensure requirements similar to those in the DOD directive. The law also provides for a penalty of not more than $5,000 if a DOD physician practices medicine without licensure or waiver.

Many Active Duty Physicians Are Unlicensed

According to service officials, in the 1970's the services began requiring physicians who had completed all required training to have a current state license at the time of entry into the service. Physicians who entered the service before all post-graduate training had been accomplished were not required to obtain or maintain a current state license. DOD Directive 6025.6 changed this by stipulating that all on-board physicians who provide patient care independently possess and maintain a valid and current medical license. Persons in post-graduate training are

required by the directive to obtain a license within 1 year of completion of their training.

The services told us that in mid-1987, about 85 percent of the Army and Air Force physicians and 78 percent of the Navy physicians were licensed. All three services told us during our review that they were confident most of the unlicensed physicians would fulfill the licensure requirement by July 18, 1988, and that they did not anticipate any physician shortages or other adverse impacts to result from the new requirement. In contrast, DOD comments on our draft report express concerns about the possible effects on access to health care if a large number of physicians are not allowed to provide independent care because they do not have licenses. DOD said that although recent data indicates that about 90 percent of the physicians are licensed, it is likely that between 200 and 450 physicians will not have a license by the required date. DOD said that if between 600 and 900 physicians are unlicensed when the licensure requirement takes effect, the present personnel could not absorb the workload. Under this condition, DOD estimates a significant effect on access to medical care and costs under the Civilian Health and Medical Program of the Uniformed Services.

As a part of our review, we sent a questionnaire to a statistically valid sample of 1,350 military physicians[2] to ascertain, among other things, (1) the number of physicians who did not have a current state medical license, and (2) the plans of unlicensed physicians for meeting the requirement. The questionnaire responses, which were collected in late 1986, show that a projected 82.8 percent of the DOD physicians reported that they had current state medical licenses. The remaining physicians (a projected total of 1,782) did not have a current license; these were 15.8, 23.4, and 13.3 percent of the physicians in the Army, Navy, and Air Force, respectively.

Our review also showed that 1,207 of the projected 1,782 unlicensed DOD physicians had never been licensed. Further, 457 of the 1,207 physicians told us they intend to obtain their state license through examination, while 523 plan to obtain their license through endorsement,[3] 111 are hopeful they will be granted a state license based upon their medical experience, 28 indicated they plan to pursue other methods for

[2]See app. I for sampling methodology. The universe from which our sample was taken excluded students in post-graduate training.

[3]Obtaining a license after already having met the requirements.

obtaining their licenses, and 88 physicians did not provide any details on their plans to obtain a license.

Our Chief Medical Advisor believes that the passage of such examinations, which lead to state licensure, would be difficult for anyone who has been away from school more than a few years. This opinion is supported by comments made by an official of the 7th Medical Command, Europe, in regard to difficulties foreign nationals who have been out of school for several years have in passing the test administered by the Educational Commission for Foreign Medical Graduates. Also, a projected 9.6 percent of the physicians who have never been licensed told us in their questionnaire responses that they anticipate a problem in obtaining a license either because of examination difficulty or because they lack adequate credits or training.

For those physicians who are unable to obtain a license, DOD will have to make case-by-case decisions on the course of action to be taken. In commenting on this perception, DOD said that it plans to review applications for licensure waivers very closely, and issue waivers only to experienced health care personnel with documented evidence of qualifications and expertise in their profession.

Foreign National Physicians Are a Special Problem

Many foreign national physicians employed by DOD may not be able to meet the new licensure requirement because they have not passed the examination administered by the Educational Commission for Foreign Medical Graduates. DOD data were incomplete on the number of foreign national physicians who do not possess a license from their country of residence. Having such a license as well as possessing a certificate from the Commission will be required by July 18, 1988. The Assistant Secretary of Defense-Health Affairs, has authority under the directive to grant waivers of the licensure requirement, and is doing so for some foreign national physicians. As of December 1987, approximately 13 waivers had been granted to foreign national physicians in the Air Force and 49 waivers to foreign national physicians in the Army.

Information obtained from the offices of the Surgeons' General showed that a total of 246 foreign national physicians were employed in August 1987, and that 134 had not passed or attempted to pass the Commission's examination (see table 2.1.)

Table 2.1: Foreign National Physicians Employed by DOD, August 1987

	Number Employed	Number not passing the examination
Army	182	82
Navy	10	10
Air Force	54	42
Total	**246**	**134**

The Army had the largest number of foreign nationals who had not passed the examination—82, and most of these are in West Germany. DOD and service officials said that there are many excellent foreign national physicians who have not passed the examination. The 7th Medical Command has 133 of the Army's 182 foreign national physicians, most of whom are practicing medicine in West Germany.

The issue of qualifying foreign nationals dates back to at least 1976, when the Army's 7th Medical Command imposed a requirement that employment of foreign national physicians would be on a temporary basis pending their completion of the test administered by the Educational Commission for Foreign Medical Graduates. The requirement permitted a physician to take the examination twice if necessary, but provided that if the examination were not passed within 15 months, the physician's employment was to be terminated. A number of on-board foreign nationals were "grandfathered" at that time and not required to take the examination. On September 15, 1978, the 7th Command decided to grant waivers to those physicians who had failed the examination and for those whom treatment facility commanders wanted to keep on their staffs. This practice was stopped in September 1984. As of May 1987, 47 foreign national physicians were employed who had been grandfathered or granted examination waivers.

The foreign nationals practicing in DOD facilities in West Germany are licensed in such countries as Burma, Egypt, Great Britain, India, Pakistan, the Philippines, Turkey, and Yugoslavia.

DOD Is Granting Waivers

According to Health Affairs and Army officials, DOD decided to grant waivers from the licensure requirement to foreign national physicians because (1) many foreign nationals have been out of medical school for several years, and officials believed that requiring them to pass the Educational Commission for Foreign Medical Graduates examination, which is heavily geared toward the basic sciences taught to recent medical

school graduates, would be unfair; (2) overseas manpower ceilings, particularly in West Germany, could hinder the replacement of foreign national physicians by U.S. Army uniformed and civilian physicians; and (3) in West Germany, German law grants foreign nationals a right to bring court suits when they are terminated for reasons other than incompetence.

The Chief, Civilian Personnel, 7th Medical Command in Europe told us that compensation due physicians who do not pass the examination and who have their employment terminated would be decided by the German courts. He further said that the 7th Medical Command has limited experience in the area. In one case that he could recall, a terminated physician was awarded 70,000 to 80,000 deuchmarks or the equivalent of between $40,000 and $50,000 in 1987 dollars.

To provide a basis for granting waivers to foreign nationals in Germany, the Deputy Assistant Secretary of Defense-Health Affairs and the Army's 7th Medical Command agreed to the following procedures. The 75 physicians who have failed to pass or who had not taken the examination due to grandfathering were asked to take a written and/or an oral examination developed by the Uniformed Services University of Health Sciences. The foreign nationals' employment date and medical specialty determined which examination they were asked to take. The 7th Medical Command asked physicians employed before 1985 to take only an oral examination and physicians hired after that date to take both written and oral examinations. Physicians employed after 1985 who practice specialty medicine were asked to take only the oral examination. Performance in the examination will result in pass, conditional, or fail recommendations to the Commanding General, 7th Medical Command. These recommendations and statements from the physicians's Medical Command will form the basis for the 7th Medical Command decision to request a waiver of licensure, where appropriate, from the Assistant Secretary of Defense-Health Affairs.

Of the 75 physicians asked to take the examinations, 51 took the required exams. Of those who did not take the examinations, 17 refused and 7 had medical reasons. Forty-nine of the 51 physicians were recommended for a waiver by the university.

As of September 1987, the Air Force allowed its foreign national physicians the option of taking the Uniformed Services examination. For those physicians who chose not to take the examination, they can apply for a waiver request based solely on their past performances. The Navy

was still considering whether it will offer foreign nationals the opportunity to take the examination.

A DOD Health Affairs official said that a waiver would not automatically be granted even if the physician successfully passed the examination. He said that test results along with other evidence of competency, such as records showing the physicians' ability to provide quality care, would be considered in granting waivers to foreign nationals. Each service decides which records to provide DOD as proof of the physician's competency.

We have previously reported to the Congress that adequate assessment of foreign medical graduates is important because some foreign medical schools have deficiencies in their education and training programs.[4] In 1980 we reported that greater attention was needed in the assessment of foreign medical graduates because education and training programs at several foreign medical schools we visited were not comparable to those offered in this country. Our 1985 report described the difficulties that the medical licensing boards in four states had in making adequate licensing decisions for some foreign medical graduates because of the problems involved in assessing the quality of their education.

Conclusions

Validating the qualifications of DOD physicians is an important step to ensuring that only qualified physicians practice medicine in military facilities. DOD has made substantial progress in this area. But it is time to complete the job pertaining to on-board physicians, which has been underway for several years.

Specifically, the Army should complete evaluations of the more than 300 physicians whose medical school diplomas could not be verified. The Navy should validate the qualifications of the physicians at Marine Corps installations and those stationed on-board ships without waiting until they are reassigned to a Naval medical facility. The Air Force should validate its physicians' qualifications against all available data bases and verify with the original source of the information whenever possible. Not until the qualifications of all DOD physicians have been verified can DOD be assured that only qualified physicians are practicing medicine.

[4]Policies on U.S. Citizens Studying Medicine Abroad Need Review and Reappraisal (HRD-81-32, Sept. 21, 1980). Federal, State, and Private Activities Pertaining to U.S. Graduates of Foreign Medical Schools (GAO/HRD-85-112, Sept. 27, 1985). Testimony before the Committee on Labor and Human Resources, U.S. Senate, Mar. 25, 1985.

DOD will be faced with difficult decisions of what to do with those physicians that remain unlicensed. As DOD progresses with the process of case-by-case determinations on whether or not to grant waivers to foreign national physicians, we believe each waiver should be documented by records of demonstrated competence. This process also provides DOD an opportunity to reassess the educational credentials of the foreign national physicians for whom it is considering granting such waivers.

Recommendations

We recommend that the Secretary of Defense direct the Secretaries of the Army, Navy, and Air Force to complete validations of the qualifications of all physicians practicing medicine in military facilities. These actions should include (1) validating the qualifications of all DOD physicians for whom validations have not been completed against data bases maintained by the American Medical Association, the Federation of State Medical Boards, and, where appropriate, the Educational Commission for Foreign Medical Graduates, and (2) performing original source validation of the education, training, and certification, of all physicians for whom original source validation has not been performed whenever possible.

Agency Comments and Our Evaluation

DOD concurred with our recommendations and listed the initiatives that have been taken over the last several years to insure that only qualified physicians practice medicine in the military. DOD said that the recommended actions have already been accomplished.

We agree with DOD that substantial progress has been made toward assuring that military physicians have the proper qualifications. The efforts appeared to increase after we briefed the Assistant Secretary of Defense-Health Affairs in September 1987, and emphasized the need to complete the task of validating the qualifications of all physicians. The Army consistently increased the number of physicians whose qualifications had been validated, including verification with original sources, to a point approaching 100-percent validation. While DOD commented that the Air Force had also verified close to 100-percent of physician credentials, the Air Force began including all sources in its verifications in October 1987. Action should be continued to complete this one-time validation of the qualifications of all Army and Air Force physicians as we recommended above.

DOD said that our draft report was incorrect in saying that the Navy needed to validate the qualifications of physicians at Marine Corps

installations and those on-board ships. Since this was contrary to information developed during our review, we met with Navy medical officials and requested information on how the Navy was sure that the qualifications of all on-board physicians had received a one-time validation. Navy medical officials could not provide evidence that this was done. Therefore, we believe that the Navy needs to assure DOD that each physician who is practicing medicine independently has the proper qualifications.

Hospital Credentialing and Privileging Systems Should Comply With DOD Requirements

DOD requires that clinical privileges (the type of medical procedures to be performed) be individually awarded to all physicians given the authority and responsibility to initiate, alter, or terminate a regimen of care. Hospital credentials committees are responsible for reviewing physicians' credentials and recommending the award of clinical privileges, if appropriate, to the hospital commander. The award of privileges, which presupposes a review of credentials, is intended to ensure that physicians possess the education, training, other qualifications, and demonstrated competence to deliver quality professional health care. Because DOD physicians change duty stations frequently throughout their careers and their qualifications and competence may be unknown at their new stations, adequate documentation and review of physician credentials is essential to the award of privileges at new stations.

Our review of the individual credentials files for 426 physicians, randomly selected from 1,070 files at nine hospitals, showed that the files generally did not contain complete or adequate documentation required by DOD and service regulations to support the award of clinical privileges. Documentation deficiencies included

- missing or unauthenticated copies of (1) medical school, residency, and internship diplomas, (2) certificates from the Educational Commission for Foreign Medical Graduates, and (3) specialty board certifications;
- missing or expired records of the training status of physicians credentialed to practice in emergency rooms;
- incomplete or undocumented records intended to show, among other things, patient complaints and malpractice involvement that are necessary for performance-based credentialing; and
- incomplete and untimely clinical privilege reviews and approvals.

Poor medical care does not necessarily result from incomplete documentation on physicians' qualifications and performance or from the untimely award of clinical privileges. On the other hand, complete implementation of the system required by DOD offers much more assurance that only qualified physicians will be allowed to practice medicine in properly approved specialties.

Within each of the services, the presence or absence of documentation varied by hospital, evidencing that some hospitals have implemented the requirements better than others. However, none of the individual credentials files or credentials committee minutes showed the information or documentation that was considered, discussed, and reviewed in

the evaluation and award of clinical privileges. Without this documentation, we were unable to determine if privileges were awarded only after a complete review of physician performance as required by DOD and service regulations.

The DOD Inspector General and the Auditors General of the Army, Navy, and the Air Force reported similar deficiencies in a series of reports issued between February 1984 and June 1985. Although the Assistant Secretary of Defense-Health Affairs and the Surgeons General reported that corrective actions have been taken on these and other reported deficiencies, our review shows that improved management oversight is needed at the hospital level to ensure that promised improvements are made.

DOD and Service Regulations Delineate Credentialing and Privileging Requirements

DOD Directive 6025.4, Credentialing of Health Care Providers, February 11, 1985, established policy, prescribed procedures, and assigned responsibilities for granting clinical privileges to physicians in DOD facilities. The directive specifies the minimum education, training, and clinical experience documentation and states that complete, original documents or authenticated copies must be furnished before a physician can be granted privileges. In addition, the directive specifies that the award and renewal of clinical privileges must be tied to objective data that reflects the physician's professional performance and capabilities, and requires that documentation of medical malpractice involvement and a physician's profile be included in the credentials file to document clinical and professional activities. The DOD Directive was issued, and quality assurance directives previously issued by the individual services were revised, following the quality assurance reviews by the DOD Inspector General and the Auditors General of the three services.

