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Letting Life Run Its Course: Do-Not-Resuscitate Orders and Withdrawal of Life-Sustaining Treatment

William A. Woodruff
Campbell University School of Law, woodruffw@campbell.edu

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Korean and Vietnam Wars not only were denied early, unconditional repatriation, but were denied their retained status. Moreover, even were an enemy to permit unconditional repatriation, a very good case could be made for denial of its application to U.S. Army medical personnel, inasmuch as under the U.S. Army's new policy those persons could return to combatant rather than medical duties. Hence the "retained status" relinquished by MSC officers, AMEDD noncommissioned officers, and other medical personnel who must surrender their DD Form 1934 medical identification card because they do not meet the "exclusively engaged" criteria of article 24 exists more in appearance than fact. However, in order to protect those medical personnel who do meet the stricter criteria of article 24, GWS, MSC officers, AMEDD noncommissioned officers, and other medical personnel not meeting the "exclusively engaged" criteria of article 24, GWS, must exchange their medical personnel identification card (DD Form 1934) for the standard DD Form 2A military identification card.

10. A question remains as to when a MSC officer, AMEDD noncommissioned officer, or other medical personnel shifts from the article 24 medical status to that of article 25 personnel, and the duration of that change. The GWS and Commentary are silent on this matter. The description of duties contained in paragraph 2 of this memorandum suggests that certain billets have been identified as those in which MSC officers, AMEDD noncommissioned officers, and other medical personnel may be called upon to perform nonmedical duties. If they have not been identified, it is incumbent upon the Office of the Surgeon General to identify them and provide for the relinquishment of the DD Form 1934 by the officer or noncommissioned officer upon assumption of that position.

11. There exists no requirement for such relinquishment to be for the duration of a conflict. A nurse in a foreign army serving as an ammunition bearer (who, at best, would be entitled to article 25 protection) hypothetically could be reassigned to a field or rear area hospital, at which time he or she would meet the "exclusively engaged" criteria of article 24. The same is true for MSC officers, AMEDD noncommissioned officers, or other medical personnel. An officer or noncommissioned officer serving in a billet that might require him or her to perform nonmedical duties (who, at best, would be entitled to article 25 protection) could reassume full medical personnel status upon reassignment to a position in which he or she meets the "exclusively engaged" criteria of article 24, GWS.

12. With respect to a helicopter pilot who alternates flying medical evacuation missions and conventional combat missions, such an individual is not entitled to medical personnel status nor authorized to carry the DD Form 1934 medical identification card; he may not shift from carrying one identification card to another depending on the day's mission(s). The same is true with respect to reassignment, as discussed in the preceding paragraph. Reassignment must be in the common usage sense of the word, i.e., semipermanent, and not a revolving door through which an individual passes depending on his or her duties on a particular day. Either practice would be inconsistent with the "exclusively engaged" criteria of article 24, and could place legitimate medical personnel at undue risk.

13. Conclusion. It is recommended that those billets be identified in which MSC officers, AMEDD noncommissioned officers, or other medical personnel would not be "exclusively engaged in the search for, or the collection, transport or treatment of the wounded or sick, or in the prevention of disease; for acting as" staff exclusively engaged in the administration of medical units and establishments so that individuals serving in such billets may exchange their DD Form 1934 identification card for the DD Form 2A card for the period in which they are so serving. This office is prepared to offer additional advice and assistance as required in accomplishment of this.

14. This memorandum has been coordinated with the International Law Offices of The Judge Advocates General of the Navy and Air Force, who concur with its contents and conclusion.

FOR THE JUDGE ADVOCATE GENERAL:

W: Hays Parks
Special Assistant for Law of War
Matters

Letting Life Run Its Course: Do-Not-Resuscitate Orders and Withdrawal of Life-Sustaining Treatment

Lieutenant Colonel William A. Woodruff
Senior Instructor, Administrative and Civil Law Division, TJAGSA

Introduction

As medical technology progressed to the point that a patient's vital signs could be sustained almost indefinitely, society began to question the value of these "chronic persistent vegetative state" with no real hope of recovery. These questions and the apparent conflict between scientific advances and the essence of human life were brought into sharper focus on April 15, 1975, when an emergency rescue team was summoned to help Karen Quinlan, a 20-year-old woman who had stopped breathing for two 15-minute periods. Upon arrival at the hospital, Karen had a temperature of 100 degrees, her pupils were unreactive to light, and she was unresponsive to painful stimuli. Over the next several weeks she developed a "sleep-wake" cycle and reacted to painful stimuli, but remained respirator dependent and in a coma. Her physicians characterized her condition as a "chronic persistent vegetative state" with no real hope of return to a cognitive condition.

Several months later, after Karen's doctors refused to discontinue the respirator because they thought to do so would violate accepted standards of medical practice, Joseph Quinlan, Karen's father, petitioned the New Jersey Superior Court for appointment as Karen's guardian and asked the court for permission to disconnect the respirator. The Superior Court denied the petition. In a landmark decision, the Supreme Court of New Jersey reversed and held that Karen Ann Quinlan's privacy rights under both the state and federal constitutions outweighed the state's interest in preserving life and, because she was incompetent, her father could exercise that right for her. The court also held that once the

3 In re Quinlan, 70 N.J. at 41-42, 355 A.2d at 664.
treatment physicians determined, and the hospital ethics committee agreed, that there was no reasonable hope of Karen emerging from her comatose condition to a cognitive state, the respirator could be withdrawn without fear of any criminal or civil liability.  

Subsequent to the Quinlan decision, thirty-nine states and the District of Columbia enacted “Living Will” statutes, “Death With Dignity” laws, “Natural Death” acts, or similar provisions in an attempt to remove the uncertainty that forced Joseph Quinlan into court.  

Generally speaking, the statutes allow individuals to execute “living wills” or “advance directives” to inform physicians of their desires should they be in a terminal condition and/or comatose and incompetent to decide what medical treatment to accept or reject.  

In spite of the legislative activity, the courts have been increasingly involved in deciding when and under what circumstances life-prolonging treatment can be withheld or withdrawn.  

As the practice of writing “do-not-resuscitate” (DNR) orders and withdrawing life support from terminally ill patients became more accepted in the civilian community, questions arose concerning the policy in Army hospitals. In 1978 the Army Health Services Command


asked the Army Surgeon General if the Texas Natural Death Act applied to Army hospitals in Texas. The Surgeon General replied that the Act did not apply and that Army policy did not allow DNR or withdrawal of life support orders. ⁸

As more courts, legislatures, and physicians recognized the benefits of allowing patients to make these fundamental choices, the Army Surgeon General made several attempts to revise the Army policy. Each time a proposed policy was staffed for legal review, The Judge Advocate General cautioned that it was at least possible that a physician withdrawing life support or failing to order resuscitation could face criminal prosecution in some circumstances. Apparently unwilling to subject Army physicians to this risk, the Surgeon General did not change the policy.

