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## Issues with the Determination of Brain Death: The Case for Religious and Moral Exceptions

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## **I. Introduction**

The double doors open to the emergency room, where paramedics are wheeling in patients, a child is receiving stitches while holding her mother's hand, and a patient behind a curtain is screaming as nurses run to him. The hospital corridor is stuffy, and the air has an undertone of bleach. The walls are painted a slate gray and are scraped in places from the hundreds of gurnies that have bumped into them. The pictures on the walls in the waiting room are cheap prints of uplifting scenes. Here in the waiting room, loved ones sit, with anxious faces, some silent and staring off into the distance, others tapping a foot and rustling through last week's New York Times to keep themselves occupied, others weeping silently in the corner. When a physician walks into the waiting room, all heads turn towards the door, watching the physician, restless to hear their names being called, in hope to find out the fate of their loved one(s). A family's name is called, and they are escorted into another room. Here they are told that their son was in a major car accident, leading to a traumatic brain injury. The physicians promise they did the best they could to save their son, but he is being kept alive by life support and has no brain function, explaining that he is "brain dead."

Imagine for a moment that you are on the receiving end of this information. What would you do? What questions would you ask? How would you process what you were hearing? Unfortunately, these kinds of conversations happen every day throughout the United States. But what if, this family's son would be taken off the ventilator in one state because by law he is considered dead, but in another state the physicians would keep him on the ventilator because he is not proclaimed dead. Is that possible? To consider the same person to be alive in one part of the country but dead in another seems illogical. However, this happens today in the United States.

When it comes to the diagnosis of brain death, the legal definition may be determined by neurological criteria. This dates back to a report in 1968 by the Harvard Ad Hoc Committee on death whereby irreversible coma was determined to be a new criterion of death.<sup>1</sup> The medical community has adopted that definition, with a majority of states codifying the standard as well.<sup>2</sup> Nonetheless, people have begun to push for change in the medical definition, especially since there have been multiple reports of individuals exhibiting brain activity after physicians have declared them brain dead. Some people believe it is morally wrong to decide that someone is dead due to their lack of brain activity. Others object to the diagnosis of brain death because of their religions, especially for members of the Orthodox Jewish, Japanese Shinto, and Buddhist communities. A couple of states accommodate religious and moral exceptions, but only based on reasonableness. New Jersey is the only state where a physician can pronounce death on the basis of cardio-respiratory criteria if there is religious/moral opposition.<sup>3</sup>

This article seeks to provide readers with an alternative perspective on the current definition of brain death. The decisions revolving around death, especially brain death, should not be based on scientific methods or a legal definition but rather on a family's religious and philosophical views. Determining death under the neurologic criteria represents a social construction resulting from a move to increase the number of organs available for transplantation. Individuals should be allowed to state a preference during advanced care planning as to which definition of death most likely aligns with their personal beliefs. All states should establish a more respectful and coherent law or implement a conscience clause that gives the family a choice on how they would define death based on their religious or moral views.

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<sup>1</sup> Helga Kuhse et. al., *Bioethics: An Anthology* 220 (John Wiley & Sons, Inc., 3<sup>rd</sup> ed. 2016).

<sup>2</sup> *Id.*

<sup>3</sup> N.J. REV. STAT. § 26:6A-5; N.J. ADMIN. CODE § 13:35-6A.6.

This article will first explore the origins of the concept of brain death, including the various definitions of brain death that have been up for debate since the mid-twentieth century. Section II will also discuss the criticism and confusion of brain death as well as the causes of brain death. Section III will look at the American Academy of Neurology (AAN) guidelines that describe the process on how physicians identify and declare brain death. Section IV will focus on the current laws regarding brain death, including states that already have exemptions in place. Section V will analyze different religious and philosophical views on brain death. Section V will also discuss that the definition of brain death used today is incoherent and should be either altered to add a conscience clause or made anew and reflect New Jersey's legislation, giving the patients or patient's families the individual choice of defining death. Section VI will address the criticisms of an alteration of the brain death criteria.

## **II. Background**

### **a. The Historical Development of Brain Death**

Traditionally, the legal and medical communities believed that death occurred when breathing ceases and the heart stops beating permanently.<sup>4</sup> However, with the development of ventilators and other life-sustaining technologies the definition changed.<sup>5</sup> In the 1950's, the implications of the traditional view of death started to trouble physicians because ventilators could maintain patients for years at a time.<sup>6</sup> Technology made it difficult to declare a patient dead. The opportunity for organ transplantation inspired a desire to declare death without harming the organs that might be transplanted upon declaration of death.<sup>7</sup>

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<sup>4</sup> Morris B. Abram M.A. J.D. et. al. , *Defining Death: Medical, Legal, and Ethical issues in the Determinate of Death* 3 (July 1981).

<sup>5</sup> *Id.*

<sup>6</sup> *Id.*

<sup>7</sup> *Id.*

In 1959, French scientists identified the state of coma dépassé, a state beyond a coma.<sup>8</sup> Physicians believed that this state of profound neurological loss belonged in a category of its own.<sup>9</sup> In 1968, the first formal definition of brain death was published by the Ad Hoc Committee of the Harvard Medical School.<sup>10</sup> The article noted that new approaches to life-sustaining technology were placing considerable burdens on families and hospitals, and that people kept on ventilators could serve as a source of valuable, high-quality organs.<sup>11</sup> The article also proposed a new way to determine death, based on the permanent cessation of neurological functioning.<sup>12</sup> According to the committee brain death was defined as an individual who had sustained traumatic brain injury that causes an irreversible coma and the ability to breathe independently.<sup>13</sup> An article published shortly after the Ad Hoc Committee report commented that there was a need for a public dialogue about the new criteria for death because the public was very confused about the notion of brain death.<sup>14</sup> The issue was never really resolved.

After the *committee* released the new definition of brain death, many organizations, including the World Health Organization and the World Medical Association accepted the definition as a formal legal and medical term.<sup>15</sup> By 1970, states began to change their laws so that death could be pronounced on the basis of irreversible loss of brain function in addition to the traditional criteria focusing on circulation and heartbeat.

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<sup>8</sup> P. Mollaret & M. Goulon, *Le coma dépassé (mémoire préliminaire)*, 101(1) REVUE NEUROLOGIQUE 3-5 (1959).

<sup>9</sup> Calixto Machado et al., *The Concept of Brain Death Did Not Evolve to Benefit Organ Transplants*, 33 J. MED. ETHICS 197, 197-98 (2007).

<sup>10</sup> Harvard Ad Hoc Committee, *Report of the Harvard Medical School to Examine the Definition of Brain Death*, 205 J. AM. MED. ASS'N, 337, 337-40 (Aug. 5, 1968).

<sup>11</sup> *Id.*

<sup>12</sup> *Id.*

<sup>13</sup> *Id.*

<sup>14</sup> John D. Arnold et al., *Public Attitudes and the Diagnosis of Death*, 206 J. AM. MED. ASS'N, 1949, 1953-54 (1968).

<sup>15</sup> 2 AVRAHAM STEINBERG, M.D., ENCYCLOPEDIA OF JEWISH MEDICAL ETHICS, 697 (Fred Rosner M.D. trans., Feldheim Publishers 1<sup>st</sup> ed. 1993).

