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REPORT BY THE  
**Comptroller General**  
OF THE UNITED STATES

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## Military Hospitals Need Stronger Guidance On Presidential, VIP, And Officer Accommodations

The Department of Defense has not carried out GAO's December 1974 recommendations that the Secretary of Defense establish criteria for Presidential and other VIP accommodations in military hospitals and instruct the military departments to discontinue separating officer and enlisted patients. As a result;

- A new Presidential suite was constructed in the Washington, D.C., area although existing facilities were adequate.
- A Presidential suite was being maintained in California without Defense headquarters or White House knowledge.
- The definition of and accommodations provided to VIPs continue to vary widely.
- Some Navy hospitals, including those identified in GAO's 1974 report, continue to separate officer and enlisted patients.

GAO renewed and strengthened its 1974 recommendations in this report.



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HRD-79-61  
APRIL 17, 1979





COMPTROLLER GENERAL OF THE UNITED STATES

WASHINGTON, D.C. 20548

B-161475

The Honorable William Proxmire  
Chairman, Subcommittee on Priorities and  
Economy in Government  
Joint Economic Committee  
Congress of the United States

Dear Mr. Chairman:

In response to your May 11, 1978, request, we have made a followup study to determine the progress made by the Department of Defense in implementing the recommendations in our December 24, 1974, report (B-161475) on Presidential and other VIP accommodations in military hospitals and on separation of officer and enlisted patients.

As instructed, we did not obtain written comments on the report. However, we did discuss its contents with appropriate officials from the Department of Defense and the military services, and we have considered their views in preparing the report.

As arranged with your office, we are sending copies of this report to the Secretary of Defense and other interested parties.

Sincerely yours,

A handwritten signature in cursive script, appearing to read "James B. Stotts".

Comptroller General  
of the United States



D I G E S T

Because the Defense Department has not provided strong guidance on establishing Presidential, VIP, and officer accommodations in military hospitals

- a new Presidential suite was constructed at Walter Reed Army Medical Center although adequate facilities were available at the National Naval Medical Center, Bethesda, Maryland;
- a 1,064-square-foot Presidential suite in Camp Pendleton was being maintained and reserved solely for the President even though it has not been needed;
- the definition of and accommodations provided to VIPs continue to vary widely; and
- officer and enlisted patients are still being separated at some Navy hospitals.

GAO recommended in December 1974 that Defense establish criteria regarding the number, size, and furnishings of Presidential suites; require the services to obtain Defense approval of the establishment of future suites; and assess the adequacy of the Bethesda suite to provide medical care to the President and convert either the Bethesda suite or the suite in the planned Walter Reed replacement hospital to other uses. Defense agreed with GAO's recommendations and planned to make the suite at the new Walter Reed hospital the only Presidential suite.

The new Walter Reed hospital opened in December 1978. However, Defense did not establish criteria for Presidential suites and, in May 1978, reversed itself and declared that the Bethesda suite was adequate to provide care to the President and

would remain as the Presidential suite. It said that the Presidential suite in the old Walter Reed hospital was used for other VIP patients and that the suite in the new hospital would be similarly used.

The Bethesda suite, established in 1965 with modification costs of about \$215,000, has not been altered since 1974 and apparently was adequate to provide medical care to the President when Defense notified GAO in 1975 that it would continue construction of a new Presidential suite at Walter Reed. The Bethesda suite contains 10 rooms totaling about 6,500 square feet--almost four times as much room as the average single family home built in the United States during 1977.

Although it was planned and constructed as a Presidential suite, Defense plans to use the 2,800-square-foot suite in the new Walter Reed hospital for other VIPs. Because the new hospital contains a separate 7,200-square-foot VIP facility, GAO questions the need for this additional suite.

A 1,064-square-foot Presidential suite in the new Naval Regional Medical Center at Camp Pendleton, which a Navy representative said in August 1974 would be converted to other patient rooms, is still maintained as a Presidential suite. The suite in the old Camp Pendleton hospital was used for other VIPs when not needed for Presidential use, but the suite in the new hospital, which opened in late 1974, is reserved solely for Presidential use. It has never been used.

The Director, White House Military Office, advised GAO in November 1978 that the Carter administration "was not aware of the continuing existence of this facility" and "does not deem it necessary for there to be a Presidential suite in the State of California."

Navy headquarters officials told GAO that they do not consider Camp Pendleton a Presidential suite because it is not maintained in a state of readiness for Presidential occupancy. They said that, because of the

hospital's low occupancy rate, the suite had not been needed for other patients and was not converted to other patient uses.

Although the Bethesda Presidential suite was occupied only six times for a total of 7 days between January 1977 and October 1978, Defense has not used the suite for other medical or nonmedical purposes. The Director, White House Military Office, advised GAO that "\* \* \* the Commanding Officer is authorized to make the suite available for other patients when not otherwise occupied," but said that security may be a significant factor in determining other acceptable uses.

The Secretary of Defense should:

- Establish criteria for Presidential suites.
- Require the services to obtain Defense and White House approval of the establishment or remodeling of suites.
- Discontinue the Camp Pendleton suite.
- Convert the Presidential suite in the new Walter Reed hospital to other patient uses in lieu of using it as a VIP suite.
- Determine acceptable uses for the Bethesda suite when it is not needed for Presidential use.

In response to GAO's 1974 recommendations concerning VIP accommodations other than Presidential suites, Defense established space-planning criteria governing the size of those accommodations and describing circumstances justifying their establishment. The criteria do not, however, provide hospital commanders guidance in determining

- who is entitled to VIP treatment,
- how many VIP rooms to establish,
- how to furnish the VIP rooms, or
- what staffing to provide.

As a result, the military hospitals' definitions of VIPs and the accommodations and staffing provided continue to vary widely. At the 42 hospitals GAO identified as having specific accommodations designated for VIP use:

- The definition of a military VIP ranged from a minimum of a chief master sergeant to a minimum of a general.
- The number of rooms ranged from 1 to 11.
- The size of the accommodations ranged from a private room of about 120 square feet to suites of over 500 square feet.
- Furnishings provided in the VIP rooms ranged from the same as other rooms in the hospital to substantial additions, such as sofas, table lamps, chandeliers, refrigerators, and carpeting.