The Surgeon General's reticence changed when the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research recommended that institutions develop policies to implement DNR orders in appropriate cases. ⁹ Relying upon the recommendations and reputation of the President's Commission, the Surgeon General decided to approach the DNR and withdrawal of life support policies as separate issues, and in 1985 promulgated a uniform policy governing DNR orders in Army hospitals. ¹⁰

While the new DNR policy brought the Army in line with the civilian medical community's emerging practice standards concerning resuscitation decisions, the Army policy still did not allow withdrawal of life support. ¹¹ The ink was hardly dry on the new DNR policy, however, when Mrs. Martha Tune, the 71-year-old widow of an Army officer, entered Walter Reed Army Medical Center on February 21, 1985, complaining of shortness of breath and chest pain. ¹² Her physicians ordered mechanical ventilation to treat her respiratory problem. Subsequent diagnostic procedures revealed fluid collecting around the heart, and laboratory examination of the fluid indicated the presence of cancer.

Treatment with antibiotics and surgery restored normal heart function, but Mrs. Tune developed adult respiratory distress syndrome (ARDS) and became respiration dependent. Serial x-rays suggested the presence of tumors in her lungs. ¹³ The combination of ARDS and cancer made death a certainty, and the respirator was only prolonging the inevitable. Mrs. Tune asked the physicians to remove the respirator and allow her to die. Her doctors told her that if they had known the full extent of her illness they would not have ordered the respirator originally, but since she was already on the respirator, Army policy did not allow withdrawal of life-sustaining treatment. ¹⁴

On February 27, 1985, Mrs. Tune's son filed a pro se action in the District Court for the District of Columbia seeking an order requiring Walter Reed to remove Mrs. Tune from the respirator. After appointing a guardian ad litem and satisfying himself that Mrs. Tune was competent, that she had a terminal illness, and that she understood the consequences of her request, the judge ordered the hospital officials to remove the respirator. ¹⁵

The Tune case removed any latent doubts about the legality of withdrawing life support in federal facilities, and shortly thereafter the Army Surgeon General published a uniform policy allowing withdrawal of life-sustaining treatment under specified circumstances. ¹⁶ The remainder of this article will discuss the substance of the Army's DNR and withdrawal of life support policies and will highlight areas that merit special attention from judge advocates and members of the health care team.

Do-Not-Resuscitate Orders

A patient who suffers cardiac or respiratory arrest in an Army hospital will be resuscitated unless there is a written DNR order in the medical record. ¹⁷ In other words, initiating resuscitation is automatic and will only be suspended when there is a written order to the contrary. This prohibits "slow codes" and "notify MOD before coding" practices that developed to avoid the policy against DNR orders. ¹⁸

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¹⁰ Army Reg. 40-3, Medical Services: Medical, Dental, and Veterinary Care, chap. 19 (15 Feb. 1985) [hereinafter AR 40-3].

¹¹ Id. para. 19-1b.


¹³ Id.

¹⁴ Id.

¹⁵ Id. at 1456.


¹⁷ AR 40-3, para. 19-3a.

¹⁸ "Slow codes" and "notify MOD [medical officer of the day] before coding" were informal agreements between the medical staff, patients, and patients' families to delay the initiation of cardiopulmonary resuscitation (CPR) in a terminally ill patient who arrested. By delaying the initiation of CPR, the patient died before he could be resuscitated and placed on life support apparatus. These practices were not limited to Army facilities, but were common wherever written DNR orders were thought to be violations of law, policy, or good medical practice. See generally Younger, Do-Not-Resuscitate Orders: No Longer Secret, But Still a Problem, 17 Hastings Center Rep. 24 (1987); Fried, Terminating Life Support: Out of the Closet, 295 New Eng. J. Med. 390 (1976).
Under the Army policy, a DNR order is appropriate when a patient "will not benefit from resuscitation." According to the regulation, patients who will not benefit from resuscitation "include those who are irreversibly, terminally ill or those in a persistent chronic vegetative state." Though the regulation may seem to allow a DNR order for patients who do not fit the definition of "irreversibly, terminally ill," 21 or who are not in a "persistent or chronic vegetative state," 22 other provisions are more restrictive. For example, the regulation provides that the "voluntary choice of a competent and informed patient who is irreversibly, terminally ill will determine whether cardiopulmonary resuscitation will be undertaken." Furthermore, before the order is written the prognosis must be determined by the patient's attending physician and the chief of the service or the deputy commander for clinical services or his or her delegate. Thus, the regulation requires that even the competent patient fit the irreversibly, terminally ill prognosis before a DNR order is appropriate. While this is consistent with the Army policy governing withdrawal of life support, 23 it has the potential of infringing upon the patient's right to refuse medical treatment. The regulation does recognize, however, that a "competent patient has the legal right to refuse medical treatment at any time, even if it is lifesaving." In view of the contradictory provisions of the regulation, the "tough case," i.e., a non-terminal patient requesting a DNR order or refusing other lifesaving treatment, should be resolved individually under the law of the state where the facility is located. 24 This usually involves balancing the government's interest in preserving life, protecting innocent third parties (especially children who are dependent upon the patient), preventing suicide, and preserving the integrity and ethics of the medical profession against the patient's right to privacy, self-determination, and, in appropriate cases, free exercise of religion. 25

The DNR order is only an order to forego the otherwise automatic initiation of cardiopulmonary resuscitation; it does not alter other treatment decisions. To avoid possible confusion, physicians should write orders for supportive care, the relief of pain, and other treatment separately. Only credentialed physicians who are members of the medical staff may write DNR orders; residents and other doctors in graduate medical education programs may not write DNR orders. Like any other aspect of medical care, the completion of the medical record is important. Army policy requires that the DNR be written on the order sheet, dated, and signed. Furthermore, the physician must include in a progress note an explanation of the rationale behind the order. The progress note must also disclose whether the patient is competent and how the competency