The Army, Navy, and Air Force have established regulations to implement the DOD requirement for performance based credentialing. The regulations vest the responsibility for awarding clinical privileges in the hospital commander and require that a credentials file be established and maintained to document education, training, qualifications, and demonstrated competence for each physician granted clinical privileges.

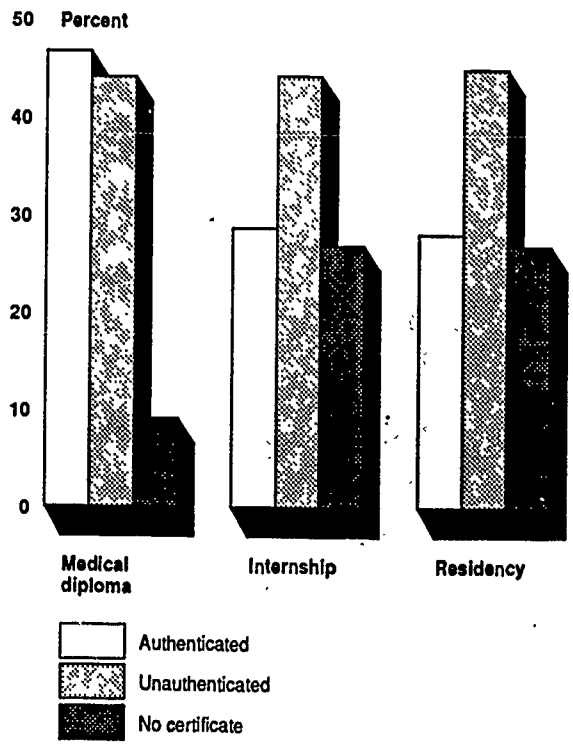
Hospital Privileges Granted Based on Inadequate Documentation of Education and Training

Our review of the 426 individual credentials files at nine hospitals showed that documentation of education and training was frequently deficient. Diplomas and certifications from medical schools and internship and residency training programs, from the Educational Commission for Foreign Medical Graduates, as well as from specialty boards, were frequently not in the files. In some cases, the files contained required documentation, but did not include statements of authentication.

Inadequate Documentation of Medical School and Post-Graduate Training

As shown in figure 3.1, medical school and post-graduate[1] training were frequently not documented as required in the individual physician credentials files reviewed at the nine hospitals.

Figure 3.1: Documentation of Education and Training in Individual Credentials Files



Note: Percents do not always equal 100 as explained in appendixes IV-VI.

[1]Post-graduate training refers to internship and/or residency training.

Analyses of the files by service showed 62.8 percent of the medical school diplomas in Navy files were authenticated; in the Army, 35.8 percent were authenticated; and in the Air Force, 35.4 percent were authenticated. At the same time, the Army had no diplomas in 13.5 percent of the files, followed by the Navy and Air Force, which had no diplomas in 6.1 and 1.6 percent of their files, respectively. Missing and unauthenticated post-graduate training documentation existed across all three services.

Within each of the services, the presence or absence of documentation varied by hospital location, evidencing that some hospital commanders have implemented the requirements better than others. For example, authenticated medical school diplomas were in 84.2 percent of the files at the Navy hospital in Naples, Italy, and 96.0 percent of the files at the Navy hospital in Oakland, California. At the Navy hospital in Portsmouth, Virginia, however, only 32.6 percent of the files (plus or minus an 11.6-percent sampling error) contained authenticated medical school diplomas. Details of education and training documentation by service and facility are presented in appendixes IV-VI.

In the latter part of 1984, the American Medical Association matched the names of service physicians against the Association's data bases to authenticate physician education and training in all three services. (See ch. 2.) The Association forwarded the authentications to the services' Surgeons General offices, and the Army and Navy Surgeons General notified medical facilities of each authentication. The facilities were directed to place data regarding the matches in individual credentials files. The Air Force did not provide the authentications to its facilities. The Medical Service Program Manager, Office of the Air Force Surgeon General, told us that in his opinion, hospital credentials committees do not have to keep reverifying credentials when physicians are reassigned. He told us that the Air Force has completed a central verification of physicians' credentials.

For the Army and Navy files that were missing education diplomas and training certificates, or contained unauthenticated documents, we compared the education and training data listed on the physicians's application to the American Medical Association data. This comparison showed 13.7 percent of the reported medical school data and over 31 percent of the post-graduate training data were not authenticated by the American Medical Association data. (See app. VII.) This further shows the importance of verifying physicians' qualifications to the original source so

that a determination can be made on the education and training qualifications of the physicians involved.

Inadequate Documentation of Certifications from the Educational Commission for Foreign Medical Graduates

The credentials files of foreign medical graduates frequently did not contain required certificates from the Educational Commission for Foreign Medical Graduates. The Commission, through a program of certification, assesses the readiness of graduates of foreign medical schools to enter residency or fellowship programs in the United States that are accredited by the Accreditation Council for Graduate Medical Education. Certification is also a prerequisite for licensure to engage in the private practice of medicine in virtually every state.

At the nine hospitals, we estimated 10.7 percent of the physicians are foreign medical graduates. The DOD Directive requires that credentials files for these physicians contain an authenticated copy of the Commission certification. At the nine hospitals, 73.8 percent of the files (plus or minus a 12.2-percent sampling error) for foreign medical school graduates did not contain authenticated certificates as required by the DOD directive. Missing and unauthenticated certifications spanned all three services, with ranges of missing and unauthenticated documents varying among hospitals. Details of Educational Commission certification by service and facility are contained in appendix VIII.

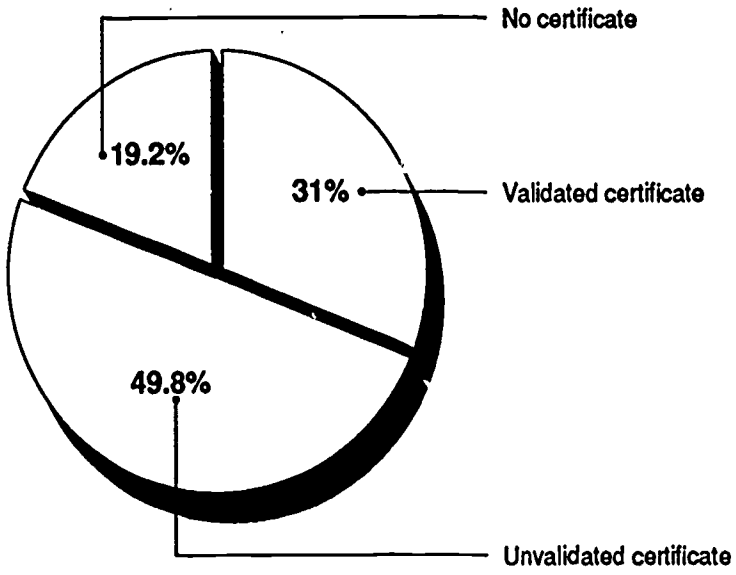
Inadequate Documentation of Specialty Board Certification

We estimate that 630 physicians in our sample universe were certified by medical specialty boards. As shown in figure 3.2, 19.2 percent of the certified physician files did not contain specialty board certificates, 49.8 percent had certificates in their files, but there was no evidence of validation of the certifications.

Missing and unvalidated certifications spanned all three services, with ranges of missing and unvalidated documents varying among hospitals. Details of specialty board certification by service and facility are contained in appendix IX.

Hospital commanders, credentials committee chairpersons, and credentials staff offered various reasons for the credentials files not containing required education and training documentation. Generally, the reasons cited were that (1) physician backgrounds had previously been verified but not documented, (2) physicians arrived without credentials files,

Figure 3.2: Documentation of Specialty Board Certification in Individual Credentials Files



and (3) the documentation had been overlooked through administrative oversight.

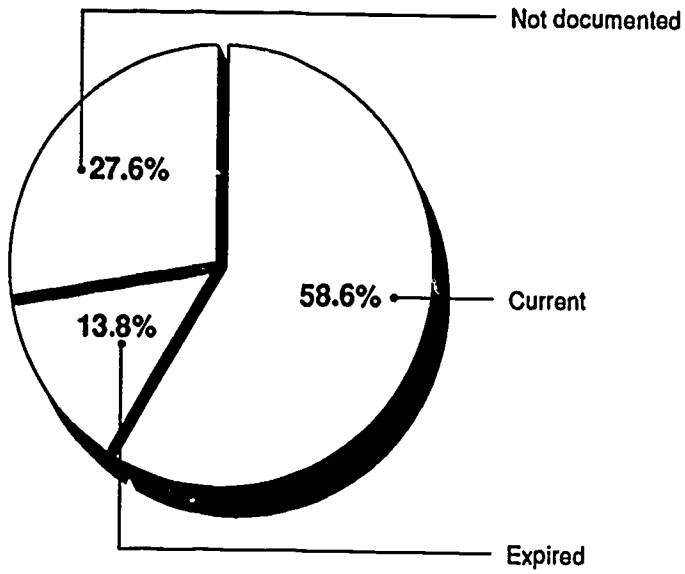
Inadequate Documentation of Training Status of Emergency Room Physicians

DOD and service regulations require that physicians staffed to work part time in the emergency care area must be currently trained in cardiopulmonary resuscitation or advanced cardiac life support. Evidence of such training must be documented in individual physician's credentials files. We examined the credentials files for 129 physicians in our sample that were privileged and assigned to work part time in the emergency care areas. As figure 3.3 shows, 58.6 percent of the files contained documentation of current cardiopulmonary resuscitation or advanced cardiac life support training while 13.8 percent contained documentation of expired training and 27.6 percent contained no documentation of training.

Training documentation for the part-time emergency room physicians spanned all three services, with the ranges of expired training and lack of evidence of training documents varying among hospitals. Details of training documentation by service and facility are contained in appendix X.

Hospital commanders, credentials committee chairpersons, and credentials staff told us that some physicians with expired training or with

Figure 3.3: Cardiopulmonary Resuscitation or Advanced Cardiac Life Support Training of Physicians Staffed Part Time in the Emergency Room



missing evidence of training may have received required training but had not submitted training documentation for their files. They also told us that some physicians with expired training are scheduled for future training.

Required Provider Profiles and Medical Malpractice Documentation Missing From Files

Performance based credentialing, or tying the award and renewal of privileges to objective data that reflect the physician's professional performance, is not being accomplished as required by the DOD Directive and service implementing regulations.

At the nine hospitals, we found that credentials files frequently did not contain required physician activity profiles that reflect such information as the number of malpractice claims, number of reported incidents,[2] number of validated patient complaints, number of patients with complications during or following treatment, all information obtained by agencies investigating the physicians, and the number of patient deaths.

[2]Incidents are unusual occurrences, such as medication errors, misdiagnoses, sudden or unexplained deaths, and surgical errors.

Also, the files did not always contain documentation of alleged or proven involvement in malpractice, which is required by the Directive and service implementing regulations.

At the nine hospitals we visited, complete provider activity profiles were included in 17.2 percent of the files, incomplete profiles not containing required information were in 55.5 percent, and no profiles were in 27.3 percent. Hospital officials gave the following reasons for the files not including the required profile information: (1) lack of staff resources, (2) misinterpretation of regulatory requirements, and (3) lack of a mechanized system to accumulate data. Details of physician activity profile documentation by service and facility are shown in appendix XI.

Our review also showed that medical malpractice was not documented as required in 9 of 21 credentials files for physicians that were identified by legal claims officials at the hospitals as being involved in medical malpractice. We found that physician involvement in medical malpractice is not always identified at installations, thus, malpractice information is not included in all credentials files of physicians alleged or proven to be involved in malpractice. For example, at Tripler Army Medical Center, the Deputy Commander for Clinical Services told us that service regulations requiring the recording of malpractice information in credentials files have not been implemented because of the potential negative effect on obtaining malpractice insurance if a physician leaves the service. A claims attorney at Tripler further told us that he does not investigate malpractice claims to affix responsibility, and that physician involvement is not highlighted in the claims files The attorney told us that during the period October 1, 1984 to May 31, 1986, 37 malpractice claims were filed at Tripler, but none were investigated or reviewed to affix responsibility. Instead, claims were investigated to determine the extent of the government's liability.

Following our review, the Tripler Risk Management Committee met and agreed to write the Army's Health Services Command for further guidance on identification of physician malpractice involvement. The minutes show that the committee wanted a local policy to state that the Risk Management Committee would review all malpractice claims, but would refer to the Credentials Committee only those claims determined to involve negligence or malpractice.

The Legal Officer, Navy Mid-Atlantic Regional Medical Command, said that generally, Naval hospitals have interpreted the requirement to include malpractice information in credentials files only if it has been

determined that a physician has provided substandard care and the hospital commander, regional command, or headquarters orders that the information be included in the physician's credentials file. At Portsmouth Naval Hospital, we found malpractice information was ordered to be included in the files of only 1 of 11 physicians identified as being involved in malpractice claims.

Further analysis shows that of the malpractice cases identified, the Air Force placed documentation in all of the involved physician files; the Navy in 75 percent of the files; and the Army in 11 percent of the files. Details of malpractice documentation by service and hospital are contained in appendix XII.

The high percentage of medical malpractice documentation in the Air Force files may be attributable to the fact that the Air Force is the only service that has a system for collecting data from the malpractice claims processing system and providing the data to hospitals. As we reported in June 1987,[3] the Air Force claims service notifies each hospital when a credentialed provider assigned to it is named in a malpractice claim and also notifies the hospital of the outcome of the claim; for example, denied or paid. This notification was designed to help assure that involvement in malpractice claims is recorded in the provider's credentials file.

In reviewing the credentials files at the nine hospitals, we noted that although the award and renewal of privileges is supposed to be performance based, there is no evidence that the chiefs of services or departments, credentials committees, or hospital commanders considered objective data in the privileging process. In addition, the credentials committee chairperson at William Beaumont Army Medical Center said there are no objective standards within the Army or the hospital to use in measuring physician performance. As an example, the chairman told us that in a decredentialing action involving a radiologist at Beaumont, it was necessary to determine an error rate for all radiologists at the hospital from a review of films by a private sector radiologist. This review revealed the error rate of the subject radiologist to be higher than the error rates for other radiologists at Beaumont.

[3]DOD Health Care: Better Use of Malpractice Data Could Help Improve Quality of Care (GAO/HRD-87-30 June 1987).

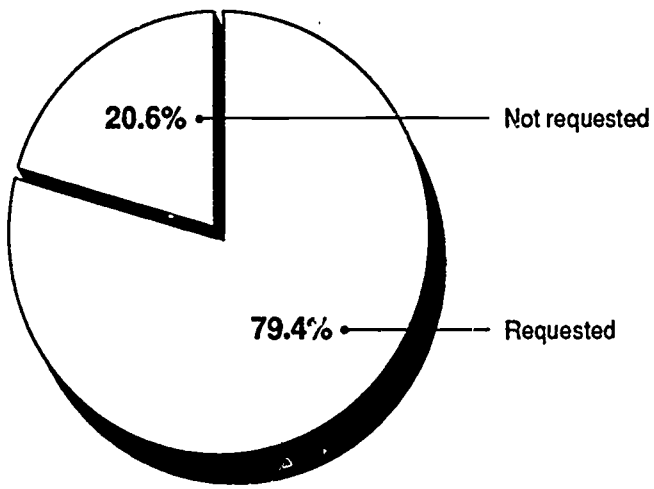
Clinical Privileges Awarded Without Adequate Review or Timely Approval

Clinical privileges have been awarded to physicians who had not officially requested them and without adequate or timely review and approval by the chiefs of service or department, the credentials committees, or the hospital commanders. All three services require that physicians officially request privileges and that the requests be reviewed and recommended for approval or disapproval by hospitals' chiefs of service or department and by their credentials committees. The hospital commanders are responsible for final approval.

