

Title: Determination of Death

I. POLICY:

It is the policy [HOSPITAL NAME] that a patient is considered dead when a physician,¹ in accordance with accepted medical standards, determines that the patient has sustained irreversible cessation of either (1) circulatory and respiratory functions, or (2) all functions of the entire brain, including the brain stem. Whether cardiopulmonary or neurological criteria are used for a specific patient is based on clinical indications. A patient shall be pronounced dead by a physician² immediately following such determination.

II. DEFINITIONS

- A. *Reasonable efforts to accommodate* – efforts that take into consideration a patient’s or family’s religious or cultural practices or concerns related to brain death (or those stated by the patient’s legal representative or surrogate) and which are balanced with the needs of other current or prospective patients in urgent need of care as well as community and legal standards regarding end of life care.
- B. *Reasonably brief period of accommodation* – an amount of time afforded to gather family or next of kin at the patient’s bedside.
- C. *Legal Representative* – an individual authorized to make healthcare decisions for a patient due to appointment by the Courts to be the patient’s Conservator or designated in a Power of Attorney for Health Care (or other legally-recognized advance medical directive) to be the patient’s Agent or Attorney-in-Fact.
- D. *Surrogate* – an adult, other than a Legal Representative, legally recognized to make decisions for the patient.
- E. *Licensed Independent Practitioner* – a member of the Medical Staff who holds a License or a Physician-in-Training who holds a License and who is enrolled in an approved postgraduate Physician-in-Training program at the Medical Center where engaging in the practice of medicine is required as part of such training program.
- F. *Physician* – a member of the Medical Staff with appropriate clinical privileges to provide indicated medical services.
- G. *Physician of Record* – a member of the Medical Staff who, without reference to Medical Staff membership category, is the principal provider of professional services to the patient during hospitalization and directs the care for that patient during the course of the stay as evidenced by signed written orders and progress notes. The Physician of Record may designate another Physician to act on his or her behalf.

¹ Exception: a physician-in-training, as a licensed independent practitioner, may fulfill this function in certain circumstances. See Section IV A below.

² Exception: In accordance of the medical centers, “Pronouncement of Death by a Registered Nurse,” policy.

III. PURPOSE:

To provide guidelines for determining and pronouncing that a patient is legally dead.

IV. PROCEDURE:

A. Cardio-Pulmonary Death

When, in accordance with accepted medical standards, a licensed independent practitioner determines that a patient has sustained an irreversible cessation of circulatory and respiratory functions, the patient is dead and death is pronounced.³

B. Neurological/Brain Death

In Anticipation of Brain Death

When a treating physician has reason to believe, based on clinical indications and accepted medical standards, that a patient has already or may soon suffer an irreversible cessation of all functions of the entire brain, including the brain stem, the physician should inform the patient's legal representative or surrogate of such.

Determining Brain Death

When there are clinical indications that a patient may have suffered an irreversible cessation of all functions of the entire brain, including the brain stem, a neurological determination of death will be made in accordance with the following steps:

Exception: See Section CI below.

1. A physician must validate that the patient lacks cortical and brainstem function utilizing accepted medical standards. Reversible causes of unconsciousness and lack of brain stem reflexes shall be ruled out. In addition, apnea shall be demonstrated (except when apnea testing cannot be performed safely).

NOTE: Special effort must be given when the patient is a child, especially if the child is under five (5) years of age.

2. A second physician must independently confirm the assessment of irreversible cessation of all brain functions utilizing accepted medical standards. In most cases, this confirmation will be made as soon as possible following the first assessment, and should not exceed 1-2 hours whenever possible.
3. It is recommended (but not required) that one of the two physicians involved in determining that the patient has suffered an irreversible cessation of all brain function be a qualified neurologist, neurosurgeon, or have been trained in critical care medicine or emergency medicine.
4. Both physicians must document in the patient's medical record the procedures utilized to determine irreversible cessation of all brain functions and the factual basis for the determination by those procedures.

