

Protecting the Process: 10 U.S.C. § 1102 and the Army's Clinical Quality Management Program

Major Edward B. McDonald*

I. Introduction

A judge advocate practicing in the field of health law is frequently faced with many overlapping or related legal issues arising from adverse medical events. For example, the Health Law Judge Advocate (HLJA) receives notice from the hospital risk manager (RM) that a potentially compensable event (PCE) occurred last night.¹ All that is known is a baby (Baby Lucy) may have been severely injured after being administered carbon dioxide gas instead of oxygen for approximately forty minutes immediately after delivery.² The extent of the injury is unknown, but is likely severe.³ The RM is gathering information and the event will likely be reviewed at the next risk management committee (RMC).⁴ Soon, the HLJA receives a call from the public affairs officer (PAO) concerning media interest in the event and the military treatment facility (MTF) commander's desire to release a statement in response to inquiries.⁵ Concurrently, the HLJA expects a medical claim will arise from this adverse event.⁶

* Judge Advocate, U.S. Army. Presently assigned as Brigade Judge Advocate, 3d Brigade Combat Team, 1st Infantry Division and Combined Task Force–Duke, Afghanistan. The author was formerly assigned as the Deputy Command Judge Advocate, Tripler Army Medical Center, Hawaii.

¹ U.S. DEP'T OF ARMY, REG. 40-68, CLINICAL QUALITY MANAGEMENT (22 May 2009) [hereinafter AR 40-68]. The Risk Manager (can be civilian or military) is responsible for: "(1) Identify[ing] and quantify[ing] healthcare related risk. (2) Participat[ing] in the risk analysis process. (3) Coordinat[ing] the PCE and malpractice claims management processes. (4) Develop[ing] and revis[ing] risk management policies and procedures. (5) Educat[ing] staff (all levels, all disciplines) concerning risk reduction/mitigation. (6) Provid[ing] data on a periodic basis to MTF senior leadership concerning RM issues and trends." *Id.* para. 13-2c. Potentially compensable event is defined as "[a]n adverse event that occurs in the delivery of health care or services with resulting injury to the patient. It includes any adverse event or outcome, with or without legal fault, in which the patient experiences any unintended or unexpected negative result. It pertains to all patients regardless of beneficiary status." *Id.* sec. II.

² Rob Perez, *Hospital Cases End Tragically*, HONOLULU ADVERTISER, Feb. 5, 2006, available at <http://the.honoluluadvertiser.com/article/2006/Feb/05/ln/FP602050348.html>. Hereinafter, the injured baby used as the introductory example will be referred to as "Baby Lucy."

³ *Id.*

⁴ See *infra* note 12 (providing a description of the responsibilities of the RMC).

⁵ See generally Perez, *supra* note 2.

⁶ See generally U.S. DEP'T OF ARMY, REG. 27-20, CLAIMS para. 2-2 (8 Feb. 2008) [hereinafter AR 27-20]; see also U.S. DEP'T OF ARMY, REG. 27-40, LITIGATION para. 3-9 (19 Sept. 1994) [hereinafter AR 27-40]; see also U.S. DEP'T OF ARMY, PAM. 27-162, CLAIMS PROCEDURES paras. 2-2, 2-34 (21 Mar. 2008) [hereinafter DA PAM. 27-162]. There are tort firms and attorneys that specialize in military medical malpractice claims. For large or complex claims, a local attorney, who is familiar with the local Army medical center or clinic, quickly learns of the possible claim and begins representing the claimant. The local attorney will then usually bring in a

larger specialty firm to assist in pursuing the claim. This assertion is based on the author's recent professional experiences as the Deputy Command Judge Advocate, Tripler Army Medical Center, from June 2009 to June 2011 [hereinafter Professional Experiences]. Additionally, "[i]n the context of patient safety, incidents involving patients are classified as either adverse events or close calls." AR 40-68, *supra* note 1, para. 12-4a. An adverse event is defined as "[a]n occurrence or condition associated with the provision of care or services that caused harm/injury to the beneficiary. Adverse events may be due to acts of commission or omission." *Id.* glossary, at 154.

Adverse events like the example of Baby Lucy have a tremendous emotional and financial impact upon families, expose the U.S. Army to multimillion dollar claims, adversely affect careers, and impact the trustworthiness of the military medical system.⁷ Not all adverse events can be prevented, but the "occurrence" or "resulting harm" may be minimized with a functioning clinical quality assurance (QA) program (CQAP).⁸

The key mechanism that permits a CQAP to properly function is 10 U.S.C. § 1102.⁹ For a HLJA, understanding how the U.S. Army implements its CQAP and 10 U.S.C. § 1102 will not only assist the HLJA in providing accurate and timely advice concerning adverse medical events, but will also provide the HLJA with a solid foundation for understanding how a MTF operates to minimize or mitigate future adverse events.¹⁰

This article provides a general framework for understanding the Army's CQAP, which is called the Clinical Quality Management (QM) Program (CQMP), and 10 U.S.C. § 1102.¹¹ It also explains the credentialing, privileging, and RMC processes, which are major components of the CQMP.¹² Lastly, it identifies common

⁷ See Perez, *supra* note 2; see also Professional Experiences, *supra* note 6. Beneficiary is defined as "[a]nyone eligible to receive health promotion, illness prevention, inpatient and outpatient health care and services within the military health system." AR 40-68, *supra* note 1, glossary, at 156.

⁸ See S. REP. NO. 99-331, at 245–46 (1986); see also AR 40-68, *supra* note 1.

⁹ S. REP. NO. 99-331, at 245–46; see also 10 U.S.C.A. § 1102 (West 1986) (this is the original version that this article compares to a recent amendment).

¹⁰ S. REP. NO. 99-331, at 245–46; Professional Experiences, *supra* note 6. The term military treatment facility (MTF) will collectively refer to military medical center, hospital, and clinic. AR 40-68, *supra* note 1, glossary, at 164.

¹¹ AR 40-68, *supra* note 1, para. 1-1. See generally 10 U.S.C.A. § 1102 (this is the most current version that will be contrasted against the version cited in note 9).

¹² See generally AR 40-68, *supra* note 1. The risk management committee is responsible for "provid[ing] impartial oversight and review of all PCEs and medical malpractice/disability claims management activities." *Id.* para. 13-3a, a(1).

concurrent roles that a HLJA may perform, the regulations that govern his actions, and reference secondary resources that may assist the HLJA in addressing some of the issues that arise.

II. History of 10 U.S.C. § 1102

A HLJA must understand the rationale for the original 1986 version of 10 U.S.C. § 1102 because it sets forth the basic foundation for protecting the QA process. Understanding it will help the HLJA explain the legal advice that he provides to stakeholders concerning QA matters. It will also assist the HLJA in formulating arguments in defense of record non-disclosure if a question arises concerning protection of a particular record that fails to fall squarely within the enumerated protections of 10 U.S.C. § 1102 or case law. The ability to formulate such arguments may prove very important in light of recent and substantial changes contained in today's 10 U.S.C. § 1102.¹³

Before 1986, no statutory protection existed for the quality assurance process.¹⁴ Instead, protection was based upon federal case law and state statutes.¹⁵ The lack of concrete protections in light of the various mechanisms available for compelling disclosure of information and testimony created a substantial obstacle in determining and preventing the cause and reoccurrence of medical adverse events.¹⁶ Specifically, unrestricted access to Army Medical QA information hinders the primary goal of the medical system: the delivery of quality healthcare because people are unlikely to come forward and provide information.¹⁷

Reflecting these concerns, Senate Report No. 99-331 sets forth that the purpose for creating 10 U.S.C. § 1102 was

to “encourage . . . candid peer review and quality assurance.” The report notes that “[m]edical quality assurance programs are the primary mechanism [for] . . . monitor[ing] and ensur[ing . . .] quality medical care . . .” and “[c]entral to these quality assurance review activities is the peer review process.”¹⁸

