NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

CORPORATE BRAIN DEATH POLICY

PURPOSE:

To describe the guidelines, procedure, and documentation requirements for:

- Initiation of a brain death evaluation,
- Determination of brain death,
- Pronouncement of death based on brain death,
- Removal of medical and ventilator support, and
- Cases that present special considerations such as pregnant patients, young children, or objections by an appropriate individual to a determination of brain death.

POLICY:

- Brain death shall be determined according to generally accepted medical practice.
- Brain death evaluation is performed according to the Guidelines for Determining Brain Death, published by the New York State Department of Health and the New York State Task Force on Life and the Law, November 2011 (Attachment A).
- The patient's next of kin and/or other person closest to the patient (such as a surrogate or health care agent) shall be notified when a brain death evaluation is being performed and again when a determination of brain death is made.
- Reasonable accommodation shall be made for the religious or moral objections of the patient to the use of the brain death standard to determine death, when such an objection has been expressed by the patient prior to loss of decision-making capacity, by next of kin, or other person closest to the patient (such as a surrogate or health care agent).
- Organ donation shall be considered in all cases.
- Patient and family shall be treated with sensitivity and respect.
- Compliance with applicable laws and regulations is required.

DEFINITIONS:

- Brain death: the irreversible loss of all functions of the brain, including the brain stem.
- Brain death evaluation: the process of determining that a patient is brain dead, including performance and interpretation of ancillary tests needed for the determination of brain death.

- Legally Authorized Representative: For purposes of this policy, the patient's next of kin and/or other person closest to the patient (such as a surrogate or health care agent).

GUIDELINES:

New York State regulation defines brain death as the irreversible loss of all functions of the brain, including the brain stem. The three essential findings in brain death are coma, absence of brain stem reflexes, and apnea.

A. Brain death evaluation is initiated when a patient:

   1. Is unresponsive,

   2. Has unreactive pupils, and

   3. Requires a ventilator.

B. Legally Authorized Representative is notified (or reasonable attempts are made to notify the Legally Authorized Representative) that a brain death evaluation is being performed.

   1. Notification of the Legally Authorized Representative should occur early in the brain death evaluation process.

   2. If notification of the Legally Authorized Representative is unsuccessful or if a Legally Authorized Representative cannot be identified, assistance of hospital administration should be obtained.

   3. Brain death evaluation does not require consent or permission from the Legally Authorized Representative.

C. New York Organ Donor Network (NYODN, 1-800-GIFT-4-NY) is notified that a brain death evaluation is being performed.

   1. NYODN determines if the patient would be a medically suitable organ donor.

D. Brain death evaluation is performed under the direction of a physician who is privileged to make that evaluation.

   1. The hospital should have a privileging mechanism to identify physicians who are competent to perform brain death evaluations. For specialists in neurology, neurosurgery, critical care medicine, and critical care surgery, determination of brain death and performance of apnea tests for brain death are to be included as core privileges.

   2. The physician performing the brain death evaluation must not be a member of the organ transplant team.

3. Brain death evaluation is performed according to the Guidelines for Determining Brain Death, published by the New York State Department of Health and the New York State Task Force on Life and the Law, November 2011 (Attachment A).

    a. If a sufficient period of time has passed since the onset of a brain insult to exclude the possibility of recovery (in practice, usually several hours), a single neurologic examination and an apnea test should be adequate to determine brain death.

4. If the patient is an infant or child, additional considerations may apply (Attachment A, Appendix 1).

5. The time of death is recorded as the time brain death is determined.

E. The Legally Authorized Representative is notified (or reasonable attempts are made to notify the Legally Authorized Representative) of the determination of death before medical support is removed.

1. If there is an objection to the determination of death or to the removal of medical support by the Legally Authorized Representative, Risk Management shall be informed.

    a. Ethics consultation is also recommended.

    b. The determination of brain death must still be made and the pronouncement documented.

2. If there is an objection by the Legally Authorized Representative to a brain death determination that is on a religious or moral basis, reasonable efforts to accommodate the objection shall be undertaken.

    a. Reasonable accommodation after the determination of death includes the continued provision of ventilator support and routine nursing care for a reasonable period (generally not to exceed 72 hours from the time of pronouncement). Treatment for an indefinite period of time after the determination of death is not required.

    b. Reasonable accommodation after the determination of death does not require performance of any diagnostic or therapeutic procedures, including (but not limited to): blood tests, radiologic tests, physiologic monitoring, administration of medications for any purpose, nutrition or hydration support, cardio-pulmonary resuscitation (notwithstanding absence of a DNR order), or treatment in a critical care unit.

3. If there is an objection by the Legally Authorized Representative to a brain death determination that is not based on a religious or moral basis, reasonable efforts to accommodate the objection are not required. After discussion with Risk Management, medical support may be removed. However, hospital staff should demonstrate

sensitivity to family members and help them to accept the determination and fact of death.

4. If there is a request by the Legally Authorized Representative to delay removal of ventilator support pending arrival of another family member, such delay is permitted (in general, not to exceed 24 hours from the time of pronouncement) based on the availability of hospital resources for patients.

5. If the patient is pregnant, medical support shall be removed only after consultation with Risk Management.

F. Consent for organ donation is sought if a brain dead patient may be a medically acceptable organ donor. Consent is requested from an individual only after he or she has been informed of the patient's death.