³ Exception: In accordance with the medical centers, "Pronouncement of Death by a Registered Nurse," policy.

5. Neither of the two physicians involved in determining death shall participate in the harvesting or transplanting of organs or tissues obtained from the patient. These physicians may, however, participate in decisions regarding the patient becoming an organ donor.
6. The patient shall be determined to be dead after the second physician has confirmed the irreversible cessation of all brain functions. Death shall then be pronounced.
7. A physician, assisted (whenever possible) by appropriate additional members of the patient care team (nurses, social workers, chaplains, etc.), shall explain to the patient's legal representative or surrogate that the patient is dead under California law and that medical interventions, including cardiopulmonary support, will now be discontinued. It shall also be explained what to expect once support is discontinued.

Exception: See Section C2 below.

Exception: When the patient is an organ donor, medical interventions, including cardiopulmonary support, are not immediately withdrawn after death is pronounced. Procedures specific to the care for the organ donor are provided in "Organ Transplantation: Donation of Organs, Tissues, and Eyes," policy.

8. Appropriate medical, nursing, and additional staff will discontinue all medical interventions and disconnect all supporting systems in accordance with established standards and protocols.

Exception: Individual nursing and additional staff have the right to decline to participate in the withdrawal of support systems. See "Staffing: Staff Rights Mechanisms," policy.

9. Upon cessation of cardiac and respiratory activity, the patient's body should be transferred to the hospital's morgue in accordance with Medical Center policy (*See "Decedent Affairs Protocol," policy*).

C. Requests for Accommodation

1. *Requests for Reasonable Efforts to Accommodate*

If a patient's legal representative or surrogate expresses to members of the patient's care team concerns about the neurological determination of death based on the patient's and/or family's religious or cultural beliefs or practices, the hospital shall make reasonable efforts to accommodate those concerns.

- a. If the request for accommodation was made to a member of the patient's care team other than the patient's physician of record, that individual will alert the physician of record in a timely manner. Once informed, the physician of record will arrange to meet with the patient's legal representative or surrogate who made such a request.

- b. The physician of record or any other member of the patient's care team should request assistance from Chaplaincy, Case Management, or other appropriate hospital services that can help ensure that members of the [HOSPITAL NAME] staff involved in caring for the patient have an adequate understanding of the religious or cultural practices or concerns underlying the request for accommodation.
- c. The patient's physician of record should also consider soliciting input from community clergy or lay leaders to help inform the physician of record regarding what will serve as reasonable efforts to accommodate the request. [HOSPITAL NAME] Chaplains can assist in obtaining such input.
- d. The physician of record shall establish a plan defining what reasonable efforts will be made in order to accommodate the request.⁴⁴ If the request to accommodate is made after the initial assessment that the patient lacks cortical and brainstem function but prior to the second assessment by which brain death is confirmed, the physician of record may temporarily delay the second assessment until after appropriate religious or cultural input has been considered.
 - i. The length of such a delay must be well defined and concordant with the reasonable accommodation sought.
 - ii. During such a delay, medical interventions shall not be withdrawn unless agreed upon by the physician of record and the requestor for accommodation, nor should medical interventions be escalated.
- e. The physician of record shall document in the patient's medical record the plan defining what, if any, reasonable efforts will be made in order to accommodate the request. The physician of record shall discuss this plan with the patient's legal representative or surrogate as well as nursing staff and other members of the patient's care team.
- f. If the physician of record is not able to develop a plan and/or obtain agreement from the patient's legal representative or surrogate defining what reasonable efforts will be made in order to accommodate the request, the physician of record shall request consultation from the [ADMINISTRATIVE ENTITY UNDER WHICH ETHICS CONSULTATION IS PROVIDED]. The [ADMINISTRATIVE ENTITY UNDER WHICH ETHICS CONSULTATION IS PROVIDED] may subsequently convene a special meetings of the [HOSPITAL NAME] Bioethics Committee, or an *ad hoc* sub-group of it (in accordance with the medical center's policy on Clinical Ethics Consultation)

2. *Requests for a Reasonably Brief Period of Accommodation*

If a patient's legal representative or surrogate requests a reasonably brief period of accommodation, the hospital shall make a good faith effort to honor that request. The period of accommodation will begin at the time of neurological determination of death and last until already existent cardiopulmonary support is withdrawn.

