

Medical Department



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Section I

Medical Department of the Navy

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I-1

Definition

(1) The Medical Department of the Navy is composed of the medical corps, the dental corps, the medical service corps, the nurse corps, the hospital corps, and the dental technicians. The Medical Department administers commands and facilities devoted to providing medical and dental services, including the Bureau of Medicine and Surgery (BUMED) activities under the command or support of BUMED, and the medical and dental departments of other major claimants and offices.

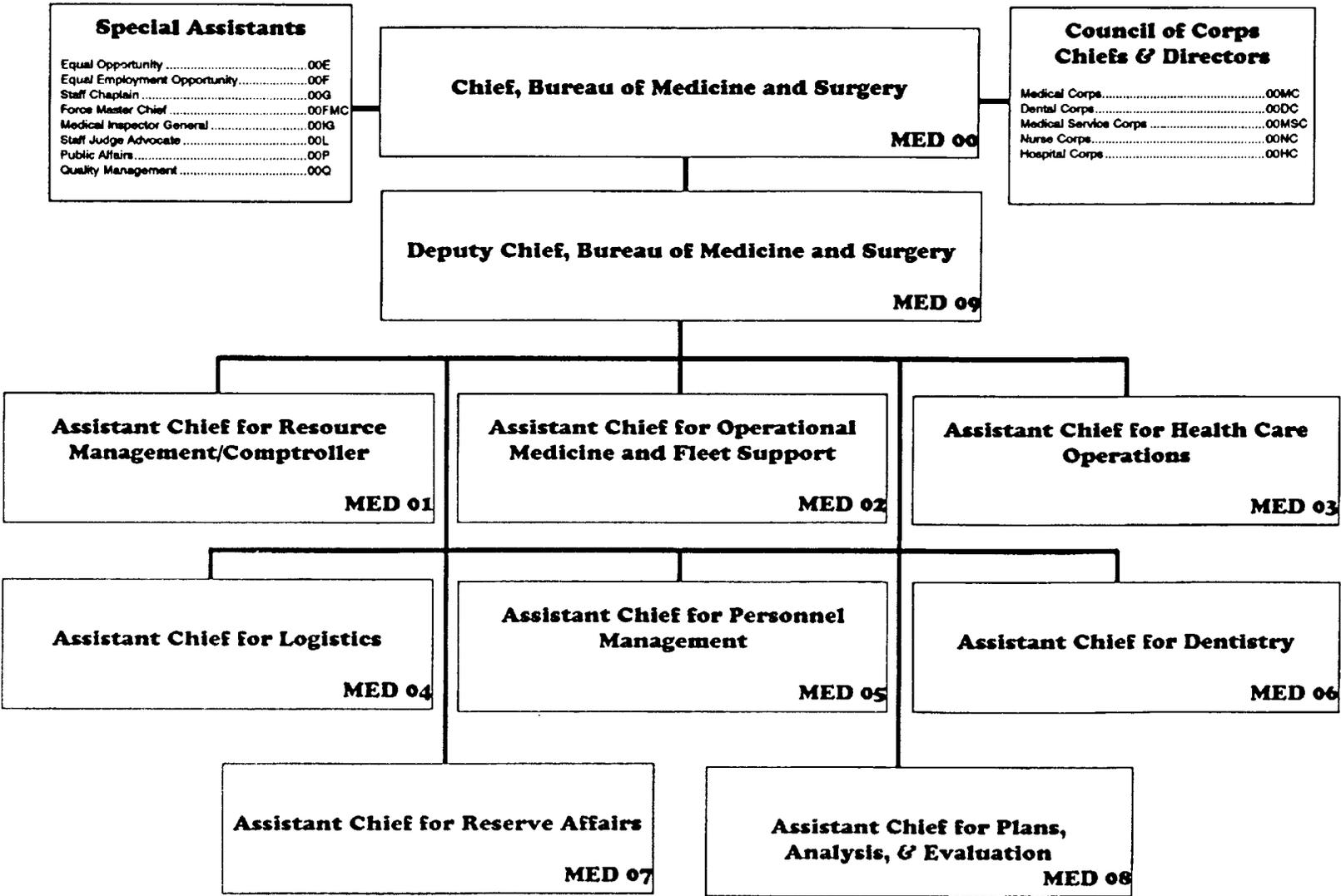
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BUMED Organization

(1) **Chart.** BUMED's organization is shown in the following chart.

(2) The **Chief, Bureau of Medicine and Surgery** is assisted and advised by the organizational entities shown on the chart whose responsibilities are briefed in the following organization statements.

(3) The **Chief, Bureau of Medicine and Surgery's mission** is to ensure personnel and material readiness of shore activities as assigned by the Chief of Naval Operations for command; to develop health care policy for all shore-based treatment facilities and operating forces of the Navy and Marine Corps; to provide primary and technical support in the direct health care delivery system of shore-based treatment facilities and operating forces of the Navy and Marine Corps; and to manage the use of the Civilian Health and Medical



Program of the Uniformed Services (CHAMPUS), and other indirect health care delivery systems.

(4) The **Deputy Chief, Bureau of Medicine and Surgery** ranks next to the Chief of the Bureau in authority in BUMED and the Medical Department. The Deputy shall have such authority and duties with respect to the Bureau and the Medical Department as the Chief of the Bureau may delegate or prescribe, and shall act with full responsibility and authority in the absence of the Chief of the Bureau.

(5) The **Special Assistant for Equal Opportunity Programs** acts as advisor and assistant to the chief in matters pertaining to the command managed equal opportunity (CMEO) and the Navy affirmative action programs for military personnel of BUMED command activities.

(6) The **Special Assistant for Equal Employment Opportunity Programs** acts as advisor and assistant to the Chief, BUMED in equal employment opportunity (EEO) matters for civilian personnel of BUMED command activities.

(7) The **Staff Chaplain** serves as the principal advisor to the Chief, BUMED on religious and moral matters and assists in the administration of religious ministries.

(8) The **Force Master Chief** functions as the principal enlisted advisor to the Chief, BUMED to keep him apprised of existing or potential situations, procedures, and practices that affect the enlisted men and women of Navy Medicine (hospital corpsmen, dental technicians, and deployable medical systems personnel (DEPMEDs)). The Force Master Chief takes precedence over all other enlisted members within Navy Medicine.

(9) The **Medical Inspector General (IG)** coordinates the BUMED portion of the Naval Command Inspection Program by inspecting, investigating, and reporting professional, technical, and administrative matters affecting the efficiency, effectiveness, and integrity of the operation of medical and dental activities.

(10) The **Staff Judge Advocate** serves as legal counsel to the Chief, BUMED and BUMED staff and provides legal advice, support, and counsel regarding medico-legal matters.

(11) The **Special Assistant for Public Affairs** informs Medical Department personnel, other members of the naval service, and the general public about the mission, programs, and activities of BUMED and Navy Medicine and advises the Chief, BUMED concerning the public information needs of the bureau and Navy Medicine.

(12) The **Special Assistant for Quality Management** assists Chief, BUMED and the Executive Steering Council in formulating principles and policies and prescribing procedures to ensure that all aspects of the operation of the Medical Department are of the highest quality; that an infrastructure is established and maintained that enables continuous quality improvement throughout the organization;

and that BUMED is trained and equipped to facilitate quality improvement in its daily operation.

(13) The **Council of Corps Chiefs and Directors** collectively analyzes and discusses issues that effect all Navy Medical Department communities. The council is comprised of Chief, BUMED, the Chief of the Medical Corps, the Chief of the Dental Corps, the Director of the Medical Service Corps, the Director of the Nurse Corps, the Director of the Hospital Corps, and a senior civilian representative appointed by Chief, BUMED.

(a) The **Chief of the Medical Corps** serves as the principal advisor to and advocate for all members of the Medical Corps; provides Chief, BUMED with centralized, coordinated advice on policy development to efficiently manage the Medical Corps; provides a corporate forum for addressing issues of concern to the Navy's physician constituency; and ensures all statutory and regulatory physician community management responsibilities are met.

(b) The **Chief of the Dental Corps** develops, coordinates, evaluates, advises, monitors, and represents the Medical Department on policies, plans, and requirements affecting Navy dental officers. The Chief of the Dental Corps also assesses and provides policy guidance in the areas of procurement, selection, promotion, dental special pays, undergraduate and graduate dental education, use, distribution, assignment, career development, and disposition of Navy dental officers; acts as the Navy Medical Department spokesman, regarding all dental professional matters, to military and civilian counterparts; and performs all functions prescribed by law or regulation for the Chief of the Dental Corps.

