# A STUDY TO DETERMINE IF ETHICS COMMITTEES SHOULD BE A DECISION-MAKING AND REVIEW MECHANISM FOR MATTERS RELATING TO NO-CODE ORDERS IN THE CONTINENTAL UNITED STATES ARMY MEDICAL DEPARTMENT HOSPITALS WITH OVER ONE HUNDRED TOTAL OPERATING BEDS

A Graduate Research Project

Submitted to the Faculty of

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In Partial Fulfillment of the

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of

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by



Captain Lee W. Briggs, MSC

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This study was conducted to determine if ethics committees should be a decision making and review mechanism. A survey was distributed to all continental US Army hospitals with over one hundred operating beds. The survey measured attitudes on the roles of ethics committees in "Do Not Resuscitate" orders patients. The study found a clear lack of guidance for preceding in these cases. The author recommended a written no-code policy from the OTSG, the policy should require a committee to handle ethical issues, that the committee review various ethical issues, and the facility commander be encouraged to use non-physicians of his choosing on this committee. Keywords: Military medicine, Medical Services, Office of the Surgeon General (OTSG)

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# I. INTRODUCTION

## Conditions Which Prompted the Study

> "When has a patient reached the season that is termed in Ecclesiastes 'a time to die?' Unless we answer such questions now, our ICUs will become the cemeteries of the future, occupied by multitudes of artificially fed and maintained human beings who are neither alive nor dead."[1]

American medicine and society in general have, in the past decade, been forced to confront the growing problem of whether or not to withhold or withdraw increasingly sophisticated life support systems from patients whose future quality of life is questionable. This type of decision-making inevitably raises complicated medical, financial, ethical, and legal issues in treatment decisions, such as the issuance of no-code orders (do not resuscitate [DNR] orders). One approach to facilitate this decision-making process has been the use of hospital ethics committees (See Appendix A).

This section of the introduction reviews the history, controversy, documented success and effectiveness, and increased national interest in hospital ethics committees; the history and trend toward written medical no-code policies; the changing federal perspective concerning the legality of no-code orders and use of an ethics committee as a review and decision-making process for such actions; the Army Medical Department's (AMEDD) stand on a formal no-code policy and lack of formal ethics

committees; and finally, how all these facts have generated the need for this study.

Hospital ethics committees have arisen independently for a variety of reasons. These reasons have ranged from determining which patients should be selected for hemodialysis (prior to Medicare benefits being extended to people with end stage renal disease)[2] to which patients should be allowed to have an abortion.[3] The Justice System was a primary influence on the formulation of ethics committees. The key legal instrument was the New Jersey Supreme Court's ruling on the Karen Quinlan case in 1976. The court directed that the patient's guardian, family, and physician

> "shall consult with the hospital 'Ethics Committee' or like body of the institution in which Karen is then hospitalized. If that consultative body agrees that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state, the present life-support system may be withdrawn and said action shall be without any civil or criminal liability therefore on the part of any participant, whether guardian, physician, hospital or others."[4]

Two recent surveys show contrasting results concerning the prevalence of ethics committees. However, one must take into account the population surveyed. Stuart Younger, M.D., in his study for the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (President's Commission), reported that ethics committees were found in 17 (4.3%) of the 400 sample hospitals with more than 200 beds, and that no ethics committees were found in the 202

hospitals with fewer than 200 beds. Younger further reported that, after weighting the sample elements to compensate for disproportionate probability of inclusion, approximately 1% of all hospitals in the United States have ethics committees. The report also states that religious affiliation and public versus private administration did not significantly affect the likelihood of having a committee.[5] On the other hand, the Catholic Health Association reported that a 1983 survey of Catholic hospitals revealed that 228, or 41%, of responding institutions had ethics committees in 1982.[6] Although prevalence of ethics committees may be a subject of debate, the key is that they do exist and are functioning.

Little is known about the goals and objectives of these ethics committees for two major reasons. The first and most logical is the obligation of hospital committees to preserve confidentiality. The second and most challenging is that institutions are unwilling to become involved in the developing controversy about ethics committee merits and goals. Several authors[7,8,9,10] have expressed serious reservations about hospital ethics committees. Robert M. Veatch, PhD, for example, views hospital ethics committees as groups of strangers who are unfamiliar with the wishes of particular patients and who consequently bureaucratize death. He posits that they do not eliminate the systematic biases of the medical profession and that their members have no special moral expertise.[11] Those

who do advocate the establishment of hospital ethics committees disagree about their purpose.[12,13,14,15] Primary committee objectives range from providing advice and counsel to physicians only to providing procedural guidelines by which patients and families can exercise their right to make decisions. Veatch maintains that "hospital ethics committees are a new development, and it is still unclear which types will gain support and how they will evolve."[16]

Two ethics committees that have spoken up and shared their merits and goals have been the Optimum Care Committee at the Massachusetts General Hospital and the Terminal Care Committee of the Ann Arbor Veterans Administration Medical Center. According to the Massachusetts General Hospital committee, their main benefits were

> "clarification of misunderstanding about the patient's prognosis, reopening of communication, re-establishment of unified treatment objectives and rationale, restoration of the sense of shared responsibility for patient and family, and, above all, maximizing support for the responsible physician who makes the medical decision."[17]

The Ann Arbor Veterans Administration committee stated that their particular group experience illustrated that

> "hospital ethics committees can play advisory and educational roles within a large medical center. They can provide support for patients, medical professionals, and families who face difficult dilemmas about terminal illness. They can function as forces to sensitize medical personnel to the challenges presented by medicine's growing power over death. They can serve as catalysts for interdisciplinary communication. Finally, they can promote the development of new programs for informed and humane care of the terminally ill."[18]

Dr. Ronald E. Cranford, chairman of a national conference on institutional ethics committees co-sponsored by the American Society of Law and Medicine and Concern for Dying held in Washington, D.C., in late spring 1983, pointed to several contributions that ethics committees can make. They include:

> "linking trends in society at large with those at the grass-roots level; providing a systematic means for decision-making in dealing with ethical questions that arise within the hospital; constituting a forum for dialogue, discussion, and debate; and facilitating consensus when it can be reached or pointing out where it cannot."[19]

In addition to the above comments, Dr. Younger's study for the President's Commission also had some interesting statistics concerning the perceived effectiveness and membership of currently existing committees. The study reported uniformly positive responses to questions about committee effectiveness. Major reported benefits were: facilitating decision-making by clarifying important issues (73.3%); providing legal protection for hospital and medical staff (60%); shaping consistent hospital policies with regard to life support (56.3%); and providing opportunities for professionals to air disagreements (46.7%). Membership of the ethics committees consisted of the following professional mix: 100% had physicians as members; 82% had clergy; 53% had an administrator; 47% had a nurse; 41% had an attorney; 29% had a social worker; 24% had laypersons; 12% had house officers; and 12% had people listed as other.[20] From these results, one realizes that ethics committees are perceived to be effective by the majority of those institutions which have them,

and that their membership often consists of a variety of key players, not just physicians.

The President's Commission, using the data compiled by Dr. Younger and others, released a report entitled Deciding to Forego Life-Sustaining Treatment, dated March 1983, which recommended that the nation's hospitals set up medical ethics panels for the specific purpose of helping to decide when to continue life-sustaining treatment. The Department of Health and Human Services (DHHS), the American College of Hospital Administrators (ACHA), the American Society of Law and Medicine (ASLM), the American Hospital Association (AHA), and the California Medical Association (CMA) have also recently joined the pro-ethics committee bandwagon.

DHHS in the controversial federal "Baby Doe Rule" went back to the drawing boards and published a final regulation on 12 January 1984, billed as a compromise among all concerned. According to the final regulations, the previously mandated hotline for reporting alleged violations of laws prohibiting discrimination against handicapped newborns will remain intact. But notices listing hotline numbers no longer will need to be posted in public areas of hospitals. The notice, which now must be made visible only to hospital staff caring for the newborns, also will recommend that callers first refer denial-of-care problems to "infant care review committees."[21] The prophetic title of a June 1983 Modern Healthcare magazine article

entitled "Outcry Over 'Baby Doe' May Revive Little-Used Hospital Ethics Committee" appears to have been fulfilled.

At a recent two-day conference on ethics committees, Stuart A. Wesbury Jr., PhD, president of the ACHA, emphasized the administrator's responsibility to organize forums to discuss ethical issues. The ACHA monthly news has also consistently published notes on ethics and ethics committees.[22,23] In addition to ACHA, other published authors have strongly encouraged administrators to take a role in organizing ethics committees.[24,25]

The ASLM has recently announced the publication of its Ethics Committee Newsletter and has organized and presented seminars at various locations entitled "Institutional Ethics Committees and Healthcare Decision-Making." The newsletter is designed to fill the need for the exchange of ideas, policies, and experiences related to hospital ethics committees.[26] Volume One, Number Two of the newsletter was published in November 1983.[27] The seminars were held in February 1984 in Los Angeles, California, and Houston, Texas. Another seminar is scheduled for mid-June in Cambridge, Massachusetts. Again, these dates show the current and increasing trend of interest in such committees.

The AHA's General Council created a Special Committee on Biomedical Ethics in 1982. This multidisciplinary committee designed guidelines for hospital committees on biomedical ethics which were approved by the council on 27 January 1984 (See Appendix B). The AHA is also sponsoring a seminar entitled

"Ethics, Values, and Rights," in Denver, Colorado in mid-June 1984. This seminar will specifically address the role of institutional ethics committees. These actions by AHA document not only an increasing interest in ethics committees as noted above but also a need for general guidance concerning such committees and their role in the hospital.

The book Megatrends points out that there are six States which set the pace for national trends. One of these is California.[28] On 1 October 1983, the California Medical Association became the first state medical association in the country to adopt a policy position advocating that each hospital in California establish an institutional ethics committee.[29] Need one say more concerning future state medical association trends?

Written hospital "no-code" policies were another trend that had its beginning in the mid-seventies. The key that triggered these policies was the recognition by professional organizations that non-resuscitation was appropriate in certain situations. For example, the 1974 version of the "Standards for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC)" of the American Heart Association and the National Academy of Sciences states:

> "Cardiopulmonary resuscitation is not indicated in certain situations, such as in cases of terminal irreversible illness where death is not unexpected."[30]

Following the publishing of this and other national standards, several hospitals published written no-code policies.[31,32,33] According to the President's Commission, the prevalence of written policies nationwide is not known. However, they reported that, from their experience in organizing hearings and from letters they have received, indications are that many hospitals are drafting policies.[34]

The Commission itself has put out three basic DNR concerns that it believes institutional policymakers need to address. They are the need for explicit policies; the need for balanced protection of patients; and the need for internal advice and review.[35] In conjunction with the first concern, they recommend that hospitals "have an explicit policy on the practice of writing and implementing DNR orders." They state that "in the absence of an established mechanism, decision-making might fail to meet the requirements of informed consent, or the responsibility for making and carrying out the decision might be assigned to an inappropriate person."[36] In conjunction with the last concern, they recommend that hospital DNR policy "provide for appropriate resolution of disagreements on resuscitation decisions." They state that "intrainstitutional review of decisions that raise persistent disagreements has been shown to be very effective in some institutions, both for clarifying the issues in a case and for achieving compassionate and responsive resolution of the issues."[37] The Alabama, Minnesota, and New York medical societies have followed suit by publishing brief

guidelines to help establish the approved standard of care regarding DNR orders.[38] A 1982 survey of hospitals in San Francisco County and City found that policies had been written by all acute care hospitals but two. Again, one must recall what the book Megatrends says about California and national trends. Another key according to this study was that the two hospitals without policies were federal hospitals run by the Veterans Administration (VA) and the Army.[39]

The President's Commission report echoed the findings of the San Francisco County and City survey and recommended that the various federal agencies (VA and DOD specifically) develop DNR policies and practices in accordance with the previously noted commission guidelines.

The President's Commission report noted that for the VA the closest to an official policy statement on DNR orders was a Chief Medical Director's letter dated 20 November 1979 (See Appendix C). Referencing a recent court case where the VA was sued for refusing to discontinue a life-sustaining treatment (Foster vs. Tourtellotte, No. CV81-5046, S.D. Cal. May 27, 1982), the Commission recommended that the VA revise its no-code policy or encourage individual hospitals to do so. They stated:

> "...at the very least the policy should be adjusted to ensure that patients' interests and preferences become its central focus."[40]

With this encouragement from the President's Commission, the VA's Department of Medicine and Surgery on 25 August 1983

published Circular 10-83-140, Subject: Guidelines for "Do Not Resuscitate (DNR)" Protocols Within the VA (See Appendix D). These guidelines are fairly general; however, they specify requirements for consultation, consensus, or committee involvement, and the following of state law when not inconsistent with the provisions of their circular. A sample of a VA state policy for Kansas, which has a Natural Death Act, is at Appendix E.

The Commission noted that the medical treatment facilities (MTFs) operated by DOD "currently address the DNR issue in quite disparate ways."[41] The National Naval Medical Center in Bethesda, Maryland, for example, wrote a policy dated 9 February 1983 which basically conformed with the recommendations of the President's Commission (See Appendix F).[42] One key aspect of this particular policy was that, although only credentialed physicians were allowed to write no-code orders, a medical ethics committee was organized to act as a decision-making and review committee on matters relating to DNR orders. The committee was composed of seven members with varied professional backgrounds including a physician as well as a Medical Service Corps (MSC) officer. The committee was required to meet monthly and review all DNR orders. It also acted immediately in cases which involved third-party interests, disagreement with the patient, and military personnel.[43]

An updated Navy policy of 27 June 1983 is at Appendix G. According to this new policy, the Navy still requires an ethics

committee and designates it as a decision-making and review mechanism.

The Air Force has published very general guidelines concerning "orders not to resuscitate", stating "Air Force hospitals should be guided by local law and local medical practice in the management of terminally ill patients."[44] A letter giving guidance to New Mexico Air Force hospitals on DNR procedures with inclosures of the Air Force's general policy and Wilford Hall USAF Medical Center's DNR guidelines are at Appendix H.

Even with the VA, Navy, and Air Force examples, according to the President's Commission, "there seems to (be) a general reluctance (in DOD MTFs) to allow DNR orders, perhaps stemming from such policies as the Army Surgeon General's letter of December 13, 1977 (See Appendix I), which seems to say that, except when mandated under natural death acts, orders may never be given not to resuscitate a patient."[45]

Military physicians have recently spoken up against the current Army policy referencing the ambiguous AR 600-20 and various state cases (e.g., the Karen Quinlan case) and the federal case of Foster vs. Tourtellotte as grounds for the Department of the Army (DA) to develop guidelines for handling terminally ill patients. They further recommended, in that the Natural Death Legislation has only been enacted in eleven states and is quite limited, that DA develop its own broad no-code guidelines which would cover the limited state directives and

give further guidance to those MTFs without such state legislation (See Appendix J).[46]

A telephonic investigation was conducted on 17 January 1984 to determine the current no-code policy and status of ethics committees in the AMEDD since the President's Commission report was published in March 1983. According to Army Colonel Stanek, Deputy Director of Professional Services, Office of the Surgeon General (OTSG), the Army's no-code policy "went to bed" with the Judge Advocate General's (JAG) comments in March 1983. According to COL Stanek, there were legal concerns about the risk for the individual practitioner. He stated, however, that the no-code policy recommendation is currently being "dusted off" for a relook. COL Butke, Quality Assurance Office, OTSG, stated that there are no formal ethics committees per se in the Army, but there will be if a no-code policy is approved. The two colonels noted above plus LTC Slayton, Clinical Medical Division, Health Services Command (HSC), and COL Gibbs, Chaplain, HSC, felt that research concerning ethics committees in conjunction with a no-code policy would be of interest to HSC and OTSG. The majority of those surveyed above felt that there were informal ethics committees organized throughout the AMEDD but did not know to what extent.

It appears from the trends of the times that both ethics committees and written no-code policies will eventually be a reality in the AMEDD. Furthermore, two US Army-Baylor graduate students have done recent research involving DNR orders. In

1983, McNair completed a study concerning the Army physicians' opinion of DNR orders, and in 1982 Lashlee completed a study concerning the cost effectiveness of initiating a hospice at Madigan Army Medical Center with implications for Army-wide utilization. A key point was surfaced concerning the latter study. The plans to establish a "continuing care unit" failed because of the incompatibility of the type of care required and the lack of an acceptable AMEDD no-code policy.[47] These projects demonstrate that questions concerning DNR orders are topics of current AMEDD research interest. However, after a review of the literature, it appears that no AMEDD research has been done to determine if the two trends noted at the beginning of this paragraph will be compatible with each other and the Army in the future.

## Statement of Research

To determine if ethics committees would be a viable decision-making and review mechanism for matters relating to no-code orders in the continental United States (CONUS) AMEDD hospitals with over one hundred total operating beds.

## Projected Parameters

### Objectives

1. To thoroughly review the literature concerning ethics committees and no-code policies in both the AMEDD and the civilian healthcare arena.

2. To collect informational data through the use of a survey administered to selected key personnel at selected AMEDD medical treatment facilities.

3. To determine if there is a perceived need for a written no-code policy in the CONUS AMEDD hospitals with over 100 total operating beds.

4. To determine the prevalence, key player awareness, and effectiveness of ethics committees in the CONUS AMEDD hospitals with over 100 total operating beds.

5. To determine if there is a perceived need for an ethics committee as a review and decision-making mechanism for no-code orders in the CONUS AMEDD hospitals with over 100 total operating beds.

6. To determine the perceived organization and function of an ethics committee if the CONUS AMEDD hospitals with over 100 total operating beds were directed to form such committees.

7. To determine if there is a relationship between one's position and one's perceived need for ethics committees as a decision-making and review mechanism in the CONUS AMEDD hospitals with over 100 operating beds.

8. To formulate conclusions and recommendations for OTSG and the Commander, Health Services Command, from the survey results.

## Criteria

The criteria of this research were:

1. The number of surveys returned was required to be large enough to estimate the AMEDD needs addressed in the survey at a .10 level of significance with 90% confidence.

2. A survey response of 50% or greater to any survey question was required to be considered significant.

## Assumptions

Known assumptions included:

1. That all AMEDD facilities surveyed were dealing with cases which involved the decision-making process of refusing, withholding or withdrawing of life support systems on a regular basis.

2. That the information gleaned from those surveyed was correct and representative of the AMEDD as a whole.

## Limitations

Known limitations were:

1. Only specific supervisors were queried. Therefore, the perceptions of the individuals providing the actual day-to-day

patient care, the legal staff, and the next of kin were not accessed.

2. When determining if there was a relationship between one's position and one's perceived need for ethics committees as a decision-making mechanism, other independent variables such as religion, sex, age, etc., were not considered.

3. The results, recommendations, and conclusions were limited to information gleaned from the survey.

4. The study was limited to the CONUS AMEDD facilities that have 100 or more total operating beds.

## Review of the Literature

A review of the literature to date, as noted above in the conditions which prompted the study and in the attached bibliography, indicates that a great deal has been recently written concerning ethics committees and no-code policies in hospitals. The key documents beneficial in this project were Dr. Younger's study for the President's Commission concerning the prevalence of ethics committees in the United States and the American Hospital Association's guidelines for hospital committees on biomedical ethics. The idea of limiting the size of the hospital survey population in this project to hospitals with 100 beds or more came from Dr. Younger's finding that no ethics committees existed in the 202 hospitals surveyed with fewer than 200 beds. The hospital size of 100 beds was selected instead of 200 beds

because of the marked differences between civilian and military hospitals and the need for a fairly good-size hospital population to study. Also some of the wording in Dr. Younger's survey questions was used in a somewhat different context in this project's survey. In addition, the AHA has established some excellent ethics committee functional, composition, and deliberation guidelines for hospitals. Hence, both the AHA guidelines and Dr. Younger's survey results were used as a standard for comparison of survey results in this study.

## Research Methodology

1. A 15-question survey was the sole data collection tool for retrieving information to accomplish the research objectives (See Appendix K).

2. An advance telephone request was made to the Army-Baylor University healthcare resident or hospital adjutant at the 21 CONUS AMEDD hospitals with 100 or more total operating beds, requesting their assistance as on-site survey coordinators (See Appendices L and M for list of hospitals and list of on-site coordinators, respectively).

3. Five copies of the survey were forwarded to each coordinator with a request that the surveys be distributed to their hospital commander, deputy commander for clinical services (DCCS), deputy commander for administration (DCA), chief nurse, and hospital chaplain. Each survey was accompanied by a

self-addressed envelope with a request to complete within fifteen calendar days. Each survey was also coded with a letter (A through U) representing the hospital to which the survey was sent (See Appendix L). This code was used to initiate follow-up action if the survey was not returned in a timely manner.

4. A phone call was made to each site coordinator seven days after the initial mailing to insure the surveys were received. If surveys from a particular site were not received after the twentieth day from initial mailing, follow-up phone calls were made at five-day intervals until the survey was received or rejected.

5. The total population for this study equates to 21 hospitals and 105 surveyees. To meet the required sample size according to the criteria noted above, replies had to be received from 17 hospitals and 42 surveyees (See Appendix N).

6. The information was collected and categorized by question and type of answer, and the significant results were used to determine key conclusions and recommendations.

7. A copy of the completed study was requested by a recently formed Brooke Army Medical Center's task force on ethics committees, and a copy was also sent to the Commander, HSC, and to OTSG.

FOOTNOTES

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22. "Wesbury Speaks Out on Ethics at April DC Conference," ACHA New, Vol 46, No. 6, June 1983, p. 5.