⁴ The Bioethics Committee will produce and periodically update a document containing examples of possible efforts to accommodate, to be attached to this policy

- a. If the request for accommodation was made to a member of the patient's care team other than the physician coordinating the initial assessment and confirmatory diagnosis of brain death, that individual will alert the physician in a timely manner (and before cardiopulmonary support is disconnected).
 - b. The length of time set aside for family or next of kin to gather at the bedside shall be established by the physician after discussion with the requestor and shall take into consideration the needs of other current or prospective patients in urgent need of care. This period of time must be well defined and appropriately brief.
 - c. During the reasonably brief period of accommodation, no new medical interventions will be initiated and all medical interventions other than cardiopulmonary support should be withdrawn. Available family or next of kin shall be advised that if cardiac or respiratory function ceases before all are able to gather at the bedside, no efforts will be made to respond to such cessation.
 - d. The physician shall document in the patient's medical record the plan to be followed during this reasonably brief period of accommodation.
3. The patient's legal representative or surrogate may request and receive a written statement summarizing [HOSPITAL NAME] policy regarding such accommodations.⁵ If possible, this written statement is to be provided upon request; if the written statement is not available upon request, it is to be provided as soon as possible. When circumstances allow, effort should be made to provide this written statement prior to the determination that the patient is dead.

V. RELATED POLICIES AND PROCEDURES

- California Healthcare Association Consent Manual, 36th Edition, 2009.
- [HOSPITAL NAME] Medical Staff Rules and Regulations, General Provisions and Definitions

⁵ The Bioethics Committee will produce and periodically update a document written in lay language summarizing [HOSPITAL NAME] policy's addressing requests for accommodation.

ADDENDUM: Determination Of Death Policy

EXAMPLES OF REASONABLE EFFORTS TO ACCOMMODATE

(for [HOSPITAL NAME] staff use only)

The central aim of making reasonable efforts to accommodate requests from families belonging to religious or cultural groups that reject the neurological determination of death is to demonstrate an appreciation of and sensitivity to their beliefs and values while at the same time not undercutting or denying current medical and broader social norms and corresponding legal standards which endorse the use of neurological criteria for determining death. Below are examples of possible efforts, which may be considered as reasonable. These examples are meant to demonstrate some of the kinds of efforts, which might be considered when developing a plan for accommodation. They are not definitive, exhaustive, nor required.

A. When the request for accommodation is made prior to the initial assessment that the patient lacks cortical and brainstem function:

- delay (for a well-defined period of time) initiating an initial assessment of the patient's cortical and brainstem function but not escalate or replace any medical interventions
- elect to use cardiopulmonary criteria for determining death, and
 - continue the medical interventions the patient is currently receiving for a well defined period of time (the length of time to be concordant with the reasonable accommodation sought), but not escalate or replace any medical interventions
 - withdraw and withhold all medical intervention except ventilatory support

B. When the request for accommodation is made after the initial assessment that the patient lacks cortical and brainstem function but before the second assessment by which brain death is confirmed

- continue the medical interventions the patient is currently receiving for a well defined accommodation sought) but not escalate nor replace any medical interventions
- withdraw and withhold all medical intervention except ventilatory support
- continue ventilatory support until cardiac arrest occurs but not escalate, replace or re-initiate current medical interventions (including ventilation) as well as withhold all additional medical interventions