In the Baby Lucy case, without protection, the RMC charged with determining the exact cause of the baby's injury and providing recommendations to prevent or mitigate a similar event in the future would have great difficulty eliciting the required information from those who participated in the event.¹⁹ The individuals appearing before the RMC would be very hesitant to speak frankly and provide information knowing that this information could be obtained by the press or virtually anyone under a Freedom of Information Act (FOIA) request; possibly subject them to civil litigation; require deposition or appearance in court; cause workplace disharmony; create stigma; and just about any other concern that people reasonably associate with informing on others and participating in a judicial or administrative process.²⁰ This obstacle, however, was largely eliminated in 1986 with the passage of 10 U.S.C. § 1102.²¹

III. Current State of the Law and Army Regulation 40-68, the Army's Clinical Quality Management Program Implementing Regulation

It is likely that the extent of the protections originally afforded by 10 U.S.C. § 1102 was recently narrowed.²² As a result, the Army's CQMP may have been adversely affected.²³

¹³ 10 U.S.C.A. § 1102 (West 2012); *see also id.* § 1102 (West 1986).

¹⁴ Major William A. Woodruff, *Confidentiality of Medical Quality Assurance Records*, ARMY LAW, May 1987, at 5, 5–6. This article provides a very good explanation of the protections available before 10 U.S.C. § 1102 was enacted and highlights the major facets of 10 U.S.C.A. § 1102 (West 1986). The article was published shortly after enactment. It does not contain court treatment of 10 U.S.C. § 1102, subsequent changes to 10 U.S.C. § 1102, or current information regarding AR 40-68. *Id.*

¹⁵ Woodruff, *supra* note 14, at 6.

¹⁶ *See id.*; *see also* S. REP. NO. 99-331, at 245–46 (1986). For example, absent protection, the following is a nonexclusive list of provisions that could possibly be used to obtain quality assurance information: (1) Requests for information under 5 U.S.C.A. § 552 (West 2009) (Freedom of Information Act (FOIA)), 5 U.S.C.A. § 552a (West 2010) (Privacy Act). (2) Applicable provisions of the FED. R. OF CIV. P. 26 (Duty to Disclose; General Provisions Governing Discovery), 30 (Depositions by Oral Examination), 31 (Depositions by Written Questions), 34 (Producing Documents, Electronically Stored Information, and Tangible Things, or Entering onto Land, for Inspection and Other Purposes), and 45 (Subpoena). (3) Applicable provisions of the FED. R. OF CRIM. P. 16 (Discovery and Inspection) and 17 (Subpoena). Professional Experiences, *supra* note 6.

¹⁷ S. REP. NO. 99-331, at 245–46; *see also* Woodruff, *supra* note 14, at 5.

¹⁸ S. REP. NO. 99-331, at 245.

¹⁹ *See* AR 40-68, *supra* note 1, ch. 13; S. REP. NO. 99-331, at 245; *see generally* Woodruff, *supra* note 14.

²⁰ *See* S. REP. NO. 99-331, at 245–46; *see also* Woodruff, *supra* note 14.

²¹ *See* 10 U.S.C.A. § 1102 (West 1986); *see generally* Woodruff, *supra* note 14.

²² *See* 10 U.S.C.A. § 1102 (West 1986); *see also id.* § 1102 (West 2012).

²³ *See generally* AR 40-68, *supra* note 1; *see generally* U.S. DEP'T OF DEF., INSTR. 6025.13, MEDICAL QUALITY ASSURANCE (MQA) AND CLINICAL QUALITY MANAGEMENT IN THE MILITARY HEALTH SYSTEM (MHS) (17 Feb. 2011) [hereinafter DoDI 6025.13]. The provision establishes the Department of Defense's (DoD) medical and clinical quality assurance program for the DoD. It also sets forth DoD's policies regarding clinical quality management, confidentiality of records and information created as part of the MQA program, etc. The provisions identify and require implementation activities to be carried out by the military services. *See also* U.S. DEP'T OF DEF., REG. 6025.13-R, MILITARY HEALTH SYSTEM (MHS) CLINICAL QUALITY ASSURANCE (CQA) PROGRAM REGULATION (11 June 2004). This provision expounds upon and implements DoDI 6025.13. It specifically cancels and replaces DoD Directive 6025.13, but does not cancel DoDD 6025.13-R. Instead, DoDD 6025.13-R refers to the prior version of DoDD 6025.13. Generally, HLJAs will only have to refer to AR 40-68. Professional Experiences, *supra* note 6. For information concerning

A. Current State of 10 U.S.C. § 1102

1. *The Statute*

Under 10 U.S.C. § 1102(a), “[m]edical quality assurance records created by or for the Department of Defense as part of a *medical quality assurance program* are confidential and privileged. Such records may not be disclosed to any person or entity, except as provided in subsection (c).”²⁴ Additionally, unless an exception applies, the statute prohibits in either a judicial or administrative proceeding: (1) testimony concerning the medical quality assurance record; (2) discovery of the quality assurance record; or (3) admitting the record into evidence.²⁵ The statute also creates a specific exemption to FOIA and limits civil liability for those individuals providing information to “a person or body that reviews or creates quality assurance information.”²⁶

Until the most recent amendment, “medical quality assurance program” was defined as

any activity carried out . . . by or for the Department of Defense to assess the quality of medical care, including activities conducted by individuals, military medical or dental treatment facility committees, or other review bodies responsible for quality assurance, credentials, infection control, patient care assessment (including treatment procedures, blood, drugs, and therapeutics), medical records, health resources management review and identification and prevention of medical or dental incidents and risks.²⁷

On 1 January 2012, however, Congress amended the statute by redefining “medical quality assurance program” as “any *peer review activity* carried out.”²⁸ Further, the amendment defined “peer review” as “any *assessment* of the quality of medical care *carried out by a health care professional*, including any such assessment of professional performance, any patient safety program root cause analysis

or report, or any similar activity described in regulations prescribed by the Secretary.”²⁹

When read together and given their common meaning, the new definitions appear to substantially narrow the scope of protection originally provided by limiting the protection to only those records that have occurred under “peer review” by a “healthcare provider.”³⁰ In contrast, the statute previously covered “any activity” and did not limit the protections to “assessment . . . carried out by health care professional.”³¹ The changes may create new challenges and impact how the courts subsequently treat challenges to non-disclosure of records created within the current military quality assurance program.

Specifically, records believed to be protected may now be unprotected due to the unclear and likely narrowed scope of 10 U.S.C. § 1102. For example, while the protections could arguably extend only to those records assessed by a health care professional, the statute, however, does not define health care professional.³² If Congress did not mean to limit the assessment to health care professionals, why did it include and define “peer review” with this limitation?³³ As a result, information such as adverse event data collected by a non-health care professional RM or assistant may not be protected. Further, the definitional change will likely lead to changes in the Department of Defense and Service implementing regulations, cause changes in institutional practices, and require retraining of personnel.³⁴ Lastly, each of these possible outcomes will likely have a substantial financial impact on the military in a time of fiscal uncertainty and dwindling resources.

other service medical quality assurance program implementation, see U.S. DEP’T. OF AIR FORCE, INSTR. 44-119, MEDICAL QUALITY OPERATIONS (16 Aug. 2011) or U.S. DEP’T. OF NAVY, BUREAU OF MEDICINE AND SURGERY (BUMED) INSTR. 6010.13, BUMED-3C4 (19 Aug. 1991).

²⁴ 10 U.S.C.A. § 1102(a) (West 2012) (emphasis added).

²⁵ *Id.* § 1102(b). For exceptions to disclosure and testimony concerning quality assurance records see *id.* § 1102(c).