Privileges Awarded Without Documentation of Official Request

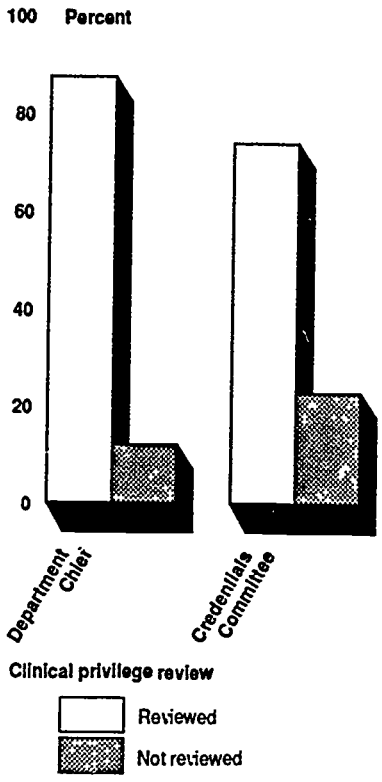
Credentialing regulations for all three services require that physicians officially request privileges to perform specific procedures. Physicians are not to request privileges in areas for which they do not have the required experience and qualifications. An analysis of 719 privileging actions for our sample of 426 physicians revealed that many physicians were awarded privileges for which, as shown in figure 3.4, documentation of official requests were not contained in the files.

Figure 3.4: Documentation of Clinical Privilege Requests for Awarded Privileges



Official privilege requests for awarded privileges were missing from credentials files at eight of the nine hospitals, with the greatest percentage of those missing at Air Force locations (see app. XIII).

Figure 3.5: Documentation of Clinical Privilege Review in Individual Credentials Files



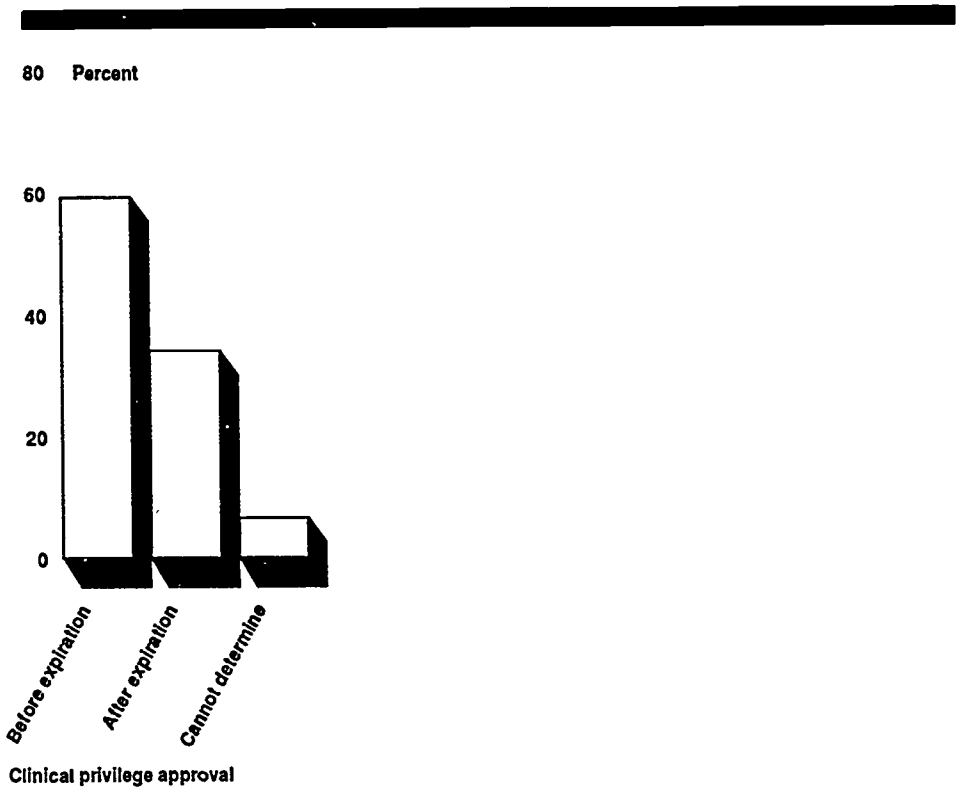
Privileges Awarded Without Documentation of Hospital Reviews

In DOD hospitals, physician privilege requests are to be reviewed and recommended for approval or denial to the hospital commanders by (1) the appropriate chiefs of service or department and (2) the hospital credentials committees. The hospital commander has the final approval responsibility of privilege requests. The Air Force permits the hospital commander or a designated representative to be sole reviewer for temporary privileges that are awarded for up to 180 days.

As shown in figure 3.5, an analysis of 719 privileging actions for the 426 physicians in our sample showed that many privilege requests had not been reviewed by service or department chiefs—we included designated representatives with department chiefs—and/or credentials committees.

As shown in appendixes XIV and XV, approvals were granted without Department Chief or designated representative reviews at six of the nine hospitals visited, and without credentials committee reviews at seven of the nine hospitals visited.

Figure 3.6: Timeliness of Hospital Commander Privilege Approvals



Hospital Commanders Not Renewing Privileges in a Timely Manner

Hospital commanders are responsible for approving privilege renewals and credentials files are to contain current privilege approvals. Analysis of the status of privileges when they were renewed, however, showed that hospital commanders frequently are not timely in approving privilege renewals. Figure 3.6 shows the results of our analysis of the timeliness of privilege renewal approvals by commanders at the nine hospitals visited. As shown, more than one-third of the privilege renewals we examined were not approved by hospital commanders until after the prior privileges had expired. Details by service and hospital location are contained in appendix XVI.

We also analyzed the status of the most recent privileges for sampled physicians at the time of our review and found that about 11.7 percent of the physicians were practicing with expired privileges. It should be noted, however, that 51.6 percent (plus or minus a 9.8-percent sampling error) of the physicians at William Beaumont Army Medical Center were practicing with expired privileges. This large percentage of expirations

occurred largely because a regulation was misinterpreted by the Hospital Commander and physician privileges were extended without existing privileges being reviewed. Thus, the review process was circumvented and privileges were not reviewed or approved at the required times. Details of the status of privileges at the time of our review by service and hospital are contained in appendix XVII.

Hospital commanders, credentials committee chairpersons, quality assurance staff, and credentials coordinators offered various reasons why clinical privileges were allowed to expire. Generally, reasons included administrative oversight, improper credentials file administration, unavailability of commanders to sign privileges, untimely receipt of regulation changes, lack of command emphasis, and misinterpretation of regulations.

Similar Deficiencies Previously Reported by DOD and Service Inspectors General

In June 1985, the DOD Inspector General reported on quality assurance reviews performed at 23 medical treatment facilities by DOD auditors and the Auditors General of the Army, Navy, and Air Force between May 1983 and October 1984. The reports identified deficiencies in, among other things, (1) the process for awarding privileges to physicians; (2) training of emergency room physicians; and (3) implementation of risk management programs to identify potential malpractice and resolve problems in the areas of medication errors, misdiagnoses, sudden or unexplained deaths, and surgical errors.

The Assistant Secretary of Defense-Health Affairs and service commands acknowledged all reported deficiencies and revised their quality assurance regulations, manuals, and policies. Improvements directly related to the matters discussed in this report included

- the issuance of DOD Directive 6025.4, Credentialing of Health Care Providers;
- the services' verification of qualifications and licensure status of on-board physicians;
- strengthening recruitment procedures to verify qualifications before bringing physicians on-board; and
- developing an Automated Quality of Care Evaluation Support System to improve the quality assurance programs and generate information on malpractice claims, inadequate care, or other incidents to be included in individual credentials files.

Central Data Base Could Improve Administration of Credentialing

At present, the services have no centralized data base containing authenticated information on physicians' education, training, experience, certification, licensure status, and the status of actions against privileges. Such a system, in our opinion, could improve DOD management's visibility of the qualifications of its physicians. By storing collected information in a central data system, individual hospitals would have a central source available to verify physician qualifications and licensure status, rather than having to contact licensure and certifying agencies, among others, each time a physician rotation or other status change occurs. In addition, the Army and Navy Quality Assurance officials told us that the system could be used to fulfill the reporting requirements of the Health Care Quality Improvement Act of 1986 (title IV of Public Law 99-660, Nov. 14, 1986), which requires that certain quality assurance information be reported to the Secretary of Health and Human Services.

The Army and Navy have recognized the need for a centralized system, however, the Army is the only service presently in the process of implementing a data system that should allow hospitals to access credentials information from a single source. Because of budgetary constraints, the Head of Navy Quality Assurance and Standards Branch told us that development of a centralized data system has been delayed. The Medical Service Program Manager, Air Force Office of the Surgeon General told us the Air Force does not plan to develop a similar system.

Army's Implementation of Centralized System Underway

The Army began implementing a data system to collect and store information on physician qualifications as a result of recommendations included in the Army Surgeon General's Health Care Task Force report on credentials validation. The Task Force report, dated January 27, 1986, concluded that the Army has no uniform central source from which to

- verify board certification for Army physicians that receive American Specialty/Osteopathic Board certification after entering active duty;
- monitor current licensure actions (granting, restricting, expiration, or revocation) of Medical Corps officers on active duty; and
- record credentialing actions such as limitations and restrictions

The Task Force also reported that a centralized system appears to be the most logical method of monitoring the requirement for DOD physicians to have a current and valid state medical license by July 18, 1988. The report further justified the centralized system on the basis that civilian

agencies could use a single information source to obtain data on quality monitoring functions and policy formulation.

The Army's Deputy Director of Quality Assurance in the Surgeon General's office told us that implementation of the central data system took place in late September 1987. He also told us that start-up costs were estimated to be about $350,000 to $400,000 and that annual costs would be about $25,000 to $30,000 to operate the centralized data system.

Navy's Plan to Implement System Is Delayed

The Head of Navy Quality Assurance and Standards Branch in the Surgeon General's Office, told us that the Navy plans to implement a centralized data system to collect and store verified information on physician qualifications, but that the system never proceeded beyond the early stages of development, primarily because of budget constraints. As mentioned in chapter 2, the Navy has not completed the validation of its medical providers' qualifications. The official also told us the Navy's validation efforts, which include not only physicians but other providers, such as nurses, have been hampered by, among other things, a lack of personnel.

The Commander and the Legal Officer of the Navy Mid-Atlantic Regional Medical Command told us that a central data base would improve the effectiveness and efficiency of the credentialing process. They believed the system would

- improve credentials file administration because it could be programmed to track important information, such as the expiration dates for credentials, and to notify individual hospitals of the need to take action;
- provide accumulated data to headquarters, regional commands, and others, such as the Inspector General, to use in conducting studies, compliance audits, and continuous monitoring of key aspects of the credentialing process;
- reduce overall personnel resources necessary to maintain, verify, and update credentials files, because far fewer personnel would be needed to maintain a central data base than are currently needed to maintain information in all Navy hospitals. Maintaining files in a central location and verifying data only once would also remove the need for hospital credentials committees to reverify a file each time it accompanies a practitioner to a new duty station; and
- increase the availability of health personnel staff days because practitioners frequently are not permitted to provide care until their credentials file arrives at the new facility and the data is properly verified and

updated. The information necessary for the credentials committee and the commander to award temporary privileges could be electronically transmitted from the central data system.

Centralized Data Systems Will Be Used to Fulfill Health Care Quality Improvement Act Requirements

On November 14, 1986, the Congress passed The Health Care Quality Improvement Act of 1986 (title IV of Public Law 99-660), in response to congressional concerns about the quality of medical care in the United States. Among other things, the law requires that health care entities and boards of medical examiners report to the Secretary of Health and Human Services whenever certain types of adverse actions, such as limitation of clinical privileges or license suspension, are taken against physicians. The law also requires the Secretary of Health and Human Services to seek to enter into a memorandum of understanding with the Secretary of Defense to apply the reporting requirements of the legislation to DOD health care facilities. The Quality Assurance Senior Policy Analyst, Office of the Assistant Secretary of Defense-Health Affairs, told us that a memorandum of understanding was signed on September 21, 1987.

The Army Deputy Director, Quality Assurance Division, and the Navy Chief, Quality Assurance, Office of the Surgeons General, told us their centralized systems will be used to fulfill the requirements of the new law. However, the methods by which the systems will fulfill these requirements had not been decided.

Conclusions

We believe the DOD Directive and services regulations adequately address the key factors necessary to ensure that physicians are awarded privileges only to practice medicine in areas for which they are qualified. However, increased management attention and oversight are needed at the hospital level to ensure that physicians are being awarded clinical privileges on the basis of education, training, experience, and demonstrated competence. Many credentials files at the nine hospitals visited did not contain documentation on the key factors that DOD and service regulations require. Hospital commanders are not ensuring that all privileges are officially requested and awarded in a timely manner to ensure that physicians are practicing with current privileges. In addition to the potential consequences to beneficiaries of allowing physicians whose performance has not been documented to practice medicine, it would appear that this could potentially create problems in defending the government against malpractice claims involving these physicians.

Awarding clinical privileges to physicians to practice medicine is a key area in any medical quality assurance system. We are concerned that such a key element continues to be a problem even though the DOD Directive and service regulations require what appears to be a good system for awarding privileges. The ultimate question appears to be how to direct and motivate hospital commanders and key subordinates to fully implement the required system. We believe that DOD and the military services should reemphasize the importance of fully implementing the performance-based credentialing system that is required.

Finally, we believe the implementation of central data systems by the three military services should eliminate duplication of efforts in verifying data and permit management oversight needed to improve the efficiency and effectiveness of the credentialing process.

Recommendations

The Secretary of Defense should direct the Assistant Secretary of Defense-Health Affairs, in conjunction with the service secretaries, to issue a directive that reemphasizes the importance of fully implementing the performance-based credentialing system at all military hospitals.

The Secretary of Defense should also direct the Secretaries of the Navy and Air Force to establish central data bases to support the credentialing system. Such systems should also be used to support requirements of the Health Care Quality Improvement Act of 1986, and should be interfaced with the centralized malpractice information system we recommended in our June 1987 report, which could be a source of additional information on physician performance.