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39. Medical-Legal Interprofessional Committee, No Code Subcommittee, "Survey of No Code Guidelines in San Francisco Bay Area Hospitals," 1982.

40. President's Commision for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment, Washington, DC: U.S. Government Printing Ofice, March 1983, p. 254.

41. Ibid.

42. Ibid.

43. "Guidelines for Orders Not to Resuscitate," NHBETH Instruction 6320.37, National Naval Medical Center, Bethesda, MD, 20814, 9 February 1983.

44. Letter from the Department of the Air Force,Office of the Command Surgeon, to ALMAJCOM-SOA/SG, Subject: Management of Terminally Ill Patients, dated 21 July 1982.

45. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment, Washington, DC: U.S. Government Printing Office, March 1983, p. 254.

46. Letter from Dr. James G. Zimmerly, J.D., M.P.H., Col, MC, USA, to LTG Bernard T. Mittemeyer, MC, USA, "Termination of Life Support and Entering of No-Code Orders," dtd 1 April 1982.

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## II. DISCUSSION

This chapter presents an overview of the dates the survey was conducted; gives a synopsis of those who returned the questionnaires; and documents the significant results pertaining to each of the project objectives with information gleened from the questionnaires.

### Overview of Survey Procedures and Results

On 27 February 1984, 105 surveys were distributed to the 21 selected site survey coordinators, and follow-up was done as outlined in the research methodology. On 23 April 1984, 86 surveys had been received from 16 MTF commanders, 18 DCCSs, 16 DCAs, 18 hospital chaplains, and 18 chief nurses, with completed returns received from all 21 of the preselected hospitals. In that these returns were sufficient to satisfy one of the project criteria noted earlier, it was determined to complete the categorization of the survey data by question and type of answer and not to include additional data from surveys received after 23 April 1984.

### A Perceived Need for a Written AMEDD No-Code Policy

The project objective of determining if there is a perceived need for a written no-code policy in the selected hospitals was

accomplished through analysis of five of the survey questions. The first three questions were:

1. Do you feel a need for a more explicit AMEDD policy concerning care for the terminally ill?

2. Are verbal no-code orders given at your MTF?

3. Do you feel the AMEDD should have a written no-code policy?

The final two questions were follow-up questions to a positive answer to number 3. They were:

1. Should this written AMEDD policy be broad in scope and require MTFs to publish their own specific policy IAW state law and other variables?

2. Should this written AMEDD policy include a requirement for a designated MTF "ethics" committee as a decision-making and review mechanism for no-code orders?

There were significant results and comments made concerning all five questions, which were sufficient to satisfy the project objective mentioned at the beginning of this paragraph.

85% of all surveys returned, 75% of the responding MTF commanders, and 78% of the responding DCCSs felt a need for a more explicit AMEDD policy concerning care for the terminally ill. One MTF commander's comments pointed out not only the need for a different AMEDD policy for the terminally ill but also the need for a better worded survey question. He stated, "We have an explicit AMEDD policy which says that all patients will be

resuscitated without regard to their prognosis or current condition. This, I understand, was thrust upon an accepting AMEDD by the Judge Advocate General's Office. The specter of resuscitating a cachexic patient ridden for months with the pain of cancer, who has finally attained a peaceful death, is the antithesis of good medical care." A MEDDAC chief nurse's remarks were also pertinent. He/she stated: "Nursing is once more in the middle of a very emotional issue merely because we are there when death comes--fatal availability. If the AMEDD can't resolve this issue satisfactorily, it is essential that we gain additional resources to support home care or care at a hospice when community resources in these areas are limited or absent. Perhaps we (AMEDD) shouldn't be pace setters in social issues, but we must at least be current and not burden any one discipline with the decision or the failure to make a decision."

54% of all surveys returned gave an answer other than "No" when asked if verbal no-code orders were given at their MTF, and 30% (including 25% of the responding MTF commanders and 39% of the responding DCCSs) answered specifically "Yes." After marking "No" to this question, one MTF commander commented, "We obey all written orders and the "No-No Code" policy of OTSG is obeyed. It is inappropriate for the physician to relinquish the responsibility and authority for deciding resuscitative measures to nursing personnel by the use of verbal orders, which leaves the nurse unprotected from subsequent legal entanglements. We have also elected that, when a resuscitation is performed, it will be

performed correctly, and that the so-called "slow code" is not permitted. While performing resuscitations on certain patients is bad medical care, to document the negligent application of bad medical care would further compound the problem." Another MTF commander who marked "No" to this question added the following comment concerning his MTF: "We have a written patient-refuses-resuscitation-policy (very similar to the VA and AF policies)." A "No" answer to this question by a MEDCEN chief nurse was accompanied by the following comment: "Resuscitation after cardiac arrest used to be used for patients whose death was not expected. Now, no one is allowed to die naturally when it is expected. A cardiac arrest code is called on everyone, and all measures are employed. It is really not a matter of continuing life support but of not starting it in the first place and prolonging death." It appears from the above comments that, although the OTSG "No-No Code" orders are followed by many, they are followed reluctantly and in some cases not at all.

85% of all surveys returned, including 81% of the responding MTF commanders and 78% of the responding DCCSs, felt that the AMEDD should have a written no-code policy. One MEDDAC chief nurse added the following comment to a "Yes" answer to this question. He/she stated, "OTSG must come out with a policy as relates to no-code. Presently, the decision to code or not is left in the hands of the least trained--the paramedic who finds the 'arrested' patient. If our MDs were permitted to coordinate

with patient and family and then make a decision and write the order, the decision would at least be left in a 'Professional's' hands!!" In addition to the above comments, one chief nurse attached a copy of his/her institution's no-code instructions to his/her questionnaire. The instructions echo the OTSG policy but gives some additional guidance concerning the decision-making procedure (See Appendix O).

Of those who answered "Yes" to the need for an AMEDD written no-code policy, 86% (including 92% of the MTF commanders who marked "Yes" and 100% of the DCCSs who marked "Yes") felt that this written AMEDD policy should be broad in scope and require MTFs to publish their own specific policy IAW state law and other variables. Furthermore, of those who answered "Yes" to the need for an AMEDD written no-code policy, 64% (including 39% of both the MTF commanders and DCCSs) felt that this AMEDD policy should include a requirement for a designated MTF "ethics" committee as a decision-making and review mechanism for no-code orders. It was noted that, of all surveys returned, 55% answered in the affirmative to this question, thus making it a significant result.

Some of the additional comments on the surveys helped justify the sharp difference noted above in the percentages of support on the two follow-up questions. A MEDDAC chaplain stated: "The question's wording of the ethics committee being a <u>decision-making</u> body caused me to be very uncomfortable with your survey. In the military, the staff can only 'recommend.' It is

the commander who decides. Hence, I marked "No" on the basis of your idea of an ethics committee and its task." A MEDDAC DCCS stated: "1) Hospitals already have too many committees. 2) Guidance from AMEDD or state should be sufficient; an ethics committee would be an extra layer of cushioning so that the individual physicians would not feel solely responsible for decisions. 3) I think no-code should be an individual decision between physician and patient (or family member)." A MEDCEN DCCS stated: "The AMEDD desperately needs a 'No-Code' Reg which could be supplemented (i.e., made more restrictive; descriptive) at any MTF. THE REG SHOULD NOT REQUIRE AN ETHICS COMMITTEE, i.e., THIS SHOULD BE AN MTF DECISION!" A MEDCEN commander stated: "If the Army Med. Department would adopt a policy on 'no-code' along the lines recommended by the President's Commission, there would be very little need for an ethics committee. I have never favored the idea of practicing medicine 'by committee' action." A MEDCEN DCA who marked "Yes" in favor of the ethics committee added the following comment: "The ethics committee should provide recommendation and not be a final decision maker. That is the role of the attending physician, the DCCS, the Commander, and, most important of all, the dying patient or appropriate family member designated by state law. We don't need, nor should the Ethics Commmittee be permitted, to make final decisions." In addition to these comments, it was noted that Fitzsimons Army Medical Center has a written policy concerning determination of

death due to irreversible cessation of brain function, which utilizes a panel of physicians to make a recommendation to the commanding officer concerning the brain death of the patient (See Appendix P). This policy supports the idea, reiterated by some of the surveyees, of a committee functioning as a recommending body to the decision maker on ethically sensitive decisions. In analyzing the comments above, the word "decision-making" caused a lot of interesting discussion as to what the role of the ethics committee should be. This wording will also be noted as a point of interest and conflict as the perceived functions of the ethics committee are discussed later on in this chapter.

## Prevalence, Key Player Awareness, and Effectiveness of AMEDD Ethics Committees

The project objective of determining the prevalence, key player awareness, and effectiveness of ethics committees in the selected hospitals was accomplished through two questions and two additional follow-up questions if either of the first two questions was answered in the affirmative. The two initial questions were:

1. Does an ethics committee formally exist at your MTF? If the answer is yes, please give the name of the committee.

2. Does an informal ethics committee exist at your MTF?

The follow-up questions to a positive answer to either of the first two questions were:

1. If such committees do exist at your MTF, do you consider them effective?

2. In what areas do you consider the ethics comittee at your MTF effective? Multiple choice answers were given with the last question (See Table 2 on page 35). There were significant results and comments made concerning all four questions, which were sufficient to satisfy the project objective noted at the beginning of this paragraph.

Concerning prevalence of hospital ethics committees, 26 of 86 (30%) of those who returned surveys claimed that either a formal or informal ethics committee or both existed at their hospital. These positive replies included representation from 15 of the 21 sites surveyed (71%). Furthermore, 33% of the survey sites had at least one individual claiming that a formal ethics committee existed at their facility. Individuals from 6 MEDCENs and 9 MEDDACs answered in the affirmative, thus indicating that size and mission of facility really had no bearing on the reply.

Three of the 21 sites (14%) had three of the five individuals surveyed concur that ethics committees existed at their institution. In addition, 8 of the 21 sites surveyed (38%) had more than one surveyee report that an ethics committee existed at their location. These findings are very interesting when compared to similar studies noted in Chapter One. For example, Dr. Younger's report for the President's Commission found ethics committees in only 17 (4.3%) of the 400 sample hospitals with

more than 200 beds and no ethics committees were found at all in the 202 hospitals with fewer than 200 beds. The Catholic Health Association's survey found 41% of their responding institutions with ethics committees. Thus, it appears that the subject of prevalence of ethics committees is still debatable and very dependent on the population surveyed. However, ethics committees do exist in the AMEDD.

The names of the committees which were reported as formal or informal ethics committees at the various sites were: Risk Management and Quality Asssurance Committee; Credentialing Committee; Discharge Planning Committee; Clinical Investigation Committee; ICU Committee; and Hospital Executive Committee.

In evaluating the survey population's key player awareness of ethics committees, the number by position of surveyees claiming that ethics committees existed was compared to the total number of surveys returned by position (See Table 1, next page).

The order of awareness of ethics committees by position in the population surveyed is: DCCS, MTF Commander, Hospital Chaplain, DCA, and Chief Nurse. It appears that, if an OTSG DNR policy were to include an ethics committee, it would at least serve as an awareness device for the non-physicians in the healthcare arena, making them aware--or more aware--of not only the existence of such a committee but of its role and functions.

In determining the effectiveness of the existing AMEDD ethics committees, 15 of the 26 surveyees (58%) who claimed ethics committees existed at their facility also stated that they

Table 1. Survey sites key player awareness of ethics committees at their institution.

| Position | # of Surveyees Claiming Ethics Com.s Exist | Total # Returning Surveys | % Stating Ethics Committees Exist |
|---|---|---|---|
| MEDCEN, Commander | 2 | 5 | 40% |
| MEDDAC, Commander | 4 | 11 | 36% |
| MEDCEN, DCCS | 4 | 7 | 57% |
| MEDDAC, DCCS | 6 | 11 | 55% |
| MEDCEN, DCA | 2 | 6 | 33% |
| MEDDAC, DCA | 1 | 10 | 10% |
| MEDCEN, Chief Nurse | 0 | 5 | 0% |
| MEDDAC, Chief Nurse | 2 | 13 | 15% |
| MEDCEN, Chaplain | 1 | 5 | 20% |
| MEDDAC, Chaplain | 4 | 13 | 31% |
| TOTAL..... | 26 | 86 | 30% |
| Physician | 16 | 34 | 47% |
| Non-physician | 10 | 52 | 19% |

considered them effective, and 16 surveyees made specific checks on the survey concerning which areas they considered their ethics committee effective (See Table 2 on next page).

The significant areas of effectiveness, ranked in order of significance were: to facilitate decision-making by clarifying important issues; to educate professional staff about the important issues; and to provide legal protection for the hospital and the US Government. It was key to note that the highest effectiveness ranking was to facilitate decision-making not act as a decision maker. This was also the highest ranked effectiveness trait of the existing ethics committees in Dr. Younger's national survey for the President's Commission.

## Is There a Perceived Need for an Ethics Committee As a Review and Decision-Making Mechanism?

The project objective of determining if there is a perceived need for an ethics committee as a review and decision-making mechanism was accomplished through the analysis of one three-part question. The question read "Do you perceive a need for MTF ethics committees as a decision-making and review process for no-code orders? a) In the AMEDD in general? b) Just at the MEDCEN level? c) At your particular hospital?"

56% of all surveys returned, 31% of the MTF commanders, and 33% of the DCCSs perceived a need for the AMEDD in general to have such committees. These answers will be separated by position and further discussed in the next section of this

Table 2. Ethics committee effectiveness chart.

| Survey Choices | Choices Made By Surveyees | % of Total Replies Possible (16) |
|---|---|---|
| a. Shaping or evolving consistent hospital policies with regard to life support | 7 | 44% |
| b. Educating professional staff about important issues | 10 | 63% |
| c. Facilitating decision-making by clarifying important issues | 11 | 69% |
| d. Providing legal protection for the hospital and US Government | 8 | 50% |
| e. Providing an opportunity for health professionals who usually have less power in decision-making than physicians to air disagreements, give input, and receive explanations. | 6 | 38% |
| f. Increasing the ability of individual patients and families to influence the decision-making process. | 3 | 19% |

chapter. 78% of all surveys returned stated "No" when asked if ethics committees should only be at the MEDCEN level. 50% answered "Yes" when asked if there was a perceived need for such a committee at their particular hospital.

A follow-up question in three parts was also asked for general interest only. It read: "Even if you might not perceive a need, if so directed, do you feel that an ethics committee could be a viable decision-making and review process for no-code orders, a) In the AMEDD in general? b) Just at the MEDCEN level? c) At your particular hospital?" 61% of all surveys returned answered "Yes" to part a, 66% answered "No" to part b, and 61% answered "Yes" to part c. Again, it is felt that the word "decision-making" had an impact on the answers to both of the questions addressed in this section. As mentioned earlier, this wording conflict will be addressed later on in the discussion concerning the perceived role and functions of the ethics committee.

## Is There a Relationship Between One's Position and One's Perceived Need for an Ethics Committee as a Decicion-Making and Review Mechanism?

The project objective of determining if there is a relationship between one's position and one's perceived need for ethics committees as a decision-making and review mechanism was addressed by analysis of the replies by position to the initial

question, part a, of the discussion section immediately above. The results were annotated in Table 3 (Next page).

An important point from Table 3 is that those who play a support role to the physician expressed a stronger perceived need for an ethics committee as a decision-making and review mechanism in the AMEDD than the physicians in leadership roles. Thus, this point indicates that there is a relationship between one's position and one's perceived need for an ethics committee as a decision-making and review mechanism.

## The Perceived Functions of an Ethics Committee If the Selected Facilities Were Directed to Form Such a Committee

The project objective of determining the perceived functions of an ethics committee if the selected hospitals were directed to form such committees was accomplished by asking one key question with nine multiple choice answers. The question read: "If the AMEDD were to approve a no-code policy with an ethics committee playing a key role, what would you perceive the key functions of that committee to be?" The multiple choice answers to the above question are organized in Table 4 (pages 39-40), where replies are divided according to the position of the respondents.

The significant perceived functions of an ethics committee, ranked according to accumulative percentage, were: to review ethical issues in order to make appropriate recommendations for changes; to provide counsel and support to physicians; to make ethical and/or social policies for the care of seriously ill and

Table 3. Indication by position of a perceived need for an ethics committee as a decision-making and review mechanism in the AMEDD.

| Position | Perceived Need | Total Returning Survey | % of Total Who Indicated Perceived Need |
|---|---|---|---|
| MEDCEN Commander | 2 | 5 | 40% |
| MEDDAC Commander | 3 | 11 | 27% |
| MEDCEN DCCS | 2 | 7 | 29% |
| MEDDAC DCCS | 4 | 11 | 36% |
| MEDCEN DCA | 6 | 6 | 100% |
| MEDDAC DCA | 7 | 10 | 70% |
| MEDCEN Chief Nurse | 3 | 5 | 60% |
| MEDDAC Chief Nurse | 8 | 13 | 62% |
| MEDCEN Chaplain | 5 | 5 | 100% |
| MEDDAC Chaplain | 8 | 13 | 62% |
| TOTAL..... | 48 | 86 | 56% |
| Physician | 11 | 34 | 32% |
| Non-physician | 37 | 52 | 71% |
| TOTAL..... | 48 | 86 | 56% |

Table 4. Key AMEDD players' perception of what the main functions of an ethics committee would be if directed to have one by OTSG.

| Functions | % Concurrence of Those Responding by Position as Well as Cumulative | | | | | |
|---|---|---|---|---|---|---|
| | Cumulative | MTF Cdr | DCCS | DCA | Chief Nurse | Chaplain |
| a. To review ethical issues in patient care decisions in order to make appropriate recommendations for changes | 80% | 69 | 77 | 81 | 83 | 89 |
| b. To provide counsel and support to physicians | 67% | 44 | 71 | 63 | 72 | 83 |
| c. To make ethical and/or social policies for the care of the seriously ill and dying patients treated at the hospital | 66 | 56 | 65 | 69 | 67 | 72 |
| d. To determine continuing educational needs of personnel involved in patient care in the area of terminal care | 51 | 44 | 41 | 38 | 67 | 61 |

(continued on next page)

Continuation of Table 4

| Functions | % Concurrence of Those Responding by Position as Well as Cumulative | | | | | |
|---|---|---|---|---|---|---|
| | Cumulative | MTF Cdr | DCCS | DCA | Chief Nurse | Chaplain |
| e. To provide counsel and support to other health officials | 47 | 38 | 41 | 31 | 61 | 61 |
| f. To provide counsel and support to patients and families | 47 | 25 | 41 | 44 | 44 | 78 |
| g. To make the final decision about continuing life support | 39 | 19 | 47 | 56 | 50 | 22 |
| h. To determine medical prognosis | 17 | 6 | 18 | 25 | 11 | 22 |
| i. Other (Specify) | 12 | 13 | 0 | 6 | 17 | 22 |

dying patients treated at the hospital; and to determine continuing educational needs of personnel involved in patient care in the area of terminal care. In addition, the last block (i. Other [Specify]), contained several other recommended functions. These functions included: "to act as a mediator between patient, family, and health care providers as needed"; "to make a recommendation about continuous life support to dying patient or family members based on the state law, but final decision to rest with competent dying member or person designated by state law"; "to review no-code decision to promote proper adherence to directives and guidelines as an impartial review"; and, "not only... deal with questions concerning the terminal care of patients, but... deal with any questions of medical ethics that concerned the health care of the patients of that hospital."

There was also a list of additional comments concerning this project objective. Many of these comments were directed at function g in Table 4 (to make the final decision about continuing life support) which rated at 39% cumulative response with a noted low response of 19% from the MTF commanders. These figures give a somewhat more accurate feel of the impact the word decision-making had on the earlier discussion concerning the perceived need for an ethics committee as a decision-making and review mechanism in the AMEDD hospitals. This finding plus the earlier noted perceived significant functions indicate that the

majority would favor an ethics committee but not as a decision-making body. Some of the comments concerning function g were recorded to emphasize this point. One MEDDAC chief nurse commented concerning this function: "This is the most important of all!" A MEDCEN DCCS commented that it should read: "to make recommendations for or against continuing life support to CO." A MEDCEN chaplain made the following comment concerning this function: "I changed this to read 'recommend' because I feel that the CO should have the final say-so in these very important decisions." A MEDCEN commander added the following: "I embrace the concept of an ethics committee, but absolutely not as the '<u>decision maker</u>.' It can only function as <u>advisor</u> to the responsible physician." Comments were also made concerning other functions in general. A MEDDAC commander stated: "All functions of proposed ethics committees can readily be incorporated as a function of the Medical Care Evaluation Committee as it monitors the comprehensive quality assurance plan of the hospital. Hospital commanders do not need to be told how they will implement responsibilities they have (by forming this committee or that); they do need the authority to get necessary jobs done, such as giving appropriate care to terminally ill patients." A MEDDAC chief nurse stated: "Committee input into specific cases must not be mandatory because timeliness of action usually cannot be achieved (Example: critically ill or trauma patients who may have been admitted in past twelve hours [+-] cannot wait for committee input before being allowed death with

dignity). Committee guidance to assist professional team in making sound ethical decisions--not legal--is what we need!" A MEDDAC DCA stated: "A committee would be prima facie evidence to our beneficiaries that we are honestly addressing the issues surrounding the quality of life of the terminally ill patients. It would be a support role for the physicians, family members, and, in some cases, the patients themselves." Another MEDDAC commander made the following statement: "One institutional piece that is missing that would be very helpful in aggregating the folks concerned with this area is guidance on and permission to establish hospice activities. If there was such a ward or area authorized and staffed, a coherent group could more easily be brought together and become expert in the issues." He continued: "I also am very concerned about the trend an ethics committee represents in removing physicians' judgment as an important factor and driving a wedge between the physician-patient-family relationship. We seem to be coming into an era which is institutionalizing blocks between the physician and patient/family and unnecessarily restricts his actions or takes away decisions he formerly made. I believe these trends will ultimately work to the detriment of physician satisfaction and retention." He concludes: "Thanks for the opportunity to respond to this issue...I have been one of those 'driving' HSC/OTSG to develop a DNR policy a la the VA model."