In 1978, the US Presidents Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research recognized there needed to be a uniform definition of death, so it commissioned a report, *Defining Death*, published in 1981.<sup>16</sup> The President Commission was tasked with explaining why patients who fall under the proposed neurological criteria in the Ad Hoc Committee report should be considered biologically dead.<sup>17</sup> The commission did the following three things: (1) provided a basis for the new medical practice of death determination using neurological tests; (2) explained the relationship between determining death on neurological and circulatory-respiratory grounds; and (3) proposed model language for future state statutes where they include neurological criteria (brain death) in their definition of death.<sup>18</sup>

The model language that was proposed by the Presidential Commission was later adopted in the Uniform Determination of Death Act (UDDA).<sup>19</sup> The UDDA provides a comprehensive and medically sound basis for determining death in all situations. Since the birth of the act in 1981, 47 states and the District of Columbia have adopted the UDDA.<sup>20</sup> The UDDA provides the following:

An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.<sup>21</sup>

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<sup>16</sup> *Defining Death: Medical, Legal and Ethical Issues in the Determination of Death*, [http://www.bioethics.gov/reports/past\\_commissions/defining\\_death.pdf](http://www.bioethics.gov/reports/past_commissions/defining_death.pdf) (accessed Nov. 29, 2019).

<sup>17</sup> *Id.*

<sup>18</sup> *Id.*

<sup>19</sup> UNIF. DETERMINATION OF DEATH ACT § 1-3 (AM. MED. ASS'N. & AM. BAR ASS'N. 1980).

<sup>20</sup> Eelco Wijdicks, *Brain Death Worldwide*, 58 NEUROLOGY 20, 21 (2002).

<sup>21</sup> UNIF. DETERMINATION OF DEATH ACT *supra* note 19.

Here, the UDDA merely recognized cardiorespiratory and brain death in accordance with the criteria the medical profession already universally accepted.<sup>22</sup> The act purposefully left the means of determined death unspecified to ensure that the act could evolve as technology evolved.<sup>23</sup>

## **b. Criticism and Confusions of Brain Death**

Many people in today's society do not fully comprehend the definition of brain death, and if they do, they often criticize the idea of brain death. The newly created definition of brain death after the UDDA resulted into an increasingly complicated set of views.

### **1. Confusion**

The nature of "brain death" is often confused with a person that is in a persistent vegetative state. A person in a persistent vegetative state (PVS) is a person with severe brain damages in whom coma has progressed to a state of wakefulness without detectable awareness.<sup>24</sup> Such patients have sleep-wake cycles in which the coma has progressed to a state of wakefulness without detectable awareness.<sup>25</sup> In brain death there is irreversible brain injury but also the entire loss of function to the brain stem.<sup>26</sup> This means that parts of the brain and the brain stem are considered to be non-functioning and will continue to be that way.<sup>27</sup> However, other organs, such as the heart, kidneys, or livers can still work for a certain period of time after brain death especially if the individual is using life-supporting machines and specific medications, making patients symptoms similar to that of a person in a PVS.<sup>28</sup>

### **2. Criticism**

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<sup>22</sup> *Id.*

<sup>23</sup> *Id.*

<sup>24</sup> Stephen Ashwal, M.D. & Ron Cranford M.D., *Medical Aspects of the Persistent Vegetative State*, 330 NEW ENG. J MED., 1572, 1572-1579 (Jun. 2, 1994).

<sup>25</sup> *Id.*

<sup>26</sup> *Id.*

<sup>27</sup> UNIF. DETERMINATION OF DEATH ACT *supra* note 19.

<sup>28</sup> Steinberg M.D. *supra* note 2.

From the beginning, members of the medical community have felt uneasy with the concept of brain death.<sup>29</sup> It has been claimed by some critics that the neurological criteria for determining death is to meet the growing need for vital organ donations.<sup>30</sup> Physicians and hospitals argue that is crucial to have an accurate definition of brain death to know exactly when someone dies for medical reasons as well as a host of other reasons.<sup>31</sup> They argue that the recognition of the brain death criteria has solved a dilemma for the medical community because it acknowledged that bodies can be caused by technological means to function artificially after death.<sup>32</sup> However, critics have questioned whether individuals can be truly dead when they have sustained neurological injury indicating total brain failure, but continue to circulate blood, breath, and perform other biological functions with the aid of mechanical ventilation.<sup>33</sup>

In the 1990's, Dr. Alan Shewmon's work contained a serious challenge against brain death.<sup>34</sup> Shewmon was able to demonstrate that some patients that were considered brain dead could perform functions that seemed to require a body with integrative function and which the Presidents Commission would consider to be alive.<sup>35</sup> These functions included wound healing, maintaining a warm body temperature, mounting stress responses, and fighting infections.<sup>36</sup>

There have been many cases within the past 20 years where physicians have proclaimed patients to be brain dead, when in fact they were alive. Most of these patients were organ donors or viable to donate organs. The most known story was in 2007 when Zack Dunlap suffered a

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<sup>29</sup> Laura A. Siminoff et. al., *Death and Organ Procurement: Public Beliefs and Attitudes*, 59 SOC. SCI. & MED. J. 2325, 2325-2334 (Dec. 2004).

<sup>30</sup> *Id.*

<sup>31</sup> *Id.*

<sup>32</sup> *Id.*

<sup>33</sup> See D. Alan Shewmon, *The Brain and Somatic Integration*, 26 J. MED. & PHILOS. 457, 459-69 (2001).

<sup>34</sup> *Id.*

<sup>35</sup> *Id.*

<sup>36</sup> *Id.*

quad bike accident while visiting Texas.<sup>37</sup> Zack was taken to the hospital where brain scans indicated that there was no more activity.<sup>38</sup> The physicians pronounced him “brain dead” and Zack’s family decided that they would harvest his organs for transplantation.<sup>39</sup> While discussing the process of harvesting organs, Zack recounts that he heard them discussing the details of transplanting his organs over his body, yet he could do nothing about it because he was not fully conscious.<sup>40</sup> Just minutes before the physicians rolled Zack into the operating room, his cousin stroked his foot with a pocketknife, and Zack jerked his foot away.<sup>41</sup> The physicians were astonished that Zack responded.<sup>42</sup> Five days later Zack opened his eyes and began the rehabilitation process.<sup>43</sup> Dr. Byrne, a former president of the Catholic Medical Association who began writing and criticizing brain death in 1977, stated that Zack was lucky enough to be found that he was alive before his vital organs were removed.<sup>44</sup>

Dr. Byrne believes that the story of Zack should be taken as a warning to the medical community about the insufficiency of the brain death criteria.<sup>45</sup> Dr. Byrne recognizes that over the years he had collected information pertaining to numerous cases like Zack where patients were labeled brain dead and have “returned from the dead.”<sup>46</sup> In 2007, Dr. John Shea, a clinical professor at multiple medical schools, wrote in agreement with Byrne’s concern about brain

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<sup>37</sup> Natalie Morales, *‘Dead’ man recovering after ATV accident*, NBC News (March 24, 2008), [http://www.nbcnews.com/id/23768436/ns/dateline\\_nbc-newsmakers/t/dead-man-recovering-after-atv-accident/#.Xaja9JNKjfY](http://www.nbcnews.com/id/23768436/ns/dateline_nbc-newsmakers/t/dead-man-recovering-after-atv-accident/#.Xaja9JNKjfY).