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19 AR 40-3, para. 19-3b.
20 Id.
21 An "irreversibly, terminally ill" patient is any patient with "a progressive disease or injury known to terminate in death and where no additional course of therapy offers any reasonable expectation of remission." Id. para. 19-2c.
22 A "persistent or chronic vegetative state" is a "chronic state of diminished consciousness resulting from severe generalized brain injury in which there is no reasonable possibility of improvement to a cognitive state." Id. para. 19-2f.
23 Id. para. 19-6a (emphasis added).
24 Id. para. 19-2c.
25 See infra note 57 and accompanying text.
27 AR 40-3, para. 19-3f.
28 Cf. id. para. 2-19f.
30 AR 40-3, para. 19-3c.
31 Id.
32 Id. para. 19-3d.
33 Id. para. 19-4.
34 Id.
35 A competent patient is an adult (18 years of age or over or emancipated as determined by state law) "who has the ability to communicate and understand information and the ability to reason and deliberate sufficiently well about the choices involved." Id. para. 19-2d. Minors below 14 years of age are deemed incompetent and active duty soldiers 17 years old are deemed emancipated. Id. An incompetent patient is a minor (17 years of age and under and not emancipated) or someone "who does not have the ability to reason and deliberate sufficiently well about the choices involved." Id. para. 19-2e.
determination was reached. The doctor must summarize in the progress note discussions with the patient, family members, or legal guardian and document any review by the ethics panel. The regulation specifically prohibits asking the patient to sign a release or consent form; therefore, a complete and thorough progress note is critical in defending against any claim of lack of informed consent.

The voluntary choice of the competent and informed patient determines whether a DNR order will be written. The Army policy encourages the medical staff to discuss the various options with the patient in appropriate cases. The policy also recognizes that often a direct approach to such a sensitive and personal matter is inadvisable and recommends a "general discussion" of the patient's preferences. If a "general discussion" leads to an informed and voluntary decision to request a DNR order, the order may be written. If neither the doctor nor the patient can address the issue directly, the order should not be written. In other words, the "general discussion" may be an appropriate way to raise the issue with a patient, but it is not a substitute for an informed and voluntary decision to forego cardiopulmonary resuscitation.

Once the competent patient elects to request a DNR order, he or she determines whether family members will be told of the decision. If the patient does not want family members to know of the decision, a disinterested physician or nurse (one who is not a member of the treatment team) will enter the request for confidentiality in the medical record. This procedure brings a neutral player with a different perspective into the equation and insulates the treatment team, to some degree, from the conflicting interests of the patient and his or her family. In any case, the decision of the competent patient will be respected.

Resuscitation decisions for incompetent patients are a bit more complicated. If an incompetent patient made "firm and explicit" verbal or written directives regarding resuscitation while still competent, the next of kin or legal guardian and the medical staff should honor the patient's directives "unless there is reason to believe the patient's choice has changed or would change."44 Of course, if there is reason to believe that the patient's choice has changed or would change, it places in question the "firmness" and "explicitness" of the original directives. Unfortunately, the regulation offers no guidance on what factors the medical staff and the next of kin or legal guardian should consider in determining whether the patient's choice has changed or would change.

Once the patient's incompetency has been established, the next of kin or legal guardian becomes the surrogate decisionmaker. If the attending staff and the surrogate decisionmaker agree that a DNR order is appropriate, the order may be entered in the medical record. If the surrogate disagrees with the medical staff's recommendation for a DNR order, the case must be referred to the hospital ethics panel. If the ethics panel resolves the disagreement and all parties concur in the appropriateness of the DNR order, the order will be written. If an agreement is not reached, the order will not be written and resuscitation will be initiated unless a court directs otherwise.

If an incompetent patient has no next of kin, legal guardian, or other person authorized under state law to consent to medical treatment for the patient and the medical staff believes a DNR order is appropriate, they should refer the case to the ethics panel and the deputy commander for clinical services (DCCS). The regulation does not, however, tell either the ethics panel or the DCCS what to do. Its silence on this issue may mean that they become the surrogate decisionmaker. Prudence dictates otherwise. If an incompetent patient does not have a next of kin, legal guardian, or other person authorized to consent to medical treatment under state law, the hospital should contact the local staff judge advocate and seek his or her assistance in having a guardian appointed. This, of course, applies to all treatment decisions, not just to DNR orders.

Withdrawal of Life-Sustaining Treatment

The Army policy on the withdrawal of life-sustaining treatment was, in large measure, influenced by Tune v. Walter Reed Army Medical Center and the President's

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36 Incompetency must be verified by clinical assessment of mental and emotional status. Id. para. 19-2e.
37 Id.
38 Id.
39 Id. para. 19-6a.
40 Id. para. 19-6b.
41 Id.
42 Id. para. 19-6d.
43 Id.
44 Id. para. 19-7a.
45 Id. para. 19-7d.
46 The ethics panel is composed of at least two physicians, a nurse, a chaplain, and a representative of the local staff judge advocate. Id. para. 19-2g.
47 Id. para. 19-7d.
48 Id. para. 19-7b.
The policy allows competent patients in a "terminal condition" 51 or a "persistent or chronic vegetative state" 52 to decline life-sustaining treatment. 53 It also allows the next of kin or legal guardian to decide whether treatment should be withdrawn if the patient is incompetent. 54

The basic philosophy underlying the Army's policy for withdrawal of life support is to support and sustain life when it is reasonable:

The Army Medical Department is committed to the principle of supporting and sustaining life when it is reasonable to do so. Life-supporting techniques 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 continued or additional treatment is not only unwanted by the patient but medically unsound. In such cases, medical treatment does not prevent death but merely defers the moment of its occurrence. The attending physician must decide whether continued efforts constitute a reasonable attempt at prolonging life or whether the patient's illness has reached such a point that further intensive, or extensive, care is in fact merely postponing the moment of death which is otherwise imminent. 55

Thus, under the Army policy, when medical intervention or treatment will only artificially delay the death of a patient in a persistent or chronic vegetative state or afflicted with a terminal condition, sustaining life is no longer reasonable and withdrawal of life-sustaining treatment is appropriate.