²⁶ *Id.* § 1102(f); *id.* § 1102(g).

²⁷ *Id.* § 1102(j)(1) (West 1986) (emphasis added).

²⁸ *Id.* § 1102(j)(1) (West 2012) (emphasis added).

²⁹ *Id.* § 1102(j)(4) (emphasis added).

³⁰ *Id.* § 1102(j)(1), (4). Health care provider is defined as “any military or civilian health care professional who, under regulations of a military department, is granted clinical practice privileges to provide health care services in a military medical or dental treatment facility or who is licensed or certified to perform health care services by a governmental board or agency.” *Id.* § 1102(j)(3).

³¹ See *id.* § 1102(j)(1) (West 1986). *Id.* § 1102(j)(4) (West 2012).

³² *Id.* § 1102(j)(4) (West 2012); see also *id.* § 1102(j).

³³ *Id.* § 1102(j)(4).

³⁴ Neither AR 40-68, *supra* note 1, nor the Rosalind Gagliano information papers reflect the definitional changes contained in 10 U.S.C.A. § 1102 (West 2012). U.S. ARMY MEDICAL COMMAND, OFFICE OF THE STAFF JUDGE ADVOCATE INFORMATION PAPERS (11 Apr. 2008) (*Release of Quality Assurance Information (QAI)* and (16 Feb. 2007) (*Identifying Quality Assurance Information under 10 U.S.C. §1102*)) (on file with author). As a result, it would be prudent for HLJAs practicing health care law to note the definitional changes in their legal advice concerning CQMP until reasonable certainty is developed through guidance and case law. Professional Experiences, *supra* note 6.

2. Case Law Before Amendment

Going forward, the recent changes will surely have little impact on the established treatment by the courts of records that are deemed to be a product of the medical quality assurance program. Instead, the legal question will be, as it was when 10 U.S.C. § 1102 was first enacted, whether the record is now covered by the statute.³⁵ As a result, the HLJA should understand the parameters established by the courts under the original 1986 version of 10 U.S.C. § 1102 and analyze current practices in light of the recent amendment.

Before the 1 January 2012 amendment, the courts found that the protections of 10 U.S.C. § 1102 were not waived by the government's failure to do the following: respond or object to a plaintiff's interrogatories, provide quality assurance information in response to discovery requests, or inadvertently disclose medical quality assurance records.³⁶ Further, protections are not waived and extend to military medical QA records that are possessed by a state licensing authority and placed in a public file.³⁷ In contrast, the court has held that a dental employment application held by a U.S. government contractor was not a record protected by 10 U.S.C. § 1102.³⁸

Whether intended or not, uncertainty now exists concerning the scope of protection afforded by the 2012 version of 10 U.S.C. § 1102. The rationale for and the benefits of this change remain unclear.³⁹ The possible detriments, however, are foreseeable: degraded protections, increased litigation, uncertainty, additional and needless financial expense, and "[a]s an indirect result, beneficiaries may receive less than the high quality of care they deserve."⁴⁰ Lastly, amending 10 U.S.C. § 1102 also brings into question the extent to which AR 40-68 remains sound.

B. Department of the Army Regulation 40-68—The U.S. Army Implementing Regulation for Clinical Quality Assurance

The first reference a HLJA must understand is AR 40-68. In most instances, a HLJA assigned to the U.S. Army Medical Command (USAMEDCOM) has not practiced health care law and likely lacks the basic understanding of regularly used terminology and how a MTF operates. Understanding common health care terminology and how the MTF operates is critical to providing timely and accurate medical legal advice. Not only does AR 40-68 explain the Army's CQMP, it also defines common health care terminology and provides a solid foundation for understanding how the MTF operates.

1. Overview of the Army's Clinical Quality Management Program

Army Regulation 40-68 serves as the consolidated regulation for implementing the U.S. Army's Clinical Quality Management Program (CQMP).⁴¹ For discussion purposes, think of CQMP as two functional areas—credentialing/privileging and oversight/continuous clinical improvement.

Credentialing and privileging can be described as concurrent processes to determine whether a provider is qualified and, if so, should he be authorized to provide medical services and to what extent.⁴² These processes occur before, during, and, in some instances, after someone provides medical services to beneficiaries.⁴³ With Baby Lucy, the health care providers involved may have included, along with others, a physician, a certified nurse midwife, a physician's assistant, or a nurse anesthetist.⁴⁴ Each would have undergone the credentialing and privileging process before they provided medical services to Baby Lucy and her mother.⁴⁵

³⁵ See Woodruff, *supra* note 14, at 7.

³⁶ See *In re United States*, 864 F.2d 1153 (5th Cir. 1989); see also *Smith ex. rel. Smith v. United States*, 193 F.R.D. 201 (D. Del. 2000).

³⁷ *Cole v. McNaughton*, 742 F. Supp. 587 (D. Okla. 1990).

³⁸ See *E.E.O.C. v. Med-Nat'l, Inc.*, 186 F.R.D. 609 (D. Haw. 1999).

³⁹ No congressional reasoning for the changes could be found using various legislative databases to include THOMAS, U.S.C.C.A.N., LexisNexis, ProQuest Congressional, and ProQuest Legislative Insight.

⁴⁰ See S. REP. NO. 99-331, at 245 (1986); see also *Professional Experiences*, *supra* note 6.

⁴¹ AR 40-68, *supra* note 1, summary.

⁴² Credentialing is defined as "[t]he process of obtaining, assessing, and verifying the qualifications of a health care provider to render beneficiary care/service in or for a health care organization." *Id.* glossary, at 159. Further, privileging is defined as "[t]he process whereby the privileging authority, upon recommendation from the credentials committee, grants to individuals the authority and responsibility for making independent decisions to diagnosis, initiate, alter, or terminate a regimen of medical or dental care." *Id.* glossary, at 167. Appendix A (Non-Adverse Standard Credentialing and Privileging Flow Chart) contains a flow chart of the standard credentialing and privileging process.

⁴³ See generally AR 40-68, *supra* note 1.

⁴⁴ "Health care practitioners who function independently to initiate, alter, or terminate a regimen of medical care must be privileged." *Id.* para. 9-2a.

⁴⁵ *Id.* paras. 8-3a and 9-2a.

a. Credentialing

Whether a civilian or military health care professional, credentialing begins many years before working for the U.S. Army and involves great personal expense and time (e.g., undergraduate degrees, medical degrees, medical boards, licenses, certifications, masters degrees, internships, post-graduate education, training, etc.).⁴⁶ Upon application to (civilian) or before accession in (military) the U.S. Army, a prospective health care professional must provide documentation that “constitutes evidence of current licensure, certification, registration, or other authorizing document[ation]” to establish his respective qualifications.⁴⁷ The information undergoes primary source verification (PSV).⁴⁸

Whether privileged or non-privileged, the MTF must review qualification information “for all professional health care personnel.”⁴⁹ The process is generally administered by the MTF credentials manager who is responsible for “verif[ying], update[ing], and maintain[ing]” the information while the privileged provider is performing services at the MTF.⁵⁰ The privileged provider’s professional information is generally contained in two files called the provider credentials file (PCF) and the provider activity file (PAF).⁵¹

The PCF is the provider’s permanent file and contains credentialing and performance information.⁵² The “PAF is a working file,” maintained at the credentialing office, which captures data related to a provider’s clinical practice (e.g., deaths, medical record deficiencies, inappropriate clinical drug use, complaints, etc.).⁵³ The PAF is also used to

“[p]eriodically reevaluate performance and privileges.”⁵⁴ Army Regulation 40-68 asserts that documents contained in the PCF and PAF are protected by 10 U.S.C. § 1102.⁵⁵

Some documents obtained or created during the processes, however, may no longer receive protection as the new definition of “peer review” arguably limits the protection to “any *assessment of the quality of medical care carried out* by a health care professional.”⁵⁶ This definition appears to contemplate only retrospective assessment of a provider’s clinical practice.⁵⁷ As a result, it can be argued that until the information contained in a PCF is assessed by a health care professional, the information is not protected.⁵⁸ Nevertheless, the information would still have limited protection under the Privacy Act by requiring a judge’s order before release would occur.⁵⁹

A provider’s credentialing is ongoing and contains “a series of activities designed to collect relevant data that serve as the basis for decisions regarding appointment and reappointment to the medical/dental staff.”⁶⁰ It also serves as the basis for granting privileges and the scope of those privileges.⁶¹ The decision to appoint a health care provider to the medical staff, grant privileges, and determine the scope of those privileges rests with the MTF commander.⁶² The decision typically flows from a department/division chief through the credentials committee and the ECMS to the commander.⁶³

⁴⁶ See generally *id.* ch. 7 (outlining the specific requirements for each type of privileged provider).

