VA GREATER LOS ANGELES HEALTHCARE SYSTEM

A Division of VA Desert Pacific Healthcare Network

GLA POLICY

FEBRUARY 2014

DETERMINATION OF DEATH BY NEUROLOGIC CRITERIA (BRAIN DEATH)

1. PURPOSE: To establish and define a process for the determination of brain death at the Greater Los Angeles (GLA) Veterans Healthcare System. This policy will delineate a standardized clinical examination which will be documented through the electronic medical record (CPRS) and will comply with relevant California and Federal law and procedures.

2. BACKGROUND:

No specific Brain Death policy, per se, exists in VHA. However, VHA Handbook 1101.03, Organ, Tissue and Eye Donation Process, specifies that the criteria to be used by VA staff in determining death are established by State Law. The relevant California law is Health and Safety Code Section 7180. It defines brain death in terms consistent with the Federal Uniform Determination of Death Act, which has been used across the entire United States, and is consistent with our definition below. Further, it stipulates that there must be an independent confirmation of death by a second physician and that neither the physician making the determination nor the physician making the independent confirmation shall participate in the procedures for removing or transplanting any tissues and/or organs. There was an addition to this California Law, as defined in a California department of Public Health letter to general acute care hospitals on Brain Death Policy, of 1/30/2009, requiring all such facilities to adopt policies for providing a patient's family or next of kin with a reasonably brief period of accommodation after the determination of death, as well as several other requirements. Included among these other requirements are the need to give families copies of relevant policy if requested, as well as the hospital making some general, reasonable accommodation of families' religious and cultural attitudes and practices about death.

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3. DEFINITIONS:

A. **Brain Death**: This is synonymous with death by neurologic criteria or cerebral death and is defined as the irreversible loss of clinical function of the entire brain, including the brain stem, and is characterized by a) coma or unresponsiveness, b) absence of brain stem reflexes, and c) apnea.
B. **Reasonably Brief Period of Accommodation**: an amount of time afforded to gather family, next of kin and/or friends to the bedside of a patient declared brain dead.

C. **Attending Physician** – For the purposes of this policy, this will denote a staff physician working in the Departments of Neurology, Neurosurgery, Intensive Care Unit Medicine or the Surgical Intensive Care Unit; excludes any physician in training.

4. POLICY:

It shall be the policy of this medical center and its associated facilities to diagnose brain death, when clinically appropriate, through the use of criteria that have been established by the American Academy of Neurology. These criteria will form the basis for a "Brain Death Note" which will be entered in template format into CPRS, which will be done by two separate attending physicians from specific specialties only. Once diagnosed as brain dead, reasonable accommodations will be made to the family, as is consistent with California law. Nothing in this policy shall be construed to alter the normal procedures by which a patient is declared by cardiopulmonary criteria.

5. PROCEDURES:

A. Ordinarily, a patient for whom the diagnosis of brain death is considered will be cared for in the intensive care unit (ICU). If the patient is not in the ICU, he/she will be transferred there or the Emergency Department if no bed is available. A diagnosis of brain death should not be made in a ward or other non-ICU setting as all such patients will need to be on mechanical ventilation prior to the determination of brain death.

B. For medical patients, the Attending Physician will ordinarily be the ICU Attending. These patients should have Neurology or Neurosurgery consultation requested when the diagnosis of brain death is considered. The ICU Attending and Neurology/Neurosurgery Attending will undertake independent clinical examinations of the patient's brain function and will independently document their exams through Brain Death Notes, which each will write in CPRS. The content of the notes will include the exam recommended by the American Academy of Neurology, which was published in 1995, subsequently updated and widely disseminated. If the results of these tests are consistent with brain death, at least one of these two Attending Physicians will perform and document an Apnea examination using the same CPRS template note. Attending Physicians not belonging to either of these groups will not diagnose brain death or write brain death notes.