The Army policy allows only "qualified patients," i.e., those who have a terminal condition or are in a persistent or chronic vegetative state, to request withdrawal of life-sustaining treatment. The diagnosis and prognosis must be made and certified in writing by two physicians, one of whom must be the attending physician. 56 As with the DNR policy; allowing only certain patients the right to refuse treatment denies other patients their right to decide what medical treatment to accept or reject. 57

The policy for withdrawal of life support, like the DNR policy, recognizes the competent patient 58 as the decisionmaker. 59 The next of kin or legal guardian, along with the attending physician, determines whether to withdraw life support from an incompetent patient. 60 The policy directs a surrogate decisionmaker to determine whether the withdrawal of life-sustaining treatment will be in the "patient's best interest." 61 In determining the patient's best interests, the Army policy directs the surrogate to consider: "(1) relief of suffering, (2) quality as well as extent of life sustained, and (3) substituted judgment doctrine": What the patient would have wanted if competent." 62

Army policy requires that the hospital ethics panel review the case: 1) where there is doubt about the propriety of withdrawing life support; 2) where there is disagreement among the treating physicians, among members of the family, or between the treating physician and family members; or 3) where an incompetent patient has no next of kin or legal guardian. 63 The ethics panel is an ad hoc "advisory committee" that draws members from administration, medicine, nursing, pastoral care, social work, and the community. A representative of the staff judge advocate must be a member. 64

The Army policy defines "life-sustaining" treatment as "any medical procedure or intervention which serves only to artificially prolong dying ... Intravenous therapies and lavage [sic] feeding are medical interventions." 65 Treatment and procedures designed to alleviate pain are not considered life-sustaining

50 President's Commission, supra note 9.
51 A "terminal condition" is an "incurable condition resulting from injury or disease in which imminent death is predictable with reasonable medical certainty." Withdrawal of Life-Sustaining Treatment Letter, Encl., supra note 16, para. 2b.
52 A "persistent or chronic vegetative state" is a "chronic state of diminished consciousness resulting from severe generalized brain injury in which there is no reasonable possibility of improvement to a cognitive state." Id. para. 2c.
53 Id. para. 4a.
54 Id. para. 3b.
55 Id. para. 3a.
56 Id. para. 2g.
57 See supra notes 26-28 and accompanying text.
58 The definitions of "competent" and "incompetent" are the same for withdrawal of life-sustaining treatment as they are for do-not-resuscitate orders. See supra note 35.
59 Withdrawal of Life-Sustaining Treatment Letter, Encl., supra note 16, para. 4a.
60 Id. para. 4b.
61 Id.
62 Id.
63 Id. para. 2i.
64 Id. Note that the membership of an ethics panel considering withdrawal of life support differs from that of a panel considering a DNR order. See supra note 46.
65 Id. para. 2a.

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Once a decision to withdraw life-sustaining treatment has been made, the order must be documented in the patient's medical records. The attending physician must enter the order, the date and time of the order, and his or her legible signature on the order sheet. The progress notes must include:

(1) A description of the patient's medical condition corroborating the prognosis, including reference to any consultations relevant to the decision to terminate.

(2) A summary of discussions with the patient, NOK or guardian concerning the medical prognosis and the withdrawal of life-sustaining treatment.

(3) The competency status of the patient and the basis for a finding of incompetency.

(4) The authority upon which the final decision is based (e.g., competent patient's informed consent, Ethics Panel, court, etc.).

**Potential Problems**

In an area so filled with legal, medical, emotional, ethical, spiritual, and philosophical aspects, crafting a policy to satisfy all competing interests is virtually impossible. Thus, the Army DNR and withdrawal of life-sustaining treatment policies are not perfect. Careful and caring implementation of the policies, with an awareness of potential problem areas, will, however, accommodate most concerns.

**The Ethics Panel**

Both the DNR and the withdrawal of life-sustaining treatment policies require ethics panels to become involved in certain cases. Both policies limit the involvement of the panel to those cases where there is an incompetent patient and some doubt or disagreement as to the propriety of a DNR order or withdrawal of life support. Furthermore, the membership on the panels established by the respective policy directives is not consistent, and neither policy gives any real guidance as to the role or function of the panel. Equally troubling is the fact that over eighteen months after ethics panels were required in certain circumstances, thirty-three percent of the Army hospitals responding to a survey had not established them.

The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research identified four general functions that an ethics committee can serve:

They can review the case to confirm the responsible physician's diagnosis and prognosis of a patient's medical condition.

They can provide a forum for discussing broader social and ethical concerns raised by a particular case; such bodies may also have an education role, especially by teaching all professional staff how to identify, frame, and resolve ethical problems.

They can be a means for formulating policy and guidelines regarding such decisions.

Finally, they can review decisions made by others (such as physicians and surrogates) about the treatment of specific patients or make such decisions themselves.

By limiting the involvement of ethics committees to situations where there is disagreement over the propriety of a DNR order or withdrawal of life support for an incompetent patient, or where there is no surrogate decisionmaker for an incompetent patient, the Army policies offer little guidance on the function of the ethics committee. Arguably, it exists as a decisionmaking body in the case of a patient without a surrogate. When there is a dispute over the propriety of a DNR or withdrawal of life support order, the panel's role impliedly is that of a forum for discussion that may lead to agreement. Because the membership consists of other than physicians, its role must extend beyond merely confirming the diagnosis and prognosis. The vast majority of respondents to a recent survey on ethics committees in Army hospitals thought the best use of the committee was in an advisory or consulting role in dealing with treatment decisions for the terminally ill. Those responding also identified education, case review, and policy interpretation as useful ethics committee functions.

The experience of Madigan Army Medical Center's ethics committee illustrates the education, bioethical policymaking and interpreting, and case review and consultation functions. The Madigan committee per-

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66 Id.

67 The Army policy includes "lavage feeding" as life-sustaining treatment. "Lavage" means to irrigate or wash out an organ, Dorland's Illustrated Medical Dictionary 716 (26th ed. 1981), and is not generally thought of as a way to provide nutrition. The policy probably intends to include "gavage" feeding as life-sustaining treatment. "Gavage" means "forced feeding especially through a tube passed into the stomach." Id. at 544.

68 Withdrawal of Life-Sustaining Treatment Letter, Encl., supra note 16, para. 5a.


70 President's Commission, supra note 9, at 160-61.

71 One of the documentation requirements for a withdrawal of life support order is indicating "the authority upon which the final decision is based (e.g., competent patient's informed consent, Ethics Panel, court, etc.)." Withdrawal of Life-Sustaining Treatment Letter, Encl., supra note 16, para. 5a(4) (emphasis added).

72 Carter, supra note 69, at 428.

73 Id.

74 Madden, Reeder, Cragun, Krug, and Browne, Evolution of Military Ethics Committees, 152 Mil. Med. 613 (1987).
forms its educational role by sponsoring formal and informal presentations on bioethical issues. Formal presentations range from workshops on particular issues to "ethics rounds" that use case studies to illustrate ethical problems that arise in the hospital setting. Informal teaching involves collecting and sharing ethics literature with the staff and engaging in informal discussions about hypothetical cases or actual dilemmas. The ethical ramifications of developing and implementing institutional policies dealing with the treatment of AIDS patients, organ harvesting, and the allocation of limited hospital resources are uniquely suited to ethics committee review. Consultation and case review provides members of the staff, patients, or patients' families a forum to discuss the difficult issues and decisions that modern technology places upon us. The committee does not decide for the patient, but merely provides the opportunity to discuss the issue and, if possible, reach a consensus. Even though the committee does not decide the question, the recommended or consensus solution can have a strong psychological impact upon those who must decide.