At the old Walter Reed Army Medical Center, a separate kitchen was maintained to prepare meals for VIP patients. Four cooks were assigned to the VIP kitchen; they prepared meals for an average of fewer than five patients per day in the VIP area. A kitchen is also included in the VIP area of the new Walter Reed hospital, but hospital officials were not sure whether it will be used.

The Defense Department's space planning criteria state that VIP accommodations are needed to permit VIPs to continue functioning in an official capacity while hospitalized. However, accommodations including such items as chandeliers, refrigerators, and kitchens are not needed to enable a VIP to carry out his/her normal functions. Defense should establish more specific criteria for establishing and furnishing VIP accommodations and should direct the Department of the Army to discontinue maintaining a separate VIP kitchen at Walter Reed.

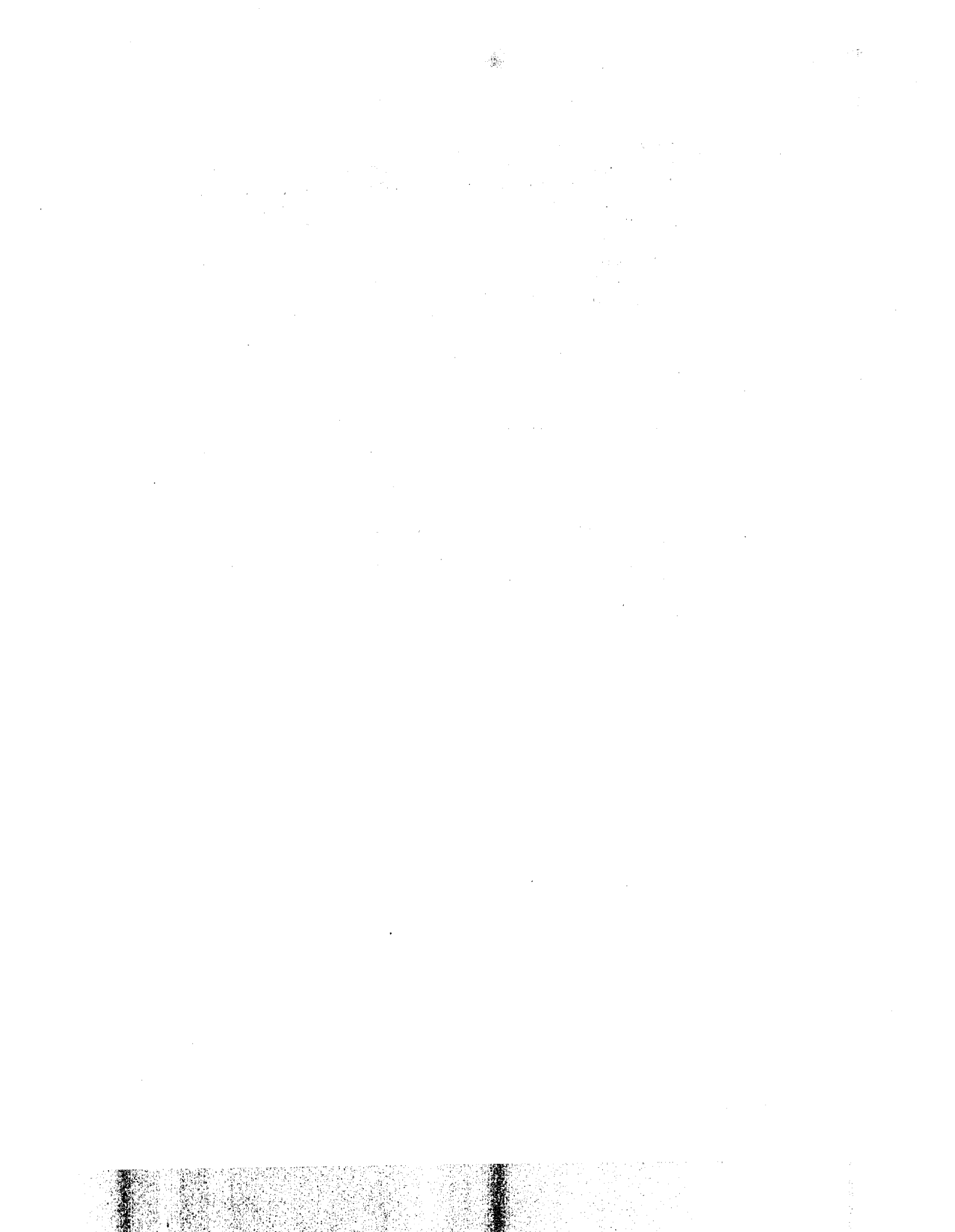
In 1974, GAO reported that the Navy's practice of separating officer and enlisted patients generally resulted in more space, more



expensive furnishings, and a higher ratio of nursing staff provided to officers. Although Defense, in response to GAO's 1974 recommendation, directed the Navy to discontinue separating officer and enlisted patients, the Navy did not advise its hospital commanders of this directive. As a result, this practice continues at some Navy hospitals, including those GAO identified in its 1974 report. According to Navy officials, separation of officer and enlisted patients occurs primarily at older hospitals having open-bay wards.

Defense should again direct the Navy to discontinue separating officer and enlisted patients and follow up to insure that hospital accommodations are assigned primarily on the basis of medical care requirements.

As instructed by the Joint Economic Committee's Subcommittee on Priorities and Economy in Government, GAO did not obtain written comments from Defense. However, GAO considered the views of officials of Defense and the services in preparing this report.



## C o n t e n t s

	<u>Page</u>
DIGEST	i
CHAPTER	
1 INTRODUCTION	1
Scope of review	2
2 CRITERIA STILL NEEDED FOR ESTABLISHING AND FURNISHING PRESIDENTIAL SUITES	3
Summary of 1974 report findings	3
Recommendations not implemented	5
Possible use of the Bethesda suite for other purposes	10
Conclusions	11
Recommendations	11
3 MORE SPECIFIC CRITERIA NEEDED FOR ESTABLISH- ING AND FURNISHING VIP ACCOMMODATIONS	13
Actions taken in response to our 1974 report	13
VIP space planning criteria are in- adequate	14
Conclusions	18
Recommendations	18
4 STRONGER DOD ACTION NEEDED TO END SEPARATION OF OFFICER AND ENLISTED PATIENTS	20
Conclusions	23
Recommendation	24
APPENDIX	
I Military hospitals visited by GAO	25

### ABBREVIATIONS

DOD	Department of Defense
GAO	General Accounting Office
VIP	very important person



## CHAPTER 1

### INTRODUCTION

In a December 24, 1974, report 1/ to the Chairman, Subcommittee on Priorities and Economy in Government, Joint Economic Committee, we recommended that the Department of Defense (DOD) establish criteria for establishing and furnishing Presidential and other very important person (VIP) accommodations in military hospitals, and instruct the military departments to prohibit the separation of officer and enlisted personnel in their existing and future hospitals. By letter dated May 11, 1978, the Chairman requested a followup study to determine DOD's progress in implementing our 1974 recommendations.