Agency Comments and Our Evaluation

DOD, in commenting on our draft report, generally concurred with the facts presented and with the first recommendation above. Regarding the first recommendation, DOD said that present directives needed to be rewritten to clarify policies and procedures and that a proposed directive to achieve this purpose was in final coordination. This directive, if it emphasizes that commanders must fully implement the performance-based credentialing system at the hospital level, should help alleviate the problems we found.

Regarding the second recommendation on the establishment of central data bases to support the credentialing system, DOD said that it wanted to make sure the Army's system was effective and efficient before requiring the Navy and Air Force to establish similar systems. DOD said

that the next 2 years will serve to identify problems and weaknesses in the developmental program.

We agree with DOD's proposal to assure that the Army's system is working before implementing systems in the Navy and Air Force. However, since the Air Force has no plans for such a system and the Navy told us that development of a system has been delayed due to budget constraints, we believe these services should be directed to proceed with planning and budgeting for such a system. This should reduce the lead time necessary to establish the system, which we believe has been needed for some time. This need is supported further by DOD's comments, which acknowledge that certain physician files were missing information on physicians' qualifications at the time of our work at the hospitals. DOD said this information was available on a centralized basis but had not yet been distributed to the hospitals. We believe the most effective means for keeping individual files up to date is through an automated system.

In addition to commenting on our recommendations, DOD stated that documentation in hospital credentials files had been greatly improved since the time of our field work. However, we are concerned that the Air Force Audit Agency found problems in complying with certain requirements at the same hospitals we visited even after we held detailed conferences at each hospital to discuss the results of our field work. Although some improvements had been made, the reports, dated November 6, 1987 and December 4, 1987, showed documentation problems with training documents and medical licenses and that physicians' requests for privileges were missing from the files. We are also concerned that DOD comments did not provide evidence of compliance with documentation requirements at the many hospitals that we did not visit.

DOD comments also stated that our review began 6 months after the DOD Inspector General report was issued and that the large military system required more than 1 year to implement major changes in documentation programs. We delayed the start of our review, with the concurrence of the congressional requestors, to give DOD sufficient time to correct the problems. These problems had been discussed with military service representatives and reported by the military audit groups between February and December 1984. This should have provided adequate time to correct the deficiencies before we did the bulk of our field work at the hospitals from the middle of 1986 to late that year.

Improvements Needed in Reporting Physicians' Clinical Privilege Restrictions

When action is taken by DOD to limit, suspend, or revoke physicians' clinical privileges, the timely reporting of the action to the Federation of State Medical Boards, a clearinghouse organization on disciplined physicians, is an important step toward preventing the physicians from obtaining the same privileges in the private sector. The Army and Air Force Offices of Surgeons General and the Navy Medico-Legal Affairs Office have not been timely in their reporting to the Federation, but have recently taken action to speed up the reporting process.

Service Procedures for Reporting of Adverse Privileging Actions

Each of the services has established systems that permit credentials committee chairpersons or higher authorities to suspend all or any portion of a physician's clinical privileges upon obtaining information of an impairment. Physician impairment is defined to include (1) physical conditions, such as impaired vision; (2) behavioral problems, such as substance abuse; and/or (3) professional performance, such as lack of technical skills or inadequate knowledge.

While specific procedures for handling adverse credentialing actions vary among the three services, all have procedures that permit, at the facility level, investigation, hearing, review, and appeal to the facility commander of all adverse credentialing actions. Facility commander decisions that modify, deny, suspend, limit, or revoke clinical privileges may also be appealed by the physician to intermediate commands and, ultimately, to the Offices of the Surgeons General, the final authorities for defining, granting, suspending, or terminating physician privileges.

The services require facility commanders to immediately notify intermediate commands and the Offices of the Surgeons General of all suspended, restricted, terminated, or reinstated medical practitioner credentials. Army and Air Force Offices of the Surgeons General and the Navy Medico-Legal Affairs notify the Federation of State Medical Boards of the identity and status of physicians who have exhausted the appeal process and continue to have restricted, limited, or suspended privileges. Regulations are not specific as to the time frame within which such notification must be made.

Before March 1986, service reporting to the Federation of a physician with credentials restrictions was required only when the physician separated from the service. However, effective March 28, 1986, the Assistant Secretary of Defense-Health Affairs issued a memorandum to all services requiring reporting to the Federation of physicians remaining in

the service who have restrictions or limitations on their clinical privileges.

Removing Physicians' Clinical Privileges

Between October 1, 1984 and June 2, 1986, the services took action to limit, suspend, or revoke the privileges of 288 physicians. Our analysis of the background characteristics of the 288 physicians showed that:

- Foreign medical graduates represented 31.9 percent of the physicians with adverse credentialing actions. This figure is more than triple the estimate for the combined services' universe of foreign medical graduates (9.4 percent).
- Substandard performance was the principal reason given in the adverse action for 72.5 percent of the foreign medical graduates, compared to 52.1 percent of U.S. trained physicians. U.S. trained physicians had more adverse credentialing actions for drug-related offenses and poor physician/patient relationships than their foreign counterparts.
- Of the 254 cases that were closed at the date of our review, 53.2 percent of the foreign medical graduates had their privileges revoked, limited, or suspended, compared to 44.2 percent of U.S. trained physicians.
- Approximately 33.7 percent of the physicians with adverse actions against their privileges were board-certified, with the predominate specialties being family practice, surgery, internal medicine, and obstetrics and gynecology.
- At least 69 percent of the physicians with adverse actions were either currently licensed at the time of our analysis or had been granted state licenses in the past; about 11 percent have never had a license. The services were unable to provide information on the licensing of the remaining 20 percent of their physicians; consequently, we were unable to ascertain with precision the percentages of licensed vs. unlicensed physicians against whom adverse credentialing actions had been taken.
- Approximately 12.5 percent of all service physicians with an adverse credentialing action also had prior adverse action(s).

Principal Reasons for Adverse Actions Against Privileges

As shown in figure 4.1, substandard performance is the principal reason for the adverse credentialing actions taken against the 288 physicians included in our review. Drug and/or substance abuse was the second most prevalent reason for such actions against physicians.

Table 4.1: Principal Reasons for Adverse Credentialing Actions

Reason for adverse action	Percent of all cases
Substandard performance	58.0
Drug or substance abuse	12.5
Sexual misconduct	6.9
Misconduct or professional attitude	6.6
Psychiatric problems	4.5
Physical limitations	3.1
Licensure or professional problems	2.4
Other or missing	6.0
Total	**100.0**

Delays in Reporting to the Federation of State Medical Boards

Timely reporting to the Federation is important because employers generally verify credentials with licensure activities at or near the time physicians become employed following their separation from the service. However, services, on average, take about 4 to 6 months to report final adverse credentialing actions to the Federation. This measurement encompasses the time between when a privilege limitation was upheld following appeal, or all administrative procedures were exhausted, and when Federation reporting actually occurred.

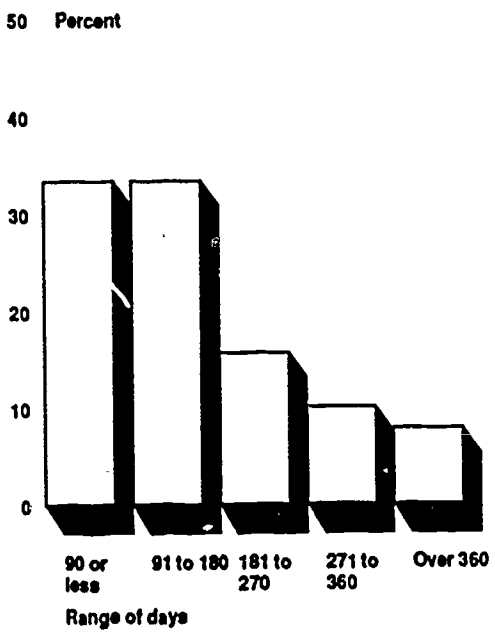
Of the 288 physicians for whom the services took action to limit, suspend, or revoke privileges, 254 cases were closed—133 with full privilege restorations and 121 with restricted privileges. As of May 1987, 91 of the 121 cases closed between October 1, 1984 and June 2, 1986 with physician privilege restrictions had been reported to the Federation. Our analyses of reporting time frames were based on these 91 cases, with results as illustrated in figure 4.1.[1]

The average time for reporting such physicians to the Federation was 193 days for the Army, 168 days for the Navy, and 130 days for the Air Force. The range of days for reporting was 0 to 553 days for the Army, 2 to 419 days for the Navy, and 31 to 333 days for the Air Force.

The Army and Air Force told us that the major reason for delays in reporting adverse privileging actions to the Federation of State Medical Boards is the need to review the cases to ensure that actions taken to restrict or revoke a physician's privileges are proper and meet legal requirements. The Navy attributed its delays to procedures that permit

[1]For cases with a final action before March 28, 1986 and a separation after this date we counted only the time between March 28, 1986, and the date that reporting to the Federation actually occurred.

Figure 4.1: Elapsed Time Between Exhaustion of Administrative Appeals and Actual Reporting to the Federation of State Medical Boards



Federation reporting to occur at the end of the quarter within which all of the administrative appeal rights for a physician have been exhausted, as opposed to reporting at the time the final action is determined.

Actions Taken to Prevent Delays in Reporting

All three services advised us that they have taken recent actions to speed up reporting. The Deputy Director of the Army Quality Assurance Division told us that the Army has assigned two additional Medical Service Corps officers to reporting duties and provided them with personal-computer capability, while the Air Force's Medical Services Program Manager told us his office has transferred Federation reporting responsibility from the Military Personnel Center/Surgeon General to the Office of the Surgeon General. The Air Force action removed the personnel center from the reporting chain, which should speed up reporting. In addition, Air Force hospitals are being required to forward all physician case file information to the Office of the Surgeon General immediately following the exhaustion of all physician appeal rights. This change is intended to speed up the Surgeon General's legal review.

The Navy's Director, Medico-Legal Affairs told us that in order to speed up case review and reporting, he increased the number of personnel in

the office responsible for monitoring and reporting physicians. In addition, he told us that notification to the Federation now occurs as soon as the physician has exhausted appeal rights rather than at the end of the quarter, as was done earlier.

Retroactive Reporting of Decredentialed Physicians

As stated, before March 1986, the services reported physicians with credentials limitations to the Federation only after service separation. However, effective with a DOD memorandum of March 28, 1986, physicians who remain in the service with credentials restrictions or limitations were also required to be reported to the Federation.

The Director of the Army Quality Assurance Division told us that the Army has retroactively reported all physicians whose credentials were restricted before March 1986, and remain in the service.

The Navy plans to report in-service physicians in accordance with a new Navy instruction dated August 11, 1987.

The Air Force's Medical Service Program Manager told us that the Air Force had not retroactively reported physicians to the Federation if they had received credentials restrictions before April 1986, exhausted their appeal rights, and remained in the service. However, following our inquiry, the official said that the Air Force will retroactively report these physicians.

Conclusions

Timely reporting to the Federation of State Medical Boards is essential for those military physicians who have had permanent clinical privilege restrictions. Such action would go a long way toward making data available to private-sector sources to help prevent physicians from practicing medicine in the same areas that these privileges had been taken away in the military. However, over the years reporting all such physicians has not been done in a timely fashion. The military services have taken some action to improve the timeliness of reporting, but more emphasis is needed including adding to the regulations a time frame when such reporting must be done. This time frame should take into account that most physicians will normally seek jobs in the private sector around the time of their separation from the military. Steps should also be taken by the Air Force and Navy to report to the Federation all physicians who have had privileges restricted but have chosen, at least for the time being, to stay in military service.

Recommendations

We recommend that the Secretary of Defense direct the Assistant Secretary-Health Affairs, in conjunction with the service secretaries, to issue a directive emphasizing the need for timely reporting of adverse privileging actions to the Federation of State Medical Boards within mandatory time frames. In addition, the directive should stress the need for the military services, especially the Air Force and Navy, to report to the Federation all physicians who have had their credentials restricted but are still in military service.

Agency Comments and Our Evaluation

DOD agreed with our recommendation and has issued a policy memorandum to improve the timely reporting of adverse privileging actions to the Federation of State and Medical Boards. This memorandum established a standard for reporting within 5 working days after completion of the physician's final appeal. We believe this action is responsive to our recommendation and should enhance the timely reporting of adverse privileging actions.

Many DOD Physicians Are Dissatisfied With Physician Utilization and Medical Resources

Many of the 1,350 DOD physicians we surveyed believe they are performing services either below (37.1 percent) or beyond (7.7 percent) their skill levels. Further, 24.5 percent believe they are practicing in areas in which they are not fully qualified, and the most frequent area they mentioned was emergency room care. Physicians also stated that their ability to provide health care to the eligible population is adversely impacted by a lack of resources, both support personnel and equipment. We reported similar findings in a 1979 report.[1]

Questionnaire Responses Indicate Physician Concerns

To address the question of whether physicians are assigned duties for which they believe they are properly qualified through education, training, experience, and past performance, we sent 450 questionnaires to a random sample of active duty uniformed and civilian physicians in each of the three services, or 1,350 questionnaires in total (see app. I). The questionnaire asked physicians to indicate, among other things, (1) whether they were being utilized at, beyond, or below their skill level; (2) their level of satisfaction that they were practicing medicine in the area(s) in which they are most qualified; (3) whether they consider their training and specialization to totally, partially, or not at all qualify them to work in their current area(s) of practice; and (4) whether they are practicing medicine in the military in one or more areas for which they do not believe they are fully qualified.

In addition to asking physicians to respond to questions on physician qualifications to perform assigned duties, we requested the respondents to provide narrative comments on the issues addressed in the questionnaire or related topics. A total of 550 physicians, about 50 percent of all respondents, provided additional comments.

The issues most frequently commented on include (1) physician utilization, (2) quality assurance systems, and (3) medical resources. Since the physicians provided subjective opinions, and many physicians commented on more than one problem or issue, the comments were not quantified for projection. Physicians did, however, comment in detail on these issues; consequently, we have included some comments in this chapter.

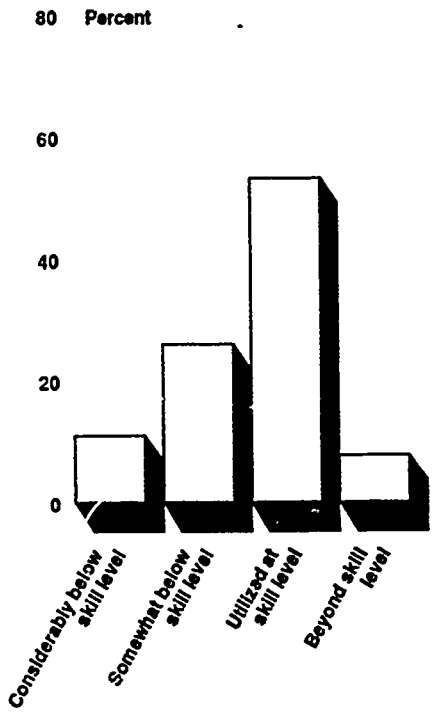
[1] Military Medicine Is in Trouble: Complete Reassessment Needed (HRD-79-107, Aug. 16, 1979).