(c) The **Director, Medical Service Corps** provides centralized, coordinated policy development and guidance for Medical Service Corps matters; develops, implements, and maintains Medical Service Corps programs which support overall mission objectives and policies established by CNO and Chief, BUMED.

(d) The **Director, Navy Nurse Corps** provides centralized, coordinated policy development and guidance for professional nursing matters in operational and conventional settings, and develops, implements, and maintains Nurse Corps programs which support and sustain overall Navy Medicine mission objectives and policies established by the CNO and Chief, BUMED.

(e) The **Director of the Hospital Corps** advises, assists, centralizes, and coordinates guidance on enlisted community (hospital corps and dental technicians) matters; develops, monitors, and advises on the career progression plans for enlisted personnel; and studies and advises on matters of training, distribution, advancement opportunities, and direction of the enlisted community.

(14) The **Chief of Staff** assists the deputy chief in the administration of the day-to-day operation of the bureau; en-

ures the systematic coordination and review of issues; provides oversight of the management of headquarters support functions; and serves as commanding officer for enlisted personnel assigned to BUMED.

(15) The **Safety Manager** manages the Occupational Safety and Health (OSH) Program for BUMED and ensures employees are provided a safe and healthful working environment.

(16) The **Special Assistant for Management Information Systems** exercises BUMED responsibility for centralized coordination over policy, planning, and integration of requirements for medical management information systems; implements the responsibilities of Chief, BUMED with respect to determination of characteristics, development, appraisal, and coordination of program execution for medical management information systems; acts as principal advisor to Chief, BUMED on medical management information and communications systems to ensure optimum use of available information systems; and acts as BUMED representative to other services and Government agencies for matters involving communications and information systems.

(17) The **Special Assistant for Command Evaluation** advises Chief, BUMED regarding issues of efficiency, economy, and effectiveness of management and procedures for the BUMED claimancy.

(18) The **Historian** develops, implements, and maintains a Navy Medical Department historical program; advises Chief, BUMED and deputy on all aspects of the Medical Department's activities; and improves the organization's corporate memory by developing a controlled collection of archival and reference documents.

(19) The **Director of Headquarters Administration** provides centralized support in the areas of military and civilian human resource management, security, travel, fiscal and supply, maintenance, printing, forms and reports, regulations and directives, and central records management; initiates and coordinates proposals for improvements and reviews administrative practices and procedures within the Bureau to ensure compliance with policies and guidance of higher authority; and coordinates logistic support for official visits to BUMED.

(20) The **Secretariat** provides centralized service regarding all unclassified mail within the bureau.

(21) The **Assistant Chief for Resource Management/Comptroller** formulates principles and policies and prescribes procedures and systems which will exercise effective control over the financial operations of BUMED claimancy; justifies and ensures optimum use of resources for the efficient delivery of health care; and develops and maintains an integrated fiduciary system for Chief, BUMED that is both accurate and responsive to OPNAV, NAVCOMPT, Office of the Secretary of Defense (OSD), Office of Management and Budget (OMB), and Congress.

(a) The **Budget Division** provides guidance and instructions for budget preparation; reviews the resources requirements and justifications of various programs of the bureau; presents BUMED requirements and justifications to Navy and OSD and participates in hearings before higher authority; recommends the distribution of available funds and administrative authority within the bureau and recommends revisions as required; prepares directives to assure compliance with higher authority policies; analyzes variances from the budget plan and works closely with the program monitors in recommending remedial action; determines areas where financial reprogramming may be affected; initiates action to adjust financial plans to available funds and, when required, submits requests for additional funds with justification.

(b) The **Progress Reports & Statistics Division** provides primary and technical support to program and functional managers which includes developing functional requirements for resource management information systems, performing return on investment analysis for managed health care proposals, commercial activities, performance measurement, legislative review and tracking of congressional action which impact on resource management, and publishing the Resource Management Handbook, resource notes, and other policy guidance.

(c) The **Accounting Division** plans, directs, controls, and administers an accounting program for BUMED claimancy. Resource guidance provided by Defense Finance and Accounting Service (DFAS) will be followed to promote economy and efficiency in management by positive and progressive accounting reporting and statistical systems, leading to optimal use of resources provided. Collects, classifies, and maintains accurate and timely financial data, forwarding this information to higher authority, in support of the DoD and the overall DON mission. Develops, maintains, and conducts innovative cost and statistical analysis tailored to the unique needs of various program managers throughout the claimancy for their use.

(e) The **Manpower Planning and Programming Division** develops staffing standards, applies them to projected workload, and identifies the total force requirements (including active duty and Reserve military, civilian, and contractor) necessary to accomplish the BUMED mission. Analyzes and evaluates force structure planning and programming for the acquisition of authorized billets. Recommends courses of action necessary to achieve required force structure.

(22) The **Assistant Chief for Operational Medicine and Fleet Support** develops and oversees the implementation of medical programs that pertain to Navy and Marine Corps operational support; defines medical research, development, test, and evaluation (RDT&E) requirements and evaluates their feasibility; provides advisory services and de-

velops technical guidelines for the implementation of operationally-related health care policies; assists the Chief, BUMED with the assimilation of operationally-related health care information obtained from platform sponsors; oversees the implementation of policies and directives for the conduct of occupational health, preventive medicine, safety, and health promotion programs; and develops and reviews technical guidelines for physical standards.

(a) The **Assistant for Chemical, Biological, and Radiological Warfare Defense** develops and oversees research, development, test and evaluation, and acquisition (RDT&E) programs relating to the medical aspects of the Navy and Marine Corps chemical, biological, and radiological (CBR) warfare defense program; provides technical review and guidance for all medical matters relating to CBR warfare defense; to maintain liaison with the Department of Defense (DoD), CNO, U.S. Marine Corps, Naval Facilities Engineering Command (NAVFACENCOM), naval systems commands, U.S. Army Surgeon General, U.S. Air Force Surgeon General, and other governmental offices as appropriate in support of CBR warfare defense efforts; and maintains liaison with NATO, other international organizations and nations as appropriate in CBR warfare defense area.

(b) The **Assistant for Research and Development** plans and directs medical and dental research, development, test, and evaluation (RDT&E) programs consistent with established direction and policies of higher authorities, and appraises and assesses RDT&E programs to ensure appropriateness and responsiveness to defined requirements.

(c) The **Undersea Medicine and Radiation Health Division** develops, executes, and oversees programs relating to Navy and Marine Corps undersea and radiation health support; provides continual appraisal of all programs affecting undersea medicine and radiation health and makes appropriate policy recommendations; and monitors and provides technical assistance for BUMED fleet liaison programs supporting Navy undersea medical and radiation health requirements under BUMED purview.

(d) The **Surface Medicine Division** develops, executes, and oversees programs relating to surface medical support; provides continual appraisal of all programs that affect surface medicine and makes appropriate policy recommendations to the Assistant Chief for Operational Medicine and Fleet Support; monitors and provides technical assistance for BUMED fleet liaison programs supporting Navy surface fleet units; and reviews all operational surface fleet medical requirements under BUMED purview and ensures timely and effective response.

(e) The **Aerospace Medicine Division** develops, executes, and oversees programs relating to Navy and Marine Corps aerospace medical support; evaluates all programs which affect aerospace medicine and makes appropriate

policy recommendations to the Assistant Chief for Operational Medicine and Fleet Support; monitors and provides technical assistance for BUMED fleet liaison programs supporting Navy and aerospace units; provides community management to Medical Department personnel; provides medical consultative services to the Navy and Marine Corps for complicated aeromedical dispositions; and reviews all aerospace medical requirements under BUMED purview and ensures timely and effective response.

(f) The **Preventive Medicine and Occupational Health Division** directs, manages, and oversees occupational safety, health, and environmental risk assessment programs which enhance the readiness and sustainability of the Operating Forces by reducing the short and long term risks of preventable disease and injury in all Navy and Marine Corps personnel; directs and oversees the development of an effective, comprehensive health promotion strategy; develops a broad range of patient education measures which can be employed to reduce morbidity and mortality; coordinates health risk assessments in support of the Navy Installation Restoration Program; manages the Navy Drug Screening Program; and manages and coordinates BUMED special programs including, but not limited to, health promotion and wellness.

(g) The **Physical Qualifications Review Division** oversees the application of physical standards and qualifications published by DoD and MANMED for all accessioning, retention, and training programs of Navy Department personnel and provides opinion and recommendation regarding service members and former service members who have a case before the Board for Correction of Naval Records, congressional inquiry, and higher authority.