These results and comments directly confirm the findings of the recently printed AHA guidelines for hospital bioethical committees which state: "Although institutional ethics committees have one or more functions, they seem particularly suited to: 1) directing educational programs on biomedical ethical issues, 2) providing forums for discussion among hospital and medical prrofessionals and others about bio-medical ethical issues, 3) serving in an advisory capacity and/or as a resource to persons involved in biomedical decision making, and 4) evaluating institutional experiences related to reviewing decisions having biomedical ethical implications. Ethics committees should not serve as profesional ethics review boards, as substitutes for legal or judicial review, or as 'decision makers' in biomedical ethical dilemmas. An ethics committee should not replace the traditional foci of decision making on these issues."[1]

## The Perceived Organization or Proper Mix of Representatives for an Ethics Committee if the Selected Facilities Were Directed to Form Such a Committee

The project objective of determining the perceived organization or proper mix of representatives for an ethics committeeif the selected facilities were directed to form such a committee was accomplished by asking one key question with ten multiple choice answers. The question read: "If the AMEDD were to approve a no-code policy with an ethics committee playing a key

role, what would you perceive the proper mix of representatives for such a committee to be?" The answers to this question are organized in Table 5 (page 46) by position of respondents and their chosen responses.

Note that two DCCSs and one DCA did not complete this particular question at all, thus they were not figured as part of the total for percentage purposes in Table 5. Also note that there were 32 surveyees who annotated 2 to 5 physicians; 12 surveyees who annotated more than one nurse; and 5 surveyees who annotated that 2 or 3 lay persons should be on the committee. These multiple annotations were only recorded as one positive response for physician, nurse, and lay person representation on the committee in Table 5. There were also seven surveyees who placed the word "or" between psychiatrist and psychologist, and one who placed the word "or" between chaplain and social worker. When the word "or" was used, both answers were recorded as a recommended committee representative in Table 5 (next page).

In the representative category of "Other," the surveyees were asked to respond specifically to additional representatives they would include on an ethics committee. These responses included: representative of the hospital commander; commander; neurologist; scientist, non-medical; quality assessment coordinator; ethicist; nurse from inpatient unit where patient is located; senior enlisted person, i.e., CSM or Chief Wardmaster of MTF; attending physician; nurse, chief ward; deputy commander;

Table 5. Key AMEDD players' perception of what the mix should be on an ethics committee

| Choices | % Concurrence of Those Responding Organized by Position | | | | | |
|---|---|---|---|---|---|---|
| Representative | Aggregate | MTF Cdr | DCCS | DCA | Chief Nurse | Chaplain |
| Physician | 99 | 100 | 100 | 93 | 100 | 100 |
| Psychiatrist | 58 | 50 | 50 | 67 | 56 | 67 |
| Psychologist | 33 | 13 | 13 | 47 | 44 | 44 |
| Nurse | 88 | 94 | 69 | 80 | 94 | 100 |
| Administrator | 66 | 63 | 56 | 80 | 72 | 61 |
| Chaplain | 88 | 88 | 63 | 93 | 94 | 100 |
| Social Worker | 58 | 50 | 38 | 73 | 50 | 78 |
| Lawyer (JAG) | 88 | 69 | 88 | 100 | 89 | 94 |
| Lay person | 41 | 31 | 38 | 47 | 33 | 56 |
| Other (specify) | 16 | 13 | 13 | 7 | 22 | 22 |
| Perceived mean size of committee | 7.07 | 6.69 | 6.19 | 6.93 | 7.06 | 7.94 |
| Standard deviation on perceived committee size | 2.05 | 1.54 | 2.20 | 2.76 | 1.86 | 2.01 |

next of kin; patient; chaplain of same faith as patient; commander or CPS; and physician as chairman.

Some additional key comments were made in this area. One MEDCEN commander stated: "If ethics committee evolves into a hospice program, social workers may need to be involved." One MTF commander placed: "prefer not! Get in the way" next to the chaplain block. One MEDDAC chief nurse wanted one administrative nurse and one clinical nurse present on the committee. One MTF commmander commented that a lay person should be a member, "only if sophistication." A MEDCEN chief nurse commented, "keep it small" in referring to the committee size. One MEDDAC commander stated the following: "My personal feeling is that the primary physician should be responsible for perceiving when, at the termination of life, resuscitation would be inappropriate. I would advise such a physician that a consultation with a colleague of the appropriate specialty would be appropriate for both the judgment that such a colleague could provide and for the documentation that the decision was well thought out. Support for the patient and patient's family should be routinely obtained in all cases of serious illness, and the appropriate professional from one of the behavioral sciences should have an on-going knowledge of the disease, the patient, and the family concerns. Where there is a question of organ transplant, a formal consultation with a physician outside of the specialty that will ultimately use the organ should also be obtained. I am very much against the inclusion of a lawyer on any committee dealing with

this issue, although selected questions may be referred for legal implications. The profession of law makes valuable contributions to a free society in the conduct of our lives and the distributions of our estate. They have contributed nothing but confusion in the passage from life to death."

In summarizing Table 5 and the additional comments, the aggregate mean for the perceived size of an ethics committee was 7.07 people with a standard deviation of 2.05. There were no strong deviations from this mean by any particular group of surveyees. Interestingly enough, there were also seven significant representatives noted in the project. They were according to the aggregate percent ranking by the surveyees: physician, nurse, lawyer, chaplain, administrator, psychiatrist, and social worker. Although these results have strongly been influenced by the population surveyed, they show that not only the physicians but the nurses, chaplains, and administrators surveyed would welcome having representation on an ethics committee, if the AMEDD were to require such a committee.

## FOOTNOTE

1. American Hospital Association, Guidelines: Hospital Committee on Biomedical Ethics, Chicago, IL: AHA, 1984, p. 1.

## III. CONCLUSIONS AND RECOMMENDATIONS

### Conclusions

From the results noted in the discussion, one can conclude that there is a strongly perceived need for a written no-code policy in the CONUS AMEDD hospitals with over 100 total operating beds. One can further conclude that such a written policy should be broad in scope and require MTFs to publish their own specific policy IAW state law and other variables. The Air Force and Veterans Administration presently have such policies (See Appendices H and D respectively).

It can also be concluded that there is a fairly high prevalence of ethics committees in the surveyed AMEDD hospitals compared to Dr. Younger's findings for the President's Commission. However, few non-physician key players, compared to physician key players, are aware of these committees or do not consider them "ethics committees." It can also be concluded that these existing AMEDD ethics committees are considered to be effective by the respondents in facilitating decision-making by clarifying important issues; educating professional staff about the important issues; and providing legal protection for the hospital and the US Government.

One can conclude that there is a perceived need among non-physicians for an ethics committee as a review and decision-making mechanism for no-code orders in the hospitals studied, but

not so for the physicians' groups. Hence, one can also conclude that there is a relationship between position and perceived need for such a committee. One should realize, however, that this physicians' perception is expressed from the supervisors' perspective, not from that of the physicians who are actually treating patients on a daily basis.

From the aggregate results, one can conclude that an ethics committee would be a viable mechanism for dealing with matters relating to no-code orders in the continental United States AMEDD hospitals with over one hundred total operating beds. However, this committee should not function as a decision-making committee per se. It can be concluded that the committee's key functions should include the following: to review ethical issues in patient care decisions in order to make appropriate recommendations for changes; to provide counsel and support to physicians; to make ethical and/or social policies for the care of seriously ill and dying patients treated at the hospital; and to determine continuing educational needs of personnel involved in patient care in the area of terminal care. It was interesting to note that these conclusions concerning key committee functions are similar to the recently published AHA guidelines for hospital bioethical committees.

It can also be concluded that the broad DNR written policy mentioned above should require MTF commanders to have a committee (existing or otherwise created) of his choosing designated to handle ethical and DNR issues.

It can be further concluded that the committee's organization or representative mix should be left up to the commander or DCCS (senior physician group). However, he/she should be strongly encouraged to use various non-physician professionals such as a nurse, a lawyer, a chaplain, an administrator, and a social worker.

## Recommendations

The following recommendations are made:

1. That OTSG publish a written no-code policy that is broad in scope and requires MTFs to publish their own specific policy IAW state law and other variables similar to the current VA policy.

2. That the written no-code policy include the requirement for a committee (existing or otherwise created) to handle ethical and DNR issues.

3. That the general functions of that committee include but not be limited to review of ethical issues in patient care decisions in order to make appropriate recommendations for changes; to provide counsel and support to physicians; to make ethical and/or social policies for the care of seriously ill and dying patients treated at the hospital; and to determine continuing educational needs of personnel involved in patient care in the area of terminal care.

4. That the MTF commander be strongly encouraged to use various non-physician professionals of his choosing on this committee, such as a nurse, a lawyer, a chaplain, an administrator, and a social worker.

# APPENDIX "A"

## Definitions

## DEFINITIONS

1. Ethics Committee. An ethics committee is a committee that has the potential to become involved in the decision-making process in specific patient cases; the committee's involvement has to precede any final decision about withholding or withdrawing life support in an individual case. For the purpose of this paper, neither the nature of the committee's involvement nor the fact that a committee may have additional functions (e.g., policymaking or teaching) excludes it from being referred to as an ethics committee. (This is the same definition used by Dr. Younger in his "National Survey of Hospital Ethics Committees" conducted for the President's Commission.

2. Treatment. Treatment includes both life-prolonging and life-saving procedures, whether surgical, pharmaceutical, or mechanical.

3. No-code Order or Do Not Resuscitate (DNR) Order. An order given in the event of a cardiac or respiratory arrest, where cardiopulmonary resuscitative measures will not be initiated or carried out ("code" being the shorthand term for the emergency summoning of a resuscitation team by the announcement of a "Code Blue" over a hospital public address system).

# APPENDIX "B"

## AHA Guidelines
## for Hospital Committees

American Hospital Association

AHA

# Guidelines

## Hospital Committees on Biomedical Ethics



This guideline document is intended to provide general advice to the membership of the American Hospital Association, as approved by the General Council.

### Introduction

The growth of medical knowledge and the rapid expansion of medical capabilities and technology have generated unprecedented opportunities and challenges in the delivery of health care. At the same time, this growth and expansion have created increasingly complex ethical choices for physicians, health care professionals, patients, and the families of patients. Recent efforts to clarify biomedical ethical issues on the institutional level have focused on the use of hospital biomedical ethics committees. Such committees, sometimes called "ethics committees," "human values committees," "medical-moral committees," or "bioethics committees," hold promise for identifying the ethical implications of these problems and their possible resolutions, if they are established with a clearly defined purpose and an understanding of their capabilities and limitations.

Institutional ethics committees are one of several approaches to address medical ethical matters. If an institution chooses this approach, the following guidelines may assist in determining the organization, composition, and function of these committees. Because such committees are relatively new and largely untested, the guidelines are not intended to be prescriptive or directive.

### Functions

Although institutional ethics committees may have one or more functions, they seem particularly suited to: (1) directing educational programs on biomedical ethical issues, (2) providing forums for discussion among hospital and medical professionals and others about biomedical ethical issues, (3) serving in an advisory capacity and/or as a resource to persons involved in biomedical decision making, and (4) evaluating institutional experiences related to reviewing decisions having biomedical ethical implications. Ethics committees should not serve as professional ethics review boards, as substitutes for legal or judicial review, or as "decision makers" in biomedical ethical dilemmas. An ethics committee should not replace the traditional loci of decision making on these issues.

Educational programs on biomedical ethics issues serve to heighten awareness and provide guidance on identification of cases where ethical problems may arise. Such programs may be offered to medical staff, the hospital staff, and the community. Forums for the discussion of these issues serve similar purposes by providing an opportunity for physicians, nurses, administrators, trustees, clergy, ethicists, and others to consider and discuss a number of diverse perspectives.

The use of ethics committees in an advisory role to assist physicians, other health care professionals, and patients and their families to make decisions when confronted with dilemmas is probably their most complex function. Ethics committees often may make recommendations at the request of an attending physician, another hospital professional closely connected with the case, the hospital administration, and the patient or the patient's family. Access to the committee should be open to all those involved in patient care decisions. Hospitals should design and implement systems to bring to the committee's attention certain kinds of issues and to address similar issues in a reasonably consistent manner.

### Composition

The members of an ethics committee should be selected in keeping with its objectives and represent a range of perspectives and expertise. It may be multidisciplinary and may include physicians, nurses, administrators, social

The American Hospital Association's General Council created a Special Committee on Biomedical Ethics in 1982. This multidisciplinary committee prepared these guidelines as part of its charge to assist hospitals in developing institutional processes to deal with the educational and decision-making challenges presented by biomedical ethical issues. These guidelines were approved by the AHA General Council on January 27, 1984.

# APPENDIX "C"

VA Statement on DNR Orders
20 November 1979

Note: This appendix was extracted from Appendix I, President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research report, Foregoing Life-Sustaining Treatment, pp. 518-519.

# Statements Concerning Federal Agencies

## Veterans Administration, Chief Medical Director's Letter on "No Code" and other Similar Orders*

1. Technological advances in medicine are usually hailed as providing great new benefits for patients. Often the social, moral, ethical and financial impact of these same advances are not perceived until years later. Perhaps some of the most perplexing issues before us today have followed in the wake of our ability to delay the moment of death by the application of a variety of technological devices. Professional publications, the news media and the law have wrestled with, and given visibility to, many of these issues. The heightened awareness of these issues has raised questions from many anxious health care professionals: *viz.*; when should support for a terminally illpatient be discontinued, who is responsible for such a decision, what are the legal liabilities of various persons under such circumstances and can a doctor order other providers (doctors or nurses) to refrain from doing something they (the providers) feel conscience bound to do? We recognize these genuine expressions of concern on the part of every health care professional but are unable to resolve most of these controversies.

2. It is worthwhile, however, to simply state that the policy of the Veterans Administration's Department of Medicine and Surgery should continue to be consistent with those ethical principles adhered to by the medical and allied professions. We should also make accommodations for those state laws which provide for certain defined rights of patients but we must also give recognition to the rights of others, including family members and health care providers, in the exercise of their religious and moral beliefs.

3. In a few states, the legislatures have enacted "Natural Death" or "Death with Dignity" statutes. Our VA medical centers located in such states are already under the direction of DM&S Circular 10-79-160, dated July 25, 1979, Subj.: "State laws regarding the withholding or withdrawal of life-sustaining procedures." Although the majority of our medical centers are not affected by such legislation, they may be affected by a variety of other local laws (*e.g.*, "Brain Death"). Nevertheless, it must be remembered that every competent adult patient usually has the right to refuse any medical treatment offered, even if that refusal might result in death.

* James C. Crutcher, M.D., Chief Medical Director, Department of Medicine and Surgery, Veterans Administration (Washington, D.C. 20420) Doc. No. IL 10-79-66 (Nov. 20, 1979).

4. In some of our medical centers a few physicians have felt compelled, under certain circumstances, to write "no code" orders. Such orders may direct someone (usually a member of a nursing staff) to refrain from performing an act which their conscience dictates be done or may intimidate someone who, in the absnce of such an order, would normally have performed the act. We believe such orders are inappropriate and do not contribute to high quality patient care. The preferable alterantive is to permit health care professionals in such situations to be free to exercise their judgment guided by their education, experience and ethical and moral persuasion.

5. On the other hand, it is essential that the progress notes entered in the record for a terminally ill patient be fully informative of the diagnosis, the prognosis, the patient's wishes (when known), the wishes of the family members and the recommendations of the attending staff (not resident) physician. With a well documented record, the choice to "code" or "no code" will remain one of professional judgment on the part of the appropriate health care provider caring for the patient at the time of cardiopulmonary arrest.

6. Compassionate care of the sick guided by the high ethical standards demanded of doctors and nurses for centuries will continue to be the best policy. With the same dedication with which we provide high quality care to patients who survive their illness, we will find satisfaction in the knowledge we have done the best possible to provide comfort, compassion and dignity for those who do not survive.

APPENDIX "D"

Veterans Administration Department of Medicine and Surgery,
CIRCULAR 10-83-140,
Subject: Guidelines for "Do Not Resuscitate" (DNR) Protocols
Within the VA, dated 25 August 1983.

Veterans Administration
Department of Medicine and Surgery
Washington, D.C. 20420

CIRCULAR 10-83-140

August 25, 1983

TO: Regional Directors; Directors, VA Medical Center Activities, Domiciliary, Outpatient Clinics, and Regional Offices with Outpatient Clinics

SUBJ: Guidelines for "Do Not Resuscitate" (DNR) Protocols witnin the VA

1. As it has in the past, the Veterans Administration remains committed to the principle of supporting and sustaining life, employing new life-saving or life-supporting techniques and therapeutic measures in so doing. However, medical science has made us realize that in some instances the implementation of therapeutic decisions and the application of medical technology may not cure a patient's disease or disability or reverse a patient's course. Some patients who suffer from a terminal illness and are incurable may reach a point where application of additional measures would become not only unwanted but medically unsound. In such cases, the physician is seen as not preventing death, but merely deferring the moment of its occurrence. The significant medical problems then are no longer therapeutic, in the strict sense of curing or treating, but rather ones of choice among degrees of treatment, involving decisions relating to control over the moment and mode of dying. In this connection, the responsible physician faces the problem of determining that continued maximal efforts constitute a reasonable attempt at prolonging life or that the patient's illness has reached such a point that further intensive, or extensive, care is in fact merely postponing the moment of a death which is otherwise imminent.

2. The basic policy of the Veterans Administration continues to be that of providing the highest quality medical care to its patients and beneficiaries, with the objective of sustaining life and practicing in conformity with the highest ethical and medical standards. It is imperative that our Medical Centers and their professional staffs and personnel remain committed to this purpose. However, this commitment should not be so strong as to overwhelm a dying patient's decisions or undermine his/her well-being or his/her right of self-determination.

THIS CIRCULAR EXPIRES ON AUGUST 24, 1984

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|---|---|---|---|
| 00 (/) DIR | 115 (/) NU MED | 135 ( ) V |
| 001 (/) A/DIR | 116A (/) PSY | 136 (/) M |
| 002 ( ) MGMT AN | 116B (/) PSYCH | 137 ( ) a |
| 04 ( ) FIS | 117 ( ) RMS | 138 ( ) E |
| 05 ( ) PERS | 118 (/) NS | 142B ( ) M |
| 11 (7) COS | 119 ( ) PHARM | 142D ( ) L |
| 1K ( ) REC | 120 ( ) DIET | 151 ( ) R |
| 90 ( ) SUPPLY | 122 (/) SWS | 160 (/) D |
| 11 (/) MED | 125 ( ) CHAP | |
| 12 (/) SURG | 127 (/) NEURO | 111 D |
| 13 ( ) LAB | 133 ( ) CANTEEN | |
| 14 ( ) RAD | | |

3. Therefore, it is appropriate that Medical Districts and/or individual Medical Centers consider for adoption protocols for application within that Medical District/Medical Center, to deal with the issues involved when terminally ill patients request that Do Not Resuscitate (DNR) orders be placed in their medical records and/or that they not be resuscitated in the event of a cardiopulmonary arrest. Even though such a protocol may have been adopted, it will continue to be VA policy that CPR will be administered to every patient who sustains a cardio-pulmonary arrest, where the medical record does not contain a DNR order that fully complies with the Medical District/Medical Center established policy. However, it is acknowleged that there will be those cases where, in the exercise of sound medical judgment, a licensed physician who knows the patient may appropriately give an instruction not to institute resuscitation at the bedside of a patient who has just experienced an arrest. Such cases would involve patients who were considered terminal, where death was imminent or expected and where resuscitative efforts would most likely have been fruitless. It may be appropriate to communicate these concerns to physicians responsible for the immediate care of the patient, in the absence of the physician who knows the patient.

4. DNR protocols established by VA Medical Districts/individual Medical Centers should contain certain specific items:

a. An introductory policy statement which sets the tone and delineates specific ethical, legal and medical considerations that may apply;

b. Specific definitions of such terms or phrases as DNR, resuscitation, terminal illness, and imminent death;

c. A patient classification scheme, to delineate that class of patients to whom the policy applies;

d. A description of the patient's (or patient's surrogate's i.e. legally appointed guardian's or representative's) role, with respect to the competent, the incompetent, and the comatose patient, as well the patient hospitalized within a state which has a "Natural Death" or "Death with Dignity" statute;

e. A description of the family role, where it is relevent;

f. Requirements for consultation, consensus, or committee involvement;

g. Requirements for the DNR order itself and who may write it;

h. Requirements for the accompanying note in the Progress Notes and who may write it;

i. Limits for time duration of the DNR order and provisions for its review;

j. Requirements for other or additional medical care, short of resuscitation; and

k. Requirements for flagging or otherwise highlighting the medical record in such a way as to indicate the entry of a DNR order therein.

2.

5. The following suggestions or recommendations are made with respect to the items listed above:

Definitions:

The terminally ill patient may be defined as one whose underlying condition is considered to be medically incurable or untreatable, in terms of currently available technology, and whose death as a result of the natural history of his/her disease process or medical problem is considered imminent, that is, expected to occur during the course of the current hospitalization. In addition the definition might also apply to those situations where the physician determines that resuscitation would be of no benefit to the patient, because the natural course of the patient's medical condition would result in death imminently and the institution of resuscitative measures, if successful, would only postpone the moment of death for a brief period of time, that is for matter of a few hours or days.