<sup>38</sup> *Id.*

<sup>39</sup> *Id.*

<sup>40</sup> *Id.*

<sup>41</sup> *Id.*

<sup>42</sup> *Id.*

<sup>43</sup> *Id.*

<sup>44</sup> John Jalsevac, *Doctor says about “Brain Dead” Man Saved from Organ Harvesting – “Brain Death is Never Really Death*, Lifesite (March 27, 2008), <https://www.lifesitenews.com/news.doctor-says-about-brain-dead-man-saved-from-organ-harvesting-brain-death-is>.

<sup>45</sup> *Id.*

<sup>46</sup> *Id.*

death, saying that the criteria of “brain death” is scientific theory and not fact and that the theory is particular open to abuse and should be treated with extra caution.<sup>47</sup>

Other stories include, George Pickering, a 27-year-old man who was pronounced brain dead in January 2015.<sup>48</sup> The physicians tried to disconnect the life support, but the father threatened the physicians, brandishing a gun.<sup>49</sup> During a three-hour standoff with the police, his son started to squeeze his father’s hand repeatedly.<sup>50</sup> George Pickering woke up later that evening.<sup>51</sup> Then there was Sam Hemming, who was involved in a major car accident.<sup>52</sup> She was pronounced brain dead.<sup>53</sup> For 18 days the physicians and family were at odds with one another.<sup>54</sup> The family did not want to transplant her organs because they felt that she was still alive.<sup>55</sup> After 19 days of the physicians pronouncing Sam brain dead, Sam started to wiggle her toes.<sup>56</sup> She woke up, and after a few weeks she made a tremendous recovery.<sup>57</sup> Her brain reprogrammed and she was able to recover physically and mentally.<sup>58</sup>

The likely explanation for such “recoveries” from brain death, according to experts is that these individuals were never brain dead in the first place and that the physicians made an error while testing these individuals to determine if they were brain dead.<sup>59</sup> Critics of the brain death

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<sup>47</sup> *Id.*

<sup>48</sup> Yanan Wang, *A Father’s Desperate – but Dangerous- Strategy to keep his ‘brain dead’ son on life support*, Washington Post (December 13, 2005), <https://www.washingtonpost.com/news/morning-mix/wp/2015/12/23/texas-man-says-he-went-to-jail-for-swat-standoff-that-saved-sons-life/>.

<sup>49</sup> *Id.*

<sup>50</sup> *Id.*

<sup>51</sup> *Id.*

<sup>52</sup> Amie Gordon, *Moments from death: Student, 22, in a Car Crash Coma WIGGLED her Toe to Stop Doctors Turning off her Life Support Machine*, Daily Mail UK (September 29, 2016), <https://dailymail.co.uk/news/article-3814394/Student-22-left-coma-horror-crash-saved-wiggled-toe-monets-doctors-turn-life-support-machine.html>.

<sup>53</sup> *Id.*

<sup>54</sup> *Id.*

<sup>55</sup> *Id.*

<sup>56</sup> *Id.*

<sup>57</sup> *Id.*

<sup>58</sup> *Id.*

<sup>59</sup> Jalsevac, *supra* note 44.

criteria feel as if physicians error has long been a public concern, especially when there is a the potential conflict of interest underlying end of life care with potential organ donors.<sup>60</sup> Many people have expressed fears that signing a donor card would result in physicians being less proactive in saving their lives.<sup>61</sup> According to a survey conducted by Donate Life America, 50 percent of respondents are concerned that physicians will not try as hard to save them if the physicians know they are organ donors.<sup>62</sup> While the cases mentioned above cannot conclude that all physicians would do less to save a patient's life if a patient is an organ donor or that the physicians are incompetent in recognizing death, there is enough statistical data to understand why people have distrust within the medical field when it comes to the brain death criteria.

### **c. What Causes Brain Death**

So, what really causes brain death? As noted above brain death is an irreversibly brain injury. What types of injuries make it irreversible? According to the AAN there are many causes of brain death. The basis of all the causes of death are due to a catastrophic injury to the brain.<sup>63</sup> Causes of brain death include: (1) cardiac arrest-when the heart stops beating and the brain is starved of oxygen; (2) a stroke- this is when the blood supply to the brain is blocked or interrupted; (3) a blood clot- this is when there is a blockage in a blood vessel that interferes with blood flow (4) a brain hemorrhage, (5) infections, (6) a brain tumor, and (7) the most common injury associated with brain death traumatic brain injury, such as blunt force trauma to the head during a car accident.<sup>64</sup>

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<sup>60</sup> Tiffanie Wen, *Why Don't More People Want to Donate Their Organs*, The Atlantic, (November 12, 2014), <https://www.theatlantic.com/health/archive/2014/11/why-dont-people-want-to-donate-their-organs/382297/>.

<sup>61</sup> *Id.*

<sup>62</sup> Tara Parker-Pope, *The Reluctant Organ Donor*, N.Y. Times (April 16, 2009), <https://well.blogs.nytimes.com/2009/04/16/the-reluctant-organ-donor/>.

<sup>63</sup> American Academy of Neurology, *Determining Brain Death in Adults*, <https://www.aan.com/Guidelines/Home/GetGuidelineContent/435> (last visited Nov. 19, 2019).

<sup>64</sup> *Id.*

According to the Centers for Disease Control (CDC) traumatic brain injury is a major cause of death and disability in the United States.<sup>65</sup> From 2006 to 2014, the increase in hospitalizations and deaths increased by 53%.<sup>66</sup> Currently traumatic brain injury contributes to about 30% of all injury deaths in the United States.<sup>67</sup> In 2014, CDC did an analysis on traumatic brain injury deaths and they concluded that nearly 57,000 deaths in the United States that year alone were related to traumatic brain injury.<sup>68</sup>

Once there has been a catastrophic injury to the brain, the brain begins to swell.<sup>69</sup> Being that the brain is contained in an enclosed cavity, the brain swelling gives rise to a massive increase in intracranial pressure.<sup>70</sup> In brain death, the increased intracranial pressure become so great that it exceeds the systolic blood pressure, thus causing a loss of blood flow to both the cerebral hemispheres and the brain stem.<sup>71</sup> Whatever the primary cause of brain death, this end result of loss of blood flow usually results in the destruction of the entire brain.<sup>72</sup> This sequence of events usually occurs within hours after the original brain injury occurred.<sup>73</sup>

### **III. How Physicians Determine a Patient is Brain Dead**

In 1995 the AAN created a guideline for physicians to use to determine whether a person has lost all brain function and is being kept alive solely through hospital machinery or medicine. In 2010 the AAN updated the guidelines by reviewing over 500 hospital policies regarding brain death statutes.<sup>74</sup> They updated the guideline after a comprehensive clinical evaluation of more

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<sup>65</sup> Centers for Disease Control and Prevention, *TBI-Related Deaths*, <https://www.cdc.gov/traumaticbraininjury/data/tbi-deaths.html> (last visited Oct. 17, 2019).

<sup>66</sup> *Id.*

<sup>67</sup> *Id.*

<sup>68</sup> *Id.*

<sup>69</sup> ENCYCLOPEDIA OF BIOETHICS 605 (3<sup>rd</sup> ed. 2004).

