California Health & Safety Code - Section 1254.4

(a) A general acute care hospital shall adopt a policy for providing family or next of kin with a reasonably brief period of accommodation, as described in subdivision (b), from the time that a patient is declared dead by reason of irreversible cessation of all functions of the entire brain, including the brain stem, in accordance with Section 7180, through discontinuation of cardiopulmonary support for the patient. During this reasonably brief period of accommodation, a hospital is required to continue only previously ordered cardiopulmonary support. No other medical intervention is required.

(b) For purposes of this section, a "reasonably brief period" means an amount of time afforded to gather family or next of kin at the patient's bedside.

(c) (1) A hospital subject to this section shall provide the patient's legally recognized health care decisionmaker, if any, or the patient's family or next of kin, if available, with a written statement of the policy described in subdivision (a), upon request, but no later than shortly after the treating physician has determined that the potential for brain death is imminent.

(2) If the patient's legally recognized health care decisionmaker, family, or next of kin voices any special religious or cultural practices and concerns of the patient or the patient's family surrounding the issue of death by reason of irreversible cessation of all functions of the entire brain of the patient, the hospital shall make reasonable efforts to accommodate those religious and cultural practices and concerns.

(d) For purposes of this section, in determining what is reasonable, a hospital shall consider the needs of other patients and prospective patients in urgent need of care.

(e) There shall be no private right of action to sue pursuant to this section.

COMPLETE BILL HISTORY

BILL NUMBER : A.B. No. 2565
AUTHOR : Eng
TOPIC : Hospitals: brain death.

TYPE OF BILL :
Inactive
Non-Urgency
Non-Appropriations
Majority Vote Required
State-Mandated Local Program
Fiscal
Non-Tax Levy

BILL HISTORY
2008
Sept. 27 Chaptered by Secretary of State - Chapter 465, Statutes of 2008.
Sept. 27 Approved by the Governor.
Sept. 17 Enrolled and to the Governor at 11 a.m.
Aug. 13 Assembly Rule 77 suspended. (Page 6434.) Senate amendments concurred in. To enrollment. (Ayes 77. Noes 0. Page 6438.)
Aug. 12 In Assembly. Concurrence in Senate amendments pending. May be considered on or after August 14 pursuant to Assembly Rule 77.
Aug. 12 Read third time, passed, and to Assembly. (Ayes 22. Noes 9. Page 4954.)
Aug. 6 Read second time. To third reading.
Aug. 5 From committee: Do pass. (Ayes 9. Noes 3.) .
Aug. 4 From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on APPR.
July 2 Read second time, amended, and re-referred to Com. on APPR.
July 1 From committee: Amend, do pass as amended, and re-refer to Com. on APPR. (Ayes 3. Noes 2.) .
June 24 Read second time, amended, and re-referred to Com. on JUD.
June 23 From committee: Amend, do pass as amended, and re-refer to Com. on JUD. (Ayes 8. Noes 1.) .
June 12 Referred to Coms. on HEALTH and JUD.
May 29 In Senate. Read first time. To Com. on RLS. for assignment.
May 28 Read third time, passed, and to Senate. (Ayes 74. Noes 2. Page 5494.)
May 27 Read second time. To third reading.
May 23 From committee: Amend, and do pass as amended. (Ayes 12. Noes 5.) (May 22). Read second time and amended. Ordered returned to second reading.
May 7 In committee: Set, first hearing. Referred to APPR. suspense file.
Apr. 23 Re-referred to Com. on APPR.
Apr. 22 Read second time and amended.
Apr. 21 From committee: Amend, do pass as amended, and re-refer to Com. on APPR. (Ayes 13. Noes 3.) (April 15).
Apr. 7 Re-referred to Com. on HEALTH.
Apr. 3 Referred to Com. on HEALTH. From committee chair, with author's amendments: Amend, and re-refer to Com. on HEALTH. Read second time and amended.

Feb. 25 Read first time.
Feb. 24 From printer. May be heard in committee March 25.
Feb. 22 Introduced. To print.

BILL ANALYSIS

Date of Hearing: April 15, 2008

ASSEMBLY COMMITTEE ON HEALTH
Mervyn M. Dymally, Chair
AB 2565 (Eng) - As Amended: April 3, 2008

SUBJECT : Hospitals: brain death.

SUMMARY : Requires a licensed hospital to adopt a plan and procedure for providing family or next of kin of a patient with a reasonable period of accommodation, as defined, in the event the patient is declared brain dead. Specifically, this bill :

1) Requires a licensed general acute care hospital, psychiatric hospital, or special hospital to adopt a plan and procedure for providing family or next of kin with a reasonable period of accommodation, as defined, in the event the patient is declared dead by reason of irreversible cessation of all functions of the entire brain, in accordance with existing law.

2) Defines "reasonable period" as an amount of time afforded to gather family or next of kin of that patient and make arrangements for special religious or cultural ceremonies.

3) Requires a hospital subject to #1) above to provide a patient upon admission with a written statement of the policy developed pursuant to this bill.

EXISTING LAW :

1) Defines as dead an individual who has sustained either: a) Irreversible cessation of circulatory and respiratory functions; or, b) Irreversible cessation of all functions of the entire brain, including the brain stem.

2) Requires independent confirmation by another physician when an individual is pronounced dead pursuant to #1) b) above.

3) Requires a health facility to keep, maintain, and preserve complete patient medical records when an individual is pronounced dead pursuant to #1) above.