Patient's Role:

Where the patient is competent and alert, and understands the implications of his/her diagnosis and prognosis, the DNR decision should be reached by the patient after discussion with the physician primarily responsible for his/her care. If the patient requests that a DNR order not be written, or instructs that resuscitative measures should be instituted, no DNR order should be written or considered by the treating team.

The patient should be encouraged to discuss the subject with family members before making this decision. However, there are some situations where a competent, alert patient might for one reason or another elect not to inform family members of this decision nor to seek their concurrence. Under the circumstances, patient privacy and confidentiality require that those wishes be respected and honored and that the family not be informed or involved. However, the patient should still be encouraged in this circumstance to involve the family in the decision.

Where the patient is comatose or otherwise incompetent, or incapable of making his/her decision, the decision should be reached after consultation with the patient's surrogate, or in the absence of such an individual, appropriate family member(s) and the physician.

Should the patient's surrogate or family member(s) disagree with the DNR order, no such order will be written. In the event there is question as to the patient's competence, psychiatric consultation should be obtained. Should the responsible physician feel that he/she cannot in good conscience and sound medical judgment comply with the patient's (or patient's surrogate's or family's) wishes regarding resuscitation, that physician should arrange to transfer the patient's care to another physician capable of appropriately and skillfully handling the patient's medical problems, who can so comply.

In situations where an incompetent or comatose patient has no surrogate (legally appointed guardian or representative) or family members, and the treating staff (including the attending physician) feels that a DNR order is appropriate, consultation should be undertaken with the Director/Chief of Staff and the District Counsel for appropriate court order to be obtained, permitting such a DNR order.

States With "Natural Death Laws":

If the patient resides in a state where statute permits a directive to an attending physician regarding "death with dignity," "right to die," "living will," or similar provisions, prior exercise of that statutory right by a patient may be considered as evidence of that patient's wishes regarding DNR orders, prior to the occurrence of coma or incompetence. However, the absence of such a declaration or directive should not be considered as an indication that the patient would not have wanted a DNR order written unless there is evidence of his/her specific wishes in that regard. Where the relevant state statute provides additional requirements to be met regarding diagnosis, prognosis, informing the patient, recordation, witnesses, etc., the requirements of state law should be followed, where they are not inconsistent with the provisions of this circular.

Consultation and Other Physician Involvement:

The individual with specific responsibility for determining the propriety of considering a DNR order in a particular case is the senior attending physician in charge of the patient's care, not a house officer. In this context, the ultimate DNR decision should be reached by the patient after discussion with the senior physician in charge of his/her care (staff or attending physician). Medical decisions regarding the patient's diagnosis or prognosis should be reached by a consensus of the medical treatment team. In larger hospitals, this will mean the attending or staff physician, involved house staff, and whatever consultants may be involved in the patient's care (oncologists, cardiologists, etc.). In smaller hospitals, where house staff is not involved with the patient's care and consultants of that level are not readily available, the decision should be reached by the patient's attending or staff physician and the Chief of Service/ Chief of Staff. In those situations where there may be some doubt concerning the propriety of a DNR order or the accuracy of the patient's diagnosis or prognosis, a medical ethics or prognosis committee or similar body may convened on an ad hoc basis to help resolve the problem.

Entry of the DNR Order:

After it has been determined that a DNR order is appropriate in a particular case and the foregoing requirements have been met, the order must be written into the patient's medical record by the attending physician, rather than a house officer or resident. A verbal or telephone order for DNR is not justifiable as sound medical or legal practice. Once the order has been entered, it is the responsibility of the attending physician to ensure that the order and its meaning are discussed with appropriate members of the hospital staff, particularly the nursing staff, so that all involved professionals understand the order and its implications.

Accompanying Entry In The Progress Notes :

At the time a DNR order is written, a companion entry should be made in the progress notes, which includes at a minimum the following information: the diagnosis, the prognosis, the patient's wishes (when known), the wishes of patient's surrogate or family member(s), where relevant, and the consensual decisions and recommendations of the treating team and consultants, with documentation of their names. In addition, there should be some reference concerning the patient's competency, where the decision was based on his/her concurrence, and applicable documentation of any "informed consent."

Where the competent patient has requested that his/her family not be involved in or informed of his/her decision, as noted above, the patient's decision and request for confidentiality should be documented in the medical record by a disinterested third party, not a member of the treatment team, e.g., a patient ombudsman or representative, a representative of Medical Administration Service, etc.

Review of the Order:

The protocol should specify the process of review for such a DNR order, and how often review should be carried out. Obviously, any time there is a significant change in the patient's medical condition, the order would automatically become void. As in any medical situation, a DNR order may by rescinded at any time by the physician at the specific request of the patient, patient's surrogate, or family member.

Related Medical Care:

It is important that all involved understand the fact that a DNR order is compatible with maximal therapeutic efforts short of resuscitation, and that the patient is entitled to receive vigorous support in all other therapeutic modalities, even though a DNR order may have been entered. It may be appropriate then, in these circumstances, to write onto the order sheet those medical efforts which will be maintained to relieve suffering and assure patient comfort, including basic nursing care (body cleanliness, mouth care, positioning); adequate analgesia; suction; intake for comfort, including hydration; and oxygen for comfort. Merely because a DNR order has been entered into a patient's record does not mean that there is justification for ignoring the patient or providing him/her less than humanistic care and concern for his/her welfare and comfort.

Conclusion:

DNR protocols can be developed to effectively deal with the trauma and suffering that frequently accompany the circumstances in which such orders are written. These protocols must give fair consideration to the patient's medical needs, the social and psychological needs of the patient's family, the legal rights and responsibilities of physician and patient, the professional needs of hospital administration and staff, and applicable state law. With the assistance of all involved, and District Counsels, sound protocols can be developed and implemented. Obviously, no patient shall be considered for a DNR order in anticipation of possible problems such as might occur as the result of unforeseen difficulties during hospitalization or as a result of surgery or in any case where the patient is not terminally ill. Under no circumstances should DNR orders be written where they are in compliance only with a request for "assisted suicide" or voluntary euthanasia. "Do Not Resuscitate" does not mean that the medical staff will take any affirmative steps to "hasten the patient on his/her way." All parties including all levels of providers should try to provide and improve acceptable therapeutic options available to the dying patient.

for W. J. JACOBY, JR., M.D.
Deputy Chief Medical Director

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APPENDIX "E"

VA Medical Center, Leavenworth, Kansas,
Medical District 22 policy memorandum,
Subject: Kansas Natural Death Act
dated March 18, 1983

MEDICAL DISTRICT 22 POLICY MEMORANDUM

VA Medical Center
Leavenworth, Kansas 66048

MDD22PM 22-83-21

March 18, 1983

SUBJECT: Kansas Natural Death Act

1. Purpose: To provide uniform implementation and practices under the Kansas Natural Death Act at the VA Medical Centers in Leavenworth, Topeka and Wichita.

2. Policy: Mentally competent persons, 18 years of age or older, have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances of a terminal condition. In order that the rights of patients may be respected even after they are no longer able to actively participate in decisions about themselves, a written declaration form is provided for patients' use (Attachment A).

3. Life-Sustaining Procedure Defined:

a. It is any medical procedure or intervention which would serve only to prolong the dying process and where, in the judgement of the attending physician, death will occur whether or not such procedure or intervention is utilized. "Life-sustaining procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain.

b. A patient to whom the preceding subparagraph a. would apply is one who has been diagnosed and certified in writing on a Progress Note to be afflicted with a terminal condition by two physicians who have personally examined the patient, one of whom shall be the attending physician, and both of whom are licensed to practice medicine and surgery in Kansas.

4. Medical Administration Responsibility: Upon notification that a patient desires to execute a declaration, the Details Clerk or Administrative Officer of the Day will:

a. Promptly furnish the patient a declaration form and guidelines prepared by the District Council (Attachment B) and, if the patient desires, a copy of 1979 Session Laws of Kansas, Chapter 199.

b. Ask the patient to examine the language of the last paragraph of the declaration form and select two witnesses who are at least 18 years of age, whom he/she feels can meet the intent of the language and who are promptly available. Note: VA employees may not witness the declaration form.

c. Provide reasonable assistance to the patient in getting the witnesses to his/her bedside such as notifying them by telephone and accompanying them to the ward.

d. Type the date, the patient's name and the city, county and state of his/her residence on the declaration form.

e. Type a gummed label "See Natural Death Declaration Form•Inside."

f. Give the signed declaration form and the label to the Ward Secretary or nurse for the following progressive actions:

(1) File the form as the top document in the "hard back" medical file.

(2) Affix the label to the outside front cover of the "hard back" medical file.

(3) Upon death of the patient, file the declaration form as the top right-hand document of the administrative record. (See exception below.)

(4) Retain the declaration form as a part of the Perpetual Medical Record.

g. If the patient brings in a pre-existing declaration, a copy will be made and appropriate parts of the foregoing Medical Administration Responsibility are for application.

EXCEPTION: An instance of patient recovery or discharge from the medical center is not anticipated. However, if such should occur, the declaration form or copy will be sent with the patient to the Chief, Medical Administration Service, or designee, for a discussion. If the patient desires to leave the declaration, or copy thereof, in his record, he/she will annotate the desire on the declaration or copy and date and sign the annotation. If the patient desires, the declaration will be given to him/her or the copy will be destroyed by the patient. Either action will be documented by the Chief, Medical Administration Service, or the designee, on a memorandum which will replace the declaration or copy in the record.

5. Physician's Responsibility:

a. If a patient expresses a desire to execute a declaration or presents acceptable proof that he/she has theretofore executed a declaration, the treating physician will:

(1) Promptly notify the Details Clerk or Administrative Officer of the Day and write an order on VAF 10-1158 for Medical Administration Service to implement the patient's request.

b. If a patient with respect to whom a valid declaration exists becomes afflicted with a terminal condition, the treating and another physician will certify thereto as provided in paragraph 3b. If thereafter the treating physician makes a judgement as provided in paragraph 3a., he will document such judgement in a progress note and he will write an order to have life-sustaining procedures withheld or withdrawn, provided, however, that if the treating physician declines to comply with the declaration because of moral, ethical or religious convictions, he/she will inform his/her Service Chief, who, with any necessary collaboration with the Chief of Staff, will arrange for another physician who can honor the declaration to provide terminal care of the patient.

c. A revocation of declaration (see paragraph 6d below) will be immediately honored and the attending physician will write a progress note appropriately describing the event.

6. Miscellaneous Provisions:

a. The 1979 Session Laws of Kansas, Chapter 199, does not provide for an incompetent person to make a declaration. If a question of competency arises, a psychiatric consultation will be obtained and if he is considered to be mentally incompetent the psychiatrist will inform him that he cannot make a declaration.

b. Patient at least 18 years of age, mentally competent, but unable to sign his/her name: He/she may direct another person of his choosing to sign for him. Such person, however, cannot be a VA employee or a witness.

c. Pregnant Patient: A declaration executed by a pregnant patient will have no effect during the course of her pregnancy.

d. Revocation of Declaration: A declaration may be revoked at any time by the declarant by any of the following methods:

(1) By being obliterated, burnt, torn or defaced in a manner indicating intention to cancel.

(2) By a written revocation of declaration signed and dated by the declarant or person acting at the direction of the declarant.

(3) By a verbal expression of the intent to revoke the declaration in the presence of a witness over age 18 years of age, who signs and dates a confirmation that such expression of intent was made.

(4) When a declaration is revoked, the typed label, "See Natural Death Declaration Form Inside," will be immediately removed, obliterated or cancelled.

7. References:

   a. DM&S Circular 10-82-58.

   b. 1979 Session Laws of Kansas, Chapter 199.

8. Rescission: District Policy Memorandum 22-82-21 dated June 3, 1981.

9. Review Date: June 1984. (136)

MARGARET C. MICHELSON
Medical District Director

Attachments A & B

Dist: 1 Ea 00-001-11
1 Ea Svc Comm Chrmn
MD22

# DECLARATION

Declaration made this _____ day of _____(month,year). I, _____, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artifically prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

Signed_____

City, County and State of Residence_____

The declarant has been personally known to me and I believe him or her to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of interstate succession or under any will of declarant or codicil thereto, or directly financially responsible for declarant's medical care.

Witness_____

Witness_____

ATTACHMENT A
MDD22PM 22-83-21

## GUIDELINES FOR SIGNERS OF NATURAL DEATH DECLARATIONS

1. The Kansas Legislature has recognized that competent persons eighteen (18) years of age or older have a right to control decisions relating to the rendition of medical care to them, including decisions to withhold or withdraw life-sustaining procedures when a condition becomes terminal.

2. It is your right to make a written Declaration instructing your physician to withhold or withdraw life-sustaining procedures in the event your condition becomes terminal. Such a Declaration would be complied with although when your condition might become terminal you might then be unable to give directions concerning your treatment.

3. A diagnosis that your condition is terminal would be made by your attending physician and by another physician, both of whom would have personally examined you. It would then become the responsibility of your treating physician to decide if life-sustaining procedures should be applied. If in his judgement death would occur whether or not such procedures were used, he would either not commence such procedures or would discontinue them if already in use. Withholding or withdrawing life-sustaining procedures would not include the administration of medication or the performance of any medical procedure deemed necessary to provide you with comfort care or to alleviate pain.

4. Medical Administration Service will provide a Declaration form and will assist you in properly completing it. A copy of the Declaration will be placed in your medical record and will remain effective unless you revoke it. If you decide to revoke a Declaration, ask Medical Administration Service for instructions.

5. The Kansas Natural Death Act provides that your directions to withhold or withdraw life-sustaining procedures "shall not, for any purpose, constitute a suicide." It is also provided that the making of a Declaration shall not affect in any manner any policy of life insurance you own or may later purchase.

6. If you wish to read the Act or if you have any questions, contact Medical Administration Service.

ATTACHMENT B
MDD22PM 22-83-21

APPENDIX "F"

Guidelines for orders not to resuscitate,
National Naval Medical Center,
Bethesda, Maryland,
dated Feb 9, 1983

Note: This appendix was extracted from Appendix I, President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research report, Foregoing Life-Sustaining Treatment, pp. 529-534.

## Department of the Navy, National Naval Medical Center*

**1. Purpose.** To establish guidelines for writing orders not to resuscitate ("no code" orders).

**2. Background.** The routine applicaton of cardiopulmonary resuscitation and Advanced Cardiac Life Support has given rise to serious questions regarding the appropriateness of resuscitating every patient who suffers an arrest. Confusion as to criteria for decisions not to resuscitate, identity of decision makers, and a proper decision making process has further obscured an already difficult problem. This instruction is intended to simplify the problem by establishing a clearly delineated decision making process, identifying the appropriate decision makers and providing both criteria for making such decisions and a system of review.

**3. Policy.** The overriding policy of this hopsital is to maintain life and health, and the autonomy of both patients and medical department personnel.

**4. Procedures for Writing Orders Not to Resuscitate.** The following elements must be contained in *every instance of* writing orders not to resuscitate (DNR orders). (Terms are defined in paragraph 8.)

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* Guidelines for orders not to resuscitate NHBETH INSTRUCTION 6320.37, National Naval Medical Center, Bethesda, Md. 20814 (Feb. 9, 1983).

a. Only credentialled physicians may write orders not to resuscitate.

b. Orders must be clearly written, signed, dated and immediately shown to the ward or unit charge nurse.

c. The order not to resuscitate must be accompanied by a progress note describing the application of the decision making process. (See Tables 2 and 3.) [drawn from earlier drafts of the Commission's Report; see Tables 2 and 3, pp. 244, 247 *supra*]. The description will include:

(1) A statement indicating: *condition* (reversability/irreversability), *physical status* (reparability/irreparability), *mental status* (competent/incompetent/diminished competence), and *prognosis* (death imminent/nonimminent).

(2) Patient and family involvement including their attitudes and responses.

(3) Optimal care treatment plan.

d. The physician's discussion with the patient or family shall be witnessed by a registered professional nurse, or social worker, who will countersign the doctor's progress note.

e. DNR orders must be reviewed daily by the ward medical officer.

f. A staff physician must countersign all DNR orders and progress notes within twelve hours of their writing.

g. The Quality Assurance/Risk Management officer must be notified of the DNR order by the physician writing the order within twelve hours of writing the order. The QA/RM officer will then notify the Chairman of the Medical Ethics Committee of the order.

**5. Questions or Disagreement.** The patient, any member of the family or of the health care provider team who questions or disagrees with the writing of the DNR order, or the absence of a DNR order, should express that disagreement in writing to the medical ethics committee.

**6. Medical Ethics Committee.** The committee will act as a decision making and review committee on matters relating to DNR orders, as well as other matters at the direction of the Commanding Officer.

a. Composition. The committee will be composed of the following seven members:

One Medical Officer
One Chaplain Corps Officer
One Judge Advocate General Corps Officer
One Medical Service Corps Officer (administrative)
One Nurse Corps Officer
One psychiatrist or psychologist
One senior member of the Hospital Corps Staff

b. Action and Decision.

(1) The committee will review monthly all DNR orders. It will act immediately, however, in those cases where immediate action is warranted or requested.

7. Discussion.

a. Paramount Role of the Patient. Underlying guidance on DNR orders the time the question of resuscitation arises. There are two is the fundamental principle that the patient's desires play the dominant role in the decision process; however, patients may not be competent at dimensions to competence: factual and legal. The dimensions can be classified on a two by two matrix.

b. Legally and Factually Competent Patient. In general, when the competent patient requests a DNR order, the request will be honored, as outlined by Table 2 [drawn from the Commission's Report, *see* Table 2, p. 244 *supra*] regardless of the expected benefits of resuscitation.

The following cases will be given immediate attention by the committee:

(1) Third Party Interests. If reasons exist not to honor the patient's request for a DNR order (e.g., the patient is pregnant, is a sole or primary provider, and so forth), the case shall be referred to the committee. If the committee agrees there is a third party interest but the patient persists in his decision, the case will be referred to the courts. If the committee concludes that there is no third party interest, then the committee will consult with the individual asserting the third party interest. If this person then agrees with the committee, the patient's wishes are followed; if not, the case may be referred to the courts.

(2) Disagreement with Patient. In the event of diagreement with the patient by any health care provider or family member, the case will be referred to the committee. If the committee concurs with the individual in disagreement with the patient, the committee will recommend that a coercive offer (i.e., that the patient be transferred to another facility) be made or will refer the case to the courts. If the committee agrees with the patient, it will meet with the disagreeing person. If the health care provider does not agree, he shall comply with the committee's decision or be removed from the case. If the family continues in disagreement, it may refer the case to the courts.

(3) Military Personnel. Governmental claims of a right to require medical care for the individual member obtain only when it can reasonably be expected that the member can be returned to duty as an active and contributing member of the armed forces. Governmental rights should not, therefore, be considered in the case of the terminally ill patient or in the patient in which treatment could constitute undue suffering. In such cases, the patient is to be treated as a legally and factually competent patient.

c. Legally Incompetent, Factually Competent Patient.

(1) Minors. The decision not to resuscitate a minor must be made by the parent or a person standing in place of the parent. In making the decision, the parent or substitute must act in the best interest of the minor. In addition, in the case of a mature minor, the minor's assent should be obtained.

d. Incompetent Patient. Subsumed under the category of the incompetent patient is the patient with diminished competence. In all decisions the underlying principle is to attempt to determine the decision the patient would have made were he fully competent and informed. This is especially true in the case of the patient whose capacity is diminished as a consequence of pain, therapeutic regimen, or other factors associated with the illness.

(1) Table 3 [drawn from an earlier draft of the Commission's Report, see Table 3, p. 247 *supra*] summarizes the decision alternatives first as a function of the provider's assessment of benefit vis à vis the family's views and second as a function of the provider's recommendation and the family's views.

(2) All cases involving incompetence or diminished competence will be routinely reviewed by the committee. Before the DNR order is written, however, the case must be reviewed at least by a legal officer and psychologist or psychiatrist to establish competence. If the order is one that on Table 3 calls for review or reexamination, then the case must be reviewed by the committee before the order is written.

(3) When the committee concurs with the physician, members of the committee may assist the physician in clarifying the provider's assessment for the family. If the family remains unpersuaded, the provider may make a coercive offer or refer the matter to the courts.

(4) When the committee concurs with the family, it shall confer with the physician. If the disagreement remains, the physician shall comply with the committee's decision or be removed from the case.

8. Definitions. In general, the definitions contained herein are either consistent with or derived from the President's Commission for the Study of Ethical Problems in Medicine, and where applicable, local laws and military regulations.

a. Assent. The passive acceptance of a decision made by others.

b. Autonomy. The right of self determination, i.e., the right of competent persons to form, revise and pursue a plan of life. In matters of patient care and orders not to resuscitate, it means that the competent patient's own values shall be decisive. It also means that health care providers shall not be

required to act in a manner contrary to their own values or professional standards.

c. Competence. The ability to make an informed choice. In the case of orders not to resuscitate, it means that the patient understands the relevant risks and alternatives with their attendant consequences. The decision should reflect deliberate choice.

(1) Legal Incompetence. That situation in which an individual is incompetent by operation of law, e.g., a minor or a person previously declared incompetent by judicial decree. Under Maryland state law, a minor who is married or who is a parent is legally competent.