DOD space planning criteria issued in July 1973 require general care nursing units (specifically medical, surgical, psychiatric, and pediatric units) in new hospitals to be 25 percent one-bed, 50 percent two-bed, and 25 percent four-bed rooms, containing 150, 220, and 440 net square feet, respectively. DOD officials told us that rooms with two to four beds are considered semiprivate rooms. However, hospitals planned or constructed before the present criteria were established may contain open bays with more than four beds.

Persons eligible to receive medical care at little or no charge in military health facilities include the President and his family, active duty and retired members of the military and their dependents, and dependents of deceased members. According to a DOD official, retired enlisted patients receive free care, and other patients pay charges of up to \$242 per day. The charges cited by the official are summarized on the following page.

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1/"Military Hospitals Should Be: (1) Provided Criteria for Presidential and VIP Accommodations (2) Instructed to Discontinue Separating Officer and Enlisted Patients" (B-161475).

<u>Category of patient</u>	<u>Charge (per day)</u>
Active duty and retired military (except retired enlisted)	\$3 to \$4
Retired enlisted	\$0
Military dependent	\$4.65
President (subsistence rate for active duty military)	\$3 to \$4
Dependents of President	\$4.65
Civilian	\$242
Vice President, Cabinet members, Congressmen	\$242

The charges cover all medical services provided, including room, surgery, and doctors' fees. The \$242 fee charged to civilians and VIPs not eligible for military health benefits is based on the average cost per patient day for all military hospitals worldwide. The above rates do not vary according to the accommodations provided.

As of November 1978, the military departments operated 134 hospitals in the United States and Puerto Rico and 39 hospitals overseas.

#### SCOPE OF REVIEW

We interviewed various DOD and military department personnel about (1) the policies and practices for establishing and furnishing Presidential suites, other VIP accommodations, and separate officer and enlisted personnel accommodations and (2) the progress made in implementing our 1974 recommendations.

We determined the extent to which accommodations existed in military hospitals by asking DOD to obtain information from each military hospital on (1) the number and size of VIP rooms, (2) the definition of a VIP, (3) the extra furnishings provided in VIP rooms, (4) how these rooms are used when not needed by a VIP, and (5) how assignments are made to private and semiprivate rooms. We visited 14 military hospitals-- 9 with VIP accommodations and 5 without. (See app. I.)

We discussed the establishment, furnishing, and use of the Presidential suites with representatives of the White House, DOD, the military departments, and the individual hospitals. We visited each of the three hospitals reporting a Presidential suite. (See app. I.)

## CHAPTER 2

### CRITERIA STILL NEEDED FOR ESTABLISHING AND FURNISHING PRESIDENTIAL SUITES

Although DOD agreed with our 1974 report recommendations concerning Presidential suites, it has not established criteria regarding the number, size, and furnishing of such suites. Furthermore, DOD determined that the Presidential suite at the National Naval Medical Center, Bethesda, Maryland, was adequate to provide medical care to the President, but it did not alter plans to construct a Presidential suite in the replacement hospital at Walter Reed Army Medical Center, which opened in December 1978. Walter Reed will, however, use the Presidential suite in the replacement hospital for other VIP patients, as it did the suite in the former hospital. According to the White House, the suite at the National Naval Medical Center could also be used for other patients at the commanding officer's discretion when not needed for Presidential use.

In addition, a Presidential suite at the Naval Regional Medical Center, Camp Pendleton, California, which a Navy official told us in 1974 would be converted to other use, is still maintained as a Presidential suite. It has never been used. Neither DOD headquarters nor the White House were aware of the continued existence of the suite when our review began.

#### SUMMARY OF 1974 REPORT FINDINGS

The first Presidential suite was established for President Truman at the Walter Reed Army Medical Center, Washington, D.C., in 1948. Since then, five others have been established in military hospitals under three Presidents:

<u>Hospital and location</u>	<u>Date established</u>	<u>President</u>
Fitzsimons General Hospital, Denver, Colo.	1955	Eisenhower
U.S. Army Medical Center, Fort Gordon, Ga.	1955	Eisenhower
Brooke Army Medical Center, Fort Sam Houston, San Antonio, Tex.	1958	Eisenhower
National Naval Medical Center, Bethesda, Md.	1965	Johnson
Naval Regional Medical Center, Camp Pendleton, Oceanside, Calif.	1969	Nixon

Two of the suites--at Fitzsimons and Fort Gordon--were discontinued before our 1974 review. A third--at Brooke--was discontinued during our review, and a Navy official told us that a fourth--at Camp Pendleton--would be converted to other use.

The two Presidential suites in the Washington, D.C., area--at the National Naval Medical Center and Walter Reed--were still active at the time of our 1974 report. Both were reserved solely for Presidential use at that time. A 2,800-square-foot Presidential suite was planned in the replacement hospital being built at Walter Reed.

We reported in December 1974 that DOD

--did not know, with the exception of Camp Pendleton, whether the suites were requested by the White House or whether the military departments established them in anticipation of Presidential visits and

--had no criteria for establishing or furnishing Presidential suites.

As a result, the size and cost of establishing the six suites varied greatly.

Construction or modification costs to establish Presidential suites ranged from \$500 at Fitzsimons to \$215,000 at Bethesda. Costs of furnishings ranged from about \$1,800 at Fort Gordon to about \$25,000 at Camp Pendleton. Size of the suites ranged from 600 square feet at Fort Gordon to 6,543 square feet at Bethesda.