<sup>70</sup> *Id.*

<sup>71</sup> *Id.*

<sup>72</sup> *Id.*

<sup>73</sup> *Id.*

<sup>74</sup> Dennis Thompson, *How do Hospitals determine if someone is brain dead?*, CBS News

than 25 separate assessments.<sup>75</sup> This new guideline gives physicians a checklist that will help them with the diagnosis of brain death.

Many of the details of the clinical neurological examination to determine brain death cannot be established by evidence-based methods.<sup>76</sup> Therefore, the detailed brain death evaluation that physicians follow is intended to be a tool, not the sole proprietor.<sup>77</sup> The AAN believes that these guidelines are informative and should help the physicians when determining if a patient is brain dead. The updated guideline consists of four steps.

**a. The Clinical Evaluation (Prerequisites)**

The first step is the clinical evaluation otherwise known as the prerequisites to the examination. In this step the physician must establish that there is an irreversible coma and determine the proximate cause of the coma.<sup>78</sup> The doctors can usually establish the cause of the coma through history, past examinations, neuroimaging, and laboratory tests.<sup>79</sup> The doctors must exclude the presence of any central nervous system depressants effects, such as sedatives or tranquilizers, by monitoring history, running a drug screen, calculating clearance using five times the drug's half-life, or, if available, their drug plasma levels below the therapeutic range.<sup>80</sup> There should be no recent administration or continued presence of neuromuscular blocking agents, as well as no severe electrolyte, acid-base, or endocrine disturbance, which is defined by laboratory values markedly deviated from the norm.<sup>81</sup>

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(December 28, 2015), <https://www.cbsnews.com/news/how-do-hospitals-determine-if-someone-is-brain-dead/>.

<sup>75</sup> *Id.*

<sup>76</sup> AMERICAN ACADEMY OF NEUROLOGY, <http://www.aan.com> (last visited November 30, 2019).

<sup>77</sup> *Id.*

<sup>78</sup> Eelco F.M. Wijdicks MD., PhD et. al., *Evidence-Based Guideline update: Determining Brain Death in Adults*, AMERICAN ACADEMY OF NEUROLOGY 1914 (June 2010).

<sup>79</sup> *Id.*

<sup>80</sup> *Id.*

<sup>81</sup> *Id.*

Once all of the aforementioned is done, the physicians then must achieve normal body temperature in the patient.<sup>82</sup> This is usually done by using a warming blanket. Once the core temperature is reached the physician must achieve normal systolic blood pressure.<sup>83</sup> After the blood pressure reaches normal rates, the physician then can move on and perform one neurologic examination.<sup>84</sup> This examination is usually sufficient enough to pronounce brain death in most of the United States, however some states require two examinations.<sup>85</sup> Legally, all physicians are allowed to determine brain death in most states.<sup>86</sup> However, neurologists, neurosurgeons, and intensive care specialist may have specialized expertise in determining brain death.<sup>87</sup> If the physician is not familiar with making the determination of brain death, the physician should familiarize themselves with the brain death criteria and should demonstrate competence during the examination.<sup>88</sup>

#### **b. The Clinical Evaluation (Neurologic Assessment)**

A neurologic exam will determine if the patient is brain dead. The exam begins with a determination of whether the patient lacks all evidence of responsiveness.<sup>89</sup> This means that eye opening or eye movement to stimuli must be absent and any other parts of the body must not produce a motor response when stimuli is used properly.<sup>90</sup>

The physician will then analyze the presence or absence of the brainstem reflexes.<sup>91</sup> This is broken up into multiple analyses. First, the doctor will look for the absence of pupillary

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<sup>82</sup> *Id.*

<sup>83</sup> *Id.* at 1915.

<sup>84</sup> *Id.*

<sup>85</sup> *Id.* at 1915.

<sup>86</sup> *Id.*

<sup>87</sup> *Id.*

<sup>88</sup> *Id.*

<sup>89</sup> *Id.*

<sup>90</sup> *Id.*

<sup>91</sup> *Id.*

response.<sup>92</sup> This is usually documented when a bright light is shined into both eyes.<sup>93</sup> Normally, the pupils are fixed in a position of 4-9 mm, if the pupils are more constricted than this, this suggests that there is a malfunctioning of the brain.<sup>94</sup> The physician then looks at the absence of ocular movements, using a test to determine head movement and reflexes.<sup>95</sup> The doctor will rotate the head briskly in both horizontal and vertical ways.<sup>96</sup> The eyes should not move relative to the head movement.<sup>97</sup> The physician will then irrigate each ear with ice water.<sup>98</sup> There should be no movement of the eyes. If there is, the patient is not brain dead.<sup>99</sup> The physician will then test the corneal reflex by touching the cornea with a piece of tissue paper, cotton swab or squirts of water.<sup>100</sup> The eyelids should not move. The physician should also test for facial muscle movement and gag reflex.<sup>101</sup> If there is any response in the muscle movement or gag reflex, then the patient cannot be considered brain dead.<sup>102</sup>

Once the physicians have tested the pupillary response and the ocular movements, they then move on to the testing of the Apnea to see if there is cessation of breathing.<sup>103</sup> Physicians will commonly look for the absence of a breathing drive.<sup>104</sup> This is usually tested with a CO<sub>2</sub> challenge.<sup>105</sup> The physicians will document the increase in the patient's carbon dioxide levels and note if they are above normal levels. Then the physicians will disconnect the patient from

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<sup>92</sup> *Id.*

<sup>93</sup> *Id.*

<sup>94</sup> *Id.*

<sup>95</sup> *Id.*

<sup>96</sup> *Id.*

<sup>97</sup> *Id.*

<sup>98</sup> *Id.*

<sup>99</sup> *Id.*

<sup>100</sup> *Id.*

<sup>101</sup> *Id.*

<sup>102</sup> *Id.*

<sup>103</sup> *Id.*

<sup>104</sup> *Id.*

<sup>105</sup> *Id.*

the ventilator and look closely for any respiratory movement for eight to ten minutes.<sup>106</sup> If no respiratory drive is observed, then the physicians must repeat this part of the examination approximately eight minutes after the first test was completed.<sup>107</sup> If the respiratory movements are absent again then the apnea test is positive, supporting the clinical diagnosis of brain death.<sup>108</sup> If the test is inconclusive, and the patient is stable during the procedure, it may be repeated for a longer period of time, ten to fifteen minutes after the patient is pre-oxygenated.<sup>109</sup>

### **c. Ancillary Tests**

The third step of the neurological assessment is the ancillary tests.<sup>110</sup> This is when patients are given a nuclear scan, MRI, and multiple other exams to determine brain death.<sup>111</sup> Ancillary tests are used when there is an uncertainty that exist from the clinical evaluation or when the apnea test could not be performed.<sup>112</sup> If an ancillary test is used and the findings were unreliable, physicians might decide not to proceed with the diagnosis of death.<sup>113</sup>

### **d. Documentation**

With the fourth and final step AAN suggest that if physicians find the patient to be brain dead they must document the death in official medical records.<sup>114</sup> The physicians should document the time of death to the time which the PCO<sub>2</sub> reached above target level.<sup>115</sup> This is when the partial pressure of carbon dioxide is in your bloodstream.<sup>116</sup> A normal range for a

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<sup>106</sup> *Id.* at 1916.

