Summary of concerning language in proposed Uniform Determination of Death Language specific to:

- **(Section 4) Notification:** Before a health-care professional begins the clinical evaluation for the determination of death of an individual under Section 3(2), a health-care institution shall make reasonable efforts to notify the individual's surrogate that the evaluation will soon begin.

- **(Section 5) Time to Gather:** After the individual is determined to be dead under Section 3(2) but before discontinuation of circulatory and respiratory support of the individual, the health-care institution shall allow a reasonable amount of time for those designated by the individual's surrogate to gather at the individual's bedside.

- **(Section 6) Accommodation:** A health-care institution shall adopt a policy in a record that sets forth the reasonable efforts it will make to accommodate [the personal] objections by the individual to a determination of death pursuant to Section 3(2). Any such objections must be expressed in the individual's medical records or through information provided to the health-care institution by an individual's surrogate.

    - (1) The policy shall allow the individual to choose that a determination of death of the individual be made solely pursuant to Section 3(1).

    - (2) The policy shall provide that any objections be made before beginning the clinical evaluation for the determination of death pursuant to Section 3(2) must be made before beginning that determination.

Operational Concerns with **Notification**:

- Mandating medical practice within law imposes inflexible legal standard on administrative/medical decision making
- Creates additional hospital administrative burden on physicians and end-of-life care
- Inserts a delay of diagnosis or non-diagnosis of brain death

Operational Concerns with **Time to Gather**:

- Who is provided the right to gather? Who chooses who is included within the right? What does the hospital do if no one gathers?
- Creates confusion for families and misleads them that neurologic death is not the same as cardiac death. Contradicts "death is death" messaging
- Creates a mandate in an area where best practices have not been demonstrated to be problematic

Operational Concerns with **Accommodation**:

- Allows the ability to block a clinical diagnosis of neurologic death
- A surrogate could insert their "opinion" and prevent diagnosis of neurologic death without proof of patient's documented wishes
- No language ever proposed to allow for personal objection of cardiac death, this creates a double standard and confusion surrounding all forms of death

Overall Concerns of Sections 4, 6, and 6:

- Potentially usurps the roles of ethics committees, palliative care, and social work

- Section 4, 5, and 6 create an unnecessary confusion and administrative/financial burden and strain on hospitals and bottle necks the healthcare system requiring on-going critical care be provided to individuals who meet the legal definition of death
- What impacts would this have on availability of ICU beds?
- Who pays for the care provided to a brain dead decedent?

Potential Questions for Committee Discussion:

- What patient flow impacts and availability of ICU beds (scarce resource) would section 4, 5, and 6 have on hospitals and physicians administratively and financially?
- Who is responsible for paying for the extremely expensive critical care provided to a person who meets the medical and legal definition of brain death?
- In regards to "Time to Gather", who does the hospital provide the right to? Who determines who all of the family is included in this right? What happens if no one gathers?
- Would any physician or hospital ever refuse to declare cardiac death if those medical/legal criteria were met? Why is brain death/neurologic death being treated so differently?