(2) Factual Incompetence. Those situations in which a patient is comatose, unconscious, suffering insane delusions or is otherwise unable to manage his or her personal affairs due to mental disability or disease.

d. Consent. Active participation in and agreement with a decision.

e. Death Imminent. That condition in which in the ordinary course of events, death will probably occur within two weeks. Note that while a death imminent prognosis is a contributing factor for an order not to resuscitate, its absence does not create a prohibition.

f. Diminished Competence. This condition exists when a patient cannot make decisions that promote his well being in accordance with his own previously expressed values and preferences. Diminished competence is often seen as a consequence of pain, therapeutic regimen, or other factor associated with the patient's illness.

g. Family. Those persons sharing a consanguineous relationship (blood) with the patient. In order of consanguinity, this includes the patient's spouse, children, parents and siblings.

h. Informed Consent. A principle of law embodied within the patient's autonomy or right of self determination. It requires that the patient must be informed of all proposed medical procedures, the material risks of those procedures, alternative courses of action and the material risks attendant to the alternatives.

i. Mature Minor. Those above the age of 14 will generally be considered mature minors. Those under the age of fourteen may be so considered at the discretion of the committee.

j. Optimal Care. Care which assures the comfort, dignity, and physical maintenance of the patient regardless of the existence of orders not to resuscitate.

k. Reparability. The extent to which the illness can be cured, corrected, or otherwise stemmed within existing knowledge and technology.

1. Reversability. The extent to which known therapeutic measures can effectively reverse the course of the illness.

m. Terminally Ill. That condition in which there is no reasonable medical possibility that the patient will avoid death and return to a normal cognitive and sapient state.

9. Action. Chiefs of directorates are required to ensure that the provisions of this instruction are understood and carried out. It is also highly recommended that those providers having to deal with orders not to resuscitate become familiar with the bibliography on the subject in the E. R. Stitt Library.

(signed)
J. J. Quinn

APPENDIX "G"

Guidelines for orders not to resuscitate,
Department of the Navy,
Naval Hospital, Naval Medical Command,
National Capital Region,
Bethesda, Maryland,
dated 27 June 1983.

DEPARTMENT OF THE NAVY
NAVAL HOSPITAL
NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION
BETHESDA, MARYLAND 20814

IN REPLY REFE
NHBETHINST
NHBETH:83:A
27 JUN 19

NHBETH INSTRUCTION 6320.37A

From: Commanding Officer

Subj: Guidelines for orders not to resuscitate

1. Purpose. To establish guidelines for writing orders not to resuscitate ("no code" orders).

2. Cancellation. NHBETH INSTRUCTION 6320.37 is hereby cancelled and superseded.

3. Background. The routine application of cardiopulmonary resuscitation and Advanced Cardiac Life Support has given rise to serious questions regarding the appropriateness of resuscitating every patient who suffers an arrest. Confusion as to criteria for decisions not to resuscitate, identity of decision makers, and a proper decision making process has further obscured an already difficult proble This instruction is intended to simplify the problem by establishing a clearly delineated decision making process, identifying the appropriate decision makers and providing both criteria for making such decisions and a system of review.

4. Policy. The overriding policy of this hospital is to maintain life and health, and the autonomy of both patients and medical department personnel.

5. Procedures for Writing Orders Not to Resuscitate The following elements mu be contained in every instance of writing orders not to resuscitate (DNR orders) (Terms are defined in paragraph 9.)

a. Only credentialled Active Clinical Staff physicians may authorize DNR orders. Such orders may be written by licensed physicians beyond GME1 and must be countersigned by the authorizing credentialled physician within twelve hours.

b. Orders must be clearly written, signed, dated and immediately shown to the ward or unit charge nurse.

c. The order not to resuscitate must be accompanied by a progress note describing the application of the decision making process. (See Tables 2 and 3. The description will include:

(1) A statement indicating: condition (reversibility/irreversibility) physical status (reparability/irreparability), mental status (competent/incompetent/diminished competence), and prognosis (death imminent/nonimminent).

(2) Patient and family involvement including their attitudes and responses.

(3) Optimal care treatment plan.

(4) The identity of the authorizing credentialled Active Clinical Staff physician if the order is written by a non-credentialled licensed physician.

d. The physician's discussion with the patient or family shall be witnessed by a registered professional nurse, or social worker, who will sign the doctor's progress note as a witness.

e. The appropriateness of each DNR order must be reviewed frequently by the medical officer primarily responsible for the patient's care.

6. Questions or Disagreement. The patient, any member of the family or of the health care provider team who questions or disagrees with the writing of the DNR order, or the absence of a DNR order, should express that disagreement in writing to the medical ethics committee.

7. Medical Ethics Committee. The committee will act as a decision making and review committee on matters relating to DNR orders, and will review monthly all DNR orders. It will act immediately, however, in those cases where immediate action is warranted or requested. Nursing service will notify the Chairman of the Committee of all patients with DNR orders daily.

8. Discussion.

a. Paramount Role of the Patient. Underlying guidance on DNR orders is the fundamental principle that the patient's desires play the dominant role in the decision process; however, patients may not be competent at the time the question of resuscitation arises. There are two dimensions to competence: factual and legal. The dimensions can be classified on the following two by two matrix:

TABLE I

Classification of Legal and Factual Competence

| | FACTUAL | LEGAL |
|---|---|---|
| Competent | | |
| Incompetent | | |

b. Legally and Factually Competent Patient. In general, when the competent patient requests a DNR order, the request will be honored, as outlined by Table 2, regardless of the expected benefits of resuscitation.

TABLE 2

**Resuscitation (CPR) of Competent Patients—Physician's Assessment in Relation to Patient's Preference**

| Physician's Assessment | Patient Favors CPR* | No Preference | Patient Opposes CPR* |
|---|---|---|---|
| CPR Would Benefit Patient | Try CPR | Try CPR | Do not try CPR; review decision** |
| Benefit of CPR Unclear | Try CPR | Try CPR | Do not try CPR |
| CPR Would Not Benefit Patient | Try CPR; review decision** | Do not try CPR | Do not try CPR |

* Based on an adequate understanding of the relevant information.

** Such a conflict calls for careful reexamination by both patient and physician. If neither the physician's assessment nor the patient's preference changes, then the competent patient's decision should be honored.

The following cases will be given immediate attention by the committee:

(1) Third Party Interests. If reasons exist not to honor the patient's request for a DNR order (e.g., the patient is pregnant, is a sole or primary provider, and so forth), the case shall be referred to the committee. If the committee agrees there is a third party interest but the patient persists in his decision, the case will be referred to the courts. If the committee concludes that there is no third party interest, then the committee will consult with the individual asserting the third party interest. If this person then agrees with the committee, the patient's wishes are followed; if not, the case may be referred to the courts.

(2) Disagreement with Patient. In the event of disagreement with the patient by any health care provider or family member, the case will be referred to the committee. If the committee concurs with the individual in disagreement with the patient, the committee will recommend that a coercive offer (i.e., that the patient be transferred to another facility) be made or will refer the case to the courts. If the committee agrees with the patient, it will meet with the disagreeing person. If the health care provider does not agree, he shall comply with the committee's decision or be removed from the case. If the family continues in disagreement, it may refer the case to the courts.

(3) Military Personnel. Governmental claims of a right to require medical care for the individual member obtain only when it can reasonably be expected that the member can be returned to duty as an active and contributing member of the armed forces. Governmental rights should not, therefore, be considered in the case of the terminally ill patient or in the patient in which treatment would constitute undue suffering. In such cases, the patient is to be treated as a legally and factually competent patient.

c. Legally Incompetent, Factually Competent Patient.

(1) Minors. The decision not to resuscitate a minor must be made by the parent or a person standing in place of the parent. In making the decision, the parent or substitute must act in the best interest of the minor. In addition in the case of a mature minor, the minor's assent should be obtained.

d. Incompetent Patient. Subsumed under the category of the incompetent patient is the patient with diminished competence. In all decisions, the underlying principle is to attempt to determine the decision the patient would have made were he fully competent and informed. This is especially true in the case of the patient whose capacity is diminished as a consequence of pain, therapeutic regimen, or other factors associated with the illness.

(1) Table 3 summarizes the decision alternatives first as a function of the provider's assessment of benefit vis a vis the family's views and second as a function of the provider's recommendation and the family's views.

TABLE 3

**Resuscitation (CPR) of Incompetent Patients—Physician's Assessment in Relation to Surrogate's Preference**

| Physician's Assessment | Surrogate Favors CPR* | No Preference | Surrogate Opposes CPR* |
|---|---|---|---|
| CPR Would Benefit Patient | Try CPR | Try CPR | Try CPR until review of decision |
| Benefit of CPR Unclear | Try CPR | Try CPR | Try CPR until review of decision |
| CPR Would Not Benefit Patient | Try CPR until review of decision | Try CPR until review of decision | Do not try CPR |

* Based on an adequate understanding of the relevant information.

(2) All cases involving incompetence or diminished competence will be routinely reviewed by the committee. Before the DNR order is written, however, the case must be reviewed at least by a legal officer and psychologist or psychiatrist to establish competence. If the order is one that on Table 3 calls for review or re-examination, then the case must be reviewed by the committee before the order is written.

(3) When the committee concurs with the physician, members of the committee may assist the physician in clarifying the provider's assessment for the family. If the family remains unpersuaded, the provider may make a coercive offer or refer the matter to the courts.

(4) When the committee concurs with the family, it shall confer with the physician. If the disagreement remains, the physician shall comply with the committee's decision or be removed from the case.

9. Definitions. In general, the definitions contained herein are either consistent with or derived from the President's Commission for the Study of Ethical Problems in Medicine, and where applicable, local laws and military regulations.

a. Assent. The passive acceptance of a decision made by others.

b. Autonomy. *The right of self determination, i.e., the right of competent* persons to form, revise and pursue a plan of life. In matters of patient care and orders not to resuscitate, it means that the competent patient's own values shall be decisive. It also means that health care providers shall not be required to act in a manner contrary to their own values or professional standards.

c. Competence. The ability to make an informed choice. In the case of orders not to resuscitate, it means that the patient understands the relevant risks and alternatives with their attendant consequences. The decision should reflect deliberate choice.

(1) Legal Incompetence. That situation in which an individual is incompetent by operation of law, e.g., a minor or a person previously declared incompetent by judicial decree. Under Maryland state law, a minor who is married or who is a parent is legally competent.

(2) Factual Incompetence. Those situations in which a patient is comatose, unconscious, suffering insane delusions or is otherwise unable to manage his or her personal affairs due to mental disability or disease.

d. Consent. Active participation in and agreement with a decision.

e. Credentialled. See NHBETHINST 6320.15 of 15 November 1982.

f. Death Imminent. That condition in which in the ordinary course of events, death will probably occur within two weeks. Note that while a death imminent prognosis is a contributing factor for an order not to resuscitate, its absence does not create a prohibition.

g. Diminished Competence. This condition exists when a patient cannot make decisions that promote his well being in accordance with his own previously expressed values and preferences. Diminished competence is often seen as a consequence of pain, therapeutic regimen, or other factor associated with the patient's illness.

h. Family. Those persons sharing a consanguineous relationship (blood) with the patient. In order of consanguinity, this includes the patient's spouse, children, parents and siblings.

i. Informed Consent. A principle of law embodied within the patient's autonomy or right of self determination. It requires that the patient must be informed of all proposed medical procedures, the material risks of those procedures, alternative courses of action and the material risks attendant to the alternatives.

j. Mature Minor. Those above the age of fourteen will generally be considered mature minors. Those under the age of fourteen may be so considered at the discretion of the committee.

k. Optimal Care. Care which assures the comfort, dignity, and physical maintenance of the patient regardless of the existence of orders not to resuscitate.

l. Reparability. The extent to which the illness can be cured, corrected, or otherwise stemmed within existing knowledge and technology.

m. Reversibility. The extent to which known therapeutic measures can effectively reverse the course of the illness.

n. Surrogate. The person who by virtue of family relationship, designation or court order is recognized as the person to decide for a patient who is incompetent or of diminished competence.

o. Terminally ill. That condition in which there is no reasonable medical possibility that the patient will avoid death and return to a normal cognitive and sapient state.

10. Action. Chiefs of directorates are required to ensure that the provisions of this Instruction are understood and carried out. DNR orders apparently inconsistent with this instruction or in need of clarification should be brought to the attention of the Medical Ethics Committee as soon as possible. It is also highly recommended th those providers having to deal with orders not to resuscitate become familiar with the bibliography on the subject in the E. R. Stitt Library.

J. J. QUINN

Dist.: II

APPENDIX "H"

Department of the Air Force,
Wilford Hall USAF Medical Center,
letter, subject: Management of Terminally Ill Patients -
Do Not Resuscitate Guidance, dated 17 February 1984.
With inclosure from Headquarters,
United States Air Force,
subject: Management of Terminally Ill Patients,
dated 21 July 1982.

DEPARTMENT OF THE AIR FORCE
WILFORD HALL USAF MEDICAL CENTER (AFSC)
LACKLAND AIR FORCE BASE, TEXAS 78236

REPLY TO ATTN OF: SGJ (Capt McLauthlin, AV 240-7808) 17 February 1984

SUBJECT: Management of Terminally Ill Patients - Do Not Resuscitate Guidance

TO: Cannon AFB JA/SG
Holloman AFB JA/SG
Kirtland AFB JA/SG

1. This letter is in response to your request for guidance concerning orders not to resuscitate.

2. In management of the terminally ill, there are two broad medical legal issues. One issue concerns the removal of life support from a person who would be dead but for artificial devices of sustenance. The other issue involves the decision not to lend extraordinary support to a person who is dying. Orders not to resuscitate are included in this second category.

3. Air Force guidance in this medical-legal area is contained in a 21 July 1982 AFMSC/SGPC ALMAJCOM letter (Atch 1), a 14 April 1980 AFMSC/SGPC ALMAJCOM letter (Atch 2), and a 5 March 1980 AF/JACC opinion (Atch 3). As these letters indicate, Air Force hospitals should look to local law and local medical practice in responding to issues raised in the management of terminally ill patients.

4. The New Mexico Right to Die Act (the "Act", 24-7-1 to 24-7-11 NMSA 1978) responds to some of the questions that may arise regarding orders not to resuscitate in New Mexico Air Force medical facilities.

a. The Act provides a means for a terminally ill, competent adult to request that maintenance medical treatment be withheld (24-7-3 NMSA). The individual can execute a document called a "living will" and may request that, if he/she is certified to be terminally ill under the state statute, maintenance medical treatment not be administered to prolong life. Attached are copies of NMHA FORMS 24 and 25 (Atch 4 and 5) which are alternate forms that can be used as "living wills" in New Mexico. Under the Act, a physician or hospital who withholds maintenance medical treatment in reliance on a living will and who has no actual notice of revocation by the patient, will not be subject to civil or criminal liability that otherwise might be incurred except liability due to negligence. Certification of terminal illness must be made in writing by two physicians, one of whom must be the patient's attending physician (24-7-5 NMSA). I have attached a form, NMHA FORM 26, that should be completed for this purpose (Atch 6). A copy of the certification should be kept in the patient's hospital record. A person may revoke a living will by destroying the document or by indicating a change of interest in the presence of an adult witness (24-7-6 NMSA). The Act does not expressly require that a person be competent at the time of revoking a living will. Any question regarding the validity of a living will should be resolved with the assistance of the Base Legal Office and/or regional Medical Law Consultant before withholding or withdrawing medical maintenance treatment.

b. The Act (24-7-4 NMSA) also permits an adult spouse or parent or guardian to execute a document requesting that maintenance medical treatment not be given to a minor who has been certified as terminally ill (Atch 7). The parent, guardian, or adult spouse must execute the document with the same formalities as required for a will. The person signing such a document must petition the probate district court for "certification upon the face of the document." Before certification takes place, the court must appoint a guardian ad litem and may hold a hearing. A hospital will be immune from civil or criminal liability other than for negligence for actions taken in withholding maintenance medical treatment from a minor in compliance with a document properly executed and certified under the Act (24-7-7 NMSA).

5. The Act does not authorize a relative to withhold maintenance medical treatment from a competent terminally ill adult. There are some other important limitations to the coverage of the Act:

a. The language specifically refers to "withholding" maintenance medical treatment. Thus, the Act may not apply in those situations where maintenance medical treatment has already begun.

b. The Act is inapplicable if the patient is not suffering from a terminal illness.

c. The exact scope of the term "maintenance medical treatment" is unclear. "Maintenance medical treatment" is defined under the Act as "medical treatment designed solely to sustain the life processes" (24-7-2 NMSA).

6. The Act provides that no other right or responsibility which a person has concerning withholding maintenance medical treatment is impaired or superseded (24-7-9 NMSA). Thus, in areas such as those listed above where the Act does not apply or where the scope of the Act is unclear, the hospital should rely on common law rules and standard practices governing non-treatment of terminally ill patients.

7. Cardiopulmonary resuscitation ("CPR") is used to prevent sudden, unexpected death due to cardiac or respiratory arrest. A patient, or a patient's family, may prefer that CPR not be used, particularly if the patient has a terminal illness and death is imminent. I have attached for your reference a copy of the do not resuscitate ("DNR") guidance used at Wilford Hall (Atch 8). These guidelines are used when the patient, the patient's family, and/or the medical staff feel that an order not to resuscitate is appropriate. Establishing definite DNR guidance is advisable. The hospital should not encourage or permit secret "no code" orders or the so-called "slow code" orders.

8. From my brief review of New Mexico law, it appears that DNR guidelines in New Mexico military medical facilities will need to be slightly different than those used at Wilford Hall. DNR guidelines in New Mexico facilities might be broken into the following categories:

a. Competent Adult Patients. Guidelines can be developed at New Mexico Air Force facilities under the Right to Die Act which allow DNR orders for competent adult patients who have signed a valid living will. These guidelines can be similar to Wilford Hall's DNR guidelines (Atch 8) at paragraph 1(b).

b. Incompetent Adult Patients with Valid Living Wills. In addition, it appears that DNR guidelines in New Mexico can be drafted for the incompetent adult patient who has a living will that was properly executed prior to the individual's incompetency.

c. Terminally Ill Minors. Under the New Mexico Right to Die Act, DNR guidelines can also cover terminally ill minors whose parent, guardian, or adult spouse has properly executed and certified the form requesting that maintenance medical treatment be withheld.

d. Incompetent Adult Patients without Valid Living Wills. DNR guidance for incompetent adults without living wills is not specifically covered by the Act. As noted above, in areas not addressed by the Act the hospital should be able to rely on common law rules and existing practice (NMSA 24-7-9). Thus, before DNR guidelines are prepared at New Mexico Air Force hospitals for incompetent adult patients without valid living wills, it would appear appropriate for base legal and medical personnel to determine if DNR orders are accepted for these patients in New Mexico civilian facilities.

9. Hopefully this information will assist in your development of DNR guidelines. As drafts of these guidelines are prepared, please forward them to my office for review. My office can then serve as a central point for the further cross-feed of information and for the development of consistant DNR guidance at all three New Mexico Air Force facilities.

Scott B. McLauthlin

SCOTT B. McLAUTHLIN, Capt, USAF, JA
Chief, Medical Law

8 Atch
1. AFMSC/SGPC ALMAJCOM Ltr, 21 Jul 82
2. AFMSC/SGPC ALMAJCOM Ltr, 14 Apr 80
3. AF/JACC Opinion, 5 Mar 80
4. NMHA FORM 24
5. NMHA FORM 25
6. NMHA FORM 26
7. NMHA FORM 27
8. WHMC DNR Guidelines

DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
BOLLING AFB DC 20332

REPLY TO ATTN OF: AFMSC/ SGPC
BROOKS AFB TEXAS 78235

21 JUL 1982

SUBJECT: Management of Terminally Ill Patients

TO: ALMAJCOM-SOA/SG

1. Our previous 14 April 1980 ALMAJCOM letter and AF/JA opinion regarding the management of terminally ill patients is still current policy and illustrate the difficulty in establishing a viable Air Force-wide policy in this sensitive area.

2. Air Force hospitals should be guided by local law and local medical practice in their management of terminally ill patients.

3. The area of "orders not to resuscitate" deserves some additional comment. In addition to documenting the consultation with the patient and/or family members in the medical records, the orders must have an automatic, periodic review. Local commanders must insure that these orders are reviewed with the periodicity required by the case.

4. Policy must at all times be developed in conjunction with the local and regional medical law consultant as well as the base staff judge advocate.

FOR THE CHIEF OF STAFF

WILLIAM J. LAWSON, Colonel, USAF, MC
Director of Professional Services
Office of the Surgeon General

1 Atch
AFMSC/SGP ALMAJCOM-SOA/SG
Ltr, 14 Apr 80 w/atch

1st Ind, AFSC/SGPC 4 Aug 82

TO: AMD/EH
USAF Rgn Hosp Eglin/SG
USAF Hosp Edwards/SG
USAF Hosp Patrick/SG
USAF Clinic Los Angeles/SG
USAF Clinic Hanscom/SG

Forwarded for your information.

FOR THE COMMANDER

EDWARD A. MILLER, Lt Colonel, USAF, MC
Chief, Clinical Medicine
Office of the Command Surgeon

1 Atch
nc



Exh 1

DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
BOLLING AFB, DC 20332

14 Apr 80

REPLY TO ATTN OF: AFMSC/ SGP
BROOKS AFB TEXAS 78235

SUBJECT: Management of Terminally Ill Patients

TO: ALMAJCOM-SOA/SG

1. The attached review and opinion provided by AF/JA is forwarded for your information. The review of the various legal standards in this very sensitive area illustrates the difficulty in establishing a viable Air Force-wide policy. For the reasons expressed in the opinion, Air Force hospitals providing treatment to terminally ill patients should be guided by local law and local medical practice to the extent available and relevant.