<sup>107</sup> *Id.*

<sup>108</sup> *Id.*

<sup>109</sup> *Id.*

<sup>110</sup> *Id.*

<sup>111</sup> *Id.*

<sup>112</sup> *Id.*

<sup>113</sup> *Id.*

<sup>114</sup> *Id.*

<sup>115</sup> *Id.*

<sup>116</sup> *Id.*

patient is between 35- 45 mm Hg.<sup>117</sup> If the respiratory movement is absent and arterial PCO<sub>2</sub> is greater than or equal to 60 mm Hg then the apnea test result is positive and supports the clinical diagnosis of brain death.<sup>118</sup> If the patient had an aborted apnea test, then the time of death would be recorded when the ancillary test has officially been interpreted that the patient is brain dead.<sup>119</sup>

#### **IV. Current Laws Regarding Brain Death and Brain Death Exceptions**

Brain death is recognized in all 50 states by a matter of law, whether by statute, regulation, or judicial decision. However, only 38 states have adopted the UDDA word-for-word.<sup>120</sup> Nine other states, have also adopted the UDDA, with the express qualification that the neurological criteria for death may only be used when an individual's respiratory and circulatory functions are maintained by artificial means (life support).<sup>121</sup> Arizona has not codified a recognition of brain death or any particular standard of the determination of death.<sup>122</sup> Arizona law simply states that the determination of death must be made "in accordance with accepted medical standards."<sup>123</sup> Virginia, on the other hand is the only state that does not allow brain death in and of itself to be the determinative factor in pronouncing death.<sup>124</sup> Virginia law focuses on

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<sup>117</sup> *Id.*

<sup>118</sup> *Id.*

<sup>119</sup> *Id.*

<sup>120</sup> ALA. CODE § 22-31-1 (2013); ALASKA STAT. § 13.06.035. (2007); ARK. CODE ANN. § 20-17-101 (2010); CAL. HEALTH AND SAFETY CODE § 7180 Art. 1 (2009); COL. REV. STAT. 12-36-136 (2013); 24 DE Code § 1760 (2012); O.C.G.A. 31-10-16 (2010); ID CODE § 54-1819 (2011); 755 ILCS 50/1 (2013); IND. STAT. 1-1-4-3; KAN. STAT. ANN. 77-205; 22 ME REV. STAT. § 2811 (2012); MD CODE § 5-202; MASS. GEN. LAWS CH. 190B § 1-107; MI COMPL § 333.1033 (2009); MN STAT. § 145.135 (2013); MS CODE § 41-36-3 (2013); MT CODE § 50-22-101 (2011); NE Code § 71-7202 (2012); NV REV. STAT. § 451.007 (2013); NH REV. STAT. § 141-D:2 (2013); NM STAT. § 12-2-4 (2013); 10 NYCRR 400.16; ND STAT. § 23-06.3; OHIO REV. CODE § 2108.40 (2013); O.S. § 63-3122 (2013); OR REV. STAT. § 432.300 (2011); 35 P.S. § 10203; RI GEN. L. § 23-4-16 (2012); S.C. CODE ANN. § 44-43-460 (2012); S.D. CODIFIED LAWS § 34-25-18.1 (2013); TN STAT. § 68-3-501 (2010); UT STAT. § 26-34-2; 18 VT STATS. § 5218 (2011); WV CODE § 16-10-1 (2012); WI STAT. § 146.71 (2012); WY STAT. § 35-19-101 (2013).; *In re Welfare of Bowman*, 94 Wash.2d 407 (1980).

<sup>121</sup> CONN. GEN. STAT. § 19a-504a (2012); FLA. STAT. § 382.009 (2013); HI REV. STAT. § 327C-1 (2013); IOWA CODE § 702.8 (2013); KY REV. STAT. § 446.400 (2009); LA. REV. STAT. ANN. § 9:111 (2012); MO. REV. STAT. § 194.005 (2013); NJ REV. STAT. § 26:6A-3 (2013); TEX. HEALTH AND SAFETY CODE § 671.001 (2011).

<sup>122</sup> ARIZ. REV. STAT. § 14-1107 (2007).

<sup>123</sup> *Id.*

<sup>124</sup> VA. CODE ANN § 54.1-2972 (2014).

the nature of cardio-respiratory functions and whether those functions will be able to occur spontaneously.<sup>125</sup> In Virginia, the law defines brain death at the time when cardio-respiratory functions cease as well as brain function.<sup>126</sup> In North Carolina, brain death is merely permissive as the basis for determination of death.<sup>127</sup> North Carolina would recognize another death determination over brain death.<sup>128</sup>

The four states that have had the biggest impact on moral and religious accommodations for brain death and that are described below are New York, California, Illinois, and New Jersey.

#### **a. New York**

New York judicially recognized brain death in 1984.<sup>129</sup> In 1987, not only did the New York Department of Health adopt the definition of brain death, it also required hospitals to accommodate religious or moral objections to brain death.<sup>130</sup> However, New York law is different than the New Jersey statute. In New York, the accommodation is not a categorical exception, rather New York hospitals just have to “establish written procedures for the reasonable accommodation of the individuals religious or moral objections to the use of the brain death standard.”<sup>131</sup> This is only when an objection has been expressed by the patient.<sup>132</sup> This gives hospitals substantial discretion in designing their accommodation policies.

#### **b. California**

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<sup>125</sup> *Id.*

<sup>126</sup> *Id.*

<sup>127</sup> NC GEN. STAT. § 90-323 (2012).

<sup>128</sup> *Id.*

<sup>129</sup> *People v. Eulo*, 63 N.Y.2d 341 (N.Y. Ct. App. 1984).

<sup>130</sup> 10 N.Y.C.R.R. § 400.16 (1987).

<sup>131</sup> *Id.*

<sup>132</sup> *Id.*

California recognized brain death when it adopted the UDDA in 1982.<sup>133</sup> In 2009, California enacted a new statute that expanded the obligations of hospitals with respect to patients that were declared brain dead.<sup>134</sup> The 2009 statute adds an accommodation similar to New York, however it is not a categorical exception. It is, however, more expansive than New York's law because New York regulations require only religious or moral objections, while California requires all types of objections, not just religious and moral.<sup>135</sup> The statute requires that hospitals should adopt a policy for providing family with "reasonably brief period of accommodation" after a patient is declared brain dead.<sup>136</sup>

California law again is broader than New York's law when it comes to religious objections. In California, if the patient's legally recognized health care decision maker, family, or next of kin voices any special religious or cultural practice and concerns the hospital must make "*reasonable efforts* to accommodate those religious and cultural practices and concerns."<sup>137</sup> This "special" accommodation is broader than California's general duty of accommodation as well as New York's duty of moral or religious accommodation.<sup>138</sup> However, it is unclear exactly how much is required when it comes to reasonable efforts. In determining reasonableness, the statute states that "a hospital shall consider the needs of other patients and prospective patients in urgent need of care."<sup>139</sup> The statute also defines that the accommodation is only a "brief period" that one needs to accommodate a family.<sup>140</sup> In other words, this

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<sup>133</sup> CAL. HEALTH & SAFETY CODE § 1254.4 (a) (2012).

<sup>134</sup> *Id.*

<sup>135</sup> *Id.*

<sup>136</sup> CAL. HEALTH & SAFETY CODE § 1254.4 (a) 2012.