To perform any of these roles, however, ethics committees must be formally established, their existence publicized, and their members trained. Unfortunately, the limited involvement of the committees envisioned by the current policies hardly provides the experience necessary for the members to perform any of their functions well. Hospital commanders who require the ethics committee to review all DNR and withdrawal of life support decisions will help the committee acquire valuable experience so that when the difficult situations arise, e.g., a disagreement over the propriety of writing a DNR order or withdrawing life support, the committee will be able to provide real assistance to the professional staff, the patient, and the patient's family. The current policies almost guarantee that the ethics committee will have less experience in dealing with these issues than the professional staff and will be of little help with the difficult cases. With the experience gained from greater involvement in a larger number of cases, the committee can perform the educational and policy formulation roles more effectively.

Selecting the Surrogate

The "next of kin" or the patient's legal guardian is the surrogate decisionmaker under both the DNR and withdrawal of life support policies. Determining the identity of the legal guardian is not difficult; the individual appointed by the appropriate court with authority to act for the patient is the one to whom the medical staff should look for health care decisions. The "next of kin" is a bit more elusive. Neither Army Regulation 40-3 nor the withdrawal of life support policy letter defines "next of kin." Intuitively, the spouse or other close family member qualifies and is generally looked to by the medical community to make decisions for incompetent patients. But in selecting a surrogate decisionmaker the question should not be: "Who is the next of kin?" Rather, we should ask: "Who best knows the patient's goals, desires, and preferences, and who is most concerned about the patient's welfare?" In most instances this person will be the spouse or other close family member. The President's Commission favors family members as surrogate decisionmakers because:

1. The family is generally most concerned about the good of the patient.
2. The family will also usually be most knowledgeable about the patient's goals, preferences, and values.
3. The family deserves recognition as an important social unit that ought to be treated, within limits, as a responsible decisionmaker in matters that intimately affect its members.
4. Especially in a society in which many other traditional forms of community have eroded, participation in a family is often an important dimension of personal fulfillment.
5. Since a protected sphere of privacy and autonomy is required for the flourishing of this interpersonal union, institutions and the state should be reluctant to intrude, particularly regarding matters that are personal and on which there is a wide range of opinion in society.

Perhaps the best surrogate decisionmaker, and one not mentioned in the Army policy, is an individual designated by the patient in a durable power of attorney, or similar document, to make health care decisions in the event of the patient's incompetency. Looking to such an individual gives full deference to the patient's autonomy and relieves the medical staff of the burden of selecting the surrogate. Furthermore, an individual with the foresight to appoint a decisionmaker has probably...
made clear his or her desires regarding the types of treatment to accept or reject. This bit of planning eases the burden on both the doctor and the decisionmaker and ensures that the patient's desires will be paramount.

There are some circumstances when the medical staff must select another surrogate. This may occur when: 1) the apparent surrogate evidences interests that conflict with those of the patient; or 2) there are indications that the surrogate does not have the patient's welfare and wishes at heart, or is not aware of or intends to disregard the patient's values, desires, or expressed wishes. Although it is the medical staff that selects the surrogate, the judge advocate must be available to assist in identifying disqualifications in the presumed surrogate and in designating an appropriate surrogate. This assistance may take the form of advising the physician to continue supportive care until a court appoints a guardian to act for the patient. If the apparent surrogate is the legal guardian or is designated through a power of attorney, court action may be required to appoint a new surrogate.

Both the DNR and withdrawal of life support policies require consultation with the ethics panel if an incompetent patient has no legal guardian or next of kin and the attending physician thinks a DNR or withdrawal of support order is appropriate. While neither policy specifically dictates that the ethics panel becomes the decisionmaker in these cases, it can certainly be inferred. The President's Commission noted the difficult and cumbersome process of obtaining judicial appointment of a guardian and recommended that health care institutions develop policies to designate surrogates for patients without close family. In spite of this fact, however, in the absence of legislation or a specific policy that clearly and unequivocally sets out the standard to follow, DNR and withdrawal of life support orders should not be written for incompetent patients who do not have an appropriate surrogate decisionmaker. In light of the seriousness of the decision at stake, it is unjustified to infer from the ambiguities in the current policy that the ethics panel becomes the surrogate decisionmaker in these cases. The better course is to continue medical treatment and seek judicial appointment of a guardian. Judge advocates must know the applicable law and procedure in their respective jurisdictions and be prepared to advise and assist in obtaining appropriate judicial action.

Deciding for the Incompetent

There can be no greater responsibility than making a life or death decision for another. The surrogate decisionmaker, who by definition shares a close bond with the patient, must make decisions while under tremendous emotional strain. Because of the seriousness of the decision and the emotional involvement of the decisionmaker, the law should provide a decisional framework. Unfortunately, the Army policy does little to aid the surrogate decisionmaker.

The Army DNR policy specifically directs surrogate decisionmakers to follow explicit verbal or written directives made by the patient while competent unless there is reason to believe that the patient's choice has changed. Thus, living wills executed under state law will serve as evidence of the patient's wishes. This approach gives full deference to the patient's rights of self-determination and privacy and lightens the burden on the decisionmaker. But where the patient has not made "firm and explicit... directives," the policy leaves the surrogate scant guidance. In this instance, the regulation merely provides that "[a]fter assessment of the benefits" a DNR order may be entered if there is agreement between the next of kin and the patient's physicians.

The policy for withdrawal of life support, on the other hand, does not mention the effect of a prior verbal or written expression and directs the surrogate to make a decision based upon the patient's "best interest." In determining the patient's "best interest," the surrogate should consider the: "(1) relief of suffering; (2) quality as well as extent of life sustained, and; (3) 'substituted judgment doctrine': What the patient would have wanted if competent." Not only does this offer little real guidance to the decisionmaker, it confuses two separate decisionmaking models, the "best interest of the patient" model and the "substituted judgment" model.

The "substituted judgment" standard requires the decisionmaker to do what the patient would have done. It gives maximum deference to the patient's right of self-determination even if that decision is not objectively in the patient's best interest. In other words, it is the patient's definition of "best interest" that is respected, rather than some objective standard. As explained by one court, the substituted judgment represents a shift in emphasis.