⁴⁷ *Id.* paras. 8-1, 8-2, 8-6, and app. F. Additionally, the “professional credentials substantiate relevant education, training, and experience; current competence and judgment; and the ability to carry out the duties and responsibilities of the assigned position or, for the privileged provider, to perform the privileges requested.” *Id.* para. 8-1.

⁴⁸ *Id.* para. 8-2, 8-6. Primary source verification is defined as “the process utilized to authenticate the accuracy of a specific credential or qualification as reported by an individual health care provider or professional. The primary source is the institution, agency, or body that is the original source of the credential or qualification.” *Id.* glossary, at 167.

⁴⁹ *Id.* para. 8-3a, b. The remainder of this article will focus entirely upon privileged providers.

⁵⁰ *Id.* para. 8-3b(2).

⁵¹ *Id.* para. 8-3. The provider activity file is considered an “extension of the PCF.” *Id.* glossary, at 168.

⁵² *Id.* para. 8-3.

⁵³ *Id.* para. 8-3 and glossary, at 168. The definition of providers’ credentials file contains a non-exclusive list of information to be captured by the provider activity file. *Id.* sec. II. The Provider Activity File (PAF) specific content requirements are located in appendix E. *Id.* app. E.

⁵⁴ *Id.* para. 8-3.

⁵⁵ *Id.* para. 8-3(2)(c).

⁵⁶ 10 U.S.C.A. § 1102(j)(4) (West 2012) (emphasis added).

⁵⁷ *Id.*

⁵⁸ *Id.* § 1102(j)(3), (4).

⁵⁹ See AR 27-40, *supra* note 6, para. 7-7b; see also U.S. DEP’T OF ARMY, REG. 340-21, THE ARMY PRIVACY PROGRAM para. 3-1k (5 July 1985); 5 U.S.C.A. § 552a(b)(11) (West 2010).

⁶⁰ AR 40-68, *supra* note 1, para. 8-4a.

⁶¹ *Id.*

⁶² *Id.* paras. 8-4b, 8-5a(3). A commander of a MTF can be a non-healthcare provider. The changes to 10 U.S.C. § 1102 make it possible, although unlikely, that a situation could arise where a non-health care provider makes a decision concerning privileging that may not constitute a “peer review.” An example is where a commander who is a non-health care provider is notified by law enforcement concerning an issue that calls into question a provider’s ability to perform medical services. As a result, the commander decides to immediately restrict the provider’s privileges. *Id.* para. 10-2. The recording of this decision would likely be placed into the provider activity file. *Id.* para. 8-3b(2)(c). Arguably, this decision would not fall within the new scope of 10 U.S.C. § 1102 because it was not assessed by a health care provider. See 10 U.S.C.A. § 1102(j)(4) (West 2012); see also Professional Experiences, *supra* note 6.

⁶³ AR 40-68, *supra* note 1, paras. 8-4 to 8-5. The Executive of the Medical Staff is defined as “[a] group, comprised of physicians and other members in leadership positions within the organization, that is responsible for activities related to self-governance of the medical staff and [professional

The credentials committee is composed of a chairperson and other permanent and alternate members.⁶⁴ A majority must “be fully appointed members of the medical/dental staff.”⁶⁵ A non-voting HLJA will likely serve as the legal advisor.⁶⁶ Up to this point, although the credentialing process has been discussed separately from the privileging process, the processes generally occur simultaneously but serve different purposes. Stated simply, the credentials committee will determine whether someone possesses the requisite qualifications. If so, it will make a recommendation to the commander concerning whether someone should practice and the scope of that practice to which he will be privileged.⁶⁷

b. Privileging

Privileging, at its core, is a pure QA process.⁶⁸ The process is not intended to serve as “a disciplinary or personnel management mechanism.”⁶⁹ Nevertheless, an adverse privileging action may result from provider misconduct.⁷⁰ Medical treatment facility commanders have much discretion when it comes to awarding and scoping clinical privileges.⁷¹ In contrast, a commander may not be able to immediately affect the credentials of a provider.⁷²

impairment] of the professional services provided by individuals with clinical privileges” *Id.* glossary, at 160.

⁶⁴ *Id.* para. 8-5b.

⁶⁵ *Id.* para. 8-5b(2). Appointment to the medical staff is a separate but concurrent process to credentialing and privileging. *Id.* para. 9-5. Appointment to the medical staff generally “reflects the provider’s relationship with the medical/dental staff and the degree to which the provider participates in medical/dental staff surveillance and review as well as quality improvement activities related to the governance of the medical/dental staff.” *Id.* As a practice tip, think of appointed members of the medical staff as fully qualified providers that generally work full time at the MTF and who can admit a patient for inpatient services. Professional Experiences, *supra* note 6.

⁶⁶ AR 40-68, *supra* note 1, para. 8-5b(4). Health Law Judge Advocates are usually present only when an adverse credentialing action is conducted. Professional Experiences, *supra* note 6. According to AR 27-20, *supra* note 6, para. 2-3e, the HLJA performing as the claims attorney should not advise on credentialing actions involving the claim due to a potential for conflict of interest. As a practical matter, the availability of personnel and resources may prohibit this prudent measure. Professional Experiences, *supra* note 6.

⁶⁷ See AR 40-68, *supra* note 1, ch. 9 and para. 9-4b(3).

⁶⁸ *Id.* para. 9-1a. There are three types of privileges—regular, temporary, and supervised. *Id.* para. 9-3.

⁶⁹ *Id.* para. 9-1a.

⁷⁰ *Id.* para. 10-4b.

⁷¹ See generally *id.* chs. 9, 10.

⁷² See *id.* para. 14. The credentials (a license, certification, etc.) of a provider may be affected by submitting information concerning a finalized adverse event or activity to a state regulatory agency, one of the national agencies, or clearinghouses. *Id.*

There are three types of privileging actions—routine, adverse, or non-adverse.⁷³ Approval, reappraisal, and renewal are considered routine privileging actions.⁷⁴ If an issue arises regarding a provider or with the provider’s performance, privileges may be “restrict[ed], reduc[ed], suspen[ded], revoke[ed], or deni[ed].”⁷⁵ These actions are considered adverse to the provider, but serve a critical QA function.⁷⁶ Alternatively, the provider’s privileges may be placed in abeyance or summarily suspended.⁷⁷ These actions are considered non-adverse, but have a similar effect with limited duration.⁷⁸

The flow of the privileging action depends upon the type and category of the action.⁷⁹ The process, no matter how it originates, involves substantial documentation and input from the respective provider and the provider’s department/service chief.⁸⁰ Routine actions will typically move from the respective provider or department/service chief through the credentials committee and ECMS to the MTF commander for approval.⁸¹ With adverse privileging actions, however, additional procedures are mandated.⁸²

This additional process is provided through “investigation, professional peer review, hearing, and appeal.”⁸³ In many instances, there will be concurrent non-health care-related administrative or legal actions.⁸⁴ A HLJA serves an important function in adverse privileging actions and any related non-health care legal matters that

⁷³ See *id.* para. 9-1b.