Physicians Feel Qualified, but Believe Talents Not Appropriately Utilized

Of the questionnaire respondents, 84.0 percent indicated that they are satisfied that they are practicing in the area in which they feel most qualified. In addition, 72.2 percent of the respondents indicated they are practicing totally within the area they consider their specialty, whereas, 22.0 percent and 3.2 percent, respectively, indicated they are partially, or not at all practicing within the area they consider their specialty.[2] Of those physicians responding that they are not practicing totally within their specialty, 32.3 percent listed emergency care as the area they are practicing in that is outside of their specialty.

However, as illustrated in figure 5.1, 44.8 percent of the physicians responded that they are utilized either beyond or below their skill levels.

Figure 5.1: How Physicians See Their Medical Talents Being Used



Thus, while many physicians believe they are totally or partially practicing within their specialty areas, many are not satisfied with their

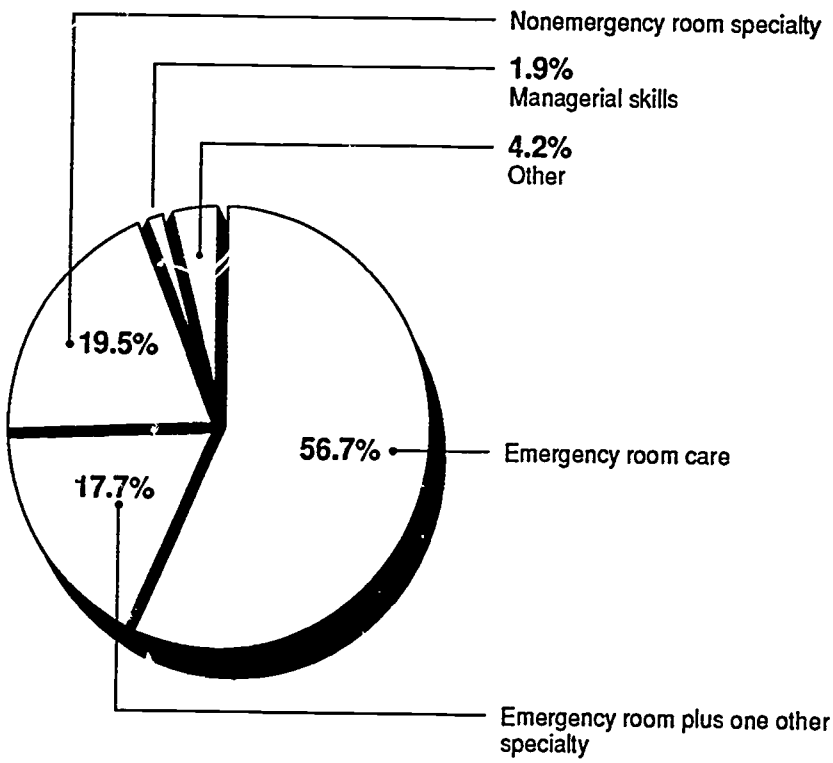
[2]Percentages do not equal 100 percent due to 2.5 percent of the respondents not answering this question and due to rounding.

level of utilization. In addition, 71 physicians provided narrative comments that (1) commanders were being discouraged from practicing medicine, (2) they experienced loss of skills due to frequent rotations or assignments to remote locations, and/or (3) specialists were used in generalist positions or in areas outside of their specialties.

Physicians Feel Inadequately Trained to Serve in Emergency Room

A question as to whether physicians believe they are practicing in areas for which they do not feel qualified, resulted in a 24.5 percent affirmative response rate. Further analysis, as shown in figure 5.2, shows that the area the physicians most frequently do not feel fully qualified to practice in was emergency room care.

Figure 5.2: Areas in Which Physicians Do Not Feel Fully Qualified to Practice Medicine



A total of 86 physicians provided narrative comments that emergency room credentials are awarded to physicians who do not feel sufficiently trained to handle emergency room responsibilities. In addition, 24 of the 86 physicians made comments indicating that they are practicing beyond their capabilities when assigned to the emergency room.

It appears that although emergency room care is a concern of physicians in all three services, it is of greater concern in the Air Force, whose physicians provided 53.5 percent of the narrative comments pertaining to the emergency room, as compared to 22.1 percent for the Army and 24.4 percent for the Navy. The Air Force has a larger number of small hospitals than the Army and Navy. Two clinical consultants to the Air Force Surgeon General told us that at these hospitals, emergency room care is often provided by physicians who are not emergency room specialists.

Physicians Concerned About Inadequate Facilities, Personnel, and Equipment

Physicians provided narrative comments that shortages of physicians, ancillary staff, and administrative support personnel and equipment problems are hampering both the quality and efficiency of medical care. For example, 26 physicians said that much of their time is spent performing administrative tasks; 38 physicians said that much of the equipment they use is old or outdated, or needed equipment is not available; and 3 physicians commented that inefficiencies result from breakdowns of equipment and repair delays.

GAO Reported Similar Physician Concerns in 1979

In 1979, we reported that salary and assignments to emergency room duty were the most common concerns that caused physicians to leave the military, followed by pay inequities, frequent movements, the uncertainties of military life, and broken promises. Other factors found to affect physicians' morale and medical practice included their having to perform administrative work and a lack of adequate support staff.

Our 1986 questionnaire was not intended to focus on these same issues, but questionnaire responses indicate that physicians are still concerned about emergency room duty and administrative matters, including a lack of adequate support staff to handle administrative matters.

Past Emergency Room and Administrative Duty Complaints

In 1979, we reported that emergency room duty was a key reason for physicians leaving the service. We also reported that contributing to the problem were physicians' feelings about having doctors work in the emergency room who do not usually participate in general medicine. Examples cited were psychiatrists and radiologists who have had insufficient general medical training to treat emergency room patients.

In the administrative area, we reported that physicians said their medical practice was constrained by administrative paperwork. They considered this to be poor use of physician resources. Finally, physicians cited

lack of support staff, inadequate office space, and inability to quickly obtain updated equipment as affecting the physicians' environment. All of these concerns were again reported to us in response to our 1986 questionnaire.

Sampling Methodology for Physicians' Questionnaires

Questionnaires Sent to 450 Physicians in the Three Services

This appendix describes our sampling plan and sampling errors for the 1,350 questionnaires sent to military physicians.

Physician Universe

To develop a universe of physicians from which samples were drawn for forwarding of questionnaires, we obtained data from several sources as detailed below.

Table I.1: Physician Universe

Physician universe	Obtained from	Information was as of
Army uniformed	Army Military Personnel Center	June 6, 1986
Army civilian	Army Civilian Personnel Center	July 16, 1986
Navy uniformed	Naval Medical Command Data Services Center	June 30, 1986
Navy civilian	Navy Civilian Personnel Center	August 1, 1986
Air Force uniformed	Air Force Military Personnel Center	June 2, 1986
Air Force civilian	Air Force Civilian Personnel Office	June 2, 1986

The data base furnished us did not include physician interns and residents. These groups were excluded because they are not individually credentialed to provide medical care except under supervision of credentialed physicians. Our universe also did not include consultants, physicians under contract, and foreign national physicians practicing overseas, as the services centralized data bases could not easily identify these persons. We also attempted to exclude researchers, but a projected 266 of 10,371 (2.6 percent) respondents stated that their primary area of responsibility is research.

Sampling Plan and Sampling Errors

A sample size of 450 physicians from each of the three services was drawn for this review. These sample sizes are based on characteristics of the universe chosen to achieve a 95-percent confidence level. Thus, for the total universe, the chances are 19 out of 20 that the estimates that we made concerning the characteristics will be within 5 percentage points of the corresponding true universe characteristics (value) for each service, and 3 percentage points overall. The following schedule presents the result of the sampling for each service's universe.

Table I.2: Sample Plan and Questionnaire Response Rates[a]

Physician grouping	Total number of physicians	Physicians sampled	Percent sampled	Total[a] questionnaires returned	Percent of questionnaires returned	Total usable[b] questionnaires	Percent of usable questionnaires
Army	4,388	450	10.26	389	86.44	374	83.11
Air Force	3,084	450	14.59	384	85.33	361	80.22
Navy	2,899	450	15.52	376	83.56	367	81.56
Total	**10,371**	**1,350**	**13.02[c]**	**1,149**	**85.11[c]**	**1,102**	**81.63[c]**

[a]Three additional questionnaires were returned without service identification labels These three questionnaires were not used.

[b]There were 15 Army, 23 Air Force, and 9 Navy uncompleted questionnaires returned by physicians that had left the service.

[c]Total is derived by averaging the three services' totals.

Our questionnaires were mailed to recipients on August 25, 1986, with first and second follow-ups occurring on October 1 and November 20, 1986, respectively. Questionnaires to Navy physicians assigned overseas and on-board ships were delivered by us to the Naval Medical Command, which forwarded them to the appropriate locations. Similarly, questionnaires to Army civilian physicians were forwarded by us to appropriate civilian personnel offices for delivery to the appropriate locations. All other questionnaires were sent by us through direct mailed, and all questionnaires were returned directly to us for analyses. To obtain a high physician response rate and more candid and reliable answers, we pledged confidentiality of individual responses.

Methodology Used for the Review of Physicians' Credentials Files

This appendix describes our universe of credentials files reviewed, population estimates, and the sampling errors associated with each attribute.

Universe of Credentials Files Reviewed

Hospitals included in the review, the physician universes at each hospital at the time of our review, and the sample size of credentials files reviewed are as follows.

Table II.1: Hospital Physician Universes

	Universe of physicians	Sample size
Army		
William Beaumont Army Medical Center, El Paso, Texas	162	62
U.S. Army Hospital, Landstuhl, West Germany	150	50
Tripler Army Medical Center, Hawaii	198	50
Navy		
U.S. Navy Hospital, Naples, Italy	38	38
Oakland Naval Hospital, Oakland, California	175	50
Portsmouth Naval Hospital, Portsmouth, Virginia	220	49
Air Force		
USAF Hospital, Barksdale, Louisiana	32	32
March USAF Hospital, California	45	45
Langley USAF Hospital, Virginia	50	50
Total	**1,070**	**426**

Our universe of 1,070 credentialed physicians consists of active duty, civilian, reserve/national guard, and civilian contract physicians. Since there were 50 or fewer credentials files at Naples, Barksdale, Langley, and March, we reviewed all of the credentials files. We randomly sampled the universe of credentialed physicians at William Beaumont, Landstuhl, Tripler, Oakland, and Portsmouth. For some attributes, such as privilege requests, files contained more than one measurable attribute.

Sampling Errors

Because we reviewed a statistical sample of credentialed physicians at the three Army and two of the Navy hospitals, each estimate developed

from the total sample of nine hospitals has a measurable precision, or sampling error. The sampling error is the maximum amount by which the estimate obtained from our sample can be expected to differ from the characteristics of the true universe. Sampling errors are usually stated at a certain confidence level—in this case 95 percent. This means, the chances are 19 out of 20 that, if we reviewed the credential files of all physicians at these nine DOD hospitals, the results of such a review would differ from the estimates obtained from our sample by less than the sampling errors of such estimates.

At the 95-percent confidence level, our sampling errors for reported attributes for which measurements were made at all nine hospitals range from 2.29 to 3.90 percent and, unless otherwise noted in the report, from 0.0 to 6.51 for reported estimates where data were collected on less than nine hospitals.

Methodology Used for the Identification and Analysis of Decredentialed Physicians

This appendix describes (1) our universe of decredentialed physicians and (2) the steps used for data verification and analysis.

Universe of Decredentialed Physicians

The Army, Navy, and Air Force Offices of the Surgeon Generals provided information on 298 physicians that were reported as having adverse credentialing actions taken against them during the period October 1, 1984 through June 2, 1986. Following our review of the data, we limited the universe to 288 physicians because:

- initial decredentialing actions occurred before October 1, 1984 for five cases and after June 1, 1986 for three cases;
- the Air Force provided one duplicate case; and
- no decredentialing action occurred against one physician because medical privileges were never awarded.

All administrative appeals or actions were not completed by June 1, 1986, the date of our analysis, for 34 of the 288 cases. Further, of the 254 cases where actions had been completed, 121 represented cases where the final action resulted in a limitation or restriction being placed on the physicians' privileges, and 133 were cases wherein the physicians' privileges were fully restored.

Data Verification and Analysis

We compared and summarized collection instrument data to identify inconsistencies and, before computer analyses, verified the keypunch accuracy of 100 percent of the instrument data. Our analyses were performed for the combined universe and each military service independently using the Statistical Package for the Social Sciences.

Documentation of Medical School Education in Physicians' Credentials Files

Hospital	Files reviewed	Authenticated diploma (in percent)	Diploma not authenticated (in percent)	No diploma in file (in percent)	Total (in percent)
Army					
William Beaumont AMC	62	21.0	72.6	6.4	100.0
USAH Landstuhl	50	70.0	20.0	10.0	100.0
Tripler AMC	50	22.0	56.0	22.0	100.0
Subtotal	**162**	**35.8**	**50.7**	**13.5**	**100.0**
Navy					
USNH Naples	38	84.2	2.6	13.2	100.0
USNH Oakland	50	96.0	2.0	2.0	100.0
USNH Portsmouth	49	32.6	59.2	8.2	100.0
Subtotal	**137**	**62.8**	**31.1**	**6.1**	**100.0**
Air Force					
USAF Hosp. Barksdale	32	100.0	0.0	0.0	100.0
USAF Reg. Hosp. March	45	17.8	80.0	2.2	100.0
USAF Reg. Hosp. Langley	50	10.0	86.0	2.0	98.0[a]
Subtotal	**127**	**35.4**	**62.2**	**1.6**	**99.2[a]**
Total	**426**	**46.7**	**44.1**	**9.1**	**99.9[a]**

[a]Does not equal 100 percent because information was not obtained from one credentials file.

Documentation of Internship Training[a] In Physicians' Credentials Files

Hospital	Files reviewed	Authenticated certificate (in percent)	Certificate not authenticated (in percent)	No certificate (in percent)	Total (in percent)
Army					
William Beaumont AMC	62	14.5	62.9	22.6	100.0
USAH Landstuhl	50	16.0	46.0	38.0	100.0
Tripler AMC	50	12.0	28.0	60.0	100.0
Subtotal	**162**	**14.0**	**44.4**	**41.6**	**100.0**
Navy					
USNH Naples	38	84.2	2.6	13.2	100.0
USNH Oakland	50	90.0	8.0	2.0	100.0
USNH Portsmouth	49	8.2	69.4	22.4	100.0
Subtotal	**137**	**47.9**	**38.7**	**13.4**	**100.0**
Air Force					
USAF Hosp. Barksdale	32	71.9	28.1	0.0	100.0
USAF Reg. Hosp. March	45	11.1	77.8	8.9	97.8[b]
USAF Reg. Hosp. Langley	50	0.0	72.0	28.0	100.0
Subtotal	**127**	**22.0**	**63.0**	**14.2**	**99.2[b]**
Total	**426**	**28.7**	**44.3**	**26.9**	**99.9[b]**

[a]Also referred to as post-graduate training.