We recommended that the Secretary of Defense:

--Establish criteria regarding the number, size, and furnishings of Presidential suites and require DOD approval of the establishment of future suites.

--Assess the adequacy of the Bethesda Presidential suite to provide medical care to the President and convert to other uses either the Bethesda suite or the planned Walter Reed suite, as appropriate.

By letter dated April 11, 1975, the Principal Deputy Assistant Secretary of Defense told us that the Department concurred in our recommendations. He said that DOD planned to make the suite at the new Walter Reed hospital the only Presidential suite for health care.



## RECOMMENDATIONS NOT IMPLEMENTED

Although DOD agreed with our recommendations, it has not implemented them. Specifically, it

- did not establish criteria concerning Presidential suites,
- constructed a Presidential suite in the replacement hospital at Walter Reed although the suite at Bethesda was found to be adequate, and
- maintained a Presidential suite at Camp Pendleton which it determined in 1974 was not needed.

## Criteria not established

DOD has not developed criteria concerning the number, size, or furnishing of Presidential suites but, according to a Department official, does require approval of the establishment of any future Presidential suites. The official told us that approval of new suites is based on a design review of the hospital by a DOD Hospital Planning Review Committee composed of representatives of the three military services. Technical procedures and criteria for planning and acquiring military health and medical facilities, including procedures for design reviews, are contained in DOD Instruction 6015.17. The instruction does not, however, specifically refer to or give criteria for Presidential suites. As a result, the Hospital Planning Review Committee has no basis on which to evaluate a proposed Presidential suite.

According to the Director, White House Military Office, a need exists for a Presidential suite where prompt, comprehensive medical care is readily available. He said that such a suite must comply with the rigid security measures necessary for Presidential protection and be adequate to function as an office so that the business of the Presidency can continue without unnecessary disruption to the other hospital functions. The Director said that the Carter administration has not provided, nor has DOD requested, guidance regarding Presidential suites or their utilization, size, or furnishings. He added, however, that hospitalizations of previous Presidents have indicated that a facility the size of the Bethesda suite is necessary to properly function as a White House office while the President is in the hospital.

Planned Walter Reed Presidential  
suite not converted to other use

Although both DOD and the White House consider the suite at Bethesda adequate to provide medical care to the President, the Department did not convert the planned Presidential suite in the replacement hospital at Walter Reed to other uses. Rather, DOD finished constructing the 2,800-square-foot suite before announcing that it would be used for other VIP patients.

By letter dated April 11, 1975, the Principal Deputy Assistant Secretary of Defense advised us that DOD concurred in our recommendation that the Department assess the adequacy of the Bethesda suite and convert either it or the planned suite in the Walter Reed replacement hospital to other uses. He advised us that DOD planned to make the suite in the new Walter Reed hospital the only Presidential suite for health care.

However, in May 1978, as the Presidential suite at the replacement hospital at Walter Reed neared completion, DOD reversed itself, declaring that the Bethesda suite was adequate to provide medical care to the President and would remain as the Presidential suite. DOD said that the Presidential suite in the existing Walter Reed hospital was used for other VIP patients. According to a Walter Reed hospital official, the Presidential suite in the replacement hospital will be used for the same purpose.

In a November 14, 1978, memorandum to Assistant Secretaries of the Army and Navy, the Principal Deputy Assistant Secretary of Defense officially designated Bethesda the Presidential suite and directed that, pending further instruction, the Walter Reed Presidential suite be converted to VIP usage.

The Bethesda suite, established in 1965 with modification costs of \$215,000, has not been altered since our 1974 report and apparently had been adequate to provide medical care for the President when DOD notified us in April 1975 that it would continue construction of a new Presidential suite at Walter Reed. The Bethesda suite contains 10 rooms totaling about 6,500 square feet--almost four times as much room as the average single family home built in the United States during 1977.

The suite, which occupies one floor of the hospital, consists of the President's bedroom and sitting room, the

First Lady's bedroom, a guest bedroom, a Secret Service bedroom, a nurses' office, a doctors' office, an examining room, a dining room, and a kitchen. The furnishings include both items purchased with appropriated funds (\$7,914) and items on loan from the White House curator, which were either purchased with nonappropriated funds or donated. No additional furnishings have been purchased since 1974.

The Director, White House Military Office, advised us by letter dated November 1, 1978, that President Carter has elected to receive his medical care at Bethesda, but has not made any recommendations about use of any other VIP suites or facilities, which would include Walter Reed.

Although DOD plans to use the Presidential suite at the new Walter Reed hospital for other VIPs, it was planned and constructed as a Presidential suite. The new hospital contains a 10,000-square-foot executive medical area divided into two contiguous sections, which can be opened into one nursing unit or maintained separately. One section contains a 2,800-square-foot Presidential suite consisting of two bedrooms with baths, a sitting room/veranda, a dining/conference room, and six additional support rooms including a kitchen. A special electronic access and security system was installed to satisfy Secret Service requirements. Hospital officials said that other security equipment has also been installed, but declined to identify it for security reasons. The other section of the executive medical area consists of 5 VIP bedroom/sitting room combinations and 15 common support rooms covering about 7,200 square feet.

At the time of our visit, the Presidential suite had not been furnished except for carpeting, electric blinds, and curtain rods. Hospital officials said that most of the furnishings in the old Walter Reed Presidential suite would be moved to the new suite.

The 1,367-square-foot Presidential suite in the former hospital was being used for other VIPs at the time of our visit. On the day of our visit, the President's bedroom was occupied by a general's wife. However, the sitting room was not in use, and the furniture was covered. A hospital official said that the sitting room would be used if the patient's condition permitted. From January 1977 through June 1978 the Presidential suite was occupied by five Members of Congress, three active duty generals, two retired generals, one dependent of a general, and one foreign dignitary. According to Walter Reed hospital officials, the Presidential and VIP accommodations in the old hospital will be converted to administrative uses.

Presidential suite still maintained  
at Camp Pendleton

A 1,064-square-foot suite in the new Naval Regional Medical Center, Camp Pendleton, California, which a Navy representative advised us in August 1974 would be converted to other patient rooms, is still maintained as a Presidential suite. Neither DOD headquarters nor the the White House was aware of the continued existence of the Camp Pendleton suite when our review began. Although the Presidential suite in the old Camp Pendleton hospital was used for other VIPs when not needed for Presidential use, the suite in the new hospital is reserved solely for Presidential use.