<sup>137</sup> CAL. HEALTH & SAFETY CODE § 1254.4 (c) (2) 2012.

<sup>138</sup> *Dix v. Superior Court*, 53 Cal 3d 442, 459 (1991).

<sup>139</sup> CAL. HEALTH & SAFETY CODE § 1254.4 (d).

<sup>140</sup> CAL. HEALTH & SAFETY CODE § 1254.4 (b) 2012.

accommodation is usually only 24 hours in duration before the hospital pulls physiological support.

**c. Illinois**

Illinois recognized brain death in 1983.<sup>141</sup> In 2007, Illinois decided to amend their laws to include an accommodation requirement.<sup>142</sup> The statute provides that every hospital “must adopt policies and procedures to allow health care professionals, in documenting a patients time of death at the hospital, to take into account the patients religious beliefs concerning the patients time of death.”<sup>143</sup> The Illinois accommodation is weaker than that of California and New York due to hospitals having the discretion in defining the accommodation.<sup>144</sup> That statute does not mandate hospitals to “adopt policies and procedures,” they only need to allow health care professionals to recognize the patient’s religious belief and take them into account when dealing with brain death.<sup>145</sup>

**d. New Jersey**

Compared to other States, New Jersey allows individuals with a religious objection to opt out of being declared dead by neurological criteria.<sup>146</sup> New Jersey is different than California, New York, and Illinois because these states have only “reasonable accommodation” law that are not similar.<sup>147</sup> In New Jersey, the law changes the individual’s death status, whereas in California, New York, and Illinois the patient is still declared dead, but the statute is for accommodations after the declaration of death. In New Jersey, an individual who otherwise

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<sup>141</sup> *In re Haymer*, 450 N.E.2d 940 (Ill. App. 1983).

<sup>142</sup> ILL. PUB. ACT NO. 095-0181.

<sup>143</sup> 210 ILL. COMP. STAT. 85/6.23 (2012).

<sup>144</sup> *Id.*

<sup>145</sup> *Id.*

<sup>146</sup> CAL. A.B. 3311 (1986); CAL. A.B. 1390 (1987).

<sup>147</sup> CAL. HEALTH & SAFETY CODE § 1254.4 (2017).

might have been declared dead in most of the United States, but for their religious objection might not reach cardiopulmonary death for months or even years.

In 1991, New Jersey decided to enact their own Act on top of the UDDA called the New Jersey Declaration of Death Act.<sup>148</sup> This statute provides that an individual who has “sustained irreversible cessation of all functions of the entire brain including the brain stem shall be declared dead.”<sup>149</sup> But the statute also includes a categorical exception.<sup>150</sup> This exception is applied when there is a religious objection to brain death. Specifically, the New Jersey Declaration of Death Act provides that the death of an individual shall not be declared upon the basis of the when a license physician declares death after a neurological assessment.<sup>151</sup> Rather, a “licensed physician [who] is authorized to declare death, has reason to believe... that such a declaration [of death] would violate the personal religious beliefs of the individual.”<sup>152</sup> This is usually determined on the basis of information in the “individual’s available medical records or information provided by a member of the individual’s family or any other person knowledgeable about the individual’s personal religious beliefs.”<sup>153</sup>

In New Jersey, if the patient has religious objections to brain death and those objections are made known to physicians, then the patient is not declared dead until the complete irreversible cessation of the patient’s circulatory and respiratory functions.<sup>154</sup> If the family does not consent to stopping ventilator support, then under the statute the patient may not be legally

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<sup>148</sup> P.W. Armstrong & R.S. Olick, *Innovative Legislative Initiatives: The New Jersey Declaration of Death Act and Advance Directives for Health Care Acts*, 16 SETON HALL LEGIS.J. 177 (1992).

<sup>149</sup> N.J. REV. STAT. § 26:6A-3.

<sup>150</sup> M.A. Grodin, *Religious Exemptions: Brain Death and Jewish Law*, 36 J. CHURCH & ST. 357 (1994).

<sup>151</sup> N.J. REV. STAT. § 26:6A-5; N.J. ADMIN. CODE § 13:35-6A.6.

<sup>152</sup> *Id.*

<sup>153</sup> *Id.*

<sup>154</sup> Eelco Wijdicks, *Brain Death*, 118 HANDBOOK CLINICAL NEUROLOGY 191, 191-203 (2013).

dead for a significant period of time after the deamination of total brain failure.<sup>155</sup> In other words, the New Jersey law grants family members a “loophole” from the general practices and standards for determining deaths.<sup>156</sup> New Jersey Declaration of Death Act is the only state that makes a patient’s life/death legal statue dependent not only upon objective medical standards but also upon subjective patient values.

## V. Individual Choice in defining Brain Death

There is a case to be made for the legitimacy of a conscientious objection to the uniform definition of brain death. A conscience clause should be adopted by the states to permit patients to choose while competent an alternative definition of death, provided that is within reason. In cases where patients have not spoken while competent, the next of kin should have the discretion within certain limits. Here in the United States we live in a democratic, pluralistic society where the level of morality, tolerates diverse opinions and actions.<sup>157</sup> In a society that respects diverse opinions, including religious ones, a conscientious objection to determining if a patient is brain dead should be tolerated, just like conscientious objections against performing abortions.<sup>158</sup>

The major need for this conscience clause is due to the numerous amount of people that have moral or religious values that do not believe that death ends at the time the brain ceases to work, rather they believe that if there is breath or cardio functioning then there is life. Patients or next of kin that are grappling with end of life care decisions should be given the choice on how they define death. The following section will dissect the various religious and moral values in regard to the brain death criteria as well as the individual choice of a conscience clause.

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<sup>155</sup> Anne L. Flamm et al., *Family Members' Requests to Extend Physiologic Support after Declaration of Brain Death: A Case Series Analysis and Proposed Guidelines for Clinical Management*, 25 J. CLINICAL ETHICS, 222 (2014).

<sup>156</sup> *Id.*

<sup>157</sup> Robert M. Veatch & Lainie F. Ross, *Defining Death: The Case for Choice* 116 (Georgetown University Press 2016).

<sup>158</sup> *Id.*

### a. Religious and Moral Views to the Brain Death Criteria

Judaism has long been known to include people who oppose brain criteria for death pronouncement. Many Orthodox rabbinical scholars strongly oppose the brain death criteria, maintaining that the preservation of human life is a cardinal commandment, that both suicide and self-endangerment are forbidden.<sup>159</sup> Rabbinical scholars believe where there is breath there is life.<sup>160</sup> An individual is only declared dead when both the breathing and heartbeat has ceased.<sup>161</sup> Judaism believes that a discontinuing of life support systems which are specifically designed and utilized in the treatment of incurably ill patients might only be permissible if one is completely certain that the discontinuation would not be shortening the act of dying or interrupting life.<sup>162</sup> When a person is declared brain dead in Judaism one must continue to support the patient's life until the heart stops, this includes not disconnecting the respirator.<sup>163</sup> Other rabbis among Judaism disagree, and state that it is permissible to disconnect the respirator once the physicians have determined the patient is brain dead.<sup>164</sup> However, both sides seem to agree that removal of organs for transplantation is against the values of Judaism and is prohibited.<sup>165</sup>

In terms of brain death, the fundamental perspective in Christianity has to do with the concept of personhood.<sup>166</sup> Human beings are said to have been created in "the image of God."<sup>167</sup> Therefore, Christians believe that all humans are bearers of the *imago dei* (the Latin term for the

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<sup>159</sup> Steinberg, MD., *supra*, note 15.