[b]Does not equal 100 percent because information was not obtained from one credentials file.

Documentation of Residency Training[a] In Physicians' Credentials Files

Hospital	Files (in percent)	Authenticated certificate (in percent)	Certificate not authenticated (in percent)	No certificate (in percent)	Total[b] (in percent)
Army					
William Beaumont AMC	62	16.1	67.7	16.1	99.9
USAH Landstuhl	50	26.0	42.0	32.0	100.0
Tripler AMC	50	14.0	34.0	52.0	100.0
Subtotal	**162**	**18.2**	**47.1**	**34.7**	**100.0**
Navy					
USNH Naples	38	47.4	0.0	52.6	100.0
USNH Oakland	50	82.0	6.0	12.0	100.0
USNH Portsmouth	49	6.1	71.4	22.4	99.9
Subtotal	**137**	**40.4**	**38.7**	**20.9**	**100.0**
Air Force					
USAF Hosp. Barksdale	32	84.4	3.1	12.5	100.0
USAF Reg. Hosp. March	45	11.1	71.1	17.8	100.0
USAF Reg. Hosp. Langley	50	2.0	82.0	16.0	100.0
Subtotal	**127**	**26.0**	**58.3**	**15.8**	**100.1**
Total	**426**	**28.1**	**45.0**	**26.9**	**100.0**

[a]Also referred to as post-graduate training.

[b]The total percent may not equal 100.0 due to rounding.

Missing/Unauthenticated Education and Training Documentation Not Authenticated by American Medical Association Data

Hospital	Files reviewed	Medical school (in percent)	Internship (in percent)	Residency (in percent)
Army				
William Beaumont AMC	62	11.3	N/A[a]	N/A[a]
USAH Landstuhl	50	28.0	84.0	72.0
Tripler AMC	50	8.0	16.0	10.0
Subtotal	**162**	**14.9**	**45.3**	**36.7**
Navy				
USNH Naples	38	13.2	10.5	47.4
USNH Oakland	50	2.0	4.0	10.0
USNH Portsmouth	49	20.4	40.8	36.7
Subtotal	**137**	**12.3**	**23.3**	**26.3**
Total	**299**	**13.7**	**33.1**	**31.3**

[a]Data was not collected for these attributes at this hospital.

Documentation of Educational Commission for Foreign Medical Graduates Certification in Foreign Trained Physicians' Credentials Files[a]

Hospital	Files of foreign medical graduates	Authenticated certificate (in percent)	Certificate not authenticated (in percent)	No certificate file (in percent)	Total[b] (in percent)
Army					
William Beaumont AMC	21	14.3	85.7	0.0	100.0
USAH Landstuhl	18	16.7	16.7	66.7	100.1
Tripler AMC	24	16.7	50.0	33.3	100.0
Subtotal	**63**	**15.9**	**52.4**	**31.8**	**100.1**
Navy					
USNH Naples	7	42.9	14.3	42.9	100.1
USNH Oakland	7	100.0	0.0	0.0	100.0
USNH Portsmouth	9[c]	50.0	50.0	0.0	100.0
Subtotal	**23**	**63.0**	**23.9**	**13.1**	**100.0**
Air Force					
USAF Hosp. Barksdale	6	66.7	0.0	33.3	100.0
USAF Reg. Hosp. March	14	14.3	57.1	28.6	100.0
USAF Reg. Hosp. Langley	9	0.0	88.9	11.1	100.0
Subtotal	**29**	**20.7**	**55.2**	**24.1**	**100.0**
Total	**115**	**26.2**	**47.7**	**26.1**	**100.0**

[a]The number of files and percentages are projected based on the files in the GAO sample except at hospitals where all files were reviewed (see app. II).

[b]The total percent does not equal 100.0 due to rounding.

[c]There were two sample files that contained certificates, one was authenticated and one was not, or 50 percent in each category. When projecting the total number of files for foreign-medical graduates, we estimated a total of nine at Portsmouth.

Documentation of Specialty Board Certification in Physicians' Credentials Files[a]

Hospital	Number of physicians	Validated certificate (in percent)	Certificate not validated (in percent)	No certificate (in percent)	Total[b] (in percent)
Army					
William Beaumont AMC[c]	N/A	N/A	N/A	N/A	N/A
USAH Landstuhl	108	16.7	47.2	36.1	100.0
Tripler AMC	166	19.0	54.8	26.2	100.0
Subtotal	**274**	**18.1**	**51.8**	**30.1**	**100.0**
Navy					
USNH Naples	15	40.0	0.0	60.0	100.0
USNH Oakland	115	87.9	9.1	3.0	100.0
USNH Portsmouth	153	11.8	76.5	11.8	100.1
Subtotal	**283**	**44.3**	**44.9**	**10.8**	**100.0**
Air Force					
USAF Hosp. Barksdale	16	81.2	0.0	18.8	100.0
USAF Reg. Hosp. March	24	25.0	58.3	16.7	100.0
USAF Reg. Hosp. Langley	33	3.0	93.9	3.0	99.9
Subtotal	**73**	**27.4**	**61.6**	**11.0**	**100.0**
Total	**630**	**31.0**	**49.8**	**19.2**	**100.0**

[a]The number of physicians and percentages are projected based on the physicians in the GAO sample except at hospitals where the files of all physicians were reviewed (see app. II).

[b]The total percent does not equal 100.0 due to rounding.

[c]Data was not collected for these attributes at this hospital.

Status of Cardiopulmonary Resuscitation/ Advanced Cardiac Life Support Training Documented in Part-Time Emergency Room Physicians' Credentials Files[a]

Hospital	Number of physicians	Current training (in percent)	Expired training (in percent)	Training not documented (in percent)	Total (in percent)
Army					
William Beaumont AMC[b]	N/A	N/A	N/A	N/A	N/A
USAH Landstuhl	69	34.8	21.7	43.5	100.0
Tripler AMC	8	0.0	0.0	100.0	100.0
Subtotal	**77**	**31.2**	**19.5**	**49.4**	**100.1[c]**
Navy					
USNH Naples	7	100.0	0.0	0.0	100.0
USNH Oakland[b]	N/A	N/A	N/A	N/A	N/A
USNH Portsmouth[b]	N/A	N/A	N/A	N/A	N/A
Subtotal	**7**	**100.0**	**0.0**	**0.0**	**100.0**
Air Force					
USAF Hosp. Barksdale	21	100.0	0.0	0.0	100.0
USAF Reg. Hosp. March	38	47.4	26.3	26.3	100.0
USAF Reg. Hosp. Langley	38	94.7	0.0	5.3	100.0
Subtotal	**97**	**77.3**	**10.3**	**12.4**	**100.0**
Total	**181**	**58.6**	**13.8**	**27.6**	**100.0**

[a]The number of physicians and percentages are projected based on the physicians in the GAO sample except at hospitals where the files of all physicians were reviewed (see app. II). Eight of the nine hospitals also had a total of 21 physicians in our sample that were privileged and staffed to work full-time in emergency care but the sampling error, due to the small number, was too large to allow us to project to the total universe of physicians.

[b]There were no part-time emergency room physicians at this hospital.

[c]The total does not equal 100.0 due to rounding.

Physician Provider Activity Profile in Physicians' Credentials Files[a]

Hospital	Number of physicians	Complete profile (in percent)	Incomplete profile (in percent)	No profile (in percent)	Total (in percent)
Army					
William Beaumont AMC	157	0.0	89.8	10.2	100.0
USAH Landstuhl	144	0.0	81.2	18.8	100.0
Tripler AMC	182	2.2	95.6	2.2	100.0
Subtotal	**483**	**0.8**	**89.4**	**9.7**	**99.9[b]**
Navy					
USNH Naples	32	0.0	100.0	0.0	100.0
USNH Oakland	126	0.0	0.0	100.0	100.0
USNH Portsmouth	153	100.0	0.0	0.0	100.0
Subtotal	**311**	**49.2**	**10.3**	**40.5**	**100.0**
Air Force					
USAF Hosp. Barksdale	32	3.1	59.4	37.5	100.0
USAF Reg. Hosp. March	43	0.0	58.1	41.9	100.0
USAF Reg. Hosp. Langley	48	0.0	2.1	97.9	100.0
Subtotal	**123**	**0.8**	**36.6**	**62.6**	**100.0**
Total	**917[c]**	**17.2**	**55.5**	**27.3**	**100.0**

[a]The number of physicians and percentages are projected based on the physicians in the GAO sample, except at hospitals where the files of all physicians were reviewed (see app. II).

[b]The total does not equal 100.0 due to rounding

[c]Provider activity profiles are not required for all 1,070 physicians in our sample universe. For example, the files for new active duty personnel reporting to their first duty station may not contain a provider profile.

Documentation of Medical Malpractice Involvement in Credentials Files

Hospital	Physicians involved in malpractice[a]	Malpractice documented in file	Percentage of cases documented in file
Army			
William Beaumont AMC	4	0	0.0
USAH Landstuhl	5	1	20.0
Tripler AMC	0	0	0.0
Subtotal	**9**	**1**	**11.1**
Navy			
USNH Naples	1	1	100.0
USNH Oakland	3	2	66.7
USNH Portsmouth	0	0	0.0
Subtotal	**4**	**3**	**75.0**
Air Force			
USAF Hosp. Barksdale	3	3	100.0
USAF Reg. Hosp. March	2	2	100.0
USAF Reg. Hosp. Langley	3	3	100.0
Subtotal	**8**	**8**	**100.0**
Total	**21**	**12**	**57.1**

[a]These represent only those cases where the physician was identified at the installation level.

Officially Requested Privileges Documented in Credentials Files

Hospital	GAO sample[a] of privileges awarded	Privileges requested (in percent)	Privileges not requested (in percent)	Total (in percent)
Army				
William Beaumont AMC	76	57.9	42.1	100.0
USAH Landstuhl	103	82.5	17.5	100.0
Tripler AMC	90	100.0	0.0	100.0
Subtotal	**269**	**84.1**	**15.9**	**100.0**
Navy				
USNH Naples	70	80.0	20.0	100.0
USNH Oakland	94	75.5	24.5	100.0
USNH Portsmouth	63	96.8	3.2	100.0
Subtotal	**227**	**84.8**	**15.2**	**100.0**
Air Force				
USAF Hosp. Barksdale	49	30.6	69.4	100.0
USAF Reg. Hosp. March	83	35.4	64.6	100.0
USAF Reg. Hosp. Langley	91	59.3	40.7	100.0
Subtotal	**223**	**44.1**	**55.9**	**100.0**
Total	**719**	**79.4**	**20.6**	**100.0**

[a]Sample totaled 426 files (see app. II).

Department Chief or Designated Representative Review of Privilege Awards

Hospital	GAO sample[a] of privileges awarded	Reviewed and approved (in percent)	Not reviewed (in percent)	Unable to determine if reviewed (in percent)	Total (in percent)
Army					
William Beaumont AMC	76	51.3	47.4	1.3	100.0
USAH Landstuhl	103	95.2	4.8	0.0	100.0
Tripler AMC	90	100.0	0.0	0.0	100.0
Subtotal	**269**	**87.1**	**12.6**	**0.3**	**100.0**
Navy					
USNH Naples	70	27.1	72.9	0.0	100.0
USNH Oakland	94	89.4	8.5	2.1	100.0
USNH Portsmouth	63	98.4	1.6	0.0	100.0
Subtotal	**227**	**86.7**	**12.3**	**1.0**	**99.9[b]**
Air Force					
USAF Hosp. Barksdale	14	100.0	0.0	0.0	100.0
USAF Reg. Hosp. March	31	100.0	0.0	0.0	100.0
USAF Reg. Hosp. Langley	27	92.6	7.4	0.0	100.0
Subtotal	**72**	**97.2**	**2.8**	**0.0**	**100.0**
Total	**568**	**87.4**	**12.0**	**0.6**	**100.0**

[a]Sample totaled 426 files (see app. II).

[b]The total does not equal 100.0 due to rounding.

Credentials Committee Review of Privilege Awards

Hospital	GAO sample[a] of privileges awarded	Reviewed and approved (in percent)	Not reviewed (in percent)	Unable to determine if reviewed (in percent)	Total (in percent)[b]
Army					
William Beaumont AMC	76	48.7	51.3[c]	0.0	100.0
USAH Landstuhl	103	93.2	6.8	0.0	100.0
Tripler AMC	90	54.4	31.1	14.4	99.9
Subtotal	**269**	**67.0**	**27.1**	**6.0**	**100.1**
Navy					
USNH Naples	70	58.6	41.4	0.0	100.0
USNH Oakland	94	62.8	36.2	1.1	100.1
USNH Portsmouth	63	98.4	1.6	0.0	100.0
Subtotal	**227**	**77.1**	**22.4**	**0.5**	**100.0**
Air Force					
USAF Hosp. Barksdale	35	100.0	0.0	0.0	100.0
USAF Reg. Hosp. March	52	100.0	0.0	0.0	100.0
USAF Reg. Hosp. Langley	64	98.4	1.6	0.0	100.0
Subtotal	**151**	**99.3**	**0.7**	**0.0**	**100.0**
Total	**647**	**73.9**	**22.8**	**3.2**	**99.9**

[a]Sample totaled 426 files (see app. II).

[b]The total percent may not equal 100.0 due to rounding.

[c]Privileges were not reviewed because the hospital commander misinterpreted the regulation.

Timeliness of Hospital Commander Approval of Privilege Renewals

Hospital	GAO sample[a] of privileges awarded	Before prior privileges expired (in percent)	After prior privileges expired (in percent)	Unable to determine (in percent)	Total (in percent)[b]
Army					
William Beaumont AMC	53	26.4	47.2	26.4	100.0
USAH Landstuhl	71	40.9	56.3	2.8	100.0
Tripler AMC	77	76.6	16.9	6.5	100.0
Subtotal	**201**	**54.4**	**36.1**	**9.5**	**100.0**
Navy					
USNH Naples	52	57.7	34.6	7.7	100.0
USNH Oakland	64	70.3	23.4	6.2	99.9
USNH Portsmouth	30	43.3	56.7	0.0	100.0
Subtotal	**146**	**59.9**	**35.8**	**4.4**	**100.1**
Air Force					
USAF Hosp. Barksdale	35	82.9	17.1	0.0	100.0
USAF Reg. Hosp. March	52	65.4	34.6	0.0	100.0
USAF Reg. Hosp. Langley	70	85.7	14.3	0.0	100.0
Subtotal	**157**	**78.3**	**21.7**	**0.0**	**100.0**
Total	**504**	**59.3**	**34.1**	**6.6**	**100.0**

[a]Sample totaled 426 files (see app. II).

[b]The total percent may not equal 100.0 due to rounding.