(h) The **Readiness Division** serves as BUMED coordinator to implement medical mobilization and contingency response policy and doctrine; monitors medical readiness and direct claimancy actions in medical support of operational forces; develops policy and guidance on disaster preparedness planning and execution by BUMED facilities in support of their responsible line commanders; reviews and coordinates dissemination of medical intelligence; and manages the Navy Blood Program.

(23) The **Assistant Chief for Health Care Operations** develops, directs, and evaluates the execution of shore-based health care delivery programs; translates policies and programs of the Chief, BUMED into plans that ensure the effective use of resources in support of DON missions; monitors the execution of health care plans prepared by MTF commanders; develops, coordinates, and publishes organization structures and management procedures to MTF commands to ensure the efficient delivery of health care; manages the implementation of policies and directives to publish health care benefits, programs, and specialized patient services.

(a) The **Direct Health Care Division** monitors, analyzes, and evaluates the delivery of health care services; acts as the liaison between the Navy health care support offices and medical treatment facilities in support of budget execution year direct health care operations; reviews, analyzes, evaluates, and recommends changes to the health care delivery system; ensures access to care consistent with stated policies; analyzes and monitors standards for performance of health care systems; and develops, implements, and monitors health care administrative methods, procedures, systems, and organizational structures and functions applicable to health care support offices and MTFs.

(b) The **Coordinated Care Division** provides prospective integrated planning to establish managed care plans for health care services in CONUS; reviews, analyzes, evaluates, and coordinates individual MTF managed care plans; assists MTF commanding officers to develop local managed care plans; coordinates all civilian health care programs which interface with Navy health care delivery systems; manages the Navy's portion of CHAMPUS; and develops coordinated health care plans for noncatchment areas.

(c) The **Patient Administration Division** provides technical guidance and advice concerning policy, eligibility, medical benefits, decedent affairs, nonnaval health care, medical records and forms, medical evacuation issues, and the administration and management of patients receiving care at Navy MTFs; coordinates programs between the uniformed services and Department of Veterans Affairs relative to patient administration matters; monitors the implementation of patient administration policy; and represents Chief, BUMED in cooperative efforts with DoD(HA) on patient administration projects and programs that cross the services.

(d) The **Quality of Life Division** provides policy guidance, monitoring, budget controls, and technical assistance for quality of life programs encompassing morale, welfare, and recreation (MWR); bachelor quarters; Fisher houses; family assignment programs (overseas and CONUS screening), Exceptional Family Member Program (EFMP), medically related services (MRS) and section 6 schools; Alcohol Rehabilitation Programs; and the Family Advocacy Program (FAP).

(e) The **Quality Assessment & Improvement Division** develops and maintains programs designed to monitor the quality of care at all levels in the Navy health care delivery system; assists in monitoring the implementation of programs and, when necessary, affect corrective action; assists medical commands in interpreting professional and accrediting agency standards; and provides professional management, educational assistance, and policy implementation guidance in the area of quality assurance.

(f) The **Medico-Legal Affairs Division** provides medico-legal advice, support, and counsel to the BUMED staff

and all commands within BUMED claimancy; directs the development and maintenance of programs designed to reduce risk at all levels within the Navy health care delivery system; and provides professional management, educational assistance, and policy implementation guidance in the area of risk management.

(24) The **Assistant Chief for Logistics** directs, manages, and coordinates health care services contracting policy and procedures within the BUMED claimancy; directs, manages, and controls logistical and material systems under BUMED during peacetime and contingency conditions; develops health care and support facilities requirements, prepares recommendations, and serves as the focal point for management concerning the scope, location, design, construction, maintenance, and equipage of medical and dental shore facilities; directs and provides guidance for the execution of base operating support functions; and develops, directs, and manages the Medical Department's Environmental Protection Program.

(a) The **Health Care Contracting Division** sets health services contracting policy and provides guidance on contracting matters; determines the technical direction of contracting throughout BUMED claimancy; and monitors the status of all contracting actions.

(b) The **Logistics Division** develops policies concerning medical logistics programs; monitors implementation of established policies; serves as focal point for BUMED claimancy; develops programs to maintain wartime medical readiness and coordinate logistic support for deployable medical systems; develops integrated logistic support policies and materiel management policies and monitors implementation; and oversees field medical logistics activities.

(c) The **Facilities Division** develops health care and support facilities requirements and maintenance, repair, and construction programs for BUMED; prepares recommendations concerning scope, location, design, construction, and maintenance of Navy medical and dental facilities; serves as the focal point for facilities construction and management of shore facilities; and provides information and develops recommendations for use in the planning and programming of replacement medical and dental shore facilities.

(25) The **Assistant Chief for Personnel Management** ensures the high quality of Medical Department personnel; reviews professional qualifications for recruitment of military personnel and maintains close liaison with the Navy Recruiting Command; directs the career and professional development and training of all Medical Department members, military and civilian; assists in the development and maintenance of an effective personnel retention program for military Medical Department personnel; plans and monitors the attainment of the appropriate mix of professional and paraprofessional personnel, military and civilian, throughout the

Navy; and administers personnel programs applicable to Medical Department officers, enlisted, and civilians.

(a) The **Special Assistant for Biomedical Communications Policy** establishes biomedical communication policy and procedures for BUMED; ensures central authority, responsibility, and support to all BUMED biomedical communication activities and functions; controls the proliferation of biomedical communication activities, equipment, and productions; and serves as special assistant to the Assistant Chief for Personnel Management, and to the Chief, BUMED for all biomedical communications, the Chief of Naval Operations (N09BG), to DoD, and to other Federal agencies in biomedical communications policy matters.

(b) The **Military Personnel Division** provides administrative support in the procurement and accession process for professional review boards held at BUMED for all Medical Department officer communities, both active and Reserve; establishes and maintains inventory and accounting of officer personnel resources; and administers special pay programs for Medical Department officer personnel.

(c) The **Civilian Personnel Division** serves as advisor on matters related to civilian personnel management, ensuring that all medical activity heads are well informed on civilian personnel matters affecting their respective commands, and monitors and evaluates services provided to medical activities by Human Resources Offices; and performs civilian personnel research on long term, systemic claimancy-wide issues that are vital to meeting the mission of navy medicine.

(d) The **Professional Development Division** develops and monitors execution of career progression plans for all Medical Department military personnel; develops, directs, and evaluates all professional, paraprofessional, technical, operational, leadership, and management training programs; and studies and advises on matters of orientation, training, assignment, and distribution as they relate to career development.

(26) The **Assistant Chief for Dentistry** develops, directs, and evaluates dental health care policies and treatment programs; translates these policies and programs into action plans, while ensuring the effective use of resources, that promote and safeguard the dental health of authorized beneficiaries; secures adequate dental resources and trained personnel for dental programs to meet Navy and Marine Corps contingency plans; develops and implements dental fleet support programs; and monitors the funding and execution of all DON dental programs.

(a) The **Resource Allocation Division** formulates and executes all dental budget matters; ensure that naval dental centers are adequately funded to accomplish their mission; liaisons with MED-01 and provides dental input for inclusion in BUMED Program Objectives Memorandum (POM) and budget submissions; monitors budget execution

progress by all BUMED dental care activities; collects dental workload data and provides indepth analyses of all data submissions.

(b) The **Dental Health Care Planning Division** develops plans and programs for the Navy Dental Health Care System in support of all peacetime and wartime requirements.

(c) The **Dental Health Care Operations Division** monitors, analyzes, and evaluates DON delivery of dental health care services; acts as the liaison with Navy health care support offices, MTFs, and DTFs in support of budget execution year direct dental health care operations; reviews, analyzes, evaluates, and recommends changes to the dental health care delivery system; ensures access to care consistent with stated policies; analyzes and monitors standards for performance of dental health care systems; and develops, implements, and monitors dental health care administrative methods, procedures, systems, and organizational structures and functions applicable to health care support offices, MTFs, and DTFs.

(d) The **Materiels and Facilities Division** coordinates, analyzes, and advises regarding all matters pertaining to programming, procurement, and use of materiels and facilities within the DON dental health care system.

(e) The **Dental Force Requirements Division** coordinates, analyzes, and advises regarding all matters pertaining to procurement, programming, and use of manpower within the DON dental health care system.

(f) The **Health Care Analysis Division** coordinates, analyzes, and advises on all matters pertaining to procurement, programming, and use of dental management information systems; coordinates all dental needs and workload data collection, and statistical analyses from field activities; and provides dental activities with analysis reports of their data submissions.

(27) The **Assistant Chief for Reserve Matters** ensures that a trained, ready, and organized Naval Reserve medical force is capable of timely integration with active duty assets to satisfy medical mobilization requirements and peacetime contributory support and recommends policy and provides primary technical support for Reserve resources and requirements, operational readiness health care issues, mutual support, personnel management, training, and dental issues.