2. We recognize that there may be a void of legal authority or definitive medical practice in some jurisdictions, particularly relative to "no code orders" (orders not to initiate extraordinary life sustaining procedures) on incompetent, terminally ill patients. Civilian medical facilities in these jurisdictions, of course, face the same uncertainty. In formulating local policies in these jurisdictions, we commend for your review the procedures and considerations set out in the article "Orders Not To Resuscitate," New England Journal of Medicine, 1976; 295: 364. Consultations with the patient and/or family members should be fully documented in the patients medical records.

3. In reviewing local medicolegal standards, assistance may be obtained from the regional medical law consultant as well as the base staff judge advocate.

HARRY T. CERHA, Colonel, USAF, MC
Deputy Director, Professional Services
Office of the Surgeon General

1 Atch
Ltr, HQ USAF/JACC, 5 Mar 80



Atch 2

DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON, D.C. 20324

5 MAR 1980

JACC

Management of Terminally Ill Patients

AFMSC/SGPC

1. This letter is in response to a request for guidance from the Office of the Deputy Surgeon General for Operations concerning the management of terminally ill patients.

2. This subject presents both physicians and attorneys with a multitude of problems, some of which have yet to be resolved by statutory or decisional law, and others of which, when resolved, have not found universal acceptance in all jurisdictions.

3. We are dealing here with essentially two problems, namely: the removal of "life support" systems from a person who is considered dead, but for artificial devices of sustenance, and the decision not to lend extraordinary support to a person who is dying.

4. Since the controversial case of In re Quinlan, 70 N.J. 10, 355 A.2d 647 (1976), a growing effort has been made to lend social acceptance to the concept of "death with dignity." This concept has, in many instances, overlapped into the area of organ transplant, since many vital organs may remain capable of functioning in another body even though they have become essentially useless in the donor body.

5. The primary difficulty encountered is to fix the time when the human body can be considered dead. Traditionally, death was assumed to occur when the following could be observed:

a. loss of muscle tone

b. cessation of pupil dilation

c. loss of coloration

d. loss of movement

e. failure to respond to stimuli

f. drop in body temperature

g. cessation of respiration

h. cessation of heartbeat and blood circulation.



Atch 3

6. The trend in more recent years, however, is to shift determining factors to the function of the brain, and modern considerations of death include:

a. an isoelectric encephelographic tracing

b. cessation of respiration

c. cessation of circulation

d. bilateral mydriasis

e. failure to respond to stimuli

f. absence of voluntary movement

g. absence of reflexes

h. opthalmoscopic evidence of cessation of circulation

i. angiographic evidence of cessation of circulation

j. absence of blood pressure

k. absence of indication of drug indiced coma

l. irreversible cessation of cerebral function over a reasonable period of time.

7. It has been observed that, "Physicians would prefer the criterion of death to be the cessation of brain function for 48 hours as indicated by the absence of waves in the electroencephelogram, rather than the cessation of the heartbeat. It is possible for the heart to go on beating for days after the brain has passed beyond possible recovery." See "Updating the Time of Death," Medical World News (1967). A 24-hour cessation period has been utilized more recently.

8. Preferences such as these have led a growing number of states to enact legislation expanding the definition of death to include the irreversible cessation of total brain function, with the final determination to be based upon local standards of medical practice. Thus, local practice might dictate that a body could be considered dead merely because of a flat electroencephelogram, as most other vital functions can be sustained by artificial means. If "brain death" becomes the measure of the end of life, the prospect of transplantation, and of removal of artificial support systems, are readily made easier to implement. On the other hand, local medical practice might also ascribe to the

belief that death does not occur until all vital functions have ceased despite the use of artificial life support mechanisms. In these jurisdictions, special care and concern must be given to being certain that the patient has succumbed to a "clinical death," the ending of all vital functions (emphasis added). It is critical that our personnel become aware of and follow the law and practice of the locale in which the Air Force hospital is located.

9. The second major problem deals with those people who are functionally alive in every respect, but who are in imminent danger of death. In offering treatment to these terminally ill patients, a physician is required to provide care which is considered reasonable according to contemporary standards of the medical profession and according to any applicable statutory or decisional law. Normally, physicians have no duty to provide treatment or care which exceeds these standards, leaving the major issue the determination of the point at which ordinary care ends and extraordinary care begins. See In re Quinlan, 70 N.J. 10, 355 A.2d 647 (1976); In re Dinnerstein, 380 N.E. 2d 134 (1978); Lane v. Candura, 376 N.E. 2d 1232 (1978); Superintendent of Belchertown State School, et al. v. Joseph Saikewicz, 370 N.E. 2d 417 (1977).

10. One definition of extraordinary care which has been offered is that point where a physician is not obligated to provide care "which cannot be obtained by or used without expense, pain, or other inconvenience, or which, if used would not offer a reasonable hope of benefit." See Pius XII P.P., Acta Apostolica Sedis, 1027-1033 (1957) as cited in Quinlan, supra. However, it should be mentioned that social, psychological and emotional factors must be considered in determining the extent of care to be exercised. See Saikewicz, supra. In addition, it becomes important to distinguish whether the treatment being offered is life-saving versus life-prolonging.

11. If the patient is deemed to be a competent adult, he, if informed by his doctor, is best qualified to judge whether the proposed treatment is acceptable. Even where it may be in conflict with state interests, courts have held that a patient can decide to discontinue extraordinary treatment. See Lane v. Candura, supra.

12. Where a patient is determined to be incompetent, a guardian may exercise the patient's rights and may discontinue treatment when there is no reasonable hope of cure or benefit. Thus, in the Quinlan decision, if a patient's guardian, the attending physician and a hospital's ethics committee concur that there is no reasonable hope that the patient could return to a sapient state, extraordinary care could be terminated.

13. In the Saikewicz decision, on the other hand, the Massachusetts Supreme Court took a position that left the court as the ultimate authority in determining whether or not extraordinary measures should be continued or utilized:

> "We do not view the judicial resolution of this most difficult and awesome decision as constituting a 'gratuitous encroachment' on the domain of medical expertise. Rather, such questions of life and death seem to us to require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created. Achieving this ideal is our responsibility, and that of the lower courts, and is not to be entrusted to any other group purporting to represent the 'morality and conscience of our society' no matter how highly motivated or impressively constituted."
> 370 N.E. 2d 435 (1977) (emphasis added)

14. It is important to note that the Saikewicz decision applies only to incompetent patients who are wards of the state and who are candidates for "life-prolonging" treatment. It does not apply to "code blue" situations for patients who are incompetent but not wards of the state; nor does it apply to competent patients. For a further discussion, see "Optimum Care For Hopelessly Ill Patients", New England Journal of Medicine (1976).

15. Because of these limited and divergent legal authorities, which we have attempted to generally discuss, it is not advisable at this time to attempt to establish Air Force-wide standards or policies pertaining to the management of terminally ill patients. Instead, it continues to remain the best course of action for each case to be handled individually within the scope of local law and local medical practice.

16. As for the proposed MacDill AFB regulations, we suggest the hospital commander consult with his regional medical law consultant and base staff judge advocate to be certain that the laws of the state in which the hospital is located are not at odds with any provision of that proposed regulation.

17. All medical law consultants at the regional medical centers will be notified to be prepared to assist each hospital commander in formulating individual hospital policies, and this office continues to stand ready to assist in any way we can.

Larry W. Shreve

LARRY W. SHREVE, Colonel, USAF
Chief, Claims and Tort Litigation Staff
Office of The Judge Advocate General

NMHA FORM 24

NAME OF HOSPITAL

# DIRECTIVE CONCERNING MAINTENANCE MEDICAL TREATMENT OF A TERMINALLY ILL ADULT

TO MY FAMILY, MY PHYSICIAN, MY CLERGYMAN, MY LAWYER:

If the time comes when I can no longer take part in decisions for my own future, let this statement stand as the testament of my wishes:

I direct that if I am certified under the New Mexico Right to Die Act as suffering from a terminal illness, then maintenance medical treatment shall not be utilized for the prolongation of my life.

If there is no reasonable expectation of my recovery from physical or mental disability, I request that I be allowed to die and not be kept alive by artificial means or heroic measures. Death is as much a reality as birth, growth, maturity and old age--it is the one certainty. I do not fear death as much as I fear the indignity of deterioration, dependence and hopeless pain. I ask that drugs be mercifully administered to me for terminal suffering even if they hasten the moment of death.

This document is executed after careful consideration. I recognize that it may place a heavy burden of responsibility upon those who share in or are affected by the decisions it mandates. It is with the intention of sharing that responsibility and mitigating any feelings of guilt that this document is executed.

DATED: _____, 19___.

_____



Atch 4

## ATTESTATION CLAUSE

This document, consisting of three pages, this included, was signed by _____ in the State of New Mexico, pursuant to the Right to Die Act, in the presence of us, who at her request and in her presence, and in the presence of each other, have signed our names as witnesses. We believe _____ has reached the age of majority and is of sound mind at this time.

WITNESSES:

_____ residing at _____
_____, New Mexico

_____ residing at _____
_____, New Mexico

## SELF-PROVING PROVISION

STATE OF NEW MEXICO )
) ss.
COUNTY OF _____)

We, _____ (Declarant), _____ (Witness), and _____ (Witness), whose names are signed to the attached or foregoing instrument, being first duly sworn, do hereby declare to the undersigned authority that _____ signed and executed this document pursuant to the Right to Die Act, and that she signed willingly or directed another to sign for her, and that she executed it as her free and voluntary act for the purposes therein described; and that each of the witnesses saw her sign and in her presence at her request and in the presence of each other, signed the foregoing document as witnesses and that to the best of our knowledge she had reached the age of majority, was of sound mind and was under no constraint or undue influence.

_____
Declarant

_____
Witness

_____
Witness

Subscribed, sworn to and acknowledged before me by _____, the declarant, and subscribed, sworn to and acknowledged before me by _____, and _____, witnesses, this ____ day of _____, 19___.

_____
Notary Public

My commission expires:

_____

NMHA FORM 25

NAME OF HOSPITAL

DIRECTIVE CONCERNING MAINTENANCE MEDICAL TREATMENT
OF A TERMINALLY ILL ADULT

HOSPITAL NUMBER _____

NAME OF PATIENT _____ AGE _____

ATTENDING PHYSICIAN _____

DATE OF SIGNING _____ TIME _____a.m./p.m.

I _____, being of sound mind, voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below:

1. If at any time I should have an incurable injury, disease or illness certified by two physicians to be a "terminal illness" under the New Mexico Right to Die Act, and where the application of maintenance medical treatment would serve only to artifically prolong the moment of my death, and where the certifying physicians determine that my death is imminent whether or not maintenance medical treatment is utilized, I direct that such treatment be withheld or withdrawn and that I be permitted to die naturally.

2. In the absence of my ability to give directions regarding the use of such maintenance medical treatment, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences for such refusal. I understand the full import of this directive and I am emotionally and mentally competent to make this directive.

DATED: _____

_____



Atch 5

## ATTESTATION CLAUSE

This document consisting of _____ pages, this page included, was signed by _____ in the State of New Mexico, pursuant to the Right to Die Act, in the presence of us who at his/her request and in his/her presence, and in the presence of each other, have signed our names as witnesses. We believe _____ has reached the age of majority and is of sound mind at the time of this signing.

WITNESSES:

_____, residing at _____
_____, New Mexico

_____, residing at _____
_____, New Mexico

NMHA FORM 26

NAME OF HOSPITAL

CERTIFICATION OF TERMINAL ILLNESS

HOSPITAL NUMBER _____

NAME OF PATIENT _____ AGE & DATE OF BIRTH_____

ATTENDING PHYSICIAN _____

DATE OF SIGNING _____, 19___ TIME _____a.m./p.m.

We, the undersigned, hereby certify that the patient named above is suffering from a terminal illness as defined in Section 24-7-2D, NMSA 1978 (The Right to Die Act).

The terminal illness from which the patient suffers is _____
_____
_____
_____
_____
_____.

Signed:

_____ _____
Certifying Physician (Attending Physician) Witness

_____ _____
Second Certifying Physician Witness



Atch 6

NMHA FORM 27

NAME OF HOSPITAL

DIRECTIVE CONCERNING MAINTENANCE MEDICAL TREATMENT
ON BEHALF OF A TERMINALLY ILL MINOR

HOSPITAL NUMBER_____

NAME OF PATIENT _____AGE & DATE OF BIRTH_____

ATTENDING PHYSICIAN _____

DATE OF SIGNING _____TIME _____a.m./p.m.

I _____, parent, guardian, spouse (strike of if inapplicable) of _____, understand that _____, my minor child, ward, spouse (strike out if inapplicable) is suffering from a terminal illness as defined in Section 24-7-2D NMSA 1978 (The Right to Die Act). The terminal illness from which _____suffers is _____
_____
_____

The physicians certifying the terminal illness are: _____
_____
_____

I direct that maintenance medical treatment of _____
_____be withheld or withdrawn and that _____ be permitted to die naturally.

I certify that neither _____ nor another parent, guardian or the adult spouse of _____has given any contrary indication of opposition to the execution of this directive.

I CERTIFY: This form has been explained to me; I have read the contents of this form or the contents have been read to me; I understand its contents; the explanation of the contents was made and all blanks or statements requiring insertion or completion



Att 7

were filled in and items not applicable were stricken before I signed.

_____

Parent, guardian, adult spouse

THIS FORM MUST BE CERTIFIED BY THE DISTRICT COURT IN THE COUNTY WHERE THE MINOR LIVES OR IN THE COUNTY WHERE THE MINOR IS HOSPITALIZED OR OTHERWISE MAINTAINED.

NMHA revised 1979

GUIDELINES FOR ISSUING ORDERS NOT TO RESUSCITATE (DNR)

1. Before issuing a DNR order, the physician will insure that each of the following guidelines are met:

a. If the patient is incapable of giving consent because of physical or mental condition or legal age:

(1) The patient is terminally ill with a poor quality of life and doubtful expectation of recovery based on the current state of medical science;

(2) Death is imminent;*

(3) The person capable of giving legal consent concurs in the decision not to resuscitate (if there is any disagreement, an independent medical consultant should be obtained to discuss the matter with this person; if this person still disagrees, the Medical Law Consultant will be contacted;

(4) All of the above ((1)-(3)) are reflected in the patient's medical record and communicated to the medical staff treating the patient; and

(5) DNR orders must be issued or countersigned by the attending staff physician before such orders are valid.

b. For patients capable of giving consent:

(1) The patient has executed a living will under the provisions of Texas law.

(2) The patient is terminally ill with a poor quality of life and doubtful expectation of recovery based on the current state of medical science;

(3) Death is imminent;*

(4) All of the above ((1)-(3)) are reflected in the patient's medical record and communicated to the medical staff treating the patient;

(5) If patient expresses a desire for all possible supportive measures, a DNR is not appropriate; and

(6) DNR orders must be issued or countersigned by the attending staff physician before such orders are valid.

2. After a DNR order is issued, the attending staff physician will insure that a daily review is made in the progress notes of the patient's condition by the treating physician and that this review is noted in the medical record.

3. If at any time the patient, if competent, expresses a desire for all possible supportive measures, a DNR is not appropriate. If the patient is not competent and the person capable of giving consent disagrees at any time with the DNR order, an independent medical consultant will be obtained to discuss the matter with this person. If this person still disagrees with the DNR order, the Medical Law Consultant will be contacted.

*In the only court case dealing with this issue, the patient's probable life expectancy was one year or less.

APPENDIX "I"

Department of the Army,
Surgeon General's letter
on the Texas Natural Death Act,
dated May 23, 1978.

Note: This appendix was extracted from Appendix I, President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research report, Foregoing Life-Sustaining Treatment, pp. 522-529.

## Department of the Army, Surgeon General's Letter on the Texas Natural Death Act*

1. Neither the "Directive to Physicians" (State of Texas Natural Death Act) nor any similiar directives regarding the withholding or withdrawal of life-sustaining procedures will be accepted or honored by Army Medical Treatment Facility [MTF] personnel.

2. The Texas Natural Death Act (TNDA) has been thoroughly evaluated by the Office of the Judge Advocate General. It appears that a "Directive to Physicians" executed in accordance with the TNDA would be legally effective only in the case of a physician licensed in the State of Texas, who is not a member of the Armed Forces, and who is practicing in an area over which the United States holds only a proprietary interest.

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* DASG-PSA (13 Dec 77) 1st Ind; DA, OTSG, Washington, D.C. 20310. To: Commander, US Army Health Services Command, ATTN: HSJA Fort Sam Houston, TX 78234 (May 23, 1978).

3. MTF's may be located on land under various kinds of Federal legislative jurisdiction: exclusive jurisdiction, concurrent jurisdiction, partial jurisdiction, and prioprietary interest only. "Exclusive Federal jurisdiction" means that *only* the Federal Government may legislate as to the area in question. "Concurrent jurisdiction" means that both the Federal Government and a state government may legislate as to all matters within the area. "Partial jurisdiction" means that at least one of the two governments may legislate as to some, but not all, questions with regard to the area. "Proprietary interest only" means that the Federal Government owns or has an interest in the land in question but has acquired none of the state's power to legislate with respect to it. It is likely, but not certain, that in at least some cases, in the absence of the TNDA, the deliberate withholding or withdrawal of medical attention resulting in the death of a patient would be a criminal homicide under both State and Federal law. Section 6 of the TNDA immunizes certain "physicians" and "health professionals" from criminal liability for the non-negligent compliance with a properly executed Directive. But, there are specific Federal statutes against homicide in areas of exclusive Federal or concurrent (and, perhaps, partial) jurisdiction (18 U.S.C. 1111-1113). The TNDA cannot affect these Federal statutes because the State of Texas cannot change Federal laws. Accordingly, whether compliance with a directive resulting in a patient's death is a crime may depend on the type of jurisdiction on which the MTF is located. Furthermore, portions of many military installations were acquired at different times and are subject to different forms of jurisdiction. Thus, it is possible for one part of a single MTF to be under exclusive Federal jurisdiction and another part to be subject to only a Federal proprietary interest.

4. To complicate the situation further, the effect of a TNDA directive may depend on the status of the physician in question.

a. Military physicians. While applicability of 18 U.S.C. 1111-1113 depends on the nature of Federal jurisdiction over the place, the Uniform Code of Military Justice (UCMJ) is applicable to active duty members of the Armed Forces acting in their official capacities regardless of their location. It has not been authoritatively decided that allowing a patient to die in compliance with a TNDA Directive would be a crime under the UCMJ, but that is a possibility. That the same act would not be a crime under a law of the state where it occurred is immaterial. Thus, a military physician could be subject to prosecution for homicide regardless of whether he was licensed in Texas and regardless of the nature of jurisdiction over the MTF where the act occurred.

b. Civilian physicians. The applicability of the TNDA to civilian physicians would depend on the nature of jurisdiction

over the place and whether the physician is licensed in Texas or in another state. As Section 2(4) of the TNDA defines "physician" as a physician or surgeon licensed by the Texas State Board of Medical Examiners, a civilian physician licensed by another state working in a MTF in Texas would not be considered a physician for purposes of the TNDA. The Act provides immunity only for "physicians" and "health professionals acting under the direction of a physician." The term "health professional" is not defined in the TNDA, and it is uncertain whether it would include non-Texas civilian physicians. If it did not, a non-Texas civilian physician complying with a TNDA Directive in an area under the criminal jurisdiction of Texas could be subject to prosecution by Texas for homicide.

5. Based on the discussion above, it is clear that the only possible uniform rule for dealing with TNDA Directives, and similar state directives, is to prohibit their use in Army MTF's. Any other approach would create an impossible situation from the standpoints of both medical and legal administration of MTF's.

6. Request this policy be given appropriate dissemination.

(signed)
ENRIQUE MENDEZ, JR., M.D.
Major General, MC
Acting The Surgeon General

APPENDIX "J"

Letter from James G. Zimmerly, M.D., J.D.
to the Surgeon General,
Department of the Army,
dated April 1, 1982.

Note: This appendix was extracted from Appendix I, President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research report, Foregoing Life-Sustaining Treatment, pp. 522-529.

## Letter from James G. Zimmerly, M.D., J.D. to the Surgeon General, Department of the Army*

SUBJECT: Termination of Life Support and Entering of *No-Code Orders*

LTC Bernhard T. Mittemeyer, MC, USA
The Surgeon General
Department of the Army
Room 3-E-469
Washington, D.C. 20310

1. We are writing to express our concern regarding policy DAGS-PSA (13 Dec 77) 1st Indorsement (Inclosure #1) regarding application of the Texas Natural Death Act and similar directives in Army Medical Treatment Facilities. In particular our concerns are as follows: 1) the policy has caused great confusion in military treatment facilities and is being given

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* (April 1, 1982).

different applications; 2) the policy is contrary to both established legal principles and a developing body of case law on point; 3) continuation of the policy is exposing the United States of America and its agents to civil liability; 4) fears of criminal prosecution are unjustified. Each of these concerns will be addressed more fully as follows:

**A. The policy has caused confusion in military treatment facilities (MTFs)**

Some MTFs have interpreted the policy to mean that their medical personnel cannot enter "no-code" orders on any patient or either withhold or withdraw extraordinary life-support measures from any patient under any circumstances. At least one MTF that has come to our attention is completely ignoring the policy. What has become clear is that most MTF medical personnel and JAG officers are quite confused as to *how strictly the policy is* to be interpreted. Particularly confusing is the language "similar directives." Does this mean directives exactly like that encompassed in the Texas Natural Death Act or *any* type of request from a terminally ill patient to cease or not begin treatment? At the very least this policy must be clarified.