The suite was originally established in August 1969, after the White House staff designated Camp Pendleton to provide any necessary medical care to President Nixon when he visited San Clemente. The original suite consisted of 10 rooms totaling 3,150 square feet. To establish the suite \$41,832 was spent--\$16,981 for modifications and \$24,851 for furnishings.

At the time of our 1974 review, a replacement hospital, including a 1,900-square-foot Presidential suite, was nearing completion at Camp Pendleton. In January 1974, hospital officials said that, if a Presidential suite was no longer needed at the new hospital, most of the space 1/ could readily be converted to patient rooms. A Navy representative advised us in August 1974 that the Presidential suite would be converted to other patient rooms.

However, when the replacement hospital opened in late 1974, it included a 1,064-square-foot Presidential suite consisting of the President's bedroom, a meeting room, a Secret Service bedroom, and a kitchen. According to a hospital official, the furnishings in the suite were transferred from the Presidential suite in the old hospital. The official said that no new items were purchased except for the kitchen equipment.

During a tour of the suite in September 1978, we noted three color televisions not present in the former Presidential suite. However, a color television is a standard furnishing in all patient rooms in the replacement hospital.

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1/One private room which had been converted into a kitchen during construction of the hospital in 1973 (at a cost of \$8,500 for modifications and equipment) could not readily be reconverted.

When we began our current review, neither DOD nor the Navy identified the Camp Pendleton suite as a Presidential suite. The Deputy Director, Facilities and Materiel, Office of the Assistant Secretary of Defense for Health Affairs, told us that the Navy advised him that it had one Presidential suite--at Bethesda. An official from the Navy's Bureau of Medicine and Surgery also told us that the only suite maintained for Presidential use was at Bethesda.

In July 1978 we asked DOD to obtain certain data concerning Presidential and VIP accommodations from each military hospital. In a September 7, 1978, memorandum to the Assistant Secretary of Defense for Health Affairs, the Navy's Surgeon General described the Camp Pendleton suite, but indicated that it was not specifically reserved for VIP use. He did not identify it as a Presidential suite.

It was not until September 22, 1978--after our request for more detailed information--that the Surgeon General told the Assistant Secretary of Defense that Camp Pendleton was maintaining a Presidential suite. At that time he advised the Assistant Secretary that

"The facilities \* \* \* were designed and constructed in support of the establishment of the Western White House. This Presidential suite has never been used and there are no plans to use it unless so directed."

Navy headquarters officials told us that they had been aware of the continued existence of the Camp Pendleton suite when our review began, but did not identify it as a Presidential suite because it was not being maintained in a state of readiness for Presidential occupancy.

Use of the Camp Pendleton Presidential suite is more restrictive now than at the time of our 1974 review. According to a hospital official, the suite is reserved solely for the President's use and has never been used. By contrast, the suite in the old hospital was used for medical purposes for returning prisoners of war, senior officers of grades O-6 and above, the Commandant of the Marine Corps, and other VIPs. In addition, it was used for nonmedical purposes as quarters for visiting senior officers and a visiting Government official.

Because of the hospital's low occupancy rate, reserving the suite for Presidential use did not result in patients being denied inpatient care. This 600-bed hospital currently operates 185 to 190 beds. The eighth floor, which includes

the Presidential suite, is not currently occupied by patients. The rooms, except for the suite, are used for training military medical personnel. Like the Presidential suite, they are ready for patient use if needed. Navy headquarters officials told us that, because of the hospital's low occupancy rate, there are no plans to convert the suite to other use.

The Director, White House Military Office, advised us that the Carter administration "was not aware of the continuing existence of this facility" and "does not deem it necessary for there to be a Presidential suite in the State of California."

POSSIBLE USE OF THE BETHESDA SUITE FOR OTHER PURPOSES

Although the Bethesda suite is seldom needed for Presidential use, DOD has not used it for other medical or non-medical purposes. Between January 1977 and October 1978, the Bethesda suite was occupied six times for a total of 7 days.

<u>Dates</u>	<u>Number of days</u>	<u>Individual using suite</u>
1/ 8/77	1	President Ford
4/14-15/77	2	Mrs. Carter
4/28/77	1	Mrs. Carter
1/28/78	1	President Carter
2/ 1/78	1	Vice President Mondale
5/28/78	1	Former President Ford

As mentioned on the previous page, the suite in the old Camp Pendleton hospital was used for other medical and non-medical purposes when not needed for Presidential use. Similarly, the Presidential suite at the old Walter Reed hospital has been used for other VIP patients.

According to the Director, White House Military Office, whether the Bethesda Presidential suite should remain vacant when not needed for Presidential use is up to the hospital commander. In a November 1, 1978, letter, the Director advised us that "\* \* \* The Commanding Officer is authorized to make the suite available for other patients when not otherwise occupied." He stated, however, that security measures which may have been requested by the Secret Service may be a significant factor in determining the use of the suite by others. He said that DOD has not requested that the Carter administration make any decisions regarding use of the suite.

The Director, White House Military Office, advised us that the President has never directed that the Presidential suite be used for a patient other than the President or Vice President or their dependents. He said that the suite could conceivably be used for visiting heads-of-state or other high-level officials who might develop medical problems while visiting our country.

### CONCLUSIONS

DOD has not implemented our 1974 report recommendations concerning Presidential suites. Criteria regarding the number, size, and furnishing of Presidential suites and regulations requiring DOD approval of future suites were not established. Nor has the Department sought or obtained guidance from the White House concerning Presidential suites. As a result, at the time of our review, a Presidential suite was being maintained at the new Camp Pendleton hospital apparently without the knowledge of either DOD or the White House. The Department needs to promptly establish criteria for Presidential suites and establish regulations requiring DOD and White House approval before suites are established or remodeled. In addition, since the Camp Pendleton suite is not needed, it should be discontinued and its furnishings used elsewhere in the hospital.

DOD determined that the Bethesda Presidential suite is adequate to provide medical care to the President, yet built a new Presidential suite at the Walter Reed replacement hospital. Although DOD plans to use the new Walter Reed suite for other VIPs, we question whether a 2,800-square-foot suite is needed for VIP patients. Also, separate and apparently adequate facilities for the care of VIPs other than the President are provided in the new hospital. (See p. 7.) The suite should be permanently converted to other patient use. In addition, DOD should work with the Secret Service in determining acceptable uses for the Bethesda suite when it is not needed for Presidential use.