83 See President's Commission, supra note 9, at 128-29.
84 AR 40-3, para. 19-7b; Withdrawal of Life-Sustaining Treatment Letter, Encl., supra note 16, para. 4b(3).
85 President's Commission, supra note 9, at 131-32.
86 See, e.g., In re Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984).
87 Both the DNR and withdrawal of life support policy designate the "next of kin" (or legal guardian if one has been appointed) as the surrogate decisionmaker. See AR 40-3, paras. 19-3b and 19-7d; Withdrawal of Life-Sustaining Treatment Letter, Encl., supra note 16, para. 4b.
88 AR 40-3, para. 19-7a.
89 Id.
90 Id. para. 19-7d.
91 Withdrawal of Life-Sustaining Treatment Letter, Encl., supra note 16, para. 4b.
92 Id.
93 See generally, President's Commission, supra note 9, at 132-33.
away from a paternalistic view of what is “best” for a patient toward a reaffirmation that the basic question is what decision will comport with the will of the person involved, whether that person be competent or incompetent. As to the latter type of person, we concluded that the doctrine of substituted judgment, while not without its shortcomings, best served to emphasize the importance of honoring the privacy and dignity of the individual. 94

Of course, in order to apply the “substituted judgment” model, there must be some evidence of what the patient would have decided. Prior oral or written directives are the best evidence of the patient’s desires and should be given effect. 95

The “best interest” model generally requires, the surrogate to consider such factors as the relief of suffering, the preservation or restoration of function, and the quality and extent of the life sustained as viewed by the patient. 96 The “quality of life” component tries to determine the value of the patient’s life to the patient and does not measure the value of life by the extent of the patient’s ability to contribute or produce in society. 97

The confusion in the Army policies is manifest. The DNR policy, while deferring to the patient’s desires if they are evidenced by oral or written directives, imposes a vague “assessment of the benefits” standard when “firm and explicit” directives are absent. The policy for withdrawal of life support purports to impose an objective “best interest” test but includes the subjective “substituted judgment” doctrine as only one factor to consider. Both policies denigrate the patient’s right of self-determination and leave surrogate decisionmakers with conflicting guidance. Because the issue in both the DNR and withdrawal of life support situations is the same, the decisionmaking standards should be uniform and give maximum deference to patient autonomy.

The approach adopted by the New Jersey Supreme Court in In re Conroy 98 for making termination of artificial feeding decisions for incompetent nursing home patients with serious and irreversible mental and physical impairments and a limited life expectancy provides a useful model. The court created a decisionmaking hierarchy that deferred to the patient’s desires as much as possible and resorted to objective criteria only when evidence of the patient’s wishes was untrustworthy or lacking completely.

The first level of decisionmaking is a pure subjective test. Under this standard the decisionmaker will make the same decision the patient would have made if competent. The court noted that written directives in the form of living wills or powers of attorney and oral statements or directives were probative of what the patient would decide if competent. 99 Reactions by the patient to medical treatment administered to others, the religious beliefs of the patient, and his or her decisions regarding other aspects of medical care were also considered by the court to give insight into the patient’s decision. 100 Against this evidence, the decisionmaker must consider the remoteness, consistency, thoughtfulness, and specificity of the patient’s prior statements and conduct in order to accurately assess their probative value.

[An offhand remark about not wanting to live under certain circumstances made by a person when young and in the peak of health would not in itself constitute clear proof twenty years later that he would want life-sustaining treatment withheld under those circumstances. In contrast, a carefully considered position, especially if written, that a person had maintained over a number of years that he had acted upon in comparable circumstances might be clear evidence of his intent. 101]

For those patients for whom the evidence of subjective intent is remote or unclear, the Conroy court allowed removal of life-sustaining treatment if either of two “best interest” tests were met. The first test, a “limited-objective test,” allows withdrawal of life-sustaining treatment “when there is some trustworthy evidence that the patient would have refused the treatment, and the decisionmaker is satisfied that it is clear that the burdens of the patient’s continued life with the treatment outweigh the benefits of that life for him.” 102 The test requires some trustworthy evidence of what the patient

95 If the patient has executed a living will or a durable power of attorney that spells out the patient’s wishes in the particular circumstances, the surrogate really has no decision to make. The patient has already decided the issue and the surrogate and the medical treatment team need only to implement the patient’s decision. Even though courts refer to this as “substituted judgment,” it is not a substitute for the patient’s judgment at all. The term should be reserved for those situations where the patient has not clearly decided the issue and the surrogate must consider all available evidence to determine what the patient would have decided if he or she were competent. See infra notes 107-08 and accompanying text.
96 President’s Commission, supra note 9 , at 134-35.
97 See, e.g., In re Conroy, 98 N.J. 321, 486 A.2d 1209, 1232-33 (1985) (“We expressly decline to authorize decision-making based on assessments of the personal worth or social utility of another’s life, or the value of that life to others... To do so would create an intolerable risk for socially isolated and defenseless people suffering from physical or mental handicaps.”).
99 Id. at 1229-30.
100 Id. at 1230.
101 Id.
102 Id. at 1232. The Army withdrawal of life support “best interest” standard, which has both an objective and a subjective component, is essentially the same as the Conroy “limited-objective” test. Unlike the Conroy test, the Army policy does not set out the benefits and burdens that should be balanced.

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would have decided, even though that evidence, standing alone, is insufficient to satisfy the pure subjective standard. Furthermore, the decisionmaker must also find that the treatment in question would “merely prolong the patient’s suffering and not provide him with any net benefit.” Determine whether the treatment provides a “net benefit” requires an evaluation of the degree, expected duration, and constancy of pain and suffering and without the life-sustaining treatment, and the possibility that the pain and suffering could be reduced or controlled by drugs or means other than terminating life support. 104

For those situations where there is no trustworthy evidence of what the patient would have decided, the Conroy court devised yet a third test. Under this “pure-objective” standard, life-sustaining treatment may be withdrawn when,

as under the limited-objective test, the net burdens of the patient’s life with the treatment... clearly and markedly outweigh the benefits that the patient derives from life. Further, the recurring, unavoidable and severe pain of the patient’s life with the treatment should be such that the effect of administering life-sustaining treatment would be inhumane. 105

The only court to consider the Army policy held that the substituted judgment standard applied. In Newman v. United States 106 Mary Ellen Newman was a comatose patient in an Army medical center. She had suffered severe and irreversible brain damage as a result of two massive heart attacks several months earlier. There was virtually no hope for her recovery and the only medical care she was receiving consisted of comfort measures, a Foley catheter, and the administration of nutrition and hydration through a naso-gastric tube. Her doctors notified her husband that she was a long term domiciliary patient and that he would have to transfer her from the Army medical facility to a private nursing home. At that point, Mr. Newman asked the Army doctors to remove the naso-gastric tube and allow his wife to die. While the physicians agreed that there was little or nothing they could do to reverse Mrs. Newman’s condition, they objected to allowing her to die of dehydration. Mrs. Newman still had a swallow reflex and could swallow food that was placed in her mouth. The tube feeding was merely more convenient and safer than trying to feed her with a spoon. When the Army doctors refused to withdraw the naso-gastric tube, Mr. Newman filed suit in federal district court asking the judge to order the Army to stop feeding his wife artificially. The court held that the substituted judgment doctrine was the proper standard to apply and that plaintiff’s testimony of his wife’s desires as she expressed them to him some years before in casual conversation was insufficient to meet the burden of proof in light of the objections by the medical staff.