<sup>160</sup> Judah David Bleich, *Neurological Criteria of Death and Time of Death Statutes*, in *JEWISH BIOETHICS* 303-316 (1979).

<sup>161</sup> *See*, Yerushalmi Yoma 8:5.

<sup>162</sup> Bleich, *supra* note 160.

<sup>163</sup> *Id.*

<sup>164</sup> *Id.*

<sup>165</sup> *Id.*

<sup>166</sup> Faroque Khan MD., *Monotheistic Faith Perspective on Brain death, DNR, Patient Autonomy and Health Care Costs*, 43(3) *J. ISLAMIC MED. ASS'N. N. AM.* 113, 113–133 (2012).

<sup>167</sup> *Id.*

image of God).<sup>168</sup> There seems to be broad agreement that the specialness of a person resides in the human brain, without which there can be no thoughts or emotions or relating.<sup>169</sup> Christians believe that a person whose brain is dead can no longer express the *imago dei*, the “image of God.”<sup>170</sup>

Catholicism believes that customary criteria for determining death are "cardio-pulmonary," i.e., death is declared after breathing and heart-beat cease.<sup>171</sup> Technological advancements in critical care, however, have made continued circulation and respiration possible through mechanical means even after brain function has ceased.<sup>172</sup> The use of neurological criteria for the determination of death is legitimate according to the Catholic Church.<sup>173</sup> Pope John Paul II approved this approach in an address he gave to the 18th International Conference of Organ Transplant Specialists in August 2000.<sup>174</sup> Pope Pius XII and Pope John Paul II both said the Church has no competency in determining death; this properly belongs to medical science.<sup>175</sup> Catholicism believes that brain death is not a new definition of death but rather the use of new symptoms to determine that death has occurred.<sup>176</sup>

Brain death remains controversial in Islam. The Quran and the Sunnah are the primary sources for the Islamic moral code, and both characterize death as a singular irreversible event.<sup>177</sup> Furthermore, the Quran differentiates between the dying process and death itself.<sup>178</sup> The dying

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<sup>168</sup> *Id.*

<sup>169</sup> *Id.*

<sup>170</sup> *Id.*

<sup>171</sup> National Catholic Bioethics Center: *Organ Donation and Determination of Death* (2019), <http://www.nbcccenter.org>.

<sup>172</sup> *Id.*

<sup>173</sup> *Id.*

<sup>174</sup> Pope John Paul II, Address to 18th International Congress of the Transplantation Society. August 29, 2000.

<sup>175</sup> *Id.*

<sup>176</sup> *Id.*

<sup>177</sup> Mohamed Y. Rady & Joseph L. Verheijde, *The Moral Code in Islam and Organ donation in Western Countries: Reinterpreting Religious Scriptures to Meet Utilitarian Medical Objectives*. 9 PHIL. ETHICS HUMAN. MED. 11 (2014).

<sup>178</sup> *Id.*

process occurs over time and result in death when spontaneous disintegration of the body beings.<sup>179</sup> In brain death, persistent somatic integration and homeostasis prevent disintegration of the body.<sup>180</sup> Therefore, the true definition of brain death conflicts with the Quran.<sup>181</sup> However, a number of worldwide authoritative Islamic professional and religious organizations endorse the brain death criteria as true death.<sup>182</sup> They concluded that the majority of the Islamic communities should accept brain death.<sup>183</sup> Some Islamic communities still view that the criterion of brain death violates the religious values of their families.<sup>184</sup>

In Buddhism, death is considered to disturb the rhythm of all living things and therefore it should not be hastened.<sup>185</sup> Buddhists believe that consciousness is not located solely in the brain and therefore the cessation of any one part of one organ, including the brain, does not extinguish consciousness and consequently cannot be regard as the death of the individual person.<sup>186</sup>

Morally, people also are against the brain death criteria. If a person is Japanese or identifies with the Japanese culture, they reject the brain death definition.<sup>187</sup> Japanese consider the brain death criteria to be an unnatural, premature definition of death that interferes with their cultural rights surrounding death.<sup>188</sup> The Japanese have leading objections to brain death criteria for the fear that organs will be removed prematurely and that transplants will be performed in

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<sup>179</sup> *Id.*

<sup>180</sup> Mohamed Y. Rady & Joseph L. Verheijde, *Brain-Dead Patients are not Cadavers: The need to Revise the Definition of Death in Muslim Communities*. 25 HEALTHCARE ETHICS COMM. F., 25, 25 – 45 (2013).

<sup>181</sup> *Id.*

<sup>182</sup> Rady & Verheijde, *supra* note 177.

<sup>183</sup> *Id.*

<sup>184</sup> *Id.*

<sup>185</sup> Masao Fujii, *Buddhism and Bioethics*, in THEOLOGICAL DEV. IN BIOETHICS, 61-68 (1988-1990).

<sup>186</sup> *Id.*

<sup>187</sup> Rihito Kimura, *Japan's Dilemma with the Definition of Death*, 1:2 KENNEDY INST. OF ETHICS J.123, 131 (1991).

<sup>188</sup> *Id.*

unacceptable circumstances.<sup>189</sup> Japanese denying brain death comes from the Confucian thought which is heavily incorporated in the Japanese society.<sup>190</sup>

All American Indian groups dramatically oppose the definition of brain death as well.<sup>191</sup> People who are Danish or who associate with the Danes do not accept the brain death definition under the UDDA and the world health organization due to the emotional perception that a persons whose heart is still beating is considered alive.<sup>192</sup>

#### **b. The Admittance of a Conscience Clause**

States should learn from New Jersey legislation of the Declaration of Death Act and make significant changes in their legislation pertaining to the definition of death. If states cannot make compelling moves towards a similar piece of legislation applied in New Jersey, then they should at least apply a conscience clause. This clause would relieve physicians, other health care providers, and patients from complying with a legislative provision on religious grounds.<sup>193</sup> Therefore, if a family believes that death occurs only on a respiratory basis, not through the brain death criteria, hospitals should acknowledge and respect the families' decision under the conscience clause.

The incorporation of the conscience clause would permit individuals, when competent, to execute documents choosing alternative definitions of death that are within reason.<sup>194</sup> The law regarding the conscience clause, would state that patients who had opted for the consciousness-based definition who had clearly irreversibly lost consciousness because their heart and lung function had cease would be pronounced dead according to the criteria measuring the heart and

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<sup>189</sup> *Id.*

<sup>190</sup> *Id.*

<sup>191</sup> Steinberg, MD., *supra*, note 15.

<sup>192</sup> *Id.*

<sup>193</sup> *Conscience Clause*, Merriam-Webster Dictionary (11<sup>th</sup> edition 2016).