### RECOMMENDATIONS

We recommend that the Secretary of Defense:

- Establish criteria regarding the number, size, and furnishing of Presidential suites.
- Establish regulations requiring DOD and White House approval of the establishment or remodeling of Presidential suites.

- Discontinue the Camp Pendleton suite and use the furnishings for other purposes.
- Convert the Presidential suite in the new Walter Reed hospital to other patient uses in lieu of using it as a VIP suite.
- Work with the Secret Service and White House in determining acceptable uses for the Bethesda suite when it is not needed for Presidential use.



### CHAPTER 3

#### MORE SPECIFIC CRITERIA NEEDED FOR

#### ESTABLISHING AND FURNISHING

#### VIP ACCOMMODATIONS

DOD space planning criteria established in response to our 1974 recommendations govern the size of VIP accommodations other than Presidential suites and describe the circumstances justifying their establishment, but they do not provide hospital commanders guidance in determining

- who is entitled to VIP treatment,
- how many VIP rooms to establish,
- how to furnish the VIP rooms, or
- what staffing to provide.

As a result, the definition of, and accommodations provided to, VIPs at military hospitals continue to vary widely.

#### ACTIONS TAKEN IN RESPONSE TO OUR 1974 REPORT

In surveying 210 military hospitals in 1973, we found 46 having VIP beds and 10 others having beds that, although not specifically designated as VIP beds, could be used as such. The 56 hospitals varied widely in their definitions of a VIP and in the number, size, and furnishing of rooms maintained for VIPs.

We recommended in December 1974 that the Secretary of Defense determine whether there was a need for other VIP accommodations in military hospitals and, if there was such a need, develop criteria for establishing and furnishing them, including

- the definition of a VIP,
- the circumstances justifying VIP accommodations,
- the size and number of rooms to establish,
- the furnishings to provide, and

--the staffing requirements.

In his April 11, 1975, letter the Principal Deputy Assistant Secretary of Defense advised us that DOD agreed with our recommendations concerning VIP accommodations. According to him, DOD believes VIP accommodations are necessary under special circumstances to support officials who require isolation from the public or whose position would invoke sufficient concern on the part of the public to require either press or special coverage by other agencies. In addition, he indicated that such facilities should be used by special patients who are not in a severe or acute phase of their illness and thus may be involved in carrying out the responsibilities of their official positions while in the hospital. He said that a definition of that type of patient was being developed and that the matter of formulating specific criteria for VIP accommodations had been referred to DOD's standing committee on medical space criteria.

In September 1976 the DOD Medical Facilities Criteria Committee developed "Space Planning Criteria" for VIP suites as part of DOD Instruction 6015.17. The VIP criteria provide that:

"VIP Suites will normally be provided in all regional and teaching hospitals to support those officials who are required to continue functioning in an official capacity or for whom concern by the general public would require press or special coverage.

"No additional space will be programmed, but where provided will be from within the allowable space to include that necessary to accommodate communications and security requirements. Existing single rooms as provided for isolation purposes will under normal circumstances provide the space required to accommodate the VIP facilities."

No additional criteria or implementing regulations have been established by the military departments.

VIP SPACE PLANNING CRITERIA  
ARE INADEQUATE

Because the space planning criteria do not specifically define a VIP, give the Hospital Planning Review Committee guidance in determining how many VIP rooms a hospital needs,

or give hospital commanders guidance in furnishing and staffing VIP areas, military hospitals' definitions of VIPs and the accommodations and staffing provided continue to vary widely.

DOD's Deputy Director, Facilities and Materiel, told us that no new VIP suites have been approved for construction since the early 1970s. DOD did not know which hospitals currently maintain VIP accommodations.

In July 1978 we requested that the commander of each military hospital provide information on

- the definition of a VIP,
- the number and size of rooms available for VIP use,
- extra furnishings or special staffing provided in VIP rooms,
- use of the VIP accommodations for non-VIPs, and
- criteria for assigning patients to private and semi-private rooms.

Of the 158 hospitals that responded, 42 had specific accommodations designated for VIP use that either (1) had extra furnishings or (2) were not routinely used for non-VIP patients. Twenty-three others reported that they would place a VIP in a private or semiprivate room routinely used for non-VIP patients. Sixteen of the forty-two hospitals having specific VIP accommodations were not reported as having such facilities in our 1974 report.

Of the 56 hospitals identified in our 1974 report as having VIP facilities,

- 26 reported that they still have such facilities,
- 22 reported that they no longer have such facilities,
- 6 had been closed or downgraded to clinic status, and
- 2 did not respond.

Persons entitled to VIP treatment and accommodations provided varied greatly at the hospitals reporting such facilities. At the 42 hospitals having identifiable VIP accommodations, the:

- Definition of a military VIP ranged from a minimum of a chief master sergeant (E-9) to a minimum of a general.
- Definition of a civilian VIP ranged from a minimum of a GS-13 Federal employee to a minimum of a Cabinet-level official.
- Number of rooms ranged from 1 to 11.
- Size of VIP accommodations ranged from private rooms of about 120 square feet to suites of over 500 square feet.
- Furnishings provided in the VIP rooms ranged from the same as other rooms in the hospital to substantial additions, such as sofas, table lamps, chandeliers, dressers, desks, upholstered chairs, refrigerators, wallpaper, carpeting, and kitchens.
- Priorities for use of the VIP accommodations ranged from routine use of the facilities by all hospital patients when not needed for a VIP to use by non-VIP patients only when no other beds were available.

Furthermore, some hospitals reported that dependents of VIPs and certain foreign officials were afforded VIP treatment.

Most hospitals in all three military departments reported medical need as the primary factor in assigning patient rooms, but about 34 percent reported that rank is also considered in assigning patients to private and semiprivate rooms. Many hospitals without VIP facilities reported that officers at or above the rank of colonel are assigned to private or semi-private rooms if available.