⁷⁴ *Id.*

⁷⁵ *Id.* para. 9-1b and ch. 10.

⁷⁶ *Id.* para. 9-1a, b.

⁷⁷ *Id.* paras. 9-1b, 10-6a, b.

⁷⁸ *Id.* para. 10-6a, b.

⁷⁹ See generally *id.* chs. 9, 10.

⁸⁰ *Id.*

⁸¹ See *id.* para. 9-4.

⁸² *Id.* para. 10-1. A detailed examination of the adverse clinical privileging process is beyond the scope of this article. Those seeking additional information should consult, Lieutenant Colonel Anthony J. Kutsch, *Risk Management: The Role of Peer Review in Potentially Compensable Event and Medical Malpractice Claims Processing in the Army Medical Department*, U.S. ARMY MED. DEP’T. J., Jan.–Mar. 2010, at 20, available at <http://www.cs.amedd.army.mil/AMEDDJournal/2010janmar.pdf>.

⁸³ AR 40-68, *supra* note 1, para. 10-1.

⁸⁴ See *id.* paras. 10-3, 10-4. Some of the types of other legal actions that may occur include: officer separation proceedings; command-directed mental health examinations; involuntary mental health referral and commitment proceedings; actions taken in accordance with the Uniform Code of Military Justice; federal lawsuits (due process proceedings); concurrent criminal and administrative investigations of all types; and Equal Opportunity complaints, etc. Professional Experiences, *supra* note 6.

may arise.⁸⁵ Specifically, the HLJA helps to ensure that “due process and legal rights are [properly] afforded” and ensures that information protected by 10 U.S.C. § 1102 is not included in any collateral matter.⁸⁶

In adverse privileging actions, a highly competent disinterested third party should conduct an investigation.⁸⁷ The investigator investigates the facts and circumstances and makes a report to the credentials committee.⁸⁸ The credentials committee reviews and considers the investigation. The chairperson of the credentials committee recommends to the MTF commander that either “no further action be taken” or the “summary suspen[sion of privileges] pending a formal peer review.”⁸⁹ If a peer review panel is required, it will “evaluate the available information and to determine if the [standard of care] was met” and “evaluate the provider’s performance, conduct, or condition to determine the extent of the problem(s).”⁹⁰ The subject provider’s participation and rights are limited during this stage of the adverse privileging process.⁹¹

The peer review panel may include one of the following recommendations concerning the subject provider’s privileges—reinstatement, suspension, restriction, reduction, or denial.⁹² The peer review panel’s recommendations and associated information is returned to the credentials committee.⁹³ The credentials committee will likely review the matter, include recommendation(s), and forward the matter to the MTF commander for a decision on the matter.⁹⁴ If the MTF commander “intends to deny, suspend, restrict, reduce, or revoke the provider’s privileges” then the commander must notify the subject provider and provide information concerning “hearing and appeal rights.”⁹⁵

The hearing is an administrative process that provides substantial due process rights.⁹⁶ Additionally, specific time requirements are mandated.⁹⁷ The hearing board determines findings and recommendations.⁹⁸ The findings and recommendations are likely detailed and each finding “must be supported by a preponderance of the evidence.”⁹⁹ The entire record is submitted through the ECMS to the MTF commander.¹⁰⁰ The matter is reviewed for legal sufficiency before the MTF commander makes a decision.¹⁰¹ Ideally, a HLJA who did not advise the peer review panel will conduct the review.¹⁰² Once a decision is made, it is communicated, along with notice of appeal rights, to the subject provider, a copy is placed in the PCF, and “the appropriate department, service, or clinic chiefs” are informed.¹⁰³ The subject provider may elect to appeal the decision.¹⁰⁴

The appeal process has strict time requirements and should be rigidly followed.¹⁰⁵ The appeal process constitutes two appeals.¹⁰⁶ The first appeal is to the MTF commander that rendered the decision.¹⁰⁷ If denied, the matter is forwarded through the Regional Medical Commander to the USAMEDCOM Quality Management Division (QMD).¹⁰⁸ The USAMEDCOM QMD establishes another appeals board, which reviews the entire matter and provides findings and recommendations to the Surgeon General.¹⁰⁹ The Surgeon General renders a decision and notifies the subject provider.¹¹⁰

⁸⁵ Professional Experiences, *supra* note 6.

⁸⁶ See AR 40-68, *supra* note 1, para. 10-3a; Professional Experiences, *supra* note 6. Defects in due process will delay the adverse privileging process and lead to due process challenges in the federal courts. There are legal firms and attorneys experienced in challenging military privileging actions. A due process violation can be a sound basis for challenge. *Id.*

⁸⁷ AR 40-68, *supra* note 1, para. 10-6d (directing use of Clinical Quality Management Quality Assurance Investigation); Professional Experiences, *supra* note 6.

⁸⁸ AR 40-68, *supra* note 1, para. 10-6d, e(1).

⁸⁹ *Id.* para. 10-6e.

⁹⁰ *Id.* para. 10-6e(c), f(1).

⁹¹ *Id.* para. 10-6f(1)(c), (d).

⁹² *Id.* para.10-6f(5).

⁹³ *Id.* para.10-6f(6).

⁹⁴ *Id.* para. 10-6f(6), (7).

⁹⁵ *Id.* para. 10-6f(7)(c).

⁹⁶ *Id.* paras. 10-7–10-8.

⁹⁷ *Id.* The stated time limitations, prohibition of attorney participation, and the overall hearing process may be used as a basis for challenging the proceeding in federal court. The HLJA should research and determine whether the MTF is strictly adhering to the published rules and, if not, assist in correcting deficiencies. Professional Experiences, *supra* note 6.

⁹⁸ AR 40-68, *supra* note 1, para. 10-8f.

⁹⁹ *Id.*

¹⁰⁰ *Id.* para. 10-9a.

¹⁰¹ *Id.* para. 10-9b.

¹⁰² Professional Experiences, *supra* note 6.

¹⁰³ *Id.* para. 10-9c(2)—10-9c(3).

¹⁰⁴ *Id.* para. 10-10a.

¹⁰⁵ See *id.* para. 10-10. Practice Tip: Any deviation from mandated rules or procedures may be used as a basis for making a due process challenge in federal court even if the deviation was made to accommodate the subject bringing the claim. Professional Experiences, *supra* note 6.

¹⁰⁶ AR 40-68, *supra* note 1, para. 10-10a to 10-10d.

¹⁰⁷ *Id.* para. 10-10 to 10-10b.

¹⁰⁸ *Id.* para. 10-10c, 10-10d to 10-10f.

¹⁰⁹ *Id.* para. 10-10d to 10-10f.

¹¹⁰ *Id.* para.10-10f to 10-10g.