<sup>194</sup> Veatch & Ross, *supra* note 157 at 149.

the lung function.<sup>195</sup> The law would make the present UDDA clear by measuring the circulatory function as an alternative means for measuring the loss of consciousness.<sup>196</sup> If the heart and lung function has stopped long enough to make a return of consciousness impossible, the individual could then be pronounced dead based on the higher brain function loss.<sup>197</sup>

The implementation of a conscience clause would require effort; however, it would not be complicated. Most of the potential problems for adding in a conscience clause is answered in the Patient Self Determination Act (PSDA).<sup>198</sup> The PSDA depends upon the hospital staff to search for an advance directive upon a patient's admission to a hospital or provide assistance in designing an advance directive if the patient desires.<sup>199</sup> The PSDA also requires that the next of kin must be notified of the opportunity to donate organs if need be.<sup>200</sup> An addition to the advance directive specifying a choice of an alternative concept of death would be easy. It is a simple clarification in the case of one asking that support be forgone when the patient is permanently unconscious.<sup>201</sup>

The burden to understand the alternative concepts of the brain death criteria would be on the patient and the next of kin and not the physicians. Health professionals would only be expected to have discussions on alternative definitions of death when they knew or had reason to know that the patient would be interested in that discussion.<sup>202</sup> If the health professional knew the patient was an Orthodox Jew or of Japanese descent and the health official knows they usually prefer a more traditional concept of death then the physicians would have the obligation

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<sup>195</sup> *Id.*

<sup>196</sup> *Id.* at 150.

<sup>197</sup> *Id.*

<sup>198</sup> *Id.* at 137.

<sup>199</sup> *Id.*

<sup>200</sup> *Id.*

<sup>201</sup> *Id.* at 138.

<sup>202</sup> *Id.*

to introduce the alternative concept of brain death criteria.<sup>203</sup> If the physician is not clear on the patient's view of the brain death criteria, there is no need to ask. In this situation, the patient or the next of kin has the duty to express their feelings and inquiries about an alternative definition of death.<sup>204</sup>

## **VI. Criticisms of the Conscience Clause**

### **a. Society should tolerate the alternative view**

Many would argue that a conscience clause is irrelevant and not needed, because brain death is death and there is no alternative definition of death.<sup>205</sup> The debate is a matter of social policy when physicians should treat someone as dead. The argument is not deciding the one true definition of death, but rather the discussion of society under public policy purposes tolerate differences in beliefs about what the true definition of brain death is.<sup>206</sup> For society to tolerate an Orthodox Jew's or Native Americans belief in a definition that is perceived by the rest of society as morally wrong is no different from having a society tolerate people's belief on abortion even though people may think it is morally wrong.<sup>207</sup>

### **b. Health Insurance will not be affected**

Another criticism would include the need for health insurance and how the state or the individual would pay for people that chose the alternative definition of brain death.<sup>208</sup> However, the effect on health insurance will most likely be minimal. All health insurance policy have some limits on coverage.<sup>209</sup> If insurance companies were worried about the impact the conscience clause would have on coverage, they could simply exclude coverage for care or offer

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<sup>203</sup> *Id.*

<sup>204</sup> *Id.*

<sup>205</sup> *Id.* at 127.

<sup>206</sup> *Id.*

<sup>207</sup> *Id.*

<sup>208</sup> *Id.* at 132.

<sup>209</sup> *Id.*

the coverage but as an additional option at an increased premium.<sup>210</sup> This would leave the patient or next of kin responsible for finding insurance coverage.

### **c. Conscience Clause is Necessary**

Some might also argue that adding a conscience clause is unnecessary because only a small group of people would favor an alternative.<sup>211</sup> While it is true that it is a small percentage of people within the United States have a brain injury, the people that would choose the option of an alternative definition of death if in the position of a brain injury would be significant. As stressed before, Orthodox Jews, some Muslims, Buddhist, Japanese, Native Americans, Danes, and others are all still committed to a definition of brain death based on the respiratory function.

The most recent case regarding brain death, was about Jahi McMath, age 13, who had tonsil surgery on December 9, 2013, in California.<sup>212</sup> After significant blood loss from her tonsillectomy, she went into cardiac arrest.<sup>213</sup> The physicians revived her but realized that there was complete loss of blood flow to her brain.<sup>214</sup> The physicians pronounced her brain dead on December 12, 2013.<sup>215</sup> The family asked the hospital to have her remain on a ventilator for 48 hours after the declaration of death.<sup>216</sup> The hospital agreed and the ventilator ended up being maintained for eight more days.<sup>217</sup> When the hospital attempted to remove the ventilator, on Christmas Eve, the family retained an attorney and asked the hospital to keep Jahi on the ventilator through Christmas.<sup>218</sup> The parents asked for both federal and state courts to intervene,

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<sup>210</sup> *Id.*

<sup>211</sup> *Id.* at 138.

<sup>212</sup> Ed. Payne, *Brain-Dead Girl Jahi McMath Released from California Hospital*, CNN (Jan. 7, 2014), <http://www.cnn.com/2014/01/06/health/jahi-mcmath-girl-brain-dead/>.

<sup>213</sup> *Id.*

<sup>214</sup> *Id.*

<sup>215</sup> *Id.*

<sup>216</sup> *Id.*

<sup>217</sup> *Id.*

<sup>218</sup> *Id.*

and the hospital was ordered to conduct the use of the ventilator until January 7, 2014.<sup>219</sup> The parents then decided to transfer Jahi to a long-term care facility in New Jersey where she was placed on a ventilator and a feeding tube.<sup>220</sup> Jahi McMath died on June 22, 2018 from complications associated with liver failure.<sup>221</sup>

The case of Jahi was brought forth front and center by the constant media attention, because Jahi had to be moved to New Jersey to be considered alive.<sup>222</sup> This case began discussions on the alternative definition of brain death, and shows that if California had a conscience clause there would have never been an issue, and Jahi would have stayed in California. What's even more interesting about Jahi case is that Jahi McMath parents did not associate with one of the normal minorities that view brain death criteria to be wrong. Jahi McMath's parents shows us that there are people that do not conform to the above religions or associations but still believes in a traditional concept of death. It seems reasonable to assume that Jahi McMath case represents only a fraction of the total number of patients or families who would prefer a more traditional concept of death.

Finally, it is important to note that we live in a society that is in an ever-growing state of inclusion. There is a significant amount of people who care enough about the concept of brain death that it should be clarified and should be a topic of discussion. These minorities' who believe in alternative definition of the brain death are having their rights violated.<sup>223</sup> Their power to make decisions on their end of life care is taken away due to the current criteria for brain death. The concept of choice is appropriate in this position, just like it would be appropriate for

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<sup>219</sup> *Id.*

<sup>220</sup> *Id.*

<sup>221</sup> *Id.*

<sup>222</sup> *Id.*

<sup>223</sup> Veatch & Ross, *supra* note 157 at 139.

a patient to determine if they want to be put on a respirator or if they want a DNR. There is a need for a conscience clause because it serves to respect the rights of minorities based on their deeply held religious and philosophical convictions.<sup>224</sup>

## **VII. CONCLUSION**

This paper sought to explain that the brain death criteria should not be a question of science but rather a religious/philosophical policy choice. Having a state choose a default for a patient's care limits a patient's decision making during their end of life treatment. After the analyses of a definition that has gone through many changes and the criticism that follows along with it, my hope is that a different perspective on the brain death criteria will be acknowledged by the medical community and a space for acceptance will be made to meet the different standards that could apply to the brain death criteria.

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<sup>224</sup> *Id.*