



CATHOLIC MEDICAL ASSOCIATION

Upholding the Principles of the Catholic Faith in the Science and Practice of Medicine

February 2, 2023

To: Members of the Uniform Law Commission

From: Craig Treptow, M.D., President, Catholic Medical Association

Re: Potential revision of the Uniform Determination of Death Act (UDDA)

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Over the past several decades, the UDDA has often been reputed to be the “standard of care” in the clinical conclusion that an individual is no longer alive. However, throughout its history, the UDDA has lacked sound science to support its use. Since the criteria recommended by the UDDA cannot be validated, their standardization is invalid. The American Academy of Neurology itself, the assumed arbiter of these guidelines, recognizes “severe limitations in the current evidence base”.¹ In light of these factors, on behalf of the Catholic Medical Association, I write to voice our strong concerns with any potential revisions to the current UDDA that will endanger our patients, their families, and the practice of medicine.

Of primary concern is the determination of death by neurologic criteria (DNC) as the sole criteria needed. A diagnosis of DNC does not equate with biological death. Whether bedside evaluation or ancillary testing is done, the accuracy of this assessment lacks scientific validity.² This is demonstrated by well-documented cases of recovery in previously DNC-diagnosed patients, as well as the wide variations in DNC determination nationally. Continuation of these clinical guidelines will not only harm our patients but will also continue to ignore the need for improvement in their assessment and treatment.

Without scientific support, any revisions of the UDDA would likely be a result of non-medical factors. If revisions allow physicians a more permissive role in the determination of DNC, the involvement of the families of the patients will be minimized if not ignored. Adequate time to address family questions, consents, and objections must be ensured. It would be a profound error to restrict this factor in a misguided attempt to protect physicians and hospitals from litigation.

Revisions to the UDDA would also raise concerns that DNC determinations are a means of rationing care. These patients require costly care, but that is

not justification for cavalier declarations of DNC to reduce costs. Doing so would be both discriminatory and unethical, as it prioritizes economics over patient rights and dignity. Of further concern is the racial disparity seen with DNC determinations, as African-Americans have “the highest rate of BD (brain death) per capita”.³

Circulatory deaths in hospitals are more than forty times more common than DNC determinations. However, according to Organ Procurement and Transplantation Network (OPTN) reports, organs are harvested from DNC patients at a rate more than twice that seen in circulatory deaths. Such a significant discrepancy raises questions regarding liberalization of DNC determinations simply to increase organ availability.

The issue at hand is not the definition of death, but the criteria. **DNC is not a diagnosis that can be made with certitude.** Since labeling a person as dead is self-fulfilling via withdrawal of treatment or organ harvesting, the criteria should be strict. The only true criterion of death requires the absolute and irreversible absence of respiratory and circulatory systems function.

If any UDDA amendments are to be considered, only two revisions are needed. First, informed consent *must* be required before assessment of possible DNC. Secondly, if the personal beliefs of the patient and/or family reject DNC on scientific, moral, or religious grounds, those beliefs *must* be respected.

Sincerely,



Craig L. Treptow, M.D.
President

¹Eelco FM, et al. 2010. Evidence-based guideline update: Determining brain death in adults. Report of the Quality Standards Subcommittee of the American Academy of Neurology. *Neurology* 74 (23) 1911-1918. DOI:10.1212/WNL.0b013e3181e242a8 (Reaffirmed July 16, 2022)

²Nair-Collins M and Joffe AR. 2021. Frequent preservation of neurologic function in brain death and brainstem death entails false-positive misdiagnosis and cerebral perfusion. *AJOB Neuroscience*. DOI: 10.1080/21507740.2021.1973148

³Seifi A et al. 2020. Incidence of brain death in the United States. *Clin Neurol Neurosurg* August 195:105885. DOI: 10.1016/j.clineuro.2020.105885