Many options, such as increased supervision, additional or re-training, mentoring, counseling, substance abuse intervention, etc., exist to address issues that affect the ability of a provider to render proper and safe medical care.¹¹¹ Terminating the provider's ability to practice will likely be the final option. Ultimately, the option selected will likely reflect that which is necessary to ensure quality and safe health care.¹¹²

2. The Risk Management Process

Another QA mechanism is the risk management (RMGT) process.¹¹³ This process can lead to an adverse privileging action.¹¹⁴ It may also lead to changes in a particular clinical or administrative practice, modification or termination of a specific clinical procedure, increased training or retraining of personnel involved in providing health care, or anything else related to the delivery of care.¹¹⁵ In short, the RMGT process is one of the most important aspects of quality assurance because it seeks to "prevent the loss of human, material, or financial resources and to limit the negative consequences of adverse or unanticipated events that occur in a healthcare setting."¹¹⁶

The goals of RMGT are achieved through an overall systematic plan that incorporates identification of possible clinical issues and practices, multi-disciplinary review and evaluation, data gathering, analysis, and reporting, along with risk reduction and mitigation training.¹¹⁷

Identification of possible clinical issues occurs at all levels of healthcare practice.¹¹⁸ In some instances, the incident itself indicates that a clinical issue may exist.¹¹⁹ In Baby Lucy, the unanticipated injury post-delivery indicates that an issue exists.¹²⁰ Another example would be the sudden and unforeseen death of a patient. The event, however, does not have to be catastrophic in nature (e.g., the chipping of a patient's teeth during intubation, a patient falling off an exam table during a procedure, or a mild,

unanticipated adverse reaction to medicine).¹²¹ Identification of a clinical risk also occurs as a result of the medical claims process.¹²² The identification occurs when an individual who believes he or she has been harmed files a claim with the servicing claims office.¹²³ Notice of the claim should be quickly reported to the RM.¹²⁴ No matter the method of notification, the identification of any potential risk is important to mitigating or preventing such risks in the future.¹²⁵ Once identified, the clinical risk is evaluated.¹²⁶

Evaluation of the clinical risk begins with the RM.¹²⁷ The RM gathers initial information or investigates the event and, along with RMGT's Clinical Advisor (RMCA) and the medical claims attorney/HLJA, makes an initial determination as to whether the event constitutes a PCE.¹²⁸ Soon thereafter, a non-involved peer conducts an impartial department or service level review of the event.¹²⁹ The peer review determines whether the standard of care (SOC) was "met, not met, or indeterminate" for the overall event and individually by those significantly involved.¹³⁰ The peer review also "include review of care findings, [a]ssignment of responsibility and the rationale supporting the decision, and any input from each provider involved unless he/she has elected to waive this opportunity."¹³¹

¹²¹ AR 40-68, *supra* note 1, para. 13-5b(8).

¹²² *Id.* para. 13-6a; *see also* AR 27-20, *supra* note 6, para. 2-9e to 2-9f; DA PAM. 27-162, *supra* note 6, para. 2-2b.

¹²³ The servicing medical claims office will usually be a function of the MTF Command JA (CJA) or at the servicing Office of the Staff Judge Advocate (OSJA) that administers the U.S. Army's Claims Service (USARCS) function for that geographic area. The MTF CJA and medical claims attorney is generally delegated authority to dispose of claims from USARCS or the servicing SJA based upon a dollar threshold. *See* AR 27-20, *supra* note 6, paras. 1-12b(3), 8-8; *see also* DA PAM. 27-162, *supra* note 6, para. 2-3b, 2-3e. Close coordination among the MTF CJA, servicing OSJA, and USARCS should be maintained. *See generally* AR 27-20, *supra* note 6, paras. 1-12, 1-14; DA PAM. 27-162, *supra* note 6, paras. 2-1b, 2-3e; Professional Experiences, *supra* note 6. Appendix C (General Medical Tort Claims Process Flow Chart) contains a flow chart of the medical claims process.

¹²⁴ Professional Experiences, *supra* note 6.

¹²⁵ AR 40-68, *supra* note 1, paras. 13-1, 13-4.

¹²⁶ *Id.* para. 13-2c(1), 13-2d(1).

¹²⁷ *Id.* para. 13-2c(1).

¹²⁸ *Id.* para. 13-4.

¹²⁹ *Id.* para. 13-5a to 13-5b. Generally, only extremely competent and experienced peers are selected for this review. Professional Experiences, *supra* note 6.

¹³⁰ AR 40-68, *supra* note 1, para. 13-5a, 13-5b(5), 13-5(6)(a). Standard of care is defined as "health care diagnostic or treatment judgments and actions of a provider/professional generally accepted in the health care discipline or specialty involved as reasonable, prudent, and appropriate." *Id.* glossary, at 170.

¹³¹ *Id.* para. 13-5b(5).

¹¹¹ *See id.* chs. 9, 10.

¹¹² *Id.* para. 9-1a.

¹¹³ *See id.* para. 13-1. Appendix B (Standard Risk Management Flow Chart with Collateral Matters) is a flow chart of the risk management process.

¹¹⁴ *Id.* para. 13-3c(2).

¹¹⁵ *See id.* para. 13-4.

¹¹⁶ *Id.* para. 13-1.

¹¹⁷ *See id.* ch. 13 and para. 13-2.

¹¹⁸ *See generally id.* chs. 12, 13.

¹¹⁹ *See id.* para. 13-4.

¹²⁰ *Id.*; *see also* Perez, *supra* note 2.

Once the peer review is complete, it is delivered to the RM for the RMC.¹³² The RM tracks, prioritizes, and schedules RMC meetings for all PCEs.¹³³ The RMC is an impartial multidisciplinary group that includes a “represent[ative] from each clinical department/service, the RM, the HLJA, and other designated (ad hoc) participants, as needed.”¹³⁴ The RMC “review[s] the facts of the case, consider[s] [the] peer review findings and recommendations,” and makes the same determinations as those required for the peer review.¹³⁵ Additionally, those significantly involved may provide in-person information to the RMC.¹³⁶ Each member of the committee, except for the RM, HLJA, and the chairperson (who only votes when there is a tie), casts a vote for each determination.¹³⁷ Although applicable medical records and notice of the peer review is provided to those significantly involved, due process is considered inapplicable to the process.¹³⁸

Once the RM committee makes its determinations and recommendations, the information is delivered through QA channels to the MTF commander for consideration.¹³⁹ Additionally, where a provider does not meet SOC, the review is also delivered to the credentials committee for adverse privileging action.¹⁴⁰ All of the information concerning a PCE is captured and maintained in an electronic system called “Centralized Credentials and Quality Assurance System (CCQAS).”¹⁴¹ Trends are reported to the ECMS and MEDCOM QM.¹⁴² If necessary, the information will be used to take action to prevent or mitigate future harm.¹⁴³ The RM process and the information gathered likely remains protected with the changes to 10 U.S.C. § 1102.

In the Baby Lucy case, the event would likely undergo a peer review and RMC review soon after the event. Depending upon cause of injury, the RMC would likely recommend immediate actions to prevent the reoccurrence,

¹³² See *id.* paras. 13-2, 13-3b.

¹³³ *Id.* paras. 13-2c(3), 13-4, 13-4b.

¹³⁴ *Id.* para. 13-3a, 13-3a(1).

¹³⁵ *Id.* para. 13-3b.

¹³⁶ *Id.* para. 13-5b(3).

¹³⁷ *Id.* para. 13-3a(1) to 13-3a(3).

¹³⁸ *Id.* para. 13-5b(3), 13-5(3)(d).

¹³⁹ *Id.* para. 13-3c(1).

¹⁴⁰ *Id.* para. 13-3c(2).

¹⁴¹ *Id.* paras. 1-4j(7)(k), 13-4d.

¹⁴² *Id.* paras. 13-2c(6), 13-2e.

¹⁴³ *Id.* para. 13-4.

to include changes in procedures, policies, and referral of providers to the credentials committee.