Until the Army policy is amended to clarify the applicable decisionmaking standards, the ambiguities in the current policy should be resolved in favor of the patient’s right to self-determination. Accordingly, surrogate decisionmakers should first determine if the patient has already made the decision. Living wills or other formal expression of desires relieves the surrogate of any “decision.” The medical treatment team and the surrogate need only implement the patient’s decision. If the patient has not made a form or formal declaration of his or her wishes, the surrogate must try to determine what the patient would have decided if competent. The surrogate should consider prior oral and written statements that reflect the patient’s views even though these statements do not directly address the precise issue at hand. The patient’s reactions to prior medical treatment given to others as well as previous decisions the patient made about personal medical care will be probative. The patient’s religious beliefs and practices will give insight into the patient’s views on how he or she might decide the issue. If the patient were competent and making the decision, he or she would evaluate all of the medical evidence available. Accordingly, the surrogate should consider the prognosis, the degree of suffering with and without the treatment, the risks of various treatment options, and the level of mental and physical functioning of the patient. 107 If there is absolutely no evidence of the patient’s subjective intent, the Conroy “pure-objective” standard provides a workable decisionmaking model. 108

104 Id. In a subsequent decision, the New Jersey Supreme Court acknowledged that “pain and suffering” consisted of more than just physical anguish; it included the humiliation and indignities of being kept alive by machines. In re Peter, 108 N.J. 365, 529 A.2d 419 (1987).

105 98 N.J. at 366, 486 A.2d at 1232. The Army DNR decisionmaking standard seems to adopt a “subjective” test initially and leap to a “pure-objective” test if “firm and explicit” directives were not made by the patient. It seems somewhat incongruous that an affirmative decision must be made to discontinue treatment that is by all accounts “inhumane.” One would think that the legal, ethical, and medical problems would be with continuing such “treatment,” not withdrawing it. The problem, however, is one of degree. Physicians do not initiate a course of treatment to hurt their patients. The difficulty arises in determining when the treatment has ceased being beneficial and begun being a burden. Some commentators have suggested that these decisions be made on an “anti-cruelty” basis. Under this approach, applied only to incompetent patients for whom there is no evidence of what their decision would be if competent, the decisionmaker balances the benefits of the diagnostic or therapeutic procedure against the harm it will inflict upon the patient. Thus, it applies the principles of beneficence and nonmaleficence. See Braithwaite and Thomasma, New Guidelines on Foregoing Life-Sustaining Treatment in Incompetent Patients: An Anti-Cruelty Policy, 104 Annals Internal Med. 711 (1986).


107 Though the Conroy court called this the best interest “limited-objective” standard, because it seeks to determine what the patient’s decision would be under the circumstances, it is really the “substituted judgment” standard. The surrogate is deciding for the patient from the patient’s perspective.

108 Because the surrogate decisionmaker should be one who is aware of the patient’s goals, desires, preferences, activities, lifestyle, philosophy, and interests, it is difficult to imagine a situation where no evidence of the patient’s subjective intent is available. Thus, the surrogate decisionmakers that must decide for patients in Army facilities should not have to resort to a “pure objective” best interest standard. The situation may arise, however, when the patient does not have a family member or close friend to act as a surrogate and a guardian must be appointed. Under these circumstances the decision of the guardian should be subject to judicial review and supervision.
Withdrawing Nutrition and Hydration

Withdrawing or withholding nutrition and hydration in appropriate situations have been sustained by the courts and endorsed by the American Medical Association. The issue is not without controversy, however. Courts and medical ethicists who approve of the cessation of artificial feeding usually find no difference between sustaining a patient with oxygen from a mechanical respirator and providing nourishment through a naso-gastric tube, intravenous line, or other method. Both artificial respiration and artificial nourishment, so the argument goes, merely prolong the inevitable moment of death and neither offers any hope of curing the illness involved. Others see a distinction that requires a different approach:

Should the provision of food and drink be regarded as medical care? It seems, rather, to be the sort of care that all human beings owe each other. All living beings need food and water in order to live, but such nourishment does not itself heal or cure disease. When we stop feeding the permanently unconscious patient, we are not withdrawing from the battle against any illness or disease; we are withholding the nourishment that sustains life.

As important as the philosophical debate over the withdrawal of nutrition is the practical matter of ensuring that the patient or the patient’s surrogate understands what support will be withdrawn. If the patient or the surrogate consents to “withdrawal of life-sustaining treatment” but does not realize that life-sustaining treatment includes food and water, can they be said to have given informed consent? The layman may think that life-sustaining treatment means the respirator but may never stop to consider that food and water are included as well.

There is no indication in the Army policy that withholding of life-sustaining treatment is an “all or nothing” proposition. A patient or surrogate may, therefore, request termination of the respirator, chemotherapy, hemodialysis, or other therapeutic measures but retain nourishment. Physicians recommending termination of treatment should explain in detail what treatment is “life-sustaining” and should clearly explain the various options. The time spent in explanation can avoid tragic misunderstandings and prevent tremendous emotional turmoil.

Documenting the Decision, Its Basis, and the Competency Determination

Both the DNR policy and the policy for withdrawal of life-sustaining treatment require documentation in the patient’s medical records. The order itself must be entered in the doctors orders. The progress notes must include a discussion of the rationale for the order, including a description of the patient’s condition, the mental status of the patient and the basis of any finding of incompetency, the results of discussions with the patient and family members, and any review by the ethics panel. The importance of this requirement cannot be overstated. Should the actions of the medical staff ever be questioned, the best evidence of what was done and why it was done will be the medical record. Short cuts or incomplete recording will seriously hamper the physicians’ ability to justify their actions. On the other hand, complete and accurate medical record entries will demonstrate the good faith efforts of the medical staff in following the prescribed policy. Judge advocates must


110 Withholding or Withdrawing Life-Prolonging Medical Treatment, Current Opinions of the Ethical and Judicial Affairs of the American Medical Association (1986), reprinted in 53 The Citation 51 (1986).