C. For surgical patients, the patient will ordinarily be co-managed between the surgical ICU staff and another relevant surgical service. It is expected that two Attending Physicians perform and document brain death notes, as above, to include at least one apnea examination, and that the Attending Physicians come from Surgical ICU service, Neurosurgery service or Neurology Service. Attending physicians not belonging to one of these groups will not diagnose brain death or write brain death notes.

D. The time of death will be officially determined based upon the time at which the arterial pCO2 rose above threshold during the Apnea test. If the Apnea test was aborted or

indeterminate, it will be determined as the time at which confirmatory testing was interpreted.

E. Pregnant patients who have been diagnosed brain dead or are in the process of a brain death evaluation will routinely be transferred to other medical centers where maternal-fetal medicine support is more routinely available.

F. Confirmatory testing for brain death, such as angiography, EEG or others, will be used at the discretion of the physicians determining brain death, and are not routinely required. They may be more indicated in the presence of severe facial trauma; preexisting papillary abnormalities; toxic levels of any sedative drugs such as, aminoglycosides, TCAs, anticholinergics, antiepileptic drugs, chemotherapeutic agents or neuromuscular blocking agents; or in the presence of sleep apnea or severe pulmonary disease resulting in chronic retention of CO2.

G. Attending physicians will utilize the Brain Death Note template in CPRS (attached) to document the clinical details of the clinical evaluations performed, as well as the apnea test.

H. After a diagnosis of brain death has been made and documented in the manner described above, the family will be explained the fact that the patient is brain dead (or has been pronounced dead by neurologic criteria.) If family request a copy of this policy, they should be given one. Reasonable efforts at accommodating the family's ability to gather at the bedside prior to the discontinuation of mechanical ventilation should be made if appropriate. It is expected that most efforts to accommodate such requests to gather should take no longer than 24 hours. In extraordinary circumstances, this may be prolonged further at the discretion of the attending physician of record, but under no circumstances should extend to weeks. Reasonable efforts to accommodate the family's religious and/or cultural practices regarding death should be explored and offered if appropriate. Consultation with the ethics advisory committee may be sought regarding this issue, especially if there is concern regarding whether or not a family's request is reasonable or not. During the period of time between the determination of brain death and the termination of mechanical ventilation, there is no obligation to provide CPR, ACLS or to otherwise escalate care.

6. <u>RESPONSIBILITIES:</u>

A. Chief of Staff: The Chief of Staff is responsible for ensuring that all service chiefs are aware of this policy and that an infrastructure is in place to support it.

B. Chiefs of Clinical Services- The chiefs of clinical services are responsible for promulgating this policy to their resident and attending physicians and for arranging teaching sessions, as needed, for their staff.

C. Ethics Advisory Committee- The Ethics Advisory Committee is responsible for general oversight of this policy and for providing teaching sessions on Brain Death policy and procedures, when requested for staff. The committee is also responsible for providing Bioethics Consultation when requested on individual clinical cases involving this subject.

D. Social Work Service- Social Work Service will be responsible for arranging meetings with family, as requested by clinical staff.

E. Attending Physician- Attending Physicians in ICU medicine, Surgical ICU, Neurology or Neurosurgery are responsible for performing clinical brain death evaluations, including apnea exams, as consistent with the American Academy of

Neurology's guidelines, and for documenting them in the attached Brain Death Note template. Other attending physicians will be responsible for making sure that they arrange for Attendings from one of these four groups to consult on this issue.

7. REFERENCES:

A. Organ, Tissue, and Eye Donation Process, VHA Handbook 1101.03
B. California Health and Safety Code, section 7180
C. California Department of Public Health Letter to General Acute Care Hospitals on Brain Death Policy of 1/30/2009
D. Practice Parameters: Determining Brain Death in Adults (Summary Statement).. Neurology 1995;45:1012-1014.

8. REVIEW DATE: Review as needed and reissue every three (3) years.

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Director