C. Concurrent Health Law Judge Advocate Roles and Responsibilities

Concurrent with the RMGT process and any resulting adverse privileging action, HLJAs must not lose sight of their additional roles and responsibilities that will likely arise with an adverse medical event. The eventual medical claim must be documented, reported, investigated, accurately maintained, and submitted to the U.S. Army Claims Service (USARCS) at various stages throughout the adjudication process.¹⁴⁴

Any USARCS Claims Attorney (CA) and Claims Investigator assigned will need support in adjudicating the claim.¹⁴⁵ This support is not limited to providing advice, context, command and stakeholder desires and concerns, medical records, witness statements, and ensuring that no QA information or documentation is included in the material provided.¹⁴⁶ It also includes any aspect of local support that enables the CA to efficiently and effectively perform his job (e.g., work space at the medical facility, computer automation support, network access, coordination for local witness interviews, security badges, escorting around the facility, introductions to stakeholders, etc.).¹⁴⁷

If the claim enters into litigation, the HLJA will also provide similar support activities as those noted for the CA to the assigned Litigation Judge Advocate and Assistant United States Attorney.¹⁴⁸ Additionally, assistance with coordination for the appearance of witnesses from the MTF at depositions, hearings, or trials may be necessary.¹⁴⁹

Further, the HLJA will be responsible for providing legal advice and oversight concerning any criminal prosecution or administrative action, to include separation, which may result from an adverse medical event.¹⁵⁰ Lastly,

¹⁴⁴ Professional Experiences, *supra* note 6; see AR 27-20, *supra* note 6, paras. 2-2, 2-3, 2-9 to 2-12, 2-22; see also DA PAM. 27-162, *supra* note 6, paras. 2-12, 2-19, 2-34b, 2-60.

¹⁴⁵ See generally Professional Experiences, *supra* note 6; AR 27-20, *supra* note 6, paras. 2-1, 2-3c, 2-22a.

¹⁴⁶ Professional Experiences, *supra* note 6; see generally DA PAM. 27-162, *supra* note 6, paras. 1-18b, 2-7c, 2-12, 2-19 to 2-24, 2-34.

¹⁴⁷ Professional Experiences, *supra* note 6.

¹⁴⁸ *Id.*

¹⁴⁹ *Id.*; see generally AR 27-40, *supra* note 6, paras. 7-1 to 7-7, 7-12 to 7-13, 7-15; see also DA PAM. 27-162, *supra* note 6, para. 2-34.

¹⁵⁰ Professional Experiences, *supra* note 6; see AR 40-68, *supra* note 1, paras. 2(d)(b), 10-3a, 10-4, 10-12 to 10-13, 11-2 to 11-5, 12-4c(3), (4), app. I-1.

requests for information and records from media and others will likely arise with an adverse medical event. Information released in response to requests requires careful review and analysis because it may include QA information, impact any claim or tort case that arises, and violate the Privacy Act or Health Insurance Portability and Accountability Act.¹⁵¹

IV. Conclusion

Baby Lucy illustrates many of the common issues and concerns that arise with adverse medical events. One of the best tools available to minimize the frequency of an adverse medical event or to reduce the harm suffered during an adverse event is a properly functioning medical QA program.¹⁵² Without robust protections and confidentiality of the medical QA process, the medical QA program will not properly function for the same reasons that lead to adverse medical events—humans are imperfect. This imperfection understandably manifests as a desire to avoid exposing oneself to potential civil liability, public or private condemnation, ridicule, invasion of privacy, additional work, etc.¹⁵³

When 10 U.S.C. § 1102 was enacted, it mitigated these human imperfections by allowing frank and thorough assessment of the entire health care process. In turn, information collected could be used to improve the medical system.¹⁵⁴ Unfortunately, the amendment likely narrows the protection afforded.

Additionally, the Baby Lucy case illustrates several roles and responsibilities that are present but separate from the QA process. Health Law Judge Advocates will have to assist in managing and counseling stakeholders with the issues that arise and in ensuring compliance with applicable laws and regulations. The best means for preparing for such events is to understand the underlying reasons for creating 10 U.S.C. § 1102, the recent changes, and AR 40-68.

¹⁵¹ See DA PAM. 27-162, *supra* note 6, paras. 1-18, 2-7h, 2-34i; *see also* AR 27-40, *supra* note 6, paras. 7-7, 7-14; 42 U.S.C. §§ 1320d-6 (2010).

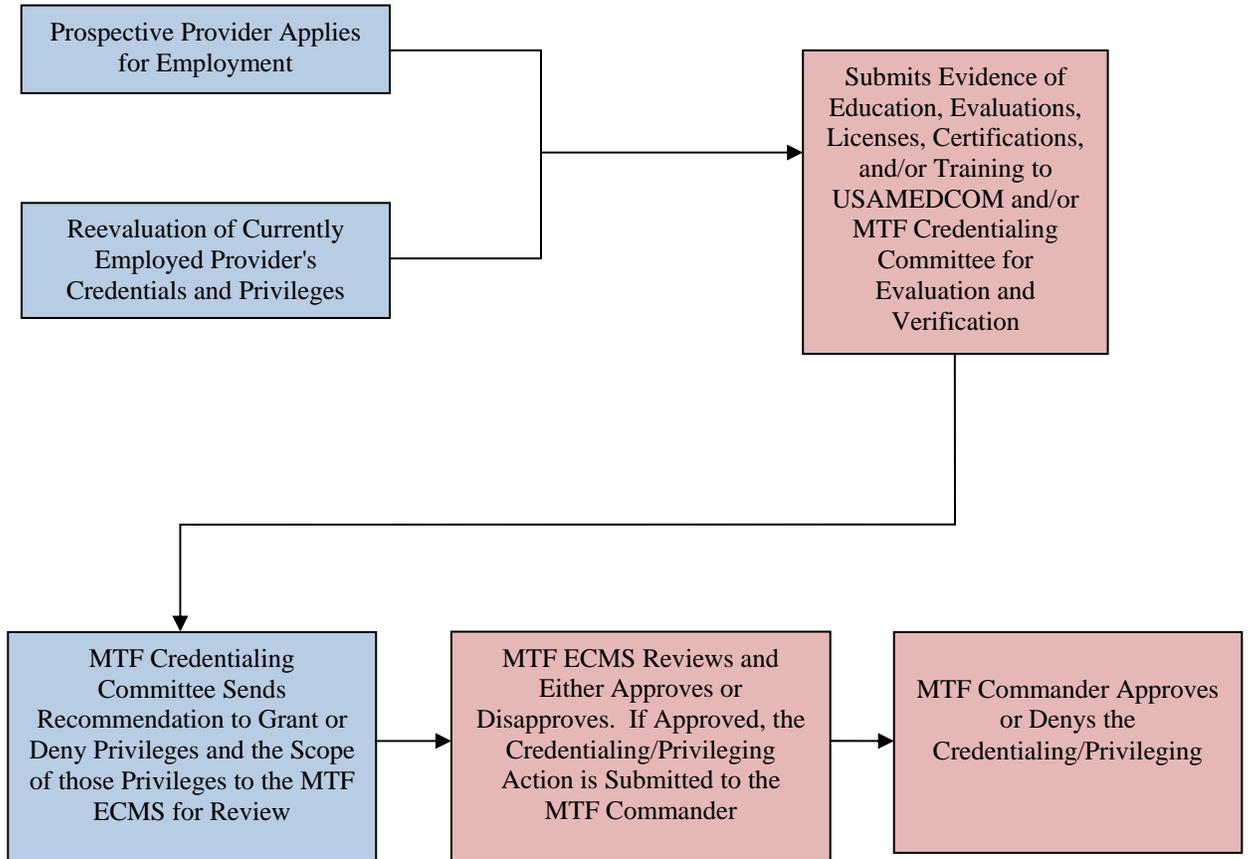
¹⁵² See S. REP. NO. 99-331, at 245–46 (1986).

¹⁵³ *See id.*

¹⁵⁴ AR 40-68, *supra* note 1, para. 13-4.