**B. The policy is contrary to established principles of medical law**

A basic tenet of medical law is that any adult of sound mind may refuse medical treatment, even if such refusal would result in the person's death. One recent case illustrating this principle is "In the Matter of Robert Quackenbush, an alleged incompetent," 383 A.2d 785 (1978). In *Quackenbush* a 72-year old patient refused to consent to the amputation of his gangrenous legs. The hospital sought a court order to do so alleging that the patient was incompetent and that failure to have the operation would result in the patient's death. The court ruled that the patient was, in fact, competent and that as a competent adult he had the right to make an informed choice about treatment even though the choice would lead to his death.

In federal law, the United States Supreme Court has stated in two landmark cases that there is a right to privacy under the United States Constitution. Therefore, governmental interference with medical treatment arranged between a physician and his or her patients would be a violation of the patient's constitutional right to privacy absent a compelling state interest. *Griswold v. Connecticut*, 381 U.S 479, 85 S. Ct. 1678, 14 L.Ed.2d 510 (1965) and *Roe v. Wade*, 410 U.S. 113, 93 S. Ct. 705, 35 L.Ed.2d 147 (1973). Other federal cases have held that patients have the right to refuse medical treatment. *Winters v. Miller*, 446 F2d 65, cert. denied, 404 U.S. 985, 92 S.Ct. 450, 30 L.Ed.2d 369 (1971) and *Rogers v. Okin*, 634 F.2d 650 (1980).

Of the few cases that take a contrary position most have involved either a pregnant woman or a parent with minor children. In those cases, the courts found that the state had a compelling interest in seeing that the parent stayed alive to give birth to or take care of the child involved. *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson*, 42 N.J. 421, 201 A.2d 537, cert. den. 377 U.S. 985 (1964).

Finally, AR 600-20, paragraph 5-29 states that "An Army member on active duty or active duty for training will *usually* be required to submit to medical care considered necessary to preserve his life, *alleviate undue suffering*, or protect or maintain the health of others." (Emphasis added.) The word "usually" leaves the door open for exceptions to the rule that life-preserving treatment can be rendered without consent. Surely either a terminally ill patient or a patient in an irreversible comatose state would fall into the exception. The rule also states that medical care can be given without consent in order to "alleviate undue suffering." It would make sense that the converse would also be true. That is, that further medical care would not be given to a patient dying of a painful disease in order to "alleviate undue suffering." Further, paragraph 5-29 defines medical care as "...preventive, diagnostic, therapeutic, and rehabilitative medical, surgical and psychiatric and dental treatment." It can certainly be argued that extraordinary life support measures do not fall within this definition. Finally, in discussing referral of a serviceman to a medical board for refusal to submit to medical treatment, paragraph 5-31 states that the medical board must answer the following question: "(1) is the proposed treatment required to relieve the incapacity and aid the soldier's return to a duty status, and may it be expected to do so?" Obviously, if the patient was terminally ill or in a permanent comatose state, the answer would be "No." As such a solider would never be able to return to a duty status, the United States Army would not have a compelling government interest in forcing such a patient to submit to medical care against his or her wishes.

**C. The policy is contrary to a growing body of case law dealing directly with no-code orders and the right of a terminally ill or comatose patient to refuse life-sustaining treatment**

1. Eight major state court decisions have been rendered which are applicable. They have predominately upheld the right of a competent adult or person acting on behalf of an incompetent adult, to refuse further treatment. The cases are as follows:

a) *In the Matter of Karen Quinlan, An Alleged Incompetent*, 70 NJ 10, 355 A.2d 647, 79 ALR3d 205 (1976)—the Supreme Court of New Jersey held that a 22-year old patient in a comatose state had a constitutional right to privacy and,

therefore, could have life-sustaining apparatus discontinued, through her guardian, if hospital ethics committee and attending physicians agreed that there was no reasonable possibility of her ever emerging from her comatose state. The court made clear that this was a decision to be made between physicians and patients, and that no court order was necessary.

b) *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977)—the court gave permission to the guardian of a 67-year old mentally retarded patient dying of acute myeloblastic monocytic leukemia to refuse painful chemotherapy treatment on behalf of the patient. The court applied the "substituted judgment doctrine," that is, what the patient would have wanted if competent. The court also based its decision on the constitutional right to privacy.

c) *In re Shirley Dinnerstein*, 380 N.E. 134 (1978)—the court held that a physician attending an incompetent, terminally ill patient may lawfully direct that resuscitation measures be withheld in the event of cardiac or respiratory arrest *without prior court approval.*

d) *Satz v. Perlmutter*, 362 So.2d 160 (1978), aff'd Fla. Supreme Ct. 379 So.2d 359 (1980)—held that a competent 73-year old patient suffering from Lou Gehrig's disease could have respirator removed from his trachea even though such removal would result in life expectancy of less than one hour. The court based its decision largely on the constitutional right to privacy.

e) *Severns v. Wilmington Medical Center*, 421 A.2d 1334 (1980); 425 A.2d 156 (1980)—husband was allowed to assert constitutional right to privacy of comatose wife and, therefore, could instruct medical authorities not to place her on a respirator, not to surgically replace a feeding tube, not to administer any drugs or medicine other than those normally used for bodily hygiene, and finally that a so-called no-code blue order be entered on her medical chart.

f) *In re Spring*, 399 N.E.2d 493 (1979), 405 N.E.2d 115 (1980)—guardian allowed to end dialysis treatment of a 77-year old man suffering from end stage renal disease and organic brain syndrome. Decision based in part upon federal constitutional right to privacy.

g) *Matter of Storar; Eichner v. Dillon*, 52 N.Y.2d 363, 438 N.Y.S.2d 266, (1981); see also Appellate Division opinion *In re Eichner "Brother Fox,"* 73 A.D.2d 431, 426 N.Y.S. 2d 517 (1980)—83-year old patient, prior to becoming incompetent due to illness, had consistently expressed his views that his life not be prolonged by medical means if there was no hope of recovery. Therefore, guardian was allowed to obtain discontinuance of patient's respirator on which patient was being maintained in a permanent vegetative state.

h) *Leach v. Akron General Medical Center*, 426 N.E.2d 809, 68 Ohio Misc. 1 (1980)—guardian of patient who was

terminally ill and in a permanent vegetative state was granted order to have the patient removed from a respirator when it was shown that the patient, if competent, would have elected not to be placed on life supports.

2. Although there is no federal case law directly on point, six of the eight state cases cited above based their decisions at least in part on the federal constitutional right to privacy enunciated in the two U.S. Supreme Court cases, *Griswold v. Connecticut* and *Roe v. Wade*, supra. Therefore, it is inconceivable that a federal court would not uphold the right of a competent, terminally ill patient (through his or her guardian if incompetent) to refuse further medical treatment.

D. The policy exposes the United States of America and its agents to civil liability

1. Several federal courts have held that providing medical care that has not been consented to constitutes an assault and battery. In *Mink v. University of Chicago*, 460 F.Supp. 713, (1980) the plaintiffs brought a class action suit on behalf of themselves and approximately 1,000 other women who had been given DES without their consent as part of a double blind study. The federal court ruled that the plaintiffs had a cause of action for battery. In *Hernandez v. United States America*, 465 F.Supp. 1071 (1979) a federal court ruled that an unconsented to operation performed in a Veterans Administration Hospital constituted an assault and battery. The court further ruled that a claim for assault and battery was not cognizable under the Federal Tort Claims Act due to the exception to such an action found in 28 U.S.C. § 2680(h). However, the court noted a few cases wherein the plaintiffs managed to get around this section in medical cases based upon negligence theory. *Lane v. United States*, 225 F.Supp. 850 (1964); *Fontenelle v. United States*, 327 F.Supp. 80 (1971).

There is also a distinct possibility that military medical personnel involved in rendering unconsented to treatment to a terminally ill or comatose patient could be held individually liable since an intentional assault and battery is generally considered to be outside the scope of a federal employee's practice and therefore coverage would not be available under the *Gonzales Act*, 10 USC § 1089.

2. It has come to our attention that at one particular MTF several families have threatened to bring suit against the U.S. Government because the MTF will not honor any directives to terminate life-support, executed in accordance with that state's natural death legislation. It has also come to our attention that, in fact, the Veterans Administration has recently been sued successfully based upon somewhat similar circumstances. The case, *Foster v. Tourtellotte, et al.*, (1981-82) U.S. District Court, Los Angeles, Hon. Robert Takasugi, Judge, was filed in October of 1981 when VA medical personnel refused to remove a

patient dying from Lou Gehrig's disease from a ventilator at his request. The plaintiff filed a complaint alleging battery, breach of fiduciary duty, violation of constitutional right of privacy, and for injunctive and declaratory relief. In support of his request to be removed from the ventilator, the plaintiff asserted his constitutional right to privacy and his common law right to refuse medical treatment.*

In granting an injunction and ordering the defendants to disengage the plaintiff from the ventilator, the court held "...as we balance the contentions of plaintiff with the concern of society for the life prolongation, this Court cannot conceive a real, substantive collision of philosophies because a reasonable society could not mandate Mr. Foster to bear the unbearable or tolerate the intolerable... Whether Mr. Foster experiences subjective pain at this time, I don't think is truly the issue. He has asserted his constitutional rights of self-dignity to demand that future medical care be terminated." *Foster*, at 22-23. Although the plaintiff's stated causes of action were not cognizable under the Federal Tort Claims Act, and he was therefore not entitled to monetary damages, the plaintiff's attorney is appealing the decision not to grant him attorney's fees which he may be entitled to. More importantly, the suit brought extremely adverse publicity to the Veterans Administration.

In conclusion, it is conceivable that military medical personnel could be sued successfully on an individual basis, and be held personally liable, on the theory of an intentional assault and battery. There is a further possibility that the United States could be sued successfully. Even if monetary damages were not awarded, patients could seek injunctive relief which would engage the United States in costly litigation and further result in adverse publicity.

**E. Fears of criminal prosecution are unwarranted**

The JAG [Judge Advocate General] opinions upon which the policy in question is based are primarily concerned with criminal prosecution under state laws, federal laws, and the Uniform Code of Military Justice (UCMJ). The theories of criminal liability would be assisting a suicide and homicide.

1. *State Law* —Twenty-three states currently have statutes against assisting suicide. An extensive search of cases over the past fifteen years revealed only a few reported cases that have ever been prosecuted under these statutes, none of which dealt in any way with a terminally ill patient or a physician. The only reported case having even a remote

* A number of the arguments that the plaintiff successfully used in *Foster* have subsequently been used herein. Copies of all of the briefs filed in and on behalf of *Foster* are available for inspection at the Armed Forces Institute of Pathology.

connection took place in 1920 in the case of *People v. Roberts*, 211 Mich. 187, 178 N.W. 690. *Roberts*, a husband, was prosecuted for administering poison to his dying wife at her request. The case did not involve physicians or extraordinary life support.

Under the case law reported in section C. above, a physician would not be guilty of homicide if he were operating under guidelines established in accordance with the said law. (To be discussed, *Infra*.)

2. *Federal Law* —Assisting a suicide is not a crime under the federal code. An extensive search of reported cases revealed no federal cases wherein a federally employed physician was ever prosecuted for homicide for either terminating or withholding life support of a terminally ill patient, or for entering a "do not resuscitate" order in a patient's chart. Further, such a prosecution would be inconceivable if the physician were following guidelines established in accordance with reported cases on the subject.

3. *UCMJ* —Assisting a suicide is not listed as an offense under the UCMJ. Extensive research did not reveal any cases wherein a physician was prosecuted under the UCMJ for homicide for either terminating or withholding life support of a terminally ill patient, or for entering a do not resuscitate order in a patient's chart. Clearly, if the Surgeon General issued a policy setting forth appropriate guidelines for dealing with terminally ill patients, any physician following the guidelines would not be subject to prosecution under the UCMJ.

**Conclusions**

**1. The Department of the Army must develop guidelines for handling terminally ill patients in MTFs that are in accordance with applicable state and federal case law**

The eight cases mentioned in section C. above set forth certain methods of handling terminally ill patients consistent with the right of such patients to refuse treatment. In addition, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research has formulated a draft paper, dated January 8, 1982, entitled "Resuscitation and the Decision Against." This paper is an example of the type of guidelines that the Department of the Army should formulate. Numerous other writings and research exist which can give the Department of the Army guidance on formulating appropriate guidelines that would be consistent with the current state of the law on this subject.

**2. State directives should be honored in MTFs**

Natural Death Legislation has been enacted in eleven states and is being considered in others. The scope of most of these acts is quite limited. If the Department of the Army had its own broad guidelines, execution of a state directive with its

limited scope of application would be covered under the guidelines. Even in the absence of appropriate Army guidelines, criminal prosecution for following such directives is unlikely for the reasons stated above.

2. The Department of Legal Medicine stands ready to discuss this matter further, to assist in the development of appropriate guidelines, and to provide any other necessary expertise.

(signed)
James G. Zimmerly,
M.D., J.D.,
MPH, Col, MC, USA
Chairman, Dept. of Legal Medicine

Prepared by:

(signed)

Jane G. Norman, J.D.
Department of Legal Medicine

CONUS AMEDD Hospitals Surveyed*

| Follow-up ID Code | MTF Name | Total Operating Beds |
|---|---|---|
| A | BAMC | 601 |
| B | DDEAMC | 433 |
| C | FAMC | 489 |
| D | LAMC | 376 |
| E | MAMC | 380 |
| F | WRAMC | 876 |
| G | WBAMC | 476 |
| H | Belvoir | 109 |
| I | Benning | 244 |
| J | Bragg | 226 |
| K | Campbell | 186 |
| L | Carson | 146 |
| M | Dix | 145 |
| N | Hood | 225 |
| O | Jackson | 201 |
| P | Knox | 165 |
| Q | L Wood | 184 |
| R | Ord | 164 |
| S | Polk | 118 |
| T | Riley | 127 |
| U | Sill | 155 |

* Information was extracted from page 40 of the Fourth Quarter FY83, Health Services Command, Command Performance Summary.

# APPENDIX "K"

## Project survey questionnaire

Dear Surveyee,

I am a graduate student in the Army-Baylor Program doing a study to determine if ethics committees would be a viable decision-making and review mechanism for matters relating to no-code orders in CONUS AMEDD hospitals with over 100 total operating beds.

To assist me with this study, I am requesting key personnel of the 21 AMEDD hospitals meeting the above description to fill out a 15-question questionnaire and return it in the inclosed self-addressed envelope within 15 days.

Your assistance is requested and appreciated. To add to the continuity of the survey, this study's definitions of ethics committees and no-code orders are listed below.

1. Ethics Committee: A committee that has the potential to become involved in the decision-making process in specific patient cases; the committee's involvement has to precede any final decision about withholding or withdrawing life support in an individual case. For the purpose of this study, neither the nature of the committee's involvement nor the fact that a committee may have additional functions (e.g., policymaking or teaching) excludes it from being referred to as an ethics committee. (This is the same definition used by Dr. Younger in his "National Survey of Hospital Ethics Committees" conducted for the President's Commission.

2. No-Code Order or Do Not Resuscitate (DNR) Order: Means that, in the event of a cardiac or respiratory arrest, cardiopulmonary resuscitative measures will not be initiated or carried out ("code" being the shorthand term for the emergency summoning of a resuscitation team by the announcement of a "Code Blue" over a hospital public address system).

Thank you for your cooperation and assistance.

LEE W. BRIGGS
CPT, MSC
Administrative Resident
USAMEDDAC, Ft Riley, KS 66442
AV 856-7146

QUESTIONNAIRE

1. To what type of organization do you belong? (check one)

_____ MEDCEN
_____ MEDDAC

2. What is your present position? (check one)

_____ MTF Commander
_____ Deputy Commander for Clinical Services
_____ Deputy Commander for Administration
_____ Chief Nurse
_____ Hospital Chaplain

3. Do you feel a need for a more explicit AMEDD policy concerning care for the terminally ill? (check one)

_____ Yes
_____ No; current directives and state laws are sufficient
_____ No

4. Are verbal no-code orders given at your MTF? (check one)

_____ Yes
_____ No
_____ No comment

5. Do you feel the AMEDD should have a written no-code policy?

_____ Yes
_____ No (skip to question #8)

6. Do you feel that this written AMEDD policy should be broad in scope and require MTFs to publish their own specific policy IAW state law and other variables? (check one)

_____ Yes
_____ No

7. Do you feel that this AMEDD policy should include a requirement for a designated MTF "ethics" committee as a decision-making and review mechanism for no-code orders? (check one)

_____ Yes
_____ No

8. Does an ethics committee formally exist at your MTF?

_____ Yes; it is mandated by state law. The name of the committee is _____.
_____ Yes; it is not mandated by state law, but one does exist. The name of the committee is _____
_____.
_____ No

9. Does an informal ethics committee exist at your MTF?

_____ Yes
_____ No

10. If such committees do exist at your MTF, do you consider them effective?

_____ Yes
_____ No (skip to question #12)
_____ Not applicable (skip to question #12)

11. In what areas do you consider the ethics committee at your MTF effective? (check each applicable space)

a. _____ Shaping or evolving consistent hospital policies with regard to life support.

b. _____ Educating professional staff about the important issues.

c. _____ Facilitating decision-making by clarifying important issues.

d. _____ Providing legal protection for the hospital and the U.S. Government.

e. _____ Providing an opportunity for health professionals who usually have less power in decision making than physicians to air disagreements, give input, and receive explanations.

f. _____ Increasing the ability of individual patients and families to influence the decision-making process.

12. Do you perceive a need for MTF ethics committees as a decision-making and review process for no-code orders

a. in the AMEDD in general? (check one)
_____ Yes
_____ No

b. just at the MEDCEN level? (check one)
_____ Yes
_____ No

c. at your particular hospital? (check one)
_____ Yes
_____ No

13. Even if you might not perceive a need, if so directed, do you feel that an ethics committee could be a viable decision-making and review process for no-code orders

a. in the AMEDD in general? (check one)
_____ Yes
_____ No

b. just at the MEDCEN level? (check one)
_____ Yes
_____ No

c. at your particular hospital? (check one)
_____ Yes
_____ No

14. If the AMEDD were to approve a no-code policy with an ethics committee playing a key role,

a. what would you perceive the key functions of that committee to be? (check each applicable space)

(1) _____ To determine medical prognosis

(2) _____ To review ethical issues in patient care decisions in order to make appropriate recommendations for changes

(3) _____ To provide counsel and support to patients/families

(4) _____ To provide counsel and support to physicians.

(5) _____ To provide counsel and support to other health officials

(6) _____ To make ethical and/or social policies for the care of seriously ill and dying patients treated at the hospital.

(7) _____ To determine continuing educational needs of personnel involved in patient care in the area of terminal care.

(8) _____ To make the final decision about continuing life support.