FISCAL EFFECT : Unknown

COMMENTS :

1) PURPOSE OF THIS BILL . According to the author, this bill is needed because there is no statewide policy providing for a reasonable amount of time to notify the family or next of kin of a patient who would be removed from life support after being declared brain dead. The author points to California Medical Association (CMA) guidelines for physicians and hospitals to follow once patients are determined to be brain dead (see # 3) below). The author points out that the process for notifying family members about the precise time of the anticipated removal of life support varies among California hospitals. The author contends that family or close friends may not be provided with enough time by hospitals and doctors to visit with the patient or to perform any cultural or religious ceremonies for the patient before the patient is removed from life support.

2) BACKGROUND . The term brain death is defined as "irreversible unconsciousness with complete loss of brain function," including the brain stem, although the heartbeat may continue. Demonstration of brain death is the accepted criterion for establishing the fact and time of death. Factors in diagnosing brain death include irreversible cessation of brain function as demonstrated by fixed and dilated pupils, lack of eye movement, absence of respiration (apnea), and unresponsiveness to painful stimuli. In addition, there should be evidence that the patient has experienced a disease or injury that could cause brain death. A final determination

of brain death must involve demonstration of the total lack of electrical activity in the brain by two electroencephalographs (EEGs) taken between twelve and twenty-four hours apart. Finally, the physician must rule out the possibilities of hypothermia or drug toxicities, the symptoms of which may mimic brain death. Some central nervous system functions such as spinal reflexes that can result in movement of the limbs or trunk may persist in brain death.

Until the late twentieth century, death was defined in terms of loss of heart and lung functions, both of which are easily observable criteria. However, with modern technology these functions can be maintained even when the brain is dead, although the patient's recovery is hopeless, sometimes resulting in undue financial and emotional stress to family members. Brain death is not medically or legally equivalent to severe vegetative state. In a severe vegetative state, the

cerebral cortex, the center of cognitive functions including consciousness and intelligence, may be dead while the brain stem, which controls basic life support functions such as respiration, is still functioning. Death is equivalent to brain stem death. The brain stem, which is less sensitive to anoxia (loss of adequate oxygen) than the cerebrum, dies from cessation of circulation for periods exceeding three to four minutes or from intracranial catastrophe, such as a violent injury.

3)CMA GUIDELINES . CMA's Council on Ethical Affairs developed a model policy and procedure related to death by neurological criteria, entitled Pronouncement of Death: Diagnosis of Death by Neurological Criteria (model policy). The stated purpose of the model policy is to give guidance to physicians and hospitals as they care for patients with brain injury or disease that leads to death and for their loved ones. The model policy calls for hospitals to have a comprehensive management strategy when death has been diagnosed in these cases, including specific criteria and procedures for the determination of death, documentation of the determination, and procedures following the determination, including procedures related to any possible organ donation. The model policy recommends early discussion with the family to prepare them before the declaration of death and offering appropriate emotional support, and psychological and spiritual counseling if the family has problems understanding or accepting the concept of death diagnosed as brain death. The model policy also states that physicians and hospitals should inform family members or next of kin that life support will be discontinued at a specified time. The model policy also states that, at the request of the family, and with physician agreement, life support services may be continued for compelling social reasons for a "reasonably brief" period of time after the declaration of death. The model policy advises that during the time of such accommodation the deceased and family should be treated with respect and be given emotional and spiritual support by hospital staff, and if they desire, by their own clergy or spiritual advisor. In addition, the model policy indicates that it may be appropriate during the accommodation to offer ethics consultation to the family or another clinical opinion by a physician of the family's choice if the family is having difficulty accepting or understanding the diagnosis.

4)OPPOSE UNLESS AMENDED . The California Hospital Association (CHA) and the Alliance for Catholic Health Care West oppose

this bill and offer amendments to limit this bill and require that hospitals adopt a policy related to brain death, inform the patient's legal representative of steps that will be taken and provide the notice of the hospital's policy only on request from the patient's legal representative. According to CHA, member hospitals agree that family members must be notified in the rare event of the brain death of their loved

one. CHA reports that all hospitals currently make every effort to compassionately relay this information when necessary. Unfortunately, CHA contends that it is not always possible for hospitals to afford every family as long as they might want to gather and make arrangements for special religious or cultural ceremonies while the deceased patient is still on life support in an intensive care unit or other specialty unit of the hospital. While hospitals make great efforts to accommodate family desires to view the body or be with the patient when life support is discontinued, CHA states this might not always be possible if a particular family member is, for example, on a different continent at the time of death.

5) COMMENTS AND QUESTIONS .

a) Plan required . This bill requires hospitals to develop a plan specifically related to providing family or next of kin with a reasonable period of accommodation in cases of brain death. The author may wish to more closely mirror the CMA ethical guidelines and require that hospitals develop and implement a comprehensive policy related to brain death diagnoses, which, as one element, would include provisions dealing with the needs of family from the time of diagnosis through the discontinuation of life support.

b) Notice requirement . This bill requires the hospital to provide every patient, upon admission, a written statement of the hospital's plan or procedure developed pursuant to this bill. The author may wish to consider amending this bill to require that the notice be provided to family members once a patient has reach the point of an imminent declaration of brain death.

REGISTERED SUPPORT / OPPOSITION :

Support

None on file.

Opposition

None on file.

Oppose unless amended

Alliance for Catholic Health Care West
California Hospital Association

Analysis Prepared by : Deborah Kelch / HEALTH / (916) 319-2097