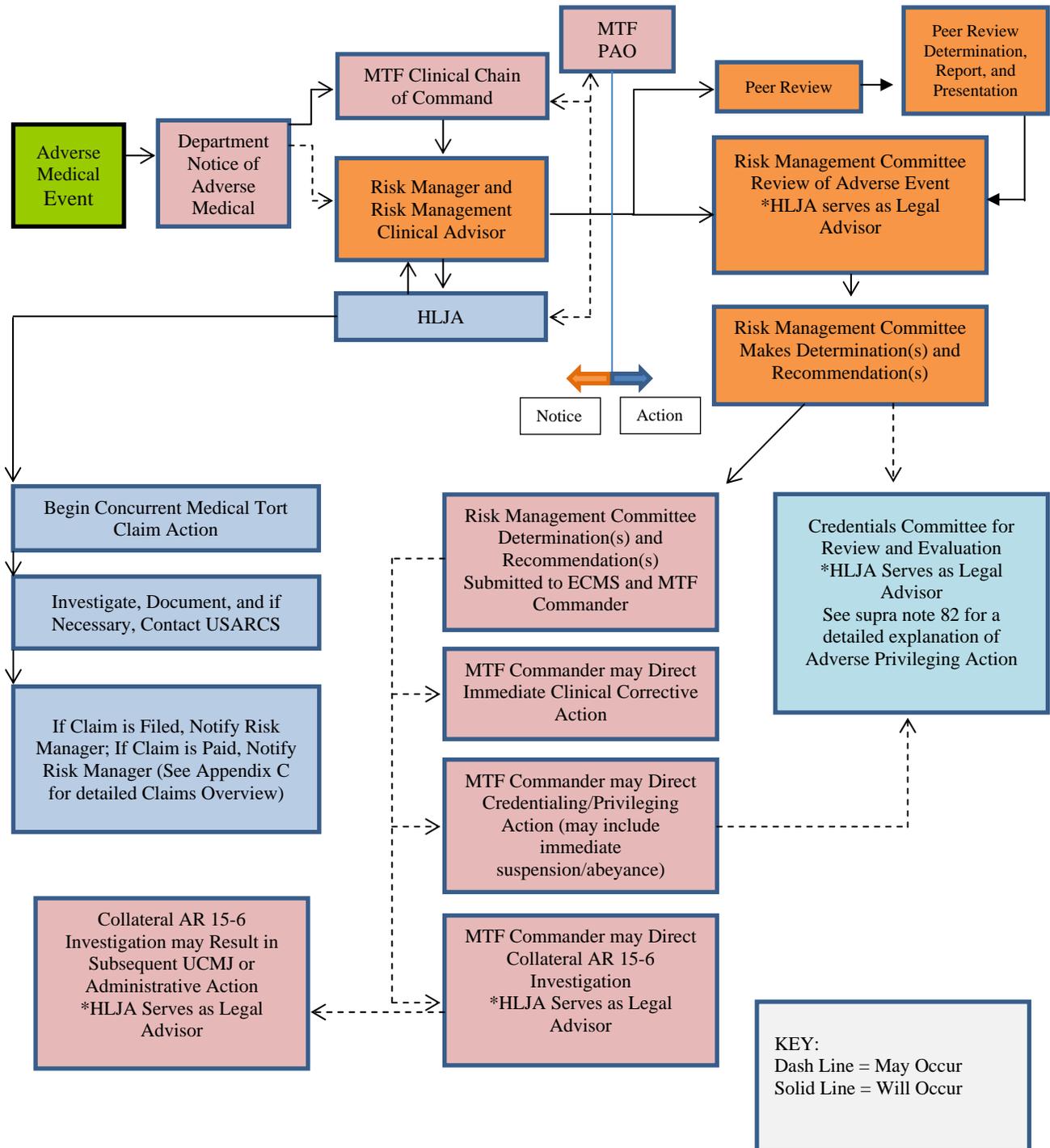
Appendix A

Non-Adverse Standard Credentialing and Privileging Flow Chart



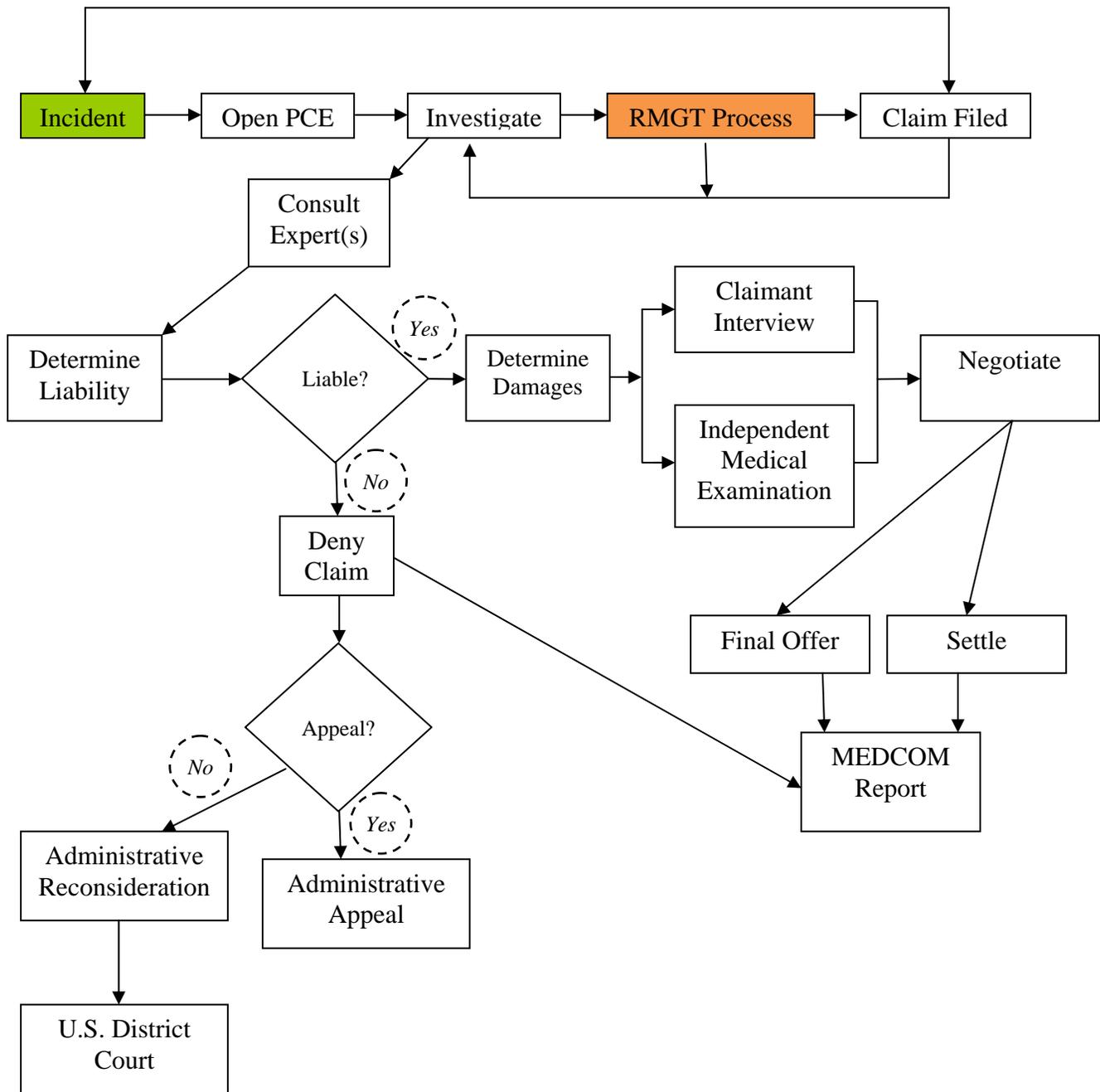
Appendix B

Standard Risk Management Flow Chart with Collateral Matters



Appendix C

General Medical Tort Claims Process Flow Chart*



*Information provided by Mr. Douglas Dribben, Attorney Advisor, Foreign Torts Branch, U.S. Army Claims Service.