111 Of the jurisdictions with legislation dealing with the withdrawal of life-sustaining treatment, Arizona, Arkansas, Colorado, Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Maine, Missouri, New Hampshire, Oregon, South Carolina, Utah, Wisconsin, and Wyoming all exclude nutrition, fluids, nourishment, or sustenance from the definition of life-sustaining or life-prolonging medical treatment. See supra note 5.

112 See, e.g., Gray v. Romeo, 697 F. Supp. 580, 587 (D.R.I. 1988) (“Although an emotional symbolism attaches itself to artificial feeding, there is no legal difference between a mechanical device that allows a person to breathe artificially and a mechanical device that artificially allows a person nourishment.”); In re Conroy, 98 N.J. 321, 373, 486 A.2d 1209, 1236 (1985) (“Analytically, artificial feeding by means of a nasogastric tube or intravenous infusion can be seen as equivalent to artificial breathing by means of a respirator. Both prolong life through mechanical means when the body is no longer able to perform a vital bodily function on its own.”); See also, Steinbrook and Lo, Artificial Feeding - Solid Ground, Not A Slippery Slope, 318 New Eng. J. Med. 286 (1988).

113 Meilaender, On Removing Food and Water: Against the Stream, 14 Hastings Center Rep. 11 (1984), quoted in D. Meyers, Medico-Legal Implications of Death and Dying § 12.27 (Supp. 1988). See In re Gardner, 534 A.2d 947, 958 (Me. 1987) (Clifford, J. dissenting) (“where food and water are being provided in a non-invasive, pain-free manner to a non-terminally ill patient, the withdrawal of such a feeding tube for the purpose of causing the patient’s . . . death ignores the legitimate and longstanding interest of the state in preserving life and preventing suicide, exposes many member of our society to potential abuse, and should not be sanctioned”); In re Peter, 108 N.J. 365, 529 A.2d 419, 432 (1987) (O’Herrn, J. dissenting) (“Any decision allowing one group of people to withdraw food and water from another human being evokes a response deep beneath the abstractions of legal reasoning.”); Alexander, Death by Directive, 28 Santa Clara L. Rev. 67, 83 (1988) (“Although it is true that artificial feeding differs from normal eating, providing food and liquids is so psychologically bound to a level of expected non-medical care that physicians, not to mention lay people, have difficulty in equating its removal with the removal of respirators and other less commonly provided forms of help.”). See also Correspondence, 319 New Eng. J. Med. 1754-59 (1988); Correspondence, 319 New Eng. J. Med. 306 (1988).

114 In re Peter, 108 N.J. 365, 382 n. 11, 529 A.2d 419, 428 n.11 (1987) (“If a patient subjectively distinguishes among various forms of life support, of course, that distinction will be respected.”).


116 AR 40-3, para. 19-4; Withdrawal of Life-Sustaining Treatment Letter, Encl., supra note 16, para. 5.
impress upon the medical community the importance of both following the published policy and documenting their actions in patients' medical records.

Conclusion

The Army policies concerning DNR orders and the withdrawal of life-sustaining treatment are reasonable attempts to balance competing interests. The interests at stake, however, are profound, and no policy can satisfy every interest in all circumstances. Physicians, nurses, lawyers, clergy, and family members all have a role to play. The issues are not only medical or only legal; they are medical, legal, ethical, spiritual, and philosophical. Judge advocates, as members of the ethics committees and as legal advisors to hospital command staffs, must be prepared to accept their responsibilities. They must, in cooperation with other interested parties, ensure that patients' rights of self-determination and privacy in medical treatment decisions are recognized and respected. At the same time, they must weigh in the balance society's interest in human life and medical ethics. Only through concern, compassion, and competency can the Army lawyer fulfill his or her responsibility in this difficult and sensitive area.

Source Selection—Litigation Issues During 1988

Major Earle D. Munns, Jr., and Major Raymond C. McCann
Instructors, Contract Law Division, The Judge Advocate General's School

Introduction

Few areas of contract formation cause as much consternation as the source selection procedures in competitive negotiated acquisitions. Unfortunately, the hundreds of protest cases filed each year indicate that offerors and government source selection officials do not fully understand the procedures to be used. This article will focus on the jurisdictional and substantive developments in the source selection process during 1988. This area of government contract law remains dynamic and troublesome.

FAR Subpart 15.6 prescribes the policies and procedures for the selection of a source or sources in competitive negotiated acquisitions. As stated therein, source selection procedures are designed to—

i. Maximize competition;
ii. Minimize the complexity of the solicitation, evaluation, and the selection decision;
iii. Ensure impartial and comprehensive evaluation of offerors' proposals; and
iv. Ensure selection of the source whose proposal has the highest degree of realism and whose performance is expected to best meet stated Government requirements.1

Formal implementation of source selection policies and procedures is the responsibility of agency heads or their designees.2 Regardless how that implementation occurs, however, the role of the government contract attorney in the source selection process is extensive and pervasive.3 The government contract attorney should be an active participant in all stages of source selection, to include: 1) the review and even the drafting of the solicitation and its evaluation criteria; 2) negotiations or discussions with offerors; 3) business and legal advice on the award decision; and 4) the defense of the source selection when protests arise.

Preparing the Request for Proposals

The Competition in Contracting Act of 1984 (CICA)4 requires that competitive proposals be evaluated solely on the factors specified in the solicitation.5 While various contracting agencies follow different practices, each recognizes the need for detailed proposal evaluation systems so that the source selection official can make a sound decision.6 Thus, a primary purpose of the Request for Proposals (RFP) is to provide the potential offerors with an understanding of the way the source selection decision will be made. Fairness requires that the basis for the source selection decision be stated in the solicitation and that the decision be made in accordance with those announced “rules of the game.”7

Describing the Evaluation Factors

In meeting this purpose, the various bid protest forums have given agencies broad discretion in describing the source selection process to be used in an acquisition. But while the evaluation factors that apply

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1 Federal Acquisition Regulation 15.603 [hereinafter FAR].
2 FAR 15.604(a).
3 See Army Material Command Pam 713-1, Source Selection Procedures (July 1987) [hereinafter AMC Pam 713-1].
5 FAR 15.608(a).
7 FAR 15.605(e).