(a) The **Resources and Policy Division** coordinates and develops Reserve medical and dental POM issues and provides primary technical support for Reserve requirement issues.

(b) The **Operational Platforms Division** provides policy and primary technical support for Reserve medical operational programs: Program 46 (Fleet Hospitals); Program 5 (Air); Program 9 (Marine Corps); and Program 7 (Naval Reserve Construction Forces) and provides liaison with COMNAVRESFOR, N095, MED-01, MED-02, and MED-05.

(c) The **Contributory Support Division** provides technical support and policy guidance to BUMED claimants on Reserve medical contributory support to the peacetime health care delivery system and coordinate program implementation.

(d) The **Reserve Personnel and Training Division** provides primary technical support for Reserve personnel management issues; develops BUMED training policy for Commander, Naval Reserve Force implementation coordinate and monitor accession, promotion, and retention policies and activities for BUMED as they impact upon medical reservists; and coordinates the callup of medical reservists during times of national emergency.

(28) The **Assistant Chief for Plans, Analysis, and Evaluation** maintains a systems approach in conducting the business of Navy Medicine; coordinates and integrates the interdisciplinary planning, analysis, and evaluation activities of BUMED; directs the ongoing strategic planning process to enable Navy Medicine to position its health care delivery system to meet the future medical requirements of the Navy and Marine Corps, and the health and wellness needs of our beneficiaries; establishes and monitors corporate measures of effectiveness; and represents Chief, BUMED in all matters relating to congressional legislative activity.

(a) The **Planning Division** establishes and maintains a systemic planning process for Navy Medicine that integrates multidisciplinary and multifactorial environmental analyses to enable Navy Medicine to achieve its mission.

(b) The **Analysis and Evaluation Division** integrates and coordinates multidisciplinary systems analysis, operations research, and rigorous performance measurement and evaluation efforts to assure comprehensive presentation of decision alternatives for Chief, BUMED; actively participates in and supports strategic and multilevel planning efforts; and provides analytical support and staff coordination for critical issues requiring rapid response.

(c) The **Congressional and Legislative Affairs Division** represents Chief, BUMED in all matters relating to congressional legislative activity in the areas of health care policy and operations.

1-4 Commanding Officers of Medical Department Activities

(1) The commanding officer or officer in charge is responsible for the direction and coordination of all functions of the activity, subject to U.S. Navy Regulations, the orders and instructions of BUMED, and those of other competent authority.

1-5 Heads of Medical Departments and Dental Departments of Ships and Stations

(1) The medical officer and the dental officer of a naval activity are responsible to the commanding officer for the medical and dental services, respectively, of that activity. The functions of the medical and dental departments of a naval activity are administered by medical, dental, medical service, and nurse corps officers and their staffs following U.S. Navy Regulations, this manual, BUMED directives, and the orders and instructions of the commanding officer and competent higher authority.

1-6

Personnel

(1) The Medical Department includes the Medical Corps, Dental Corps, Medical Service Corps, Nurse Corps, warrant officers (PA), Occupational Field XIV Hospital Corps, and dental technicians. Each corps is composed of personnel specialized appropriately to perform the designated duties for that corps. The medical, dental, and related services and health programs for which the Medical Department is responsible are carried out by the personnel of the several

corps, dental technicians, and civilians in BUMED and in the field.

1-7

Offices of Medical and Dental Affairs

(1) See article 2-22 for offices of medical affairs and article 6-54 for offices of dental affairs.

Section II. NOMENCLATURE, DEFINITIONS, AND JOINT USE

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1-10. General

(1) Medical treatment facilities of the Department of the Navy are classified as either fixed or non-fixed. To determine the precise relationship of the number of patients to the number of beds, various classifications of beds and bed status are utilized.

1-11. Fixed Medical Treatment Facilities

(1) *Facilities.*

(a) SECNAVINST 6320.19A of 7 August 1978 is quoted in part below:

1. **Purpose.** This regulation provides (a) uniform nomenclature and definitions applicable to the classification of fixed medical treatment facilities, and (b) provides standard nomenclature and definitions for use in accounting for bed capacity, bed status, bed occupancy, patient accountability, and for length of patient stay review. This regulation implements DOD Instruction 6015.1 of 22 September 1977.

2. **Policy**

a. **Fixed Medical Treatment Facility Nomenclature and Definitions.** In consonance with DOD Instruction 6015.1, fixed medical treatment facilities shall consist of three basic types—medical centers, hospitals, and clinics, which are defined herein. In accounting for bed capacity, bed status, bed occupancy, and patient accountability in fixed medical treatment facilities, the nomenclature and definitions prescribed by the Department of Defense and set forth in this regulation shall be used.

.....

3. **Definitions of Terms**a. **Fixed Medical Treatment Facilities**

(1) **Medical Center.** A medical center is a large hospital which has been so designated and appropriately staffed and equipped to provide health care for authorized personnel, including a wide range of specialized consultative support for all medical facilities within the geographic area of responsibility. Additionally, a medical center, when designated, conducts post graduate education in health professions.

(2) **Hospital.** A health treatment facility capable of providing definitive inpatient care. It is staffed and equipped to provide diagnostic and therapeutic services in the field of general medicine and surgery, preventive medicine services, and has the supporting facilities to perform its assigned mission and functions. A hospital may, in addition, discharge the functions of a clinic.

(3) **Clinic.** A health treatment facility primarily intended and appropriately staffed and equipped to provide emergency treatment and ambulatory services. A clinic is also intended to perform certain nontherapeutic activities related to the health of the personnel served, such as physical examinations, immunizations, medical administration, and preventive medicine services necessary to support a primary

military mission. A clinic may be equipped with beds for observation of patients awaiting transfer to a hospital, and for care of cases which cannot be cared for on an outpatient status, but which do not require hospitalization. Such beds shall not be considered in calculating occupied bed days by hospitals.

(b) **Administrative Titles.**—To differentiate between the various administrative types of medical centers, hospitals, and clinics, the following titles shall be used:

(1) **Naval Regional Medical Center or Naval Hospital (Location)** for a medical center or hospital that is an established shore (field) activity with a commanding officer, under the command and support of BUMED.

(2) **Naval Regional Medical Clinic (Location)**, for a clinic that is an established shore (field) activity with a commanding officer, under the command and support of BUMED.

(3) **Branch Clinic (Activity, Location)**, for a clinic, assigned to a BUMED command activity, that is located at and supports an activity under a bureau or office other than BUMED.

Note.—The titles of activities located outside the United States are preceded by the abbreviation U.S.

(2) **Beds.**—SECNAVINST 6320.19A of 7 August 1978 is quoted in part below:

b. **Bed Capacity**

(1) **Normal Bed Capacity**, or capacity for normal peacetime use, is space for patients' beds and is measured in terms of the number of beds which can be set up in wards or rooms designed for patients' beds and spaced approximately 100 to 120 square feet per bed. This definition refers only to space and excludes equipment and staff capability.

(a) For cantonment-type hospitals still in use, bed capacity may be measured in beds spaced on 8-foot centers. Former ward or room space which has been disposed of or has been so altered that it cannot be readily reconverted to ward or room space is not included in computing bed capacities.

(b) Space for beds used only in connection with examination or brief treatment periods, such as that in examining rooms or in the physiotherapy department, is not included in this figure. Nursery space is not included in the bed capacity but is accounted for separately in terms of the number of bassinets it accommodates.

(2) **Expanded Bed Capacity** is space for patients' beds and is measured in terms of the number of beds which can be set up in wards or rooms designed for patients' beds, spacing beds on 6-foot centers (approximately 72 square feet per bed). Former ward or room space which has been disposed of

or has been so altered that it cannot be readily reconverted to ward or room space is not included in computing bed capacities. Space for beds used only in connection with examination or brief treatment periods, such as that in examining rooms or in the physiotherapy department, is not included in this figure. Nursery space is not included in the bed capacity but is accounted for separately in terms of the number of bassinets it accommodates. This definition refers only to space and excludes equipment and staff capability.

c. Bed Status

(1) **Operating Bed.** A bed that is currently set up and ready in all respects for the care of a patient, it must include supporting space, equipment and staff to operate under normal circumstances. Excluded, are transient patients' beds, incubators, bassinets, labor beds and recovery beds.

(2) **Inactive Bed.** A bed that is ready in all respects—except for the availability of supporting medical staff—for the care of a patient; that is, space and equipment have been provided but the bed is not staffed to operate under normal circumstances. The bed need not necessarily be set up.