We visited eight hospitals which reported that they had VIP accommodations and six hospitals which reported that they did not. The information reported by those hospitals was generally accurate. However, while visiting the Tripler Army Medical Center, Honolulu, Hawaii, which reported having no VIP accommodations, we found that each of the three wards we visited had one private room intended for VIP use. In each

case the VIP room was also used as the ward's isolation room. These rooms also had private baths, electric beds, color televisions, and wood-finished accessories. Although the VIP rooms had these special furnishings, in our opinion, neither the rooms nor the furnishings were in good condition. According to a hospital official, current plans for renovation of the Tripler hospital do not include establishing VIP facilities.

Because hospital commanders defined VIP differently, a patient could be treated as a VIP at one military hospital yet be placed on an open-bay ward at another. For example, at Walter Reed Army Medical Center only three-star generals or above are eligible for VIP accommodations, whereas at Langley Air Force Base all officers at or above the rank of colonel are treated as VIPs. Because Walter Reed made assignments to private, semiprivate, and open-bay beds on the basis of medical need rather than rank, a two-star general could conceivably have been placed on an open-bay ward at the old Walter Reed hospital while a colonel was receiving VIP treatment at Langley.

The accommodations provided VIPs also varied greatly. The Naval Hospital, Cherry Point, North Carolina, reported that it has a 200-square-foot VIP room containing no special furnishings. By contrast, the U.S. Air Force Medical Center, Scott Air Force Base, Illinois, maintains a two-room, 457-square-foot VIP suite. The suite contains the following furnishings:

Small wooden dresser	Small refrigerator (unstocked)
Ottoman	Wooden table with four chairs
Wooden desk	Two wooden end tables
Wooden ladderback chair	Sofa
Small wooden closet	Plastic plant
Wall-to-wall carpeting	Common battery telephone
Matching draperies and bedspread	Cocktail table

Officials from the three services told us that some of the extra furnishings in VIP rooms may have been donated by former patients or service organizations, but they could not estimate the extent of such donations.

Although most VIP rooms we visited are located on the same ward with other patient rooms and share the same nursing station, the National Naval Medical Center at Bethesda and both the old and new hospitals at Walter Reed had separate nursing stations for their VIP rooms. In addition, the old

Walter Reed hospital maintained a separate kitchen to prepare meals for VIP patients. Hospital officials told us that VIPs selected their meals from the same menu given to other patients, but had their meals prepared in the VIP kitchen. On the average, the VIP kitchen's four full-time cooks prepared meals for fewer than five patients per day in the VIP area during the first 6 months of 1978. According to hospital officials, the four cooks were assigned other duties when the VIP area was not being used. VIP facilities in the Walter Reed replacement hospital, opened in December 1978, also include a kitchen. A hospital official said that a decision had not been made about use of the new facility's VIP kitchen.

An Army official told us that a VIP kitchen may be needed in certain facilities because foreign VIPs may not eat the same foods as other hospital patients.

#### CONCLUSIONS

DOD criteria established in response to our 1974 report do not give the military departments and individual hospital commanders adequate guidance in establishing and furnishing VIP accommodations and determining who is entitled to VIP treatment. As a result, the persons accorded VIP treatment and the VIP facilities and staffing provided varied considerably.

DOD's space planning criteria state that VIP accommodations are needed to permit VIPs to continue functioning in an official capacity while hospitalized. However, furnishings such as chandeliers and refrigerators are not needed to enable a VIP to carry out his/her normal functions. DOD should direct hospital commanders to limit the furnishings provided in VIP rooms to those actually required to enable a VIP to function in an official capacity.

There is no need to maintain a separate kitchen to prepare meals for VIPs, and DOD should direct the Walter Reed hospital commander to discontinue the practice.

#### RECOMMENDATIONS

We recommend that the Secretary of Defense develop more specific criteria for establishing and furnishing VIP accommodations, including

--the officials to be accorded VIP treatment;

- the size and number of rooms to be established;
- the furnishings, including security and communications equipment, to be provided; and
- the staff to be assigned.

The criteria for furnishing VIP accommodations should also apply to future purchases for existing VIP rooms. Such purchases should be limited to furnishings needed to enable the VIP to continue functioning in an official capacity.

The Secretary should also direct the Department of the Army to discontinue maintaining a separate VIP kitchen at Walter Reed Army Medical Center.

## CHAPTER 4

### STRONGER DOD ACTION NEEDED TO END SEPARATION

#### OF OFFICER AND ENLISTED PATIENTS

In response to our 1974 recommendation, DOD directed the Department of the Navy to discontinue separating officer and enlisted personnel in Navy hospitals. However, the Navy did not instruct hospital commanders to discontinue this practice, and some Navy hospitals continue it to varying extents. As stated in the preceding chapter, many other hospitals, in all three military departments, consider rank in making assignments to private and semiprivate rooms.

In 1974, we reported that the Army and Air Force hospitals we visited generally assigned patients to nursing units on the basis of their medical needs, but that the four Navy hospitals we visited--the National Naval Medical Center, Bethesda, Maryland, and the Naval Regional Medical Centers at Portsmouth, Virginia; Camp Lejeune, North Carolina; and Camp Pendleton, California--assigned officer and enlisted patients to separate nursing units. The Navy hospitals generally provided officers more space, more expensive furnishings, and a higher ratio of nursing staff.

We recommended that the Secretary of Defense instruct the military departments to prohibit separating of officer and enlisted personnel in their existing and future hospitals.

In his April 11, 1975, letter commenting on our 1974 report, the Principal Deputy Assistant Secretary of Defense advised us that officer and enlisted patients in Navy hospitals would no longer be separated. He explained that the practice was carried on only in older Navy facilities using the open-bay ward concept and that the new design criteria had already eliminated the practice in newer facilities. He said that good medical practice and proper patient management were the only criteria that would be used in bed occupancy determinations.

In an April 13, 1976, memorandum to the Assistant Secretary of the Navy for Manpower and Reserve Affairs, the Acting Assistant Secretary of Defense stated that:



"Since we continue to be criticized for this practice (separation of officer and enlisted personnel), it is extremely important that it be discontinued and that every effort be made to assure that patients are primarily assigned hospital accommodations based on their medical care requirements."

However, according to a Navy official, instructions were not issued to individual hospitals regarding separation of officer and enlisted personnel, and the Navy did not determine the extent of this practice in its hospitals. Navy officials told us that separation of officer and enlisted patients occurs primarily in older hospitals having open-bay wards, and that the practice is being eliminated as new hospitals are constructed without open bays.