ADDENDUM

BRAIN DEATH AND REQUESTS FOR ACCOMODATION

An Overview of [HOSPITAL NAME] Policy

(for families facing the brain death of a loved one)

In accordance with federal, state, and local laws and accepted standards of medical practice, there are rare circumstances in which patients are declared dead after it has been determined that they have suffered an irreversible cessation of all functions of their entire brains. This is

commonly known as “brain death.” In such circumstances, once brain death has been determined, a patient is declared legally dead and all medical interventions are withdrawn and all mechanical supports, such as a ventilator, are disconnected so that the patient’s body may be treated with dignity and shown proper respect.

In two circumstances, based on a request for accommodation by a patient’s legal representative or surrogate, the typical procedures associated with brain death may be slightly altered.

1. Reasonably Brief Period of Accommodation

These are often trying and difficult times for families, especially when the patient’s death is sudden and unexpected. In many cases, there has not even been time for families to gather together at the bedside to say their final goodbyes. In recognition of the importance that many families place on being able to gather together in such moments, [HOSPITAL NAME] has developed policy that allows families to request a reasonably brief period of accommodation in which a short amount of time is afforded to gather together at the bedside before the final support is disconnected. The length of time set aside for this purpose will be established by the patient’s physician after he or she has met with the patient’s family. Because the patient has died, typically the amount of time is quite short, often only hours, but hopefully long enough that family will have the necessary time to make their way to the hospital. Unfortunately, it is sometimes the case that even these few brief additional hours must be curtailed in order to address the medical necessities of other patients in urgent need of care. If a reasonably brief period of accommodation is possible, all medical interventions other than those providing artificial functioning of the patient’s heart or lungs will be removed; these final interventions will be removed only after family has had their allotted time to gather. Unfortunately, sometimes even before all have been able to make it to the patient’s bedside, and despite the continuation of those interventions providing artificial functioning of the patient’s heart or lungs, the patient’s heart or lungs stop nonetheless. In these circumstances, as a sign of respect for the newly deceased patient and in order to uphold the dignity of the patient’s body, no effort will be made to respond.

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2. Reasonable Efforts to Accommodate

A very small percentage of [HOSPITAL NAME] patients come from religious or cultural communities with well-established beliefs in which the neurological determination of death, e.g., brain death, is not accepted. [HOSPITAL NAME] has long striven to show respect for and attempt to accommodate patients and families who belong to such communities. At the beginning of 2009, the California legislature too acknowledged the importance of being sensitive to these kinds of difference and thus the need for hospitals and other healthcare institutions to make reasonable efforts to accommodate such different perspectives without at the same time rejecting current law and medical standards of practice. In recognition of this, [HOSPITAL NAME] has created formal policy acknowledging that the decision-makers for those patients who are approaching, are likely soon to meet, or have met the neurological criteria for determining death can request that reasonable efforts be made to accommodate their religious or cultural values. In such cases, the patient’s primary physician will seek input from a variety of sources, from both within and outside of the hospital, to help him or her ensure a proper understanding of the religious or cultural basis for the request. Other members of the patient’s

care team may also seek such input. In addition, the primary physician will pursue conversations with the patient's legal decision-maker. Based on the input he or she receives and the conversations he or she has had, the primary physician will then establish a plan defining what reasonable efforts can be made in order to accommodate the request. Once such a plan has been made, the primary physician will discuss this plan with the patient's legal decision-maker as well as with nursing staff and other members of the patient's care team. This will be done in order to ensure that all involved in caring for, and caring about, the patient, understand how to proceed. The plan will then be implemented. Whatever plan is decided upon, [HOSPITAL NAME] is committed to trying to find a balanced way of accommodating those whose well-established religious or cultural values diverge from the accepted standards, norms, and laws which endorse the use of neurological criteria for the determination of death. For general concern regarding end-of-life decision-making, please feel free to contact [HOSPITAL NAME] Ethics Department.