(3) **Transient Patient's Bed.** A bed that a designated medical center or hospital operates for the care of a patient who is being moved between medical treatment facilities and who must stop over for a short period of time while en route to his final destination.

(4) **Operating Bassinet.** A bed designed for the care of an infant that is currently set up in the newborn nursery and ready in all respects for use. It must include support space, equipment and staff to operate under normal circumstances. Excluded are infant transporters.

(5) **Inactive Bassinets.** A bed designed for the care of an infant that is ready in all respects except for the availability of supporting medical staff; that is, space and equipment have been provided but the bassinet is not staffed to operate under normal circumstances. The bassinet need not necessarily be set up.

d. Bed Occupancy

(1) **Occupied Bed.** A bed assigned to a patient as of midnight to include a patient on pass or liberty not in excess of 72 hours, and any bassinet assigned to a newborn infant. As an exception to the foregoing, a bed assigned to a patient who was admitted and discharged the same day will also be counted as an occupied bed. The definition excludes: any bed assigned to a patient subsisting out, on leave, or absent without leave; and any bed occupied by a transient patient.

(2) **Bed Occupied by Transient Patient.** A bed assigned as of midnight to a patient who is being moved between medical treatment facilities and who stops over while en route to his final destination.

e. Patient Classification

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

(2) **Outpatient.** An outpatient is an individual receiving health services for an actual or potential disease or injury that does not require admission to a medical treatment facility for inpatient care.

(3) **Transient Patient.** A patient en route from one medical treatment facility to another medical treatment facility.

(4) **Quarters Patient.** An active duty uniformed service member receiving medical or dental treatment for a disease or injury that is of such nature that, on the basis of sound professional judgment, inpatient care is not required. The quarters patient is treated on an outpatient basis and normally will be returned to duty within a 72-hour period. The quarters patient is excused from duty past 2400 hours of the current day while under medical or dental care and is permitted to remain at home, in quarters, or in clinic observation beds.

(5) **Unauthorized Absentee Patient.** A patient who is either in an unauthorized absentee status, in the case of

active duty, or the non-active duty patient who has left without permission.

f. Inpatient Actions

(1) **Admission.** The act of placing an individual under treatment or observation in a medical center or hospital. The day of admission is the day on which the medical center or hospital makes a formal acceptance of the patient who is to be provided with room, board, and continuous nursing service in an area of the hospital where patients normally stay at least overnight. If both an admission and discharge occur on the same day, then that day is considered as a day of admission and shall be counted as one occupied bed day. The admission of a newborn is deemed to occur at the time of birth.

(2) **Disposition.** The removal of a patient from a medical center or hospital by reason of discharge to duty, to home, transfer to another medical treatment facility, death, or other termination of inpatient care. The day of discharge is the day on which the medical center or hospital formally terminates the period of inpatient hospitalization.

g. Inpatient Accounting Terms

(1) **Sick Days.** The total number of days from date of admission to the date of disposition. The day of admission is counted as a sick day and the day of disposition is not counted (exception: see admission/discharge on the same day in "Occupied Bed Day" below).

(2) **Occupied Bed Days.** With the exception of paragraph (d) below, an occupied bed day is defined as a day in which a patient occupies a bed at the census taking hour (normally midnight). The following are counted as occupied bed days:

(a) Days on pass or liberty not in excess of 72 hours.

(b) Newborn infant days while occupying a bassinet.

(c) Days in the labor or delivery room.

(d) Additionally, an occupied bed day is credited whenever a patient is admitted and discharged on the same day.

Where the patient occupies a bed in more than one inpatient care area in one day, the inpatient (occupied bed day) shall be counted only in the inpatient care area in which the patient is located at the census-taking hour.

(This definition excludes days during which the inpatient is subsisting out, on convalescent leave, on authorized or unauthorized leave, on pass in excess of 72 hours, or in a transient status.)

(3) **Subsisting Out.** The nonleave status of an inpatient who is no longer assigned a bed. Those days are not counted as occupied bed days but are counted as sick days. Inpatients authorized to subsist out are not medically able to return to duty but their continuing treatment does not require a bed assignment.

(4) **Convalescent Leave.** An authorized leave status granted to active duty uniformed service members while under medical or dental care which is a part of the care and treatment prescribed for member's recuperation or convalescence. These days are not counted as occupied bed days but are counted as sick days when the convalescent leave occurs prior to disposition of the patient. Convalescent leave occurring after disposition of the patient while en route to a new command, or convalescent leave granted by a line commander after patient discharge from the hospital is not counted as occupied bed days or sick days.

(5) **Length of Patient Stay.** The number of occupied bed days from the date of admission to the date of disposition.

4. Other Definitions

a. **Visit.** Each time an eligible beneficiary presents himself to a separate, organized clinic or specialty service for examination, diagnosis, treatment, evaluation, consultation,

counseling, medical advice; or is treated and/or observed in his quarters; *and* a signed and dated entry is made in the patient's health record or other record of medical treatment (see Note 1), then a visit is considered to have been completed and is countable. However, with the exception that consecutive clinic visits to specialty clinics, i.e., physical therapy and occupational therapy, will not require a signed and dated record entry at each visit unless there is a change in the prescribed treatment or a significant physical finding is evident. In all instances, however, an acceptable record audit trail shall be maintained. For example, a clinic log or treatment card may be maintained as a source document to support an audit trail.

(1) Classification of a service as a visit shall not be dependent upon the professional level of the person providing the service (includes physicians, nurses, physicians' assistants, medical specialists, and medical technicians). Further, the definition "Occasion of Service" shall be carefully considered to assure that credit for a visit is not extended where in fact the criteria for "visit" as set forth in Note 1 is not satisfied.

(2) A patient seen at the primary care clinic and two other specialty clinics on the same day is reported as three visits. A patient visiting a clinic in the morning and again in the afternoon shall count as two visits (providing the requirements of Note 1 are satisfied). These rules apply even if the patient is admitted as an inpatient immediately following a visit. Conversely, double counting shall be avoided; for example, a visit during which both a physician and a medical technician in the same clinic have been involved shall count as only one visit. Other examples of patient/medical care contacts which shall be included and counted as visits are:

(a) Each time a patient is seen who has been referred to a clinic or specialty service by another facility. (If the person is an inpatient of the referring facility, he/she shall be counted as an outpatient.)

(b) Each time a patient is seen, even though he/she may be referred elsewhere for admission.

(c) Each time a patient is seen in the emergency room, primary medical care area, or other designated area outside of regularly established clinic hours.

(d) Each time medical advice or consultation is provided by telephone if properly documented in the health care records. (See Note 1.)

(e) Each time all or part of a complete physical examination or flight physical examination is performed in a separately organized clinic, specialty service, or general outpatient clinic. Under this rule, one complete physical examination requiring the patient to be examined or evaluated in four different clinics is reported as four visits.

(f) Each time a therapist provides primary care (e.g., patient assessment while serving in a physician extender role) and then refers a patient for specialized treatment in that same clinic, then one visit for primary care and one visit for treatment shall be counted.

(g) Each time contact is made by clinic or specialty service members (other than primary physician) with patients on hospital wards, when such services are scheduled through the respective clinic or specialty service. (See Note 2.) For example, a physical therapist being requested by the attending physician to initiate certain therapy regimens to a patient who is in traction and unable to go to the clinic, or a dietitian requested to come to the bedside of a strict bed patient to explain and delineate a particular diet. Conversely, a physical therapist or a dietitian making routine ward patient visits shall not be countable as a visit.

(h) Each time an examination, evaluation, or treatment is provided in the home, school, community center, or other location outside of the medical treatment facility by a health care provider paid from appropriate funds.

(i) Each time one of the following tasks is performed when not a part of routine medical care, and the visit is associated with or related to the treatment of a patient for a specific condition requiring followup or to a physical examination and the provisions of Note 1 are completed with:

Therapeutic or desensitization injections.

Cancer detection checks (example: PAP smears).

Blood pressure checks.

Weight checks.

Prescription renewals (do not include refills).

(j) For group therapy sessions, count each patient attending as one visit regardless of the length of the session or the number of health care personnel involved (example: psychologists, psychiatrists, social workers, dietitians) in conducting the group therapy session *and* the provisions of Note 1 are satisfied. Conversely, group activity counseling (prospective parents classes, group instruction in first aid, and other sessions of this type) will be reported as one visit regardless of the number of participants, when individual treatment, examination, evaluation, or therapy is not provided.

(k) Each time a screening physical examination is performed (example: school, sport, employment and other like examination) providing an appropriate medical record entry is made (see Note 1).

b. *Nonvisits.* Do not report the following as visits:

(1) Occasions of service such as prescriptions filled by the pharmacy, chest X-ray surveys/examinations, laboratory tests, immunizations, or other diagnostic tests that are not a part of a specific treatment.