Status of Most Recent Privileges at Time of GAO Credentials File Review

Hospital	Privileges reviewed	Current privileges (in percent)	Expired privileges (in percent)	Total (in percent)
Army				
William Beaumont AMC	62	48.4	51.6[a]	100.0
USAH Landstuhl	50	100.0	0.0	100.0
Tripler AMC	50	96.0	4.0	100.0
Subtotal	**162**	**82.0**	**18.0**	**100.0**
Navy				
USNH Naples	38	97.4	2.6	100.0
USNH Oakland	50	86.0	14.0	100.0
USNH Portsmouth	49	98.0	2.0	100.0
Subtotal	**137**	**93.1**	**6.9**	**100.0**
Air Force				
USAF Hosp. Barksdale	32	96.9	3.1	100.0
USAF Reg. Hosp. March	45	93.3	6.7	100.0
USAF Reg. Hosp. Langley	50	100.0	0.0	100.0
Subtotal	**127**	**96.8**	**3.2**	**100.0**
Total	**426**	**88.3**	**11.7**	**100.1[b]**

[a]This large percentage resulted from the hospital commander misinterpreting the regulation.

[b]The total does not equal 100.0 due to rounding.

Comments From the Department of Defense

Note: GAO's comment supplementing that in the report text appears at the end of this appendix.

ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D C 20301

HEALTH AFFAIRS

Mr. Frank C. Conahan
Assistant Comptroller General
National Security and
International Affairs Divisions
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Conahan:

This is the Department of Defense (DoD) response to the General Accounting Office (GAO) draf report entitled, "DOD HEALTH CARE: Additional Efforts Needed To Verify Physicians Qualifications," dated March 8, 1988 (GAO Code 101310/OSD Case 7553). With the exception of one finding and one recommendation, the DoD concurs with the GAO draft report. Because of the age of the data, however, most of the findings and recommendations are moot.

The DoD agrees that much has been accomplished in the past five years to document the qualifications of physicians providing care for DoD beneficiaries. The Department of the Army now has primary source verification of every active duty and civil service physician. The Department of the Navy and Air Force have also verified close to 100 percent of physician credentials.

It is important to emphasize that the GAO did its onsite audit work at the selected Military hospitals between November 1985 and October 1986. From 17 to 28 months have passed, time during which the DoD has continued its efforts to improve the physician qualification verification process, including improved automation, personnel training and clarifying Directives. Service inspections and internal audits, conducted after the GAO onsite work, indicate significant improvement.

The program developed for physician performance assessment and documentation is a complex management initiative that will take several years to be completely effective. The Department is, however, committed to its quality assurance efforts.

The detailed DoD comments on the report findings and recommendations are provided in the enclosure. The Department appreciates the opportunity to comment on the GAO draft report.

Sincerely,

for William Mayer, M.D.

Enclosure

GAO FINAL REPORT DATED MARCH 8, 1988
(GAO CODE 101310) OSD CASE 7553

"DoD HEALTH CARE: ADDITIONAL EFFORTS NEEDED TO VERIFY PHYSICIANS QUALIFICATIONS"

DEPARTMENT OF DEFENSE COMMENTS

* * * * *

FINDINGS

- **FINDING A:** DoD Actions To Assure Qualifications Of Physicians. The GAO observed that, in recent years, the DoD has taken several actions to strengthen the procedures for validating the qualifications of its physicians. The GAO reported, for example, that in 1985, a DoD Directive was issued requiring the verification of health care providers desiring entry employment. In addition, the GAO reported that, in late 1984, each Service initiated efforts to validate the qualifications of physicians. The GAO reviewed the validation procedures in each Service and concluded that the validation approaches need to be more thorough in the Navy and Air Force, while the Army needs to resolve discrepancies identified during validation efforts. Overall, the GAO acknowledged that the DoD has made substantial progress in validating its physician qualifications. The GAO concluded, however, that more needs to be done to complete the validation process. (p. 4, pp. 25-34/GAO Draft Report)

Now on p. 4 and pp. 17-22.

DoD Response: Concur. The DoD agrees that much has been accomplished in the past five years to document the qualifications of physicians providing care for DoD beneficiaries. Continued efforts are planned to improve both the efficiency and effectiveness of the process to assure qualifications of physicians. The Department of the Army now has primary source verification of the credentials of every active duty and Civil Service physician. The Departments of the Navy and Air Force have now verified close to 100 percent of physician credentials. (Note: the GAO audit finding that Navy is not verifying documents for physicians in operational assignments is incorrect. Navy operational units have been directed to verify credentials in the same manner as hospitals.)

Enclosure

The GAO examined hospital credential files between November 1985, and October 1986. More recent hospital credential file examinations show significant improvement since the time of the GAO onsite audit work. The DoD is committed to full implementation of its policies and procedures with respect to the validation of physician qualifications.

- **FINDING B: Many Physicians Still Unlicensed.** The GAO reported that DoD Directive 6025.6, dated July 18, 1985, requires physicians to possess a valid, current license by July 18, 1988. The GAO reported that, according to the Services, about 85 percent of the Army and Air Force, and about 78 percent of the Navy physicians, were licensed. The GAO noted that all three Services are confident that most of the unlicensed physicians would fulfill the licensure requirements by July 1988, and no shortages or other adverse impacts are expected. The GAO also reported, however, that as part of its review, questionnaires were sent to a sample of DoD physicians, which included information on licensure status. According to the GAO, questionnaire responses returned in late 1986 indicated that nearly 1,800 physicians did not have a current state license, including about 1,200 that had never been licensed. (The GAO noted that a DoD May 1987 assessment indicated about the same number.) The GAO observed that there are indications many DoD physicians will have trouble meeting the July 1988 licensure deadline. The GAO noted, for example, that over 9 percent of the physicians never before licensed anticipated problems, either because of examination difficulty or because they lack adequate credits or training. Should this occur, the GAO concluded that the DoD will be faced with a very difficult decision of what to do with these physicians. (pp. 4-5, pp. 35-38/GAO Draft Report)

Now on p. 4 and pp. 22-24.

DoD Response: Concur. For the past three years, the Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)) and the Military Departments have monitored data on the number of active duty physicians still unlicensed. The most recent data show that over 90 percent of health care practitioners requiring licensure are now in compliance. Most of the remaining personnel anticipate obtaining a license by the date required. It is likely, however, that between 200 and 450 physicians will not have a license by the date required.

The Department is, of course, concerned about possible effects on access to health care if a large number of physicians are no longer allowed to provide independent care for patients after implementation of this requirement. If the GAO estimate is correct (i.e., that between 600 and 900 physicians will not yet be licensed when the licensure requirement takes effect), there would be a significant

See comment 1.

effect on access to care and on CHAMPUS costs. Present personnel simply cannot absorb the workload represented by a loss of this number of physicians.

The OASD(HA) plans to review applications for licensure waiver very closely and issue waivers only to experienced health care personnel with documented evidence of qualifications and expertise in their profession. This will alleviate some of the decrease in access to care that might otherwise occur. Data from the GAO audit show that adverse clinical privileging actions occur in equal numbers for unlicensed and licensed physicians. This appears to support the belief of many that licensure does not necessarily reflect the qualifications of physicians and that selective waiver of this requirement will have no adverse effect on patient care. On the other hand, physicians with board certification, who comprise 75 percent of military physicians, underwent adverse clinical privileges actions in only 33.7 percent of cases. It is the DoD position that this supports the use of board certification for purposes of giving a waiver of licensure.

- **FINDING C: Licensure Requirements Waived For Some Foreign National Physicians.** The GAO reported that under P.L. 99-145 and DoD Directive 6025.6, the DoD is permitted to waive licensure requirements under unusual circumstances. The GAO reported that of 246 foreign national physicians employed in DoD overseas facilities, 134 had not passed the examination administered by the Educational Commission for Foreign Medical Graduates. The GAO found that the DoD has granted waivers for some of these foreign national physicians, including 13 Air Force and 49 Army foreign national physicians (as of December 1987). According to the GAO, the DoD identified several reasons for granting waivers, including the following:

  - the length of time many foreign nationals have been out of medical school, which could be a disadvantage in passing the examinations;
  - overseas manpower ceilings, which could hinder replacement of foreign nationals with U.S. physicians; and
  - the German law that grants foreign nationals a right to bring court suits when they are terminated for other than incompetence.

The GAO concluded that, as the DoD proceeds with the case-by-case determination on whether to grant waivers to foreign national physicians, it should reassess their educational background and demonstrated competence. The GAO asserted

Now on p. 4 and pp. 24-28.

that this is particularly important because of problems previously identified in the educational and training programs of several foreign medical schools. (p. 5, pp. 39-45/GAO Draft Report)

DoD Response: Concur. It should be recognized that foreign national physicians working for the DoD represent an important asset in health care for DoD beneficiaries. The number of DoD physicians has remained fairly constant over the past several years, while the number of eligible beneficiaries has increased. The Military Departments are also constrained by manpower ceilings affecting the number of military personnel allowed in host countries. To overcome this, they have recruited a number of local national physicians to help meet requirements for beneficiary care. These physicians are monitored by local clinic and hospital quality assurance programs and are subject to adverse clinical privilege actions and termination when there is evidence of poor performance. (When poor performance is documented, the host nation courts have supported termination with minimal benefits.)

Title 10 USC Section 1094 requires that these physicians possess a grant of permission to practice independently. In addition, the DoD requires that hospitals also document knowledge and qualifications of foreign national physicians. A revision of DoD Directive 6025.6, "Licensure of DoD Health Care Personnel," describes three possible ways for the hospitals to document knowledge and qualifications of foreign national physicians. These are as follows:

- certification by the Educational Commission for Foreign Medical Graduates (ECFMG);
- successful completion of an examination administered by the Uniformed Services University of the Health Sciences; or
- documented evidence of results from current monitoring and evaluation of performance from the hospital's quality assurance program.

It is the DoD position that these alternative procedures are prudent and will help to assure continued access to quality health care for DoD beneficiaries.

- FINDING D: DoD Regulations Concerning Credentialing and Privileging Requirements. The GAO reported that DoD Directive 6025.4 specifies the minimum education, training and clinical experience documentation necessary for granting

clinical privileges to physicians in DoD facilities. The GAO observed that the Directive specifies that the award and renewal of clinical privileges must be tied to objective data reflecting the physician's professional performance and capabilities. The GAO further observed that the Directive requires documentation of any medical malpractice involvement and a physician's profile be included in the credentials file. The GAO reported that the Services have established regulations to implement the DoD requirement for performance-based credentialing, and now require that a credentials file be established and maintained to document education, training, qualifications and demonstrated competence for each physician. The GAO concluded that, because DoD physicians change duty stations frequently and their qualifications and competence may be unknown at their new stations, adequate documentation and review of physicians credentials is essential to the award of privileges at the new stations. (p. 47, pp. 49-50/GAO Draft Report)

Now on pp. 30-31.

DoD Response: Concur. The OASD(HA) and the Military Departments have continued implementing policy goals established by the Directives issued in 1982 through 1984. The credentials file data reported by the GAO reflect hospital performance during the period between November 1985, and October 1987. As previously noted, data from recent Military Department inspections and internal audit examinations of credential files indicate that there has been significant improvement in this area. The Department is confident this improvement will continue and be maintained.

- FINDING E: Adequacy of Education and Training Documentation. The GAO reviewed 426 individual credentials files at nine hospitals and found that documentation of education and training was frequently deficient. According to the GAO, diplomas and certifications from medical school and training programs were frequently not in the files; and in some cases, statements of authentication were not included. The GAO pointed out that the missing and unauthenticated documentation existed across all the Services, but the extent varied by hospital location. The GAO found that the credential files of foreign medical graduates frequently did not contain the required certifications. The GAO estimated that at the nine hospitals reviewed, about 73.8 percent of the files did not contain the authenticate certificates. The GAO also found inadequate file documentation of physician specialty board certification, with these certificates missing in 19.2 percent of the files and lacking evidence of validation in another 49.8 percent of the files. Another area cited by

the GAO was documentation of training status of emergency room physicians. The GAO found that of 129 credential files of physicians privileged and assigned to work in emergency care areas, 58.6 percent contained adequate training documentation, 13.8 percent contained documentation of expired training, and 27.6 percent contained no training documentation. The GAO concluded that, while DoD regulations are adequate, increased management attention and oversight is needed at the hospital level to ensure that physicians are being awarded clinical privileges on the basis of education, training, experience and demonstrated competence. (p. 3, pp. 48-49, pp. 50-57, p. 73/GAO Draft Report)

Now on pp. 3, 30, 31, 32-36, and 45-46.

DoD Response: Concur. As discussed in the DoD responses to Findings A through D, initiatives to correct these problems began in 1984. At the time the GAO did its onsite audit work at the hospitals, hospital personnel were still in the learing/implementation phase. Documentation of education and training of DoD physicians is close to complete at this point.

- FINDING F: Adequacy Of Provider Profiles and Medical Malpractice Documentation. The GAO found that the credentials files it reviewed frequently did not contain the physician activity profiles, as required by DoD regulations. The GAO noted that these files are required to contain data, reflecting information such as number of malpractice claims, number of validated patient complaints, number of patients with complications, etc. According to the GAO, complete provider activity profiles were included in 17.2 percent of the files reviewed, while the profiles were missing required information in 55.5 percent, and no profiles were found in 27.3 percent. With regard to medical malpractice, the GAO found that such actions were not documented as required in nine of 21 credentials files identified by hospital claims officials as being involved in medical malpractice. Within the Services, the GAO found that, of the malpractice identified, the Air Force placed documentation in all the files involved, the Navy in 75 percent and the Army in 11 percent. The GAO concluded that the high Air Force percentage may be attributable to the fact that it is the only Service that has a system for collecting data from the malpractice claims processing system and providing the data to the hospitals. The GAO also pointed out that there was no evidence in the files that hospital officials considered objective data in the award and renewal of physicians privileges. Based on these results, the GAO concluded that performance based credentialing is not being accomplished as required by DoD regulations, and requires increased management attention. (pp. 47-48, pp. 58-62, pp. 73-74/GAO Draft Report)

Now on pp. 30, 36-38, and 45-46.

DoD Response: Concur. The DoD agrees that, at the time the GAO conducted its onsite audit work, there was incomplete practitioner performance evaluation documentation in the credential files. Continued efforts have been directed toward improving documentation. One example of the DoD efforts to improve physician performance documentation is a recent initiative requiring malpractice data from every closed claim. Hospitals and claims management offices will be required to cooperate in evaluating these cases in order to obtain the required data. In addition to providing a valuable source of data for the central analysis of malpractice claims, this should also improve the cooperative efforts between local legal and medical functions. An additional benefit of this program is that the Military Departments will be able to participate in reporting to the National Data Bank on malpractice when that organization is made active.