1. Consent for organ donation may be given by:

   a. The deceased adult patient who properly executed an organ donor card, driver's license authorization or other written authorization to make an anatomical gift, or by prior enrollment in an organ or tissue donor consent registry. Such authorization for donation shall not be rescinded by an objection of a member of any of the classes set forth below (F1 (b)-(h); except upon a showing that the adult patient revoked the authorization.

   b. The person designated as the patient's health care agent, subject to any written statement in the health care proxy form,

   c. The person designated as the patient's agent in a written instrument, subject to any written statement in the written instrument,

   d. The spouse, if not legally separated from the patient, or the domestic partner,

   e. A son or daughter eighteen years of age or older,

   f. Either parent,

   g. A brother or sister eighteen years of age or older,

   h. A guardian of the person of the patient at the time of his/her death.

2. The designated requester may seek consent for an anatomical gift from any of the individuals, specified in F1 (b)-(h) in the order of priority stated, when persons in prior classes are not reasonably available, willing, and able to act, at the time of death, and in the absence of actual notice of contrary indications by the patient, or actual notice of opposition by a member of the same class or prior classes as specified in F1 (b)-(h).

a. A list of designated requesters should be maintained by the Administrator on Duty and by NYODN.

3. Generally speaking, brain death may be determined by a single physician privileged to make brain death determinations. However, before a patient may become an organ donor, New York State law requires that the time of death must be certified by the physician who attends the donor at his/her death and one other physician, neither of whom shall participate in the procedures for removing or transplanting the organs.

   a. In the case of potential organ donation: The second physician must have attending privileges as a member of the medical staff of the hospital, but need not be privileged to perform brain death determinations. However, he or she should have a thorough understanding of the tests involved.

   b. When two physicians are required to certify the time of death, the second physician should review and affirm that the medical record and data fully support the determination of death. Any aspect of the clinical assessment, apnea test, or ancillary test (if applicable) may be performed again if the second physician believes it is indicated to make his or her determination concerning brain death.

4. Ventilator support shall not be removed until:

   a. Reasonable Accommodation (See Paragraph E) is not applicable,

   b. Organ recovery has been completed, or

   c. The patient is no longer being considered as an organ donor.

PROCEDURE:

RESPONSIBLE STAFF:

1. The patient's attending physician.

2. If the patient's attending physician is not privileged in the determination of brain death; a consulting physician who is privileged in the determination of brain death.

3. If the patient is potentially an organ donor: a second attending physician shall certify to the time of death. (Please refer to section F (3) for more specific details).

ACTION TO BE PERFORMED BY RESPONSIBLE STAFF:

(PRINCIPALLY THE ATTENDING PHYSICIAN)

1. Utilizes the Guidelines for Determining Brain Death, published by the New York State Department of Health and the New York State Task Force on Life and the Law, (November 2011) (Attachment A).

2. Initiates the brain death evaluation.

3. Notifies the Legally Authorized Representative of the initiation of a brain death evaluation and informs that person of the patient's status.

4. Obtains assistance of hospital administration if notification of the Legally Authorized Representative is unsuccessful or if a Legally Authorized Representative cannot be identified.

5. Verifies that NYODN (1-800-GIFT-4-NY) has been notified of the brain death evaluation. Notification of NYODN can be performed by any member of the care team.

6. Writes a pronouncement of death note in the medical record. The determination of brain death must be performed by a physician who is privileged to make that determination.

7. Notifies the Legally Authorized Representative of the determination of death.

8. Notifies the Risk Manager if there is an objection by the Legally Authorized Representative to the use of the brain death standard or to the removal of medical support.

9. Functions as clinical liaison with the Transplant Coordinator and maintains optimal donor management.

10. Consults with a second attending physician to confirm and certify the time of death only if organ donation is contemplated.

11. Directs removal of medical support/ventilator support if the patient is not a potential organ donor.

12. Ensures that emotional and pastoral support is provided to the family.

DOCUMENTATION REQUIREMENTS:

1. Medical Record Documentation*:* All phases of the determination of brain death must be documented in the medical record with the date and time. The medical record must indicate:

a. Etiology and irreversibility of coma.

b. Absence of cerebral responsiveness.

c. Absence of brain stem reflexes.

d. Absence of respiration with $PaCO_2 \geq 60$ mm Hg (or ≥ 20 mm Hg increase over baseline normal $PaCO_2$) or confirmation of brain death by a confirmatory test if the apnea test cannot be completed.

e. Justification for, and result of, ancillary tests if used.

2. Reports of any laboratory or radiology tests that were used to determine brain death.

3. Document notification of the Legally Authorized Representative of the brain death evaluation and the determination of death. If identification or notification of the Legally Authorized Representative was unsuccessful, document the reasonable efforts that were made.

4. Document any objections by Legally Authorized Representative to the determination of death or removal of medical or ventilator support.

5. Document requests for reasonable accommodation.

6. Document the request for organ donation.

7. A licensed physician shall document the pronouncement of death in the medical record with the date and time.

8. Document cause of death, if known.

9. Before a patient may become an organ donor:

   a. The time of death must be certified by the physician who attends the donor at his/her death and one other physician, neither of whom shall participate in the procedures for removing or transplanting the organs.

   b. The second physician should review and affirm that the medical record and data fully support the determination of death.

10. Document the date and the time ventilator support was removed and the name and the title of the physician who authorized it.

11. Adhere to documentation requirements required by other applicable law or regulation.

ATTACHMENTS:

A. Guidelines for Determining Brain Death. New York State Department of Health and New York State Task Force on Life & the Law, November 2011.