(2) Furnishing of medical advice or information, either directly or by telephone that does not satisfy the requirements of Note 1.

(3) Visits made to a school health program not staffed by Armed Forces health care personnel are not considered to be visits made to a separate clinic or specialty service. However, dependent children seen by employees of the medical facility such as Public Health Nurses are counted as visits (see Note 1).

(4) Visits at which treatment is rendered by providers paid from nonappropriated funds shall not be included in outpatient work load: which support appropriated fund requirements.

(5) Visits to functions listed in the Special Programs section shall not be counted as visits to any of the Ambulatory Care accounts. Also, such visits shall not be used in any cost assignment process for the Ambulatory Care accounts.

Note 1: The key to reporting visits is adequate documentation on appropriate medical records, e.g., SF 600, SF 513, OT&PT records of treatment to support an audit trail. For example, "refill prescription for birth control pills" with date and signature of the health care provider is not sufficient. The entry should indicate that discussion of use of pills and counseling did take place, for example, "discussed with patient; no apparent problem with use—patient advised to have a PE and PAP prior to next request for renewal; 6 months prescription for ovulen given."

Note 2: Visits of inpatients to Ambulatory Care Work Centers shall be separately identified from the visits of outpatients.

c. *Immunizations.* Count each injection or "dose" of an immunizing substance as an immunization, whether or not it completes a series. Count as only one immunization the double and triple immunizations given in a single injection, e.g., DPT, flu.

d. *Complete Physical Examination.* Record the total number of persons given complete physical examinations

(except flight physicals which are counted separately) such as annual, enlistment, reenlistment, appointment, promotion, requirement, periodic temporary disability retired list (TDRL) evaluations, and similar examinations. Visits made to various clinics incident to the physical examination shall be counted as visits in addition to this selective reporting.

c. *Occasion of Service.* A specific identifiable act of service involved in the medical care of a patient which does not require the assessment of the patient's condition nor the exercising of independent judgment to the patient's care (examples: a technician drawing blood, taking an X-ray, or administering an immunization). Issuance of medical supplies and equipment, i.e., colostomy bags, hearing aid batteries, wheel chairs, and hemodialysis supplies are specific examples of occasions of service and shall not be counted as visits. Pharmacy, Pathology, Radiology, and Special Procedures Services are occasions of service and are not counted as visits.

f. *Live Birth.* The complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy which after such separation, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each such product of such a birth is considered liveborn.

g. *Fetal Death.* Death occurring prior to the complete expulsion or extraction from the mother of a product of conception of 20 weeks or more gestation, or fetal weight of 500 grams or more.

1-12. Nonfixed Medical Treatment Facilities

(1) Nonfixed medical treatment facilities are:

(a) Medical facilities for field service with the Marine Corps; such as, aid stations, clearing stations, and division field and force evacuation hospitals.

(b) Medical facilities afloat (hospital ships, sick bays aboard ship).

(c) The medical advance base component contained within mobile type units; such as, construction battalions, cargo handling battalions, etc.

(2) *Designated Bed Capacity.*—The bed capacity of land-based, nonfixed, medical treatment facilities providing bed care, and of medical treatment facilities afloat, is referred to as the designated bed capacity, defined as follows: the number of patients' beds which is specified in a table of organization and equipment, advanced base catalog, or ship's specifications to be the number of beds a stated type of medical treatment facility is designed to provide. Whenever these basic capabilities of a medical treatment facility have been modified by competent higher headquarters so that the bed capacity of the facility is either augmented or diminished, the modified capacity thereupon becomes the designated bed capacity.

(3) *Operating Beds* are those beds in a functioning medical treatment facility which are set up, equipped, staffed, and in all respects ready for the care of patients. (A functioning medical treatment facility is one which is partially or completely set up and ready to receive patients. A nonfunctioning facility is one which is not set up and not ready to re-

ceive patients due to such conditions as being in training, in transit, staging, or held in tactical reserve.)

(4) *Occupied Beds* are those beds currently assigned to patients.

(5) *Operating Beds Available* are those of the operating beds not currently assigned to patients.

(6) *Base Hospitals.*—Although Navy base hospitals are fundamentally different from the non-fixed type of medical treatment facilities and from medical facilities afloat as to their missions and military operational use, their wartime bed capacities are nevertheless established in the same way. Therefore, in wartime or in time of a large-scale military mobilization, the terms defined in subarticles (2) through (5) will be used in determining and reporting the bed capacities and bed status of all these types.

1-13. Battle Casualty Reporting

(1) *Battle Casualty.*—A battle casualty is any person lost to an organization because of death, wound, missing, capture, or internment provided such loss is incurred in action. "In action" characterizes the casualty status as having been the direct result of hostile action; sustained in combat and related thereto; or sustained going to or returning from a combat mission provided that the occurrence was directly related to hostile action. *However*, injuries due to the elements or self-inflicted wounds are not to be considered as sustained in action and are thereby not to be interpreted as battle casualties.

(2) *Wounded in Action.*—The term "wounded in action" will be used to describe all battle casualties, other than the individuals "killed in action", who have incurred a traumatism or injury due to external agent or cause. Thus broadly used it encompasses all kinds of wounds and other injuries incurred in action, whether there is a piercing of the body, as in a penetrating or perforating wound, or none, as in a contused wound; all fractures; burns, blast concussions; all effects of gases and like chemical warfare agents; and the effects of exposure to radioactive substances.

(3) *Died of Wounds Received in Action.*—The term "died of wounds received in action" will be used to describe all battle casualties who die of wounds or other injuries received in action, after having reached any medical treatment facility. It is essential to differentiate these from battle casualties found dead or who died before reaching a medical treatment facility (the "killed in action" group). It should be noted that reaching a medical treatment facility while still alive is the criterion.

(4) *Killed in Action.*—The term "killed in action" will be used to describe battle casualties who are killed instantly or who die of wounds or other injuries before reaching any medical treatment facility.

1-14. Administrative Terminology

(1) The following terms are defined for use in Medical Department directives, regulations, and correspondence:

(a) *Medical Department.*—The *Medical Department of the Navy* is defined in article 1-1. The shortened term "*Medical Department*" is acceptable if shown in initial capitals to distinguish it from the *medical departments* (normally not capitalized) of the ships or stations.

(b) *Bureau.*—The words "the Bureau" may be used as a short title for the Bureau of Medicine and Surgery; however, the official abbreviation BUMED is preferred as being more specific.

(c) *Activities and Facilities.*—

(1) A Medical Department activity is a command activity of the naval establishment under BUMED command. It includes all of the activities listed in Standard Navy Distribution List FH of the Catalog of Naval Shore Activities, OPNAV P09B3-105.

(2) The term "Medical Department facilities" includes the BUMED commanded and/or supported activities, plus all of the medical and dental departments ashore and afloat.

(d) *"To" Lines for BUMED Directives.*—Three "To" lines peculiar to BUMED use have been standardized for directives applicable only to ships and stations having certain categories of Medical Department personnel aboard:

(1) Ships and Stations Having Medical Department Personnel includes commands having any or all of the following categories aboard: Medical Corps, Dental Corps, Medical Service Corps, Nurse Corps, Warrant Officer (PA), Hospital Corps, dental technician, occupational field XIV, and civilian professional and technical personnel who perform health services for the Navy.

(2) Ships and Stations Having Medical Personnel applies to those activities having any or all of the following aboard: Medical Corps, Medical Service Corps, Nurse Corps, Warrant Officer (PA), Hospital Corps, and civilian professional and technical personnel who perform medical services for the Navy.

(3) Ships and Stations Having Dental Personnel covers those activities having Dental Corps personnel, Medical Service Corps personnel, and dental technician occupational field XIV members who perform dental services for the Navy.

1-15. Joint Use of Military Health and Medical Facilities and Services

(1) DoD Directive 6015.5 of 5 February 1981 is quoted for information:

Reference: (a) DoD Directive 6015.5, "Joint Utilization of Military Health and Medical Facilities and Services," December 5, 1955 (hereby canceled)

(b) DoD Instruction 6015.17, "Technical Procedures and Criteria for Planning and Acquisition of Military Health and Medical Facilities," September 24, 1968

(c) DoD Directive 6010.4, "Dependents' Medical Care," April 25, 1962

(d) DoD Directive 5154.6, "Armed Services Medical Regulating Office," November 26, 1974

(e) Deputy Secretary of Defense Memorandum, "Executive Agent for all DoD Veterinary Activities," October 16, 1980 (hereby canceled)

A. REISSUANCE AND PURPOSE

This Directive reissues reference (a) and prescribes DoD policy and procedures concerning optimum joint use of military health and medical facilities and services. References (b) through (d) are related background documents.