- FINDING G: Adequacy Of Review And Approval to Award Clinical Privileges. According to the GAO, credentialing regulations for each of the Services require that physicians officially request privileges to perform specific procedures. The GAO found that, for about 20.6 percent of the cases reviewed, physicians were awarded privileges for which documentation of the requests was not contained in the files. The GAO also found that many of the physician privilege requests were not being reviewed by hospitals officials, as required. In addition, the GAO found that hospital commanders were not renewing physician privileges in a timely manner. The GAO pointed out that more than one-third of the privilege renewals it examined were not approved by hospital commanders until after the prior privileges had expired. The GAO further reported that at the time of its review, about 11.7 percent of the sampled physicians were practicing with expired privileges. The GAO noted, however, that this figure was affected by one Army hospital, where a large percentage of the physicians had expired privileges due to a misinterpretation of requirements by a hospital official. The GAO concluded that hospital commanders need to better ensure that all privileges are officially requested and awarded in a timely manner to make sure that physicians are practicing with current privileges. The GAO further concluded that, in addition to the potential consequences to beneficiaries, allowing physicians whose performance has not recently been assessed to practice medicine could potentially create problems in defensing the Government against malpractice claims involving these physicians. (pp. 47-48, pp. 62-67. p. 73/GAO Draft Report)

Now on pp. 30-31, 39-42, and 46.

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DoD Response: Concur. The DoD agrees that proper documentation of each process in granting clinical privileges is important and that, at the time of the GAO onsite review of hospital records, many of the files were still incomplete. Subsequent reviews have shown significant improvement. The Automated Quality of Case Evaluation Support System (AQCESS) improvements have been directed toward providing automation support of these procedures. Workshops and seminars have been geared toward instruction in proper procedures. Clinical privileging procedures have undergone significant change in recent years and many personnel involved are not familiar with the full extent of the changes. It has been and continues to be a learning process. Confusion as to proper terminology and requirements has also caused difficulty in implementing procedures. The OASD(HA) has stressed proper use of the following terms:

- **Credentialing** is the process of issuing a credential. Medical schools, States, and post-graduate training programs issue credentials. Hospitals grant clinical privileges and do not engage in the procedures of "credentialing" or "decredentialing."

- **Validation** (verification) is the process of establishing reasonable proof that a credential document is not a forgery. Verification by contacting the issuing authority is the preferred form of validating a document.

- **Authentication** of a document as a true copy establishes that the copy is of an original document. Copies of diplomas, whether authenticated or simply inserted in the file are of less importance than a validation statement from the organization that provided the education or training. When a validation statement is present in the file, a copy of the diploma is of lesser concern.

In defending the Government against malpractice claims, it it not expected that much weight would be given to a finding that a physician's clinical privileges had expired through administrative oversight. Failure to act on evidence of incompetence or misconduct would be given greater significance and DoD policies have been directed toward achieving documentation of performance and taking action based on this documentation.

- **FINDING H: Similar Deficiencies Previously Reported.** The GAO reported that, in June 1985, the DoD Inspector General issued a report on quality assurance reviews performed between may 1983 and October 1984, at medical treatment facilities by DoD auditors and the Auditors General of the Services. According to the GAO, the reports identified

deficiencies in areas such as (1) the process for awarding privileges to physicians, (2) training of emergency room physicians, and (3) implementation of risk management programs. The GAO reported that the DoD acknowleged those problems and took several actions to effect improvements, including the issuance of DoD Directive 6025.4, the strengthening of recruitment and verification procedures and the development of the AQCESS. While acknowledging these actions, the GAO concluded that the current review results (also see Findings D through G) indicate additional attention is needed at the hospital level to ensure that the promised improvements are made. (p. 49, pp. 67-68, pp. 73-74/GAO Draft Report)

Now on pp. 31, 42-43, and 45-46.

DoD Response: Concur. The DoD agrees that similar deficiencies were reported in the 1985 DoD Inspector General (IG) Report. Preliminary data from that audit led to the 1984 initiatives. It should be noted that the GAO audit began only 6 months after the DoD IG audit report was issued. At the time of the GAO on-site audit work, all three Services had almost completed their research with the American Medical Association and the Federation of State Medical Boards on DoD physicians. Because this effort was done centrally, documentation had not yet been distributed to the local files. This has since been done A system involving over 14,500 physicians requires more than one year to implement major changes in documentation programs. The DoD policies and initiatives are correcting these deficiencies. As previously stated, the DoD is committed to full implementation of DoD policies and procedures with respect to validation of physician qualifications.

- FINDING I: Need For Central Credentials Data System. The GAO found that currently, the Services have no centralized data base containing authenticated information on physicians' education, training, experience, certification, licensure status and the status of actions against privileges. The GAO observed that such a system could improve the visibility of DoD management as to the qualifications of its physicians. The GAO noted that both the Army and the Navy have recognized the need for centralized systems and, in fact, the Army is presently establishing a central data base on individual physicians to improve the efficiency of the credentialing system. The GAO reported that the Navy is also planning to implement a centralized data system, but it is still in the early stages of development. The GAO reported that both Army and Navy officials stated that these systems will be used to fulfill

the reporting requirements of the Health Care Quality Improvement Act of 1986, although the specific methods have not yet been decided. The GAO concluded that central data systems would be appropriate for all the Services, since the systems would eliminate duplicate verifications of physician qualifications, and permit improved management oversight of the credentialing process. The GAO further concluded that such systems should be used to support the reporting requirements of the Health Care Quality Improvement Act of 1986, and should be interfaced with the centralized DoD malpractice information system the GAO previously recommended (OSD Case 7215). (p. 6, pp. 68-74/GAO Draft Report)

Now on pp. 5 and 43-46.

DoD Response: Partially concur. The DoD agrees that the Army central data base has potential, but disagrees that the Navy and Air Force should be directed to implement the system at this time. The GAO report does not reflect that this is a developmental program and has not yet been proven. The Air Force and Navy are aware of the program and are considering similar measures. Before directing the Navy and Air Force to develop similar programs, data should be gathered to demonstrate the efficiency, effectiveness, and accuracy of the Army program.

- FINDING J: Need For Prompt Reporting Of Disciplined Physicians. The GAO observed that timely reporting of revoked or restricted clinical privileges of physicians to the Federation of State Medical Boards is essential to help prevent the DoD physicians from proceeding into the private sector. The GAO found that, while each of the Services has established procedures for handling and reporting adverse credentialing actions, the Services have not reported the adverse actions to the Federation in a timely manner. Overall, the GAO found that the Services have averaged four to six months to report final adverse credentialing actions to the Federation. The GAO acknowledged that all three Service recognize the need for timely reporting and have taken action to improve reporting timeliness. The GAO concluded, however, that more emphasis on timeliness is needed, such as the addition of a timeframe to the regulations specifying when reporting must be done. The GAO further concluded that this timeframe should take into account that most physicians will normally seek jobs in the private sector just prior or immediately after separation from the Service. (p. 6, pp. 76-84/GAO Draft Report).

Now on pp. 49-53.

DoD Response: Concur. Last October the GAO briefed the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) on preliminary data from this audit. As a result, on October 26, 1987, the ASD(HA) issued a policy memorandum

instructing the Military Departments to establish procedures for reporting to the Federation of State Medical Board within five days of determination by the Office of the Surgeon General that a reportable condition exists.

- **FINDING K: Physician Concerns With Utilization And Medical Resources.** The GAO reported that, to assess physician concerns, the GAO sent 450 questionnaires to a sample of active duty uniformed and civilian physicians in each of the three Services. According to the GAO, the questionnaire results indicated that 84 percent of the physicians were satisfied they were practicing in the area for which they were most qualified, but 44.8 percent said they were utilized either beyond or below their skill levels. The GAO also reported that 24.5 percent of the physicians believe they were practicing in areas for which they do not feel qualified, most frequently involving emergency room care. In addition, the GAO reported that the responses indicated physician concerns about their ability to provide health care due to adverse impacts caused by a lack of resources related to both support personnel and equipment. (The GAO noted that it reported similar findings in 1979, OSD Case 5176.) Based on the questionnaire results, the GAO concluded that many DoD physicians are dissatisfied with how they are being utilized and the medical esources available to them. (pp. 86-93/GAO Draft Report)

Now on pp. 55-59.

DoD Response: Concur. The DoD is aware of the many concerns of its physicians. In addition to those noted by the GAO, these concerns include such factors as frequent moves, a salary schedule that it significantly less than their civilian equivalents, antiquated buildings, long procurement delays in obtaining new equipment, personnel shortages, and increasing workload from an increasing beneficiary population.

RECOMMENDATIONS

- **RECOMMENDATION 1:** The GAO recommended that the Secretary of Defense direct the Secretaries of the Army, Navy and Air Force to complete validations of the qualifications of all physicians practicing medicine in military facilities, including (1) validating the qualifications of all DoD physicians for whom validations have not been completed against data bases maintained by the American Medical Association, the Federation of State Medical Boards, and, where appropriate, the Educational Commission for Foreign Medical Graduates, and (2) performing original source

Now on pp. 5 and 28.

validation of the education, training, and certification, of all physicians for whom original source validation has not been performed whenever possible. (p. 7, p. 46/GAO Draft Report)

DoD Response: Concur. The DoD agrees with the intent of this recommendation; it is essentially moot, however. The GAO conducted its onsite audit of hospital credential files between November 1985, and October 1986. The data on which this report is based are between 17 and 28 months old. Current data from Service Inspector General inspections and Service Audit Agency audits document significant improvements in the credential files from that found by the GAO during its onsite audit work.

Inaccuracies in the data bases of the American Medical Association (AMA) Masterfile, the American Osteopathic Association (AOA) Master file, and the Federation of State Medical Boards (FSMB) clearinghouse for practitioners with adverse license actions led to decisions by the Military Departments to use primary source verification, in addition to screening of physicians. Primary source verification was initiated by all three Military Departments in late 1985, and is now close to complete. (Primary source verification was not established as a standard for the Joint Commission on Accreditation of Hospitals until January 1, 1988.) Primary source verification for all health care practitioners involves contacting thousands of schools, governments, and certifying organizations for information on practitioners. Some physicians have eight or more credentials requiring verification.

The Army now has primary source verification documents on all active duty physicians and is approaching 100 percent of reserve component physicians. The Navy has relied on individual health care facilities to carry out prime source verification. (Again, it should be noted that the statement that Navy physicians in operational assignments do not undergo credentials verification is incorrect. Requirements are that all Navy physician credentials must be verified.) Recent Navy Inspector General data have documented over 90 percent compliance with this requirement for all individually privileged practitioners. The Air Force began using all sources to verify credentials in October 1987, and receives regular reports from the intermediate commands on the status of verification of credentials.

In 1985, the three Military Departments also implemented DoD policy requiring them to verify credentials of entering physicians. The GAO apparently found 100 percent of of these practitioner files to be complete.

Verifying credentials and expertise of foreign national physicians working in Military Medical Treatment Facilities is a special consideration. In 1976, Army 7th MEDCOM added a requirement for foreign national physicians to obtain certification by the ECFMG. (The ECFMG certification process includes review of quality physicians for entry into graduate medical education programs--internship and residency.) The examination questions are developed to parallel those asked in the National Board of Medical Examiners (NBME) examinations parts I and II--taken by medical school students in the United States before being admitted into a graduate medical education program (internship). (These are prelicensure examinations only in that they are prerequisites to entering the post graduate medical education required for candidates to be eligible to take part III of the NBME Examination or the Federation of State Medical Board Licensure Examination (FLEX). Part III of the NBME Examination and the FLEX are accepted as licensure qualification examinations by most state boards. Physicians are not allowed to take these examinations until near the end of their first year of postgraduate education in an accredited program.) In addition to the ECFMG, a revision of DoD Directive 6025.6, "Licensure of DoD Health Care Personnel," describes two additonal ways for the hospitals to document the knowledge and qualifications of foreign nationals, as follows:

- successful completion of an examination administered by the Uniformed Services University of the Health Sciences; and

- documented evidence of results from current monitoring and evaluation of performance from the hospital quality assurance program.

- RECOMMENDATION 2: The GAO recommended that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs, in conjunction with the Service Secretaries, to issue a directive that reemphsizes the importance of fully implementing the performance based credentialing system at all military hospitals. (p. 7, p. 74/GAO Draft Report)

Now on pp. 5 and 46.

DoD Response: Concur. The recommendation is essentially moot, however. The DoD determined that the present Directives needed to be rewritten to make policies and procedures more clear. A proposed Directive for this purpose has been written and is in final coordination at this time. This Directive stresses that credentials review and granting of clinical privileges are separate but mutually supportive activities. No person should be granted clinical privileges without the required credentials establishing education, training, experience, current expertise, and health status necessary for performance of those privileges.

- RECOMMENDATION 3: The GAO recommended that the Secretary of Defense also direct the Secretaries of the Navy and Air Force to establish central data bases to support the credentialing system. The GAO further recommended that such systems also be used to support the Health Care Quality Improvement Act of 1986 requirements and should be interfaced with the centralized malpractice information system that the GAO recommended in its June 1987, report which would be a source of additional information on physician performance. (p. 7, pp. 74-75/GAO Draft Report)

Now on pp. 5 and 46.

DoD Response: Partially concur. The DoD does not agree that the Navy and Air Force should be directed to establish central data bases at this time. The Army has initiated such an effort, which appears to have potential. The Army central data base program is still developmental, however, and has not yet been proven feasible, effective or accurate. The next two years will serve to identify program problems and weaknesses. It would not be prudent for the Navy and Air Force to invest resources in a similar program until the Army program has been fully implemented.

The DoD agrees that, where feasible, such systems should also be used to support the requirement of the Health Care Quality Improvement Act of 1986 and to interface with centralized malpractice information. Interfacing credentials data bases with central malpractice data bases is already possible and may provide useful information. The OASD(HA) has begun to receive reports on all malpractice claims closed after January 1, 1988. These data will be analyzed for trends in allegation, specialty, hospital, Military Department, and health care practitioner.

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Now on p. 54.

- **RECOMMENDATION 4:** The GAO recommended that the Secretary of Defense direct the Assistant Secretary for Health Affairs, in conjunction with the Service Secretaries, to (1) issue a directive emphasizing the need for timely reporting of adverse privileging actions to the Federation of State Medical Boards within mandatory timeframes, and (2) in this directive stress the need for the Services, especially the Air Force and Navy, to report to the Federation all those physicians who have had their credentials restricted, but are still in the Service. (p. 7, p. 85/GAO Draft Report)

  DoD Response: Concur. The DoD agrees that timely reporting of health care practitioners found incompetent, negligent, disabled, or guilty of misconduct is an essential element of successful quality assurance programs. The recommendation is moot, however, inasmuch as the ASD(HA) already issued a policy memorandum to the Military Departments on October 26, 1987, on the length of time allowed between completion of appeal and filing of reports. This memorandum established a standard for reporting within five working days after completion of the final appeal. Current data show that reports are being filed in a timely manner. The OASD(HA) will continue to monitor reports to the FSMB and will track the length of time taken to file reports following completion of appeal procedures.

The following is GAO's comment on the letter from the Department of Defense.

GAO Comment

1. This estimate, although attributed to GAO, is not a GAO estimate.

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