All 14 hospitals we visited reported that patients are assigned rooms primarily based on their medical care requirements. The five Army and the two Air Force hospitals we visited did not maintain separate nursing stations for officer and enlisted patients; however, all but two hospitals--Walter Reed Army Medical Center and Malcolm Grow Air Force Medical Center in Maryland--advised us that rank is a secondary factor in assigning patient rooms.

Only one of the seven Navy hospitals we visited--the Naval Regional Medical Center, Camp Pendleton, California--reported that rank is considered in assigning patient rooms. However, our visits to the seven hospitals revealed that four others--the National Naval Medical Center, Bethesda, Maryland; Naval Regional Medical Center, Camp Lejeune, North Carolina; Naval Hospital, Beaufort, South Carolina; and Naval Regional Medical Center, Portsmouth, Virginia--separate officer and enlisted patients to varying extents. In addition, a hospital we did not visit--the Naval Regional Medical Center, San Diego, California--reported that it separates officer and enlisted patients.

Following is a brief description of Navy hospitals that continue to separate officer and enlisted patients.

At the Naval Regional Medical Center in Portsmouth, two wards containing only private and semiprivate rooms were maintained for officers. Rooms on these wards were furnished with draperies, a bedspread, a padded chair with ottoman, a desk, and a night table. Rooms on one of the wards, which was refurbished in 1972 to provide care for returning prisoners

of war, also had carpeting. A hospital official told us that, if no beds were available on the officer wards, an officer would probably be placed in an isolation room on one of the open-bay wards.

Enlisted personnel at Portsmouth are normally placed on open-bay wards containing about 30 beds. Other than night tables and an occasional straight chair, no furnishings were provided. The head of nursing services at Portsmouth said that enlisted patients would be placed on the officer wards if the need arose. However, she said that this had never happened. She added that the nursing care provided to officer and enlisted patients is comparable even though more nurses may be assigned to the officer ward, because of problems in caring for patients in private and semiprivate rooms.

The Naval Regional Medical Center at Camp Lejeune no longer maintains a separate officer nursing unit, but still separates officers from other patients. According to a hospital official, a separate officer nursing unit is not maintained because there are normally only about six officers in the hospital at one time. Officers are placed in a ward consisting of private and semiprivate rooms. Other rooms on the ward are used for female patients and enlisted male patients. However, one area of the ward was designated "sick officers quarters." Although some enlisted patients may be placed in private or semiprivate rooms, most were placed in an open-bay ward. A hospital official said that noncommissioned officers and dependents of officers may be placed in an open-bay ward, but commissioned officers would not.

At the National Naval Medical Center in Bethesda, officials told us that rank is not a factor in assigning patient beds. However, occupancy data for the period June 24 to 30, 1978, indicate that active duty officers were generally assigned to wards containing private and semiprivate rooms whereas enlisted patients were assigned to open-bay wards. For example, the patients using medical ward T-14 (containing four private and six semiprivate rooms) and medical ward 3-C (containing primarily open-bay beds) during this period were as follows:

<u>Patients</u>	<u>Ward T-14</u>	<u>Ward 3-C</u>
Active duty officers	1	-
Retired officers	4	1
Female dependent of officer	2	-
Female dependent of enlisted	1	-
Active duty enlisted	-	8
Dependent son of Public Health Service officer	-	1
Dependent son of enlisted	-	1
Unidentified designee of the Secretary of the Navy	-	1
Retired enlisted	-	2
	<u>8</u>	<u>14</u>

The replacement hospital at the Naval Regional Medical Center, Camp Pendleton, no longer maintains separate nursing units for officer and enlisted patients, but a hospital official told us that officers are still separated from enlisted patients whenever bed space is available to do so. The official said that wards have been combined because of a nursing shortage and officer and enlisted patients are therefore being placed on the same wards. However, the official said that both medical condition and rank are considered in assigning rooms.

The Naval Hospital at Beaufort, South Carolina, maintains a separate open-bay ward for Marine recruits. Hospital officials said that recruits are placed on the open-bay ward so that they can continue being trained while hospitalized.

Although we did not visit the Naval Regional Medical Center in San Diego, information we received from DOD indicates that enlisted patients at San Diego are usually assigned to open-bay wards, while officers and their dependents are assigned to wards with private or semiprivate rooms.

#### CONCLUSIONS

Although DOD directed the Navy to discontinue separating officer and enlisted patients, the Navy did not advise hospital commanders accordingly. As a result, officer and enlisted patients continue to be separated at some Navy hospitals, including those we visited in 1974. At that time we reported that this practice generally resulted in more space, more expensive furnishings, and a higher ratio of nursing staff provided to officers.

DOD should again direct the Navy to discontinue separating officer and enlisted patients and follow up to insure that hospital accommodations are assigned primarily on the basis of medical care requirements.

RECOMMENDATION

We recommend that the Secretary of Defense direct the Department of the Navy to establish a regulation prohibiting the separation of officer and enlisted personnel in its existing and future hospitals and follow up to insure that the regulation is enforced.

MILITARY HOSPITALS VISITED BY GAO

<u>Hospital</u>	<u>VIP accommo- dations</u>	<u>Presi- dential suite</u>
National Naval Medical Center, Bethesda, Md.	X	X
Walter Reed Army Medical Center, Washington, D.C.	X	X
Naval Regional Medical Center, Camp Pendleton, Calif.		X
Malcolm Grow Air Force Medical Center, Andrews Air Force Base, Md.	X	
Air Force Hospital, Langley Air Force Base, Va.	X	
Naval Regional Medical Center, Portsmouth, Va.	X	
Naval Regional Medical Center, Camp Lejeune, N.C.	X	
Womack Army Hospital, Ft. Bragg, N.C.	X	
Tripler Army Medical Center, Honolulu, Hawaii	X	
Naval Hospital, Beaufort, S.C.	X	
Kenner Army Hospital, Ft. Lee, Va.		
Naval Regional Medical Center, Charleston, S.C.		
Naval Regional Medical Center, Long Beach, Calif.		
Eisenhower Army Medical Center, Ft. Gordon, Ga.		

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