B. APPLICABILITY

The provisions of this Directive apply to the Office of the Secretary of Defense and the Military Departments. The term "Military Services," as used herein, means Army, Navy, Air Force, and Marine Corps.

C. POLICY

The Department of Defense shall plan for and practice joint use of military health and medical facilities and services to attain the most efficient and economical operation of the Military Departments.

D. PROCEDURES AND RESPONSIBILITIES

1. *Health and Medical Personnel.* Joint use of specially trained personnel shall be practiced to obtain efficiency and economy in the operation of health and medical facilities and services. In addition, Medical and Dental Corps Reserve personnel shall be used, regardless of Military Department affiliation, on examining teams established to conduct physical examination at reserve units.

2. Use of Existing Health and Medical Facilities

a. To accomplish optimum use of existing health and medical facilities and services, every effort shall be made to reduce, consolidate, or eliminate facilities in specific areas when another facility is available to provide the necessary support. Established military medical facilities shall be made available to medical components of Reserve units in connection with training programs.

b. Beneficiaries will not be denied equal opportunity for care at a facility because the facility concerned is that of a Military Service other than that of a member or the beneficiary's sponsor.

3. *Operating Beds and Staffing Requirements.* Operational requirements of Military Services' health and medical facilities shall be based on workload experience, estimated workload, missions, and plans for optimum joint use. Significant change (expansion, curtailment, or elimination) in a jointly used health or medical service in a facility or an area shall be coordinated with the other Military Departments and reported to the Assistant Secretary of Defense (Health Affairs) before final action is taken.

4. *Dental Care.* Optimum joint use shall be made of dental facilities and services including inpatient and outpatient treatment. Hospitalized personnel shall be given authorized inpatient dental treatment. Personnel of one Military Service assigned to duty with another Service shall be given outpatient treatment. Small units or detachments, located where dental facilities of their own Service are not readily available or are uneconomical to establish, shall be

provided dental care by nearby dental facilities of other Services. Isolated individuals and groups of military personnel shall obtain dental care from civilian dentists, as authorized by the individual Military Department, when such procedures are more economical and efficient than sending patients long distances to military dental facilities or requesting mobile dental units.

5. *Veterinary Services.* The Secretary of the Army, as Executive Agent of the DoD Veterinary Services, shall effect uniform use of veterinary services throughout the Department of Defense. The Department of the Army's Veterinary Services shall be used by all Military Departments and shall include:

a. Control of animal diseases communicable to man.

b. Veterinary care for government-owned animals supported by appropriated funds.

c. Provision of military veterinarians for research and development, when required by the Military Departments.

6. *Health and Medical Education and Training.* Information regarding organized training programs, including symposia and formal postgraduate courses, shall be freely exchanged and disseminated among the Military Departments. Continuing study shall be made of military health and medical training methods and programs to standardize courses and further joint use.

7. *Preventive Medicine.* Continuing studies shall be conducted on preventive health and medical policies, organizations procedures, and publications to further standardization and joint use.

a. Preventive medicine shall include the following:

(1) Inspection of food products and sanitary inspection of establishments supplying food products to DoD Components.

(2) Use of approved lists of food supplies published by the Department of the Army.

(3) Laboratory examinations of food products.

b. Sanitary military standards for commercial food plants shall be developed by the Surgeon General, Department of the Army, for the Department of Defense.

c. The Department of the Army shall furnish to the Department of the Navy on an as required basis all services described in subparagraphs 7.a.(1) through 7.a.(3).

8. *Medical Laboratory Services.* Joint use shall be made of military hospital and other medical laboratories for the performance of clinical laboratory procedures, the examination of meat, dairy products, and other foods, the conduct of epidemiological investigations, and occupational and environmental studies. Continuing studies shall be made of medical laboratory facilities, organizations, procedures, and functions to further standardization and joint use.

F. EFFECTIVE DATE AND IMPLEMENTATION

This Directive is effective immediately. Forward one copy of implementing documents to the Assistant Secretary of Defense (Health Affairs) within 120 days.

(2) Pursuant to 10 USC §686, services and supplies may be obtained from other agencies to effect the policy contained in DOD Directive 6015.5 quoted above.

Section III General

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1-20 **American National Red Cross**

(1) **General.** The American National Red Cross was reincorporated by the act of Congress of 5 January 1905 as amended (36 USC 1 et seq.) as the agency of the Government for the fulfillment of certain treaty obligations into which the United States entered when it became signatory to the treaty of the Red Cross, or the treaty of Geneva of 22 August 1864. The number of National Red Cross societies officially recognized by the International Red Cross Committee is 63, including the American National Red Cross. The International Red Cross Committee is entrusted with the maintenance of fundamental Red Cross principles, and its essential characteristic is its absolute neutrality under the Geneva Conventions. Under these conventions the national societies are recognized by their governments as auxiliaries to the medical departments of their fighting services. They are pledged to prepare themselves in peacetime for necessary wartime work.

(2) **Welfare Program.** Pursuant to the request of the Secretary of the Navy, the American National Red Cross, in times of peace, conducts a welfare program for members of the Navy and their dependents, including home service by

local chapters, and hospital and recreation services for patients in establishments under the command of BUMED. In times of war the Secretary of the Navy may request that these programs be expanded or new services appropriate to the functions of the American National Red Cross be provided.

(3) **Representatives.** American National Red Cross representatives assigned to naval establishments are considered to be members of the staff of the establishment for organizational purposes. The American National Red Cross will designate the representative who, acting under the commanding officer is responsible for coordinating all Red Cross Activities of the establishment.

(4) **Volunteer Aid.** In conformity with U.S. Navy Regulations, volunteer aid for Medical Department establishments must be accepted only through an agency of the American National Red Cross. The foregoing, however, does not prohibit individuals and representatives of other organizations from visiting Medical Department establishments or, when approved by the commanding officer, acceptance by patients of personal gifts or services tendered by individuals.

(5) **Requests for Services.** Requests for Red Cross services in new establishments, and matters relating to the functioning of Red Cross representatives within an establishment or affecting general policy which are not provided for in current instructions, must be referred to BUMED for appropriate action.

1-21 Geneva Conventions

(1) Officers of the Medical Department must familiarize themselves with the Geneva Conventions. The Conventions are contained in the Annex to Naval Warfare Information Publication 10-2, Law of Naval Warfare, which is available to all ships and stations.

1-22 Off-duty Remunerative Professional Employment (Regulatory)

(1) **General.** Off-duty remunerative professional civilian employment, including self-employment (hereto referred to as off-duty employment) of active duty Medical Department officers is subject to policies herein stated by the Chief, Bureau of Medicine and Surgery, and policies applicable to all members of the naval service as stated by the Secretary of the Navy (SECNAVINST 5370.2 series) and the Chief of Naval Personnel (BUPERSMAN 3420500). No Medical Department officers on active duty shall engage in any off-duty employment without first obtaining the permission of the commanding officer.

(2) Guideline

(a) Medical Department officers on active duty are in a 24-hour duty status and their military duty takes precedence on their time, talents, and attention.

(b) Permission for an officer to engage in off-duty employment shall be based on a determination by the commanding officer that the permission requested is consistent with these guidelines and that the proposed employment will not interfere with the officer's military duties. If approved, employment will normally not exceed 16 hours per week. Periods in excess of 16 hours per week can be authorized only if the commanding officer finds that special circumstances exist which indicate that no conflict with military duties will occur, notwithstanding the additional hours. Permission to engage in off-duty employment maybe withdrawn at any time.

(c) A Medical Department officer in off-duty employment shall not assume primary responsibility for the care of any critically ill person on a continuing basis as this will inevi-

tably result in compromise of responsibilities to the patient, or the primacy of military obligations.

(d) Medical Department officer trainees are prohibited from off-duty employment. Other Medical Department officers are discouraged from off-duty employment. No officer shall request or be granted administrative absence for the primary purpose of conducting off-duty employment.

(e) Off-duty employment shall not be conducted on military premises, involve expense to the Federal government, nor involve use of military equipment, personnel, or supplies. Military personnel may not be employed by Medical Department officers involved in off-duty employment.

(f) Off-duty employment shall not interfere, nor be in competition, with local civilian practitioners in the health professions and must be carried out in compliance with all applicable licensing requirements. To ensure this, a statement shall be provided from the appropriate local professional association indicating that there is a need for the individual's service in the community. Local licensing requirements are the responsibility of officers wishing to engage in private practice. Those engaging in private practice are subject to all requirements of the Federal narcotic law, including registration and payment of tax.