(9)_____Other (specify)_____

_____

_____

_____

_____

_____

b. What would you perceive the proper mix of representatives for such a committee to be? (place a number next to each applicable space)

(1) _____ physician

(2) _____ psychiatrist

(3) _____ psychologist

(4) _____ nurse

(5) _____ administrator (MSC officer)

(6) _____ chaplain

(7) _____ social worker

(8) _____ lawyer (JAG)

(9) _____ lay person

(10) _____ other (specify) _____

Total number_____

15. Do you have any additional comments? If so, please write below:

# APPENDIX "L"

List of hospitals surveyed

conus amedd units with 100 or more total operating beds are underlined.
facilities with administrative residents are checked. FY84 USC PROGRAM

USC AVERAGE DAILY WORKLOAD PROGRAM FOR FY 84 AS OF 9 NOV 83

| Letter | MTF NAME | OPER BEDS | OPER BASS | TOT OP BEDS | BEDS OCCUP | ADMISS | LIVE BIRTHS | CLINIC VISITS | NICU | DENTAL PROC | LAB PROC | RADIOL PROC | PHARM PROC | RATIONS SERVED |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A | ✓BAMC | 587 | 14 | 601 | 500 | 53.8 | 2.7 | 3,290 | 2,052 | 991 | 47,276 | 2,313 | 4,773 | 736 |
| B | ✓DEPAMC | 429 | 13 | 433 | 360 | 36.8 | 2.5 | 2,330 | 1,452 | 1,711 | 43,577 | 1,414 | 3,709 | 601 |
| C | ✓FAMC | 473 | 16 | 489 | 406 | 45.3 | 3.1 | 2,040 | 1,502 | 278 | 40,081 | 2,366 | 3,779 | 673 |
| D | ✓LAMC | 368 | 8 | 376 | 300 | 27.5 | 1.5 | 1,930 | 1,169 | 591 | 36,152 | 1,284 | 2,925 | 540 |
| E | ✓MAMC | 340 | 40 | 380 | 302 | 54.6 | 7.6 | 2,920 | 1,800 | 1,951 | 31,516 | 2,283 | 3,807 | 449 |
| | TAMC | 497 | 50 | 547 | 452 | 58.1 | 9.6 | 2,510 | 1,832 | 1,427 | 42,055 | 2,314 | 3,771 | 673 |
| F | ✓WRAMC | 856 | 20 | 876 | 759 | 61.8 | 3.8 | 3,300 | 2,405 | 1,605 | 77,580 | 2,293 | 5,421 | 1,042 |
| G | ✓WBAMC | 448 | 28 | 476 | 395 | 49.5 | 5.4 | 2,590 | 1,721 | 2,267 | 28,546 | 2,223 | 3,985 | 594 |
| | PANAMA | 174 | 10 | 184 | 147 | 20.0 | 2.0 | 900 | 637 | 682 | 10,241 | 410 | 1,082 | 284 |
| H | ✓BELVOIR | 91 | 18 | 109 | 84 | 22.0 | 3.5 | 1,360 | 747 | 524 | 8,522 | 614 | 1,637 | 220 |
| I | ✓KENNING | 225 | 19 | 244 | 194 | 34.3 | 3.6 | 1,860 | 1,131 | 1,939 | 20,314 | 1,145 | 2,611 | 325 |
| J | ✓BRAGG | 203 | 23 | 226 | 180 | 39.3 | 4.5 | 2,480 | 1,362 | 3,591 | 16,997 | 1,295 | 2,836 | 363 |
| K | ✓CAMPBELL | 164 | 22 | 186 | 148 | 24.8 | 4.3 | 1,650 | 934 | 2,136 | 7,853 | 700 | 2,044 | 270 |
| L | ✓CARSON | 126 | 20 | 146 | 112 | 21.8 | 3.8 | 1,200 | 728 | 1,551 | 12,189 | 766 | 1,797 | 260 |
| M | DIX | 145 | 0 | 145 | 116 | 19.4 | 0.0 | 1,360 | 724 | 470 | 10,633 | 818 | 1,545 | 223 |
| N | HOOD | 184 | 41 | 225 | 178 | 41.5 | 7.8 | 2,500 | 1,421 | 3,534 | 26,591 | 1,252 | 3,807 | 391 |
| O | JACKSON | 193 | 8 | 201 | 160 | 32.4 | 1.6 | 1,580 | 974 | 1,227 | 13,677 | 681 | 1,761 | 279 |
| P | KNOX | 146 | 19 | 165 | 132 | 30.6 | 3.7 | 1,560 | 943 | 2,157 | 19,103 | 751 | 3,238 | 285 |
| Q | LEWOOD | 176 | 8 | 184 | 147 | 31.7 | 1.5 | 1,230 | 848 | 1,338 | 11,525 | 605 | 1,758 | 259 |
| R | ORD | 141 | 23 | 164 | 131 | 28.6 | 4.4 | 1,570 | 952 | 1,706 | 13,822 | 593 | 2,145 | 304 |
| S | ✓POLK | 103 | 15 | 118 | 91 | 15.5 | 2.9 | 1,090 | 602 | 1,144 | 7,549 | 525 | 1,253 | 184 |
| T | ✓RILEY | 107 | 20 | 127 | 99 | 22.8 | 3.9 | 1,230 | 734 | 1,647 | 8,810 | 477 | 1,125 | 205 |
| U | ✓SILL | 155 | 20 | 155 | 124 | 29.9 | 3.9 | 1,720 | 978 | 1,527 | 13,368 | 743 | 1,750 | 221 |
| | ALASKA | 30 | 7 | 37 | 29 | 7.7 | 1.4 | 350 | 225 | 970 | 2,906 | 189 | 379 | 93 |
| | BEN HARR | 13 | 0 | 13 | 10 | 2.6 | 0.0 | 280 | 120 | 0 | 1,674 | 111 | 733 | 101 |
| | DEVENS | 49 | 0 | 49 | 38 | 6.3 | 0.0 | 690 | 308 | 537 | 5,245 | 269 | 934 | 115 |
| | DUTTS | 40 | 0 | 40 | 31 | 8.0 | 0.0 | 730 | 330 | 711 | 5,698 | 384 | 866 | 83 |
| | HUACHUCA | 49 | 7 | 56 | 43 | 10.8 | 1.3 | 560 | 332 | 680 | 4,389 | 229 | 779 | 93 |
| | IRWIN | 10 | 2 | 12 | 9 | 3.2 | 0.3 | 130 | 83 | 191 | 1,109 | 80 | 143 | 64 |
| | LEAVEN | 45 | 4 | 50 | 38 | 9.4 | 0.8 | 660 | 338 | 504 | 4,856 | 227 | 679 | 95 |
| | LEE | 68 | 0 | 68 | 52 | 11.4 | 0.0 | 640 | 358 | 632 | 4,933 | 338 | 953 | 113 |
| | MCCLELL | 60 | 5 | 65 | 50 | 11.6 | 1.0 | 610 | 359 | 615 | 6,529 | 349 | 1,466 | 118 |
| | MEADE | 48 | 0 | 48 | 37 | 8.5 | 0.0 | 1,420 | 548 | 1,376 | 13,624 | 617 | 2,046 | 126 |
| | MONMOUTH | 27 | 0 | 27 | 21 | 4.9 | 0.0 | 580 | 244 | 294 | 8,654 | 234 | 745 | 90 |
| | REDSTONE | 39 | 0 | 39 | 30 | 5.4 | 0.0 | 430 | 213 | 422 | 3,568 | 203 | 668 | 69 |
| | RUCKER | 34 | 5 | 39 | 30 | 7.1 | 1.0 | 560 | 279 | 685 | 6,208 | 248 | 807 | 90 |
| | STEWART | 86 | 11 | 97 | 74 | 15.4 | 2.1 | 1,110 | 582 | 1,447 | 7,168 | 454 | 1,528 | 160 |
| | W POINT | 44 | 3 | 47 | 36 | 10.4 | 0.6 | 480 | 290 | 483 | 3,381 | 136 | 475 | 105 |
| | SHERIDAN | 0 | 0 | 0 | 0 | 0.0 | 0.0 | 240 | 72 | 167 | 2,427 | 75 | 299 | 0 |
| | TOTL USC | 6,945 | 499 | 7,444 | 6,044 | 924.7 | 96.1 | 53,690 | 32,359 | 45,699 | 630,056 | 32,638 | 76,297 | 10,730 |

CURRENT BUDGET ESTIMATE CAN ONLY FINANCE 90% OF THIS PROGRAMED WORKLOAD.

15 SEP 83 PROGRAM REVISED TO CORRECT ANOTHER PROGRAM

# APPENDIX "M"

List of hospital on-site coordinators

LIST OF ON-SITE COORDINATORS
(Administrative Residents)

Basler, CPT Peter (USA, MSC)
William Beaumont AMC
El Paso, TX 79920
AV 979-2614/2404

Becker, CPT John A. (USA, MSC)
Martin Army Community Hospital
Fort Benning, GA 31905
AV 784-2516/1512

Billingsley, CPT William M. (USA, MSC)
US Army Community Hospital
Fort Carson, CO 80913
AV 691-5536/5537

Booth, MAJ Van Ride (USA, MSC)
Madigan AMC
Tacoma, WA 98431
AV 357-6210/6825

Bradley, CPT Donald J. (USA, MSC)
Letterman AMC
San Francisco, CA 94129
AV 586-5991/2154

Briggs, CPT Lee W. (USA, MSC)
Irwin Army Community Hospital
Fort Riley, KS 66442
AV 856-7146/7101

Foley, MAJ Brian P. (USA, MSC)
Fitzsimons AMC
Aurora, CO 80045
AV 943-8313/3736

Hammel, CPT George (USA, MSC)
Dwight D. Eisenhower AMC
Fort Gordon, GA 30905
AV 780-6165

Kohler, CPT James C. (USA, MSC)
Womack Army Community Hospital
Fort Bragg, NC 28307
AV 236-2906/4802

Kiehl, CPT Paul V. (USA, MSC)
ATTN: HSXM-RES
Ireland Army Community Hospital
Fort Knox, KY 40121
AV 464-9825

Leahy, CPT Lawrence (USA, MSC)
Darnall Army Community Hospital
Fort Hood, TX 76544
AV 738-8004/2/1

Lucas, CPT William R. (USA, MSC)
Gen. Leonard Wood Army Community Hospital
Fort Leonard Wood, MO 65473
AV 581-9131/9136

Mosesman, MAJ Leonard (USA, MSC)
Reynolds Army Hospital
Fort Sill, OK 73503
AV 639-5285

Mouritsen, MAJ Carol P. (USA, AMSC)
DeWitt Army Community Hospital
Fort Belvoir, VA 22060
AV 354-2987/1255

Mouritsen, CPT Paul B. (USA, MSC)
OSC Box 445
Walter Reed AMC
Washington, DC 20307
AV 291-2712/2713

Piotrowski, MAJ Stanley L. (USA, MSC)
Brooke AMC
San Antonio, TX 78234
AV 471-3309/2438

Sanders, CPT Jimmy (USA, MSC)
Florence B. Blanchfield Community Hospital
Fort Campbell, KY 42223
AV 635-8048

White, MAJ Stephen L. (USA, MSC)
Bayne-Jones Army Community Hospital
Fort Polk, LA 71459
AV 863-3111/3102

Woodley, CPT Leon (USA, MSC)
Silas B. Hays Army Community Hospital
Fort Ord, CA 93941
AV 929-4902/6005

(Adjutants)

Commander
Walson Army Community Hospital
ATTN: HSXG-ADJ (CPT Campbell)
Fort Dix, NJ 08640

Commander
Moncrief Hospital
ATTN: Adjutant's Office (SSG Henry)
Box 500
Fort Jackson, SC 29207

# APPENDIX "N"

Required survey sample size calculations

## SURVEY SAMPLE SIZE CALCULATIONS

Purpose: To estimate the percentage or actual number of CONUS AMEDD hospitals with more than 100 total operating beds that require a survey reply and the actual number of returned surveys needed to satisfy the criteria of estimating within 10% points with 90% confidence the various objectives of the survey. The following formula will be used:

$$n = \frac{NZ^2_{\alpha/2} P(1-P)}{(d)^2(N-1)+Z^2_{\alpha/2} P(1-P)}$$

Using 21 as the total number of hospitals and .5 for P to maximize the sample size, the number of hospitals that must return at least one survey is 17. Calculations are below:

$$\frac{(21)\ (1.64)^2\ (.25)}{(.10)^2\ (20) + (1.64)^2\ (.25)} = 16.1856$$

Using 105 as the total number of surveys being sent out and .5 for P to maximize the sample size, the number of surveys that need to be returned is 42. Calculations are below:

$$\frac{(105)\ (1.64)^2\ (.25)}{(.10)^2\ (104) + (1.64)^2\ (.25)} = 41.2298$$

APPENDIX "O"

Army Disposition Form,
subject: No Code Orders,
dated 5 Oct 82

# [illegible] FORM

For use of this form, see AR 340-15; the proponent agency is TAGO.

| REFERENCE OR OFFICE SYMBOL | SUBJECT |
|---|---|
| HSHL-DC | No Code Orders |

TO All Clinical Staff FROM Deputy Commander DATE 5 Oct 82 CMT 1

COL Kimball/ss/61394

1. The Commander, HSC has re-iterated his policy that "no code" orders are not to be written on order sheets (DA 4256). This 2-year-old policy is based on guidance from OTSG and OTJAG. This guidance is currently being reviewed at OTSG. Until new policy guidance is provided, WRAMC will comply with current HSC policy on "no code".

2. The ultimate decision with regard to appropriate resuscitative measures for any patient rests with the physician of that patient and the current policy does not change or modify, in any way, that responsibility. The physician in charge will make this decision after careful consideration of the clinical status of the patient, the desires of the patient and the desires of the family. The clinical record will reflect this decision making process as with any important clinical decision.

3. Physicians will need to insure that they keep nursing personnel informed and it is important that nurses' notes reflect that communication. Upon cessation of vital functions of a patient, nursing personnel will be expected to summon the patient's physician or physician on call. The responsible physician will then make the appropriate resuscitative clinical decisions. In clinical situations in which cessation of vital function is expected consideration should be given to a written order, such as "If vital functions cease, notify patient's doctor or doctor on call immediately".

Daniel B Kimball Jr

DANIEL B. KIMBALL, JR., MD
COL, MC
Deputy Commander



DA FORM AUG 80 2496 PREVIOUS EDITIONS WILL BE USED U.S. GOVERNMENT PRINTING OFFICE:

DEPARTMENT OF THE ARMY
FITZSIMONS ARMY MEDICAL CENTER
Aurora, Colorado 80045

FAMC REGULATION
NO. 40-10

18 December 1981

**Medical Services**
**DETERMINATION OF DEATH DUE TO IRREVERSIBLE CESSATION OF BRAIN FUNCTION**

1. **Purpose.** This regulation establishes policy in regard to brain death. It also contains criteria to determine when an individual is dead from irreversible cessation of brain function, procedures to be followed to obtain a formal determination of brain death; and procedures for requesting tissue and organ donation.

2. **Scope.** This publication applies to all physicians at Fitzsimons Army Medical Center (FAMC).

3. **Definitions.** Determination of death. An individual is dead if:

a. He/she has sustained irreversible cessation of circulatory and respiratory functions; or

b. He/she has sustained irreversible cessation of all functions of the entire brain, including brain stem.

A determination of death under this section shall be in accordance with accepted medical standards. (Colorado Revised Statutes 12-36-136.)

4. **Responsibilities.** The physician in charge of the patient's care (staff Medical Corps officer other than an intern or resident) is responsible for recognizing the need for a determination of irreversible cessation of brain function.

5. **Procedures for requesting formal determination of death.**

a. The physician in charge will enter on a SF-509 (Doctor's Progress Notes) the basis for the need for a formal determination.

b. The physician in charge will notify the chaplain associated with the patient and the patient's family, the Judge Advocate, and the Director of Patient Administration, or their

*This regulation supersedes FAMC Reg 40-10, 3 February 1978.

representatives, that an examination for determination of irreversible cessation of brain function is to be recommended.

c. The physician in charge will counsel the next of kin regarding the patient's condition, the prognosis, and the nature and purpose of the examination. The fact that such counseling has taken place will be entered on the SF 509.

d. The physician in charge will send a DA Form 2496 (Disposition Form) through medical channels to the Commander, FAMC, requesting that a determination of brain death be made. The anticipated response of the next of kin (based on the above counseling session) to a determination of death will be included.

e. If the Commander, FAMC agrees with the need for determination, he will appoint a panel of three staff Medical Corps (MC) officers to examine the patient to determine if irreversible cessation of brain function has occurred. This panel will consist of one neurologist or neurosurgeon, one staff physician not part of the treating service, and one other physician. No interns or residents will be appointed. The physician in charge will not serve on the panel. The criteria set forth in paragraph 7 will be used to determine if irreversible cessation of brain function has occurred.

f. After the panel of officers has completed its examination of the patient, a report signed by each member of the panel will be forwarded to the Commander, FAMC. This report will include the information set forth in Figure 1 and will be signed by each member of the panel. The original copy of the signed report will be filed in the patient's inpatient treatment record (ITR).

g. The physician in charge will counsel the next of kin regarding the findings of the panel and the basis for the determination that death has occurred and will record this fact of counseling on a SF 509. The counseling physician will record the responses of the next of kin in a memorandum for the Commander, FAMC. Such memorandum will be forwarded through medical channels to the Commander.

h. The Commander, FAMC will approve or disapprove the report of the panel of officers. The Commander will notify the department involved indicating his approval/disapproval of the report.

i. As soon thereafter as possible a death certificate will be prepared noting that death occurred at a time prior to discontinuance of organ support measures. All organ support measures will then be discontinued.

j. Should the next of kin at any time object to discontinuance of artificial support measures, such measures then in effect will be continued and death will not be certified. The counseling physician will immediately notify the Commander of the next of kins' objections. No action will be taken to discontinue support measures or to certify death without further guidance from the Commander.

6. **Procedures for requesting tissue/organ donations.**

A. If it is determined that the patient is dead, the physician in charge will approach the next of kin regarding tissue donation, if appropriate.

(1) If the next of kin agrees to major organ donation, permission will be obtained to transfer the donor to another medical facility for that purpose. The counseling physician will insure that a SF 532B (Authorization for Tissue Donation) is signed by the next of kin. No donation procedures will be undertaken at FAMC if the donor is to be transferred to another medical facility for certification of death and tissue removal for transplant purposes. Death will not be certified as having occurred at FAMC.

(2) If removal of tissue for transplant purposes is to take place at FAMC, death will be certified in accordance with paragrpah 5i prior to the performance of any donation procedure. The counseling physician will insure that the proper donor form is signed by the next of kin.

b. If the next of kin does not agreee to tissue donation but does accept the fact of death, death will be certified as in paragraph 5i.

7. **Criteria for determining brain death.**

a. The patient is in a state of profound coma not due to central nervous system depresssant drugs. There is no spontaneous movement of the patient's body, and a total lack of awareness of externally applied stimuli exists. Even the most intensely painful stimuli will evoke no central brain response. Simple spinal reflexes may be present, but decerebrate or decorticate posturing will not be elicitable.

b. There will be an absence of brain stem reflexes.

(1) The pupils will be nonresponsive to bright light stimulus, applied both directly and consensually.

(2) Vestibulo-ocular reflexes will be absent both to manipulation of the head and following 50 cc of ice water irrigation to the eexternal auditory canals.

(3) The ciliospinal reflex will be absent.

(4) The gag reflex will be absent.

(5) The corneal reflex will be absent.

(6) There will be no evidence of postural activity, such as decerebrate or decorticate posturing, or other centrally modulated posturing reflexes.

(7) The continual presence of spinal cord reflexes does not negate the diagnosis of brain death.

c. There will be an absence of spontaneous respirations.

(1) The examiner will be satisfied that the respirator is functioning in a correct manner prior to examining the patient for the absence of respiration.

(2) To insure that the brain receives a correct stimulus for the initiation of spontaneous respiration, the examiner will be satisfied that the arterial oxygen tension is between 35 and 90 mm Hg, and that the carbon dioxide tension is between 35 and 65 mm Hg. The patient will not be significantly hypothermic.

(3) The examination will consist of: disconnecting the mechanical ventilator and opening the endotracheal tube to room air. The patient will be observed for a period of three minutes contiunously monitoring for cardiac arrhythmias. If at the end of the three minutes of observation no discernible respirations have been detected, or if cardiac arrhythmia develops, mechanical ventilation will be resumed for the balance of the determination.

d. The examiner will review the diagnostic inquiries into the cause of the patient's situation.

(1) The examiner will be satisfied that the cause of the patient's clinical situation has been fully investigated by the application of all reasonable diagnostic inquiries.

(2) The examiner will be satisfied that there are no reasonable grounds for believing that further diagnostic inquiries are required or appropriate.

(3) The examiner will be satisfied that there are no reasonable grounds for believing that the patient's clinical situation can be reversed.

**8. Confirmatory diagnostic studies.**

a. The application of confirmatory diagnostic studies for the sole purpose of verifying the presence of the clinical elicitable data which is outlined above in paragraph 7 is not deemed to be essential for the diagnosis of brain death. None need be employed if the examining physicians and the Commander are in unamious agreement that brain death is present and that there are no reasonable grounds for believing further inquiries are required or appropriate.

b. As stated in paragraph 7d above, it is clear that ancillary special radiographic and electronic diagnostic investigations may be employed as needed to resolve any question of doubt. If all of the requirements in paragraph 7 are met, none of these diagnostic investigations are of sufficient strength to refute the clnically derived diagnosis of brain death established by meeting the criteria set forth in paragraph 7 above.

c. Electroencephalographic examination meeting the technical recommendations of Guideline #1 of the American Electroencephalographic Society, and interpreted by a competent electroencephalographer, which demonstrates the presence of electrocerebral silence is of value if there is doubt concerning the clinical diagnosis of brain death. The presence of minimal electrical activity does not refute the diagnosis of brain death established in paragraph 7 above.

d. A radioisotope scan is a very sensitive test for determining the presence of even minimal intracranial circulation. The absence of any intracranial circulation demonstrated by the radioisotope examination is of value if there is doubt concerning clinical diagnosis of brain death. The presence, however, of some intracranial circulation, radioisotopically demonstrated, does not refute the diagnosis of brain death, when established clinically along guidelines set forth in paragrpah 7 above.

e. Conventional x-ray examination of the intracranial circulation by means of carotid and/or vertebral angiography is of value if there is doubt concerning the clinical diagnosis when no evidence of contrast material entering the cranial vault can be elicited. In this situation, two separate injections of contrast material separated in time by at least ten minutes interval.

The presence of intracranial circulation of blood, angiographically demonstrated, does not refute the diagnosis of brain death. The prseence of angiographically demonstrated intracranial circulation is not in and of itself sufficient to reverse the clinical diagnosis of brain death when it has been established by means of the clinical criteria set forth in paragraph 7 above.

9. **Autopsy.** Permission for biopsy will be in accordance with the provisions of the applicable regulation.

18 December 1981 FAMC Reg 40-10

SUBJECT: Determination of Irreversible Cessation of Brain Function of _____
(Patient's name)

Commander
Fitzsimons Army Medical Center
Aurora, Colorado 80045

1. On the ___day of_____ 19__, the Commander, FAMC appointed a panel of Medical Corps Officers to evaluate _____, to determine if irreversible cessation of brain function had occurred.
(Patient's Name)

| Members of Panel | Staff position & service to which assigned |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

2. a. A brief statement of pertinent medical history and treatment.

3. b. Examinations performed by panel (including a positive comment that the panel members are satisfied that no further tests are indicated).

c. Diagnosis.

d. Prognosis.

e. Statement regarding presence or absence of causes which might lead to a false conclusion.

f. Formal conclusion as to whether irreversible cessation of brain function has occurred.

g. Signatures of all panel members will be affixed.

Figure 1. Sample report.

**The proponent agency of this regulation is the Judge Advocate. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) to the Commander, FAMC, ATTN: HSHG-JA.**

FOR THE COMMANDER:

GEORGE H. TOUCHARD, JR.
Major, MSC
Adjutant General

DISTRIBUTION:
"C" & "D"

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