(g) There may be no self-referral from the military setting to their off-duty employment on the part of military Medical Department officers.

(h) No Medical Department officer on active duty in off-duty employment may solicit or accept a fee directly or indirectly for the care of a member, retired member, or dependent of such members of the uniformed services as are entitled to medical or dental care by those services. *Indirect acceptance* shall be interpreted to include those fees collected by an emergency room or walk-in clinic staffed by a military medical officer. Entitled members must be screened and identified as such by the facility and their charges reduced to reflect that portion of the charges which are accounted for by the military medical officer's services. Nor may such a fee be accepted directly or indirectly for the care of Department of Veterans Affairs beneficiaries.

(i) The Assistant Secretary of Defense (Health Affairs) has decreed that it will be presumed that a conflict of interest exists and, hence, CHAMPUS payments will be disallowed in any claim of a CHAMPUS provider who employs an active duty military member or civilian employee. The only two exceptions are:

(1) Indirect payments to private organizations to which physicians of the National Health Service Corps (NHSC) are assigned (but direct payments to the NHSC physician would still be prohibited).

(2) Payments to a hospital employing Government medical personnel in an emergency room provided the medical care was not furnished directly by the Government personnel.

(j) Subsidiary obligations arising out of off-duty employment, such as appearances in court or testimony before a compensation board, which take place during normal working hours, shall be accomplished only while on annual leave.

(k) These guidelines do not apply to the provision of emergency medical assistance in isolated instances. Also excluded are nonremunerative community services operated by nonprofit organizations for the benefit of all the community and deprived persons, such as a drug abuse program, program volunteer, venereal disease centers, and family planning centers.

(l) Medical Department officers are expected to be aware of and comply with all other statutes and regulations pertaining to off-duty employment. Where doubt exists as to whether all applicable constraints have been considered, consultation should be effected with the local naval legal service office.

(3) The local command has primary responsibility for control of off-duty employment by Medical Department officers. Guidelines above serve as a basis for carrying out this responsibility.

(4) Medical Department officers requesting permission to engage in off-duty employment shall submit their request to the commanding officer on NAVMED 1610/1, Off-duty Remunerative Professional Civilian Employment Request, and shall sign the *Statement of Affirmation* thereon in the commanding officer's presence or designee. Approval or disapproval by the commanding officer shall be indicated in the appropriate section of NAVMED 1610/1. Medical Department officers shall advise their off-duty employers that as military members they are required to respond immediately to calls for military duty that may arise during scheduled off-duty employment. The commanding officer's approval of an officer's request for off-duty employment may not be granted without written certification from the off-duty employer that he or she accepts the availability limitations placed on the Medical Department officer.

(5) The requester shall inform the commanding officer in writing of any deviation in the stated request prior to the inception of any such changes.

(6) Permission shall be withdrawn at any time by the commanding officer when such employment is determined to be inconsistent with the above guidelines. Where permission is withdrawn the officer affected shall be afforded an opportunity to submit to the commanding officer a written statement containing the Medical Department officer's views or any information pertinent to the discontinuance of the employment.

(7) Reports are not required to be submitted to BUMED by field activities. However, during Medical and Dental Inspectors General visits or other administrative onsite visits, local command compliance with this article will be reviewed. In addition, adequate records should be maintained to pro-

vide summarized information as may be necessary for monitoring and evaluating the functioning of this program by BUMED or higher authority.

1-23

Witness in Court (Regulatory)

(1) Appearance in Litigation Matters Not Related to the Department of the Navy.

(a) A Medical Department officer who appears in court as an expert witness in litigation not related to the Department of the Navy must take leave, appear out of uniform, and establish the character of the officer's appearance and testimony as being other than on behalf of the Navy.

(b) A Medical Department officer appearing as a witness for a party in litigation not related to the Department of the Navy should request an advisory opinion from an agency ethics official as to the propriety of accepting any fee tendered for such appearance. An honorarium prohibition on receipt of compensation for an appearance, speech, or article is implemented in the Code of Federal Regulations, Title 5, Sections 2636.201 through 2636.205. Section 501(b) of the Ethics Reform Act of 1989 which instituted the honorarium ban, is presently being challenged in the courts as unconstitutional. Until such litigation is final, the ban remains in effect.

(2) Appearance in Litigation Matters Related to Department of the Navy.

(a) Official information is:

(1) All information of any kind, however stored, in the custody and control of the DoD or its components, including DON.

(2) All information relating to information in the custody and control of DoD and its component.

(3) All information acquired by DoD personnel or DoD component personnel as part of their official duties, or because of their official status within DoD or its components, while such personnel were employed by or on behalf of DoD or on active duty with the U.S. Armed Forces.

(b) If a litigation request or demand is made of DON personnel for official DON or DoD information or testimony concerning such information, the individual to whom the request or demand is made will immediately notify the cognizant DON official who will determine the availability and respond to the request or demand.

(c) Medical Department officers shall not provide such official information, testimony, or documents, submit to interview or permit a view or visit without the authorization required by SECNAVINST 5820.8 series.

(d) Medical Department officers shall not provide, with or without compensation, opinion or expert testimony concerning official DoD information, except on behalf of the United States or a party represented by the Department of Justice or with the written special authorization. Any request for the testimony of Medical Department officers shall be forwarded to the officer exercising general court martial jurisdiction for a determination per SECNAVINST 5820.8 series.

(e) In instances where the interest of the Government is not involved, a Medical Department officer who appears involuntarily as the physician or dentist having firsthand knowledge of a person eligible for care in a naval medical or dental facility may accept any fee established by rule or statute and one who appears as an expert may accept any negotiated higher expert witness fee commensurate with professional local custom. However, such fee, beyond any actual expenses, shall be delivered to the disbursing officer of the command for deposit to the Miscellaneous Receipt Account 173099, recoveries and refunds, not otherwise classified.

(f) Where a Medical Department officer appears as a witness on behalf of the Government under temporary additional duty orders, the officer is compensated following Navy travel instructions, par. 6200 in conjunction with chapter 4, part B; see also NAVCOMPT Manual, par. 042781. The officer will not otherwise request or accept a witness fee. The foregoing applies in such instances as where a Government third party claim is attached to an independent suit filed by a member or other person eligible for care in a naval medical facility, the Government is a co-claimant at suit, or the Government is being sued under the Federal Tort Claims Act and the Medical Department officer is appearing as having firsthand knowledge of the facts or as expert witness.

be endorsed by the commanding officer.

(2) **Witness in Court.** See article 1-23.

(3) **Ambulances.** Navy ambulances and Navy ambulance drivers are susceptible to efforts or requests by local police officers or other persons for aid in cases of accidents or emergencies. Operators of ambulances, either members of the hospital corps or civil employees, should be thoroughly indoctrinated:

(a) To adhere strictly to orders for picking up and transporting the patient for whom dispatched.

(b) To remain with vehicle and never to stop or to leave ambulance out of curiosity when halted by traffic condition at the scene of an accident when the driver by reason of orders to pick up and carry a Navy patient is not in a position to offer a patient care or ambulance service.

(c) To recognize that the Medical Department is expected as a matter of policy to cooperate with local authorities in emergencies when this cooperation will not interfere with a Medical Department operation, and that operators of Navy ambulances which are not carrying patients or proceeding under orders to pick up patients are expected to offer, in humanitarian emergency situations, such assistance as they are qualified to render.

(d) In any instance in which an ambulance carrying a patient or proceeding under orders to pick up a patient is stopped or otherwise subjected to interference by State or other local authorities for any reason whatever, including aid to an emergency humanitarian patient: to give courteous information about current orders; to courteously request that compliance with these orders not be subjected to interference; and to report to the commanding officer, for transmittal by the commanding officer to the Judge Advocate General of the Navy, and measures applied by State or local authorities which prevent direct compliance with orders.

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Civil Actions

(1) **Report.** Any Medical Department officer served with Federal or State court civil or criminal process or pleading arising from actions performed in the course of official duties shall immediately inform his or her commanding officer. The commanding officer shall make a prompt report to the Judge Advocate General per the Manual of the Judge Advocate General. The officer may request representation by a Department of Justice attorney. Requests for representation shall be addressed to the Judge Advocate General and shall

1-25

Restrictions Relative to Prospective Applicants (Regulatory)

(1) Officers of the medical or dental corps on active duty shall not undertake to operate upon or treat prospective applicants for the Navy or Marine Corps, Regular or Reserve, with a view to correcting defects, disqualifications, and disabilities barring